Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public via Microsoft Teams
Wednesday 30 March 2022 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
	PRESENTATION Mental Health Adult Family Group Conference Service Dr Lynn Prendergast, Associate Director, Social Care Lyndsey Taylor, Team Leader MHFGC			
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 26 January 2022	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	Chief Executive Officer Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	PS	Attached	Noting
(b)	Learning from Deaths – Mortality Review Summary of Quarters 2 & 3 2021/22 information	NH	Attached	Noting
(c)	Views of Members & Governors Report	SS	Attached	Noting
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework 2021/22	PS	Attached	Approval
(b)	Standing Committees:			
	(i) Audit Committee (for January / March)	JW	Attached	Noting
	(ii) Finance & Performance Committee	LL	Attached	Noting
	(iii) Quality Committee	RH	Attached	Noting
	(iv) People Equality & Culture Committee	ML	Attached	Noting
(c)	Board Oversight Safety Group	AR-Q	Attached	Noting

9	**RISK ASSURANCE REPORTS**			
(a)	(i) COVID-19 Assurance Report	PS	Attached	Noting
10	**STRATEGIC INITIATIVES**			
(a)	NHS People Plan 2021/2022	SL	Attached	Noting
(b)	Mental Health & Community Health Services Transformation	AG	Attached	Noting
11	**REGULATION AND COMPLIANCE**			
(a)	Trust Constitution	SS	Attached	Approval
(b)	Safe Working of Junior Doctors Quarterly Report (Oct–Dec 2021)	MK	Attached	Noting
12	**OTHER**			
(a)	Use of Corporate Seal	PS	Attached	Noting
(b)	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
(c)	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
(d)	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
(e)	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
13	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
14	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
15	**DATE AND TIME OF NEXT MEETING** Wednesday 25 May 2022 at 10.00am			
16	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** 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 26 January 2022
Held Virtually via MS Teams Video Conferencing

Attendees:	
Prof Sheila Salmon (SS)	Chair
Paul Scott (PS)	Chief Executive Officer
Alex Green (AG)	Executive Chief Operating Officer
Prof Natalie Hammond (NH)	Executive Nurse
Rufus Helm (RH)	Non-Executive Director
Dr. Mateen Jiwani (MJ)	Non-Executive Director
Dr. Milind Karale (MK)	Executive Medical Director
Sean Leahy (SL)	Executive Director of People and Culture
Nigel Leonard (NL)	Executive Director of Major Projects
Manny Lewis (ML)	Non-Executive Director
Alison Rose-Quirie (ARQ)	Non-Executive Director
Amanda Sherlock (AS)	Non-Executive Director
Trevor Smith (TS)	Executive Chief Finance & Resources Officer
Janet Wood (JW)	Non-Executive Director
In Attendance:	
James Day	Interim Trust Secretary
Chris Jennings	Assistant Trust Secretary (Minutes)
Gina Trimble	Trust Secretary Coordinator
Clare Sumner	Trust Secretary Administrator
Marine Delgrange	Graduate Management Trainee
Johnny Townson	Senior Business Support Manager
Keith Bobbin	Public Governor, Essex Mid & South
Dianne Collins	Public Governor, Essex Mid & South
Pippa Ecclestone	Public Governor, West Essex & Hertfordshire (Deputy Lead Governor)
Paula Grayson	Public Governor, Bedfordshire, Luton, Milton Keynes & Rest of England
John Jones	Public Governor, Bedfordshire, Luton, Milton Keynes & Rest of England (Lead Governor)
Pam Madison	Public Governor, Essex Mid & South
Stuart Scrivener	Public Governor, Essex Mid & South
David Short	Public Governor, North East Essex & Suffolk
Paul Walker	Staff Governor, Non-Clinical
Judith Woolley	Public Governor, Essex Mid & South
Richard Woolsey	Mental Health Senior Oversight & Support Manager, NHSE/I

SS welcomed Board members, Governors and members of the public joining this virtual meeting. SS reminded attendees of Microsoft Teams meeting etiquette.

SS advised there would be no presentation at the Board meeting, which was a reflection on the pressures on clinical services and operational managers during the Level 4 incident caused by the Omicron variant. SS advised guidance had been published by NHS England / Improvement (NHSE/I) allowing organisations to streamline some governance processes during this time, which is reflected in the agenda for today's meeting. SS hoped the presentation would be reinstated for the next Board meeting.

Signed: …… Date: ……

In the Chair

The meeting commenced at 10:00

001/22 APOLOGIES FOR ABSENCE

Apologies were received from Loy Lobo, Non-Executive Director.

002/22 DECLARATIONS OF INTEREST

SS advised MJ had been appointed as a clinical consultant to the board at BT Global Healthcare. SS advised there was no conflict with the Trust and it did not affect his time commitment as a NED for the Trust. SS advised MJ had completed the relevant electronic declaration of interest and extended her congratulations to MJ for the appointment.

003/22 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held on the 24 November 2021 were agreed as an accurate record.

004/22 ACTION LOGS AND MATTERS ARISING

The action log for the meeting held on the 24 November 2021 was reviewed. JD advised due to the "Governance-Lite" approach to the Board agenda, the first action regarding a presentation from the Vulnerable Adults Service had been deferred until July 2022.

JD advised the second open action related to the Engagement Strategy which has been deferred until March 2022 due to the upsurge in the Covid-19 pandemic.

005/22 CHAIRS REPORT INCLUDING GOVERNANCE UPDATE

SS presented a report providing a summary of key headlines and information to be shared with the Board and stakeholders, and an update on governance development within the Trust.

SS advised the report was briefer than usual and this reflected the current period, with the CEO report providing more extensive information. SS was delighted to report that all CAMHS inpatient services are now open and admitting patients. The Trust had worked closely with the CQC and partners to drive standards forward and ensure safety was at the highest level.

SS summarised other sections of the report, including details of the "Board-Lite" approach and the appointment of the new Director of Corporate Affairs. SS advised one of the first tasks for the new Director would be to take forward a well-led review, which was due for completion this year.

On behalf of the Board, SS thanked JD for all his work over the past 18 months in supporting the Trust and ensuring it remained very well governed. SS advised JD would be retiring from the Trust in the next month to ensure there was a good handover with the incoming Director. SS wished JD well for the future and congratulated him becoming a grandfather. JD thanked SS and said he had enjoyed working at the Trust as a welcome and unexpected encore to a good working life. JD felt the Trust was an exciting place with a bright future and wished everyone in the organisation well.

The Board of Directors received and noted the report.

006/22 CHIEF EXECUTIVE OFFICER REPORT

PS presented a report providing a summary of key activities and information to be shared with the Board. PS advised the report was broken into three sections. The first section looked at key issues experienced over the period since the last report. The second section looked at strategic movement and the third section looked at key performance areas. PS advised he would cover the third section as part of the next agenda item relating to the Quality & Performance Dashboards.

PS summarised section one of the report. PS advised it had been a challenging period, including responding to the Omicron variant and the increase in the vaccination programme. This had caused an enormous strain on colleagues and patients, but he was delighted with the response. Everyone had been flexible and worked together under pressure during the period. PS thanked all colleagues, volunteers and patients who had helped the Trust during the period.

PS advised the Trust had to make compromises during the period, including delaying training, delaying annual leave and asking people to work in different environments. This would have an impact on performance metrics what the Trust is trying to achieve. PS advised the command structure was now focusing on recovery and plans were in place to cover key metrics and key environments for people, to ensure the Trust and people have a chance to recover.

PS reiterated the welcome for the new Director of Corporate Affairs and felt they would be an asset for the future. PS echoed the thanks for JD and thanked him for staying with the Trust and supporting it during the period. PS wished JD well for the future.

PS summarised the second section of the report. PS advised he hoped to be able to announce the appointment of a new Executive Director of Strategy, Transformation and Digital in the near future, with the recruitment process still taking place.

PS advised there had been a large amount of work undertaken, led by AG, across the community collaborative, including the creation of virtual wards. The virtual wards created the equivalent of 200+ beds and allowed people to stay in a better environment at home, whilst supporting acute hospitals during this difficult period.

PS provided further details of investment in community mental health teams and the CAMHS inpatient recovery. PS highlighted the exciting plans that were ready for approval including the Trust was reinvesting in people and processes in the ward environment. He provided further detail in relation to NHS integrated care.

MK provided an update regarding Mental Health Diversion Services. MK advised the service had been established in light of the pressures on acute hospitals and trying to reduce the pressures on A&E services. The service allowed mental health patients to be assessed outside the A&E environment, and work had been undertaken to establish a service at Basildon Hospital. MK advised the service had been set-up in a matter of weeks, rather than months. This was thanks to Clinical and Estates colleagues. The service would be operational from the 1 February 2022.

SS thanked PS for the report and echoed the points made around individuals responding to the challenges. This exemplified the approach to ensuring action is taken around patient / service needs.

JW commented there had been a good level of engagement and reflection with NEDs and Executive Directors throughout this period, which was highlighted by the reduced need for questions from the NED team. Discussions had been held at informal briefings and standing committees, so nothing in the report was a surprise and NEDs had welcomed the opportunity to query and challenge during these informal sessions.

MJ reflected on staff feeling optimistic in relation to the pandemic and hoped this could be maintained. Staff had been consistently working over the period and it was important to care for staff who may be feeling exhausted at this time. MJ highlighted some reflective commentary on the regional landscape and the Trust as a key system player. MJ asked whether the Trust was listened to, and where it fitted within the system.

PS advised the whole health and care system had been under enormous strain. This included pressures on hospitals and social care made more difficult with additional staffing problems. There was an enormous pressure from demand and it tested relationships when under strain. The work undertaken within the community collaborative had allowed the Trust to respond impressively when requested by the acute sector. This included improving discharge, relationships, infrastructure and virtual wards. There was a good dialogue with social care when discharging patients. PS advised there were still challenges to ensure the right people were part of the discussions. There would be learning as a result of the pandemic, with investment helping responsiveness, but there would still be much to learn.

AG advised this had been a significant period of learning through surge planning. The Trust had learned the thresholds that could be tested for community services and the level of acuity not usually held, with support from acute services. There had also been learning in getting things done quickly and being able to navigate through bureaucracy in the system. It was important these lessons are not lost during the recovery phase. SS agreed working together in a prompt way must be built upon. The key point of learning was to take part and be a key influencer within the system.

PS agreed learning was key and Executive Directors continue to be engaged with the system. He thanked MK for setting-up the Mental Health Diversion service so quickly.

The Board of Directors received and noted the report.

007/22 QUALITY AND PERFORMANCE SCORECARD

PS presented a report providing a high level summary of performance against quality priorities, safer staffing levels, financial targets and NHSI key operational performance metrics and confirmed the quality / performance “inadequate indicators”. The scorecards also drew attention to the key issues that are being considered by the standing committees of the Board. The presentation of the report was combined with the section three of the CEO report, with each Executive Director providing a summary for their remit.

NH provided an update in relation to quality and safety. NH advised the annual review of the safety strategy was on the agenda and therefore would not go into too much detail within her section as it would be covered later in the meeting. NH summarised the work of the ESOG and advised a fifth priority regarding inpatient flow, had been added. NH advised the meeting works at pace by reviewing the priorities on a weekly basis and identifying action to lead to good outcomes. NH provided an overview of the work underway regarding inpatient flow and capacity, including sitreps, SMART tool and the aim to eliminate out of area placements. The work of the group had been challenged by the Omicron variant, but despite the pressure and pace it was looking to achieve the anticipated trajectory by the end of March 2022.

MK provided an update on the work around flow and capacity. MK had raised issues in the past regarding patients with personality disorder and the Trust has large inpatient bays, but also had out of area placements and bed occupancy higher than the national average. There was a risk of institutionalisation for individuals with personality disorder being on an inpatient ward for a long period of time. A protocol had been developed, working with psychological and medical colleagues, which was shared with clinical colleagues and was now being shared with patient forums. The new

protocol will have an impact on patients and length of stay. There is a priority on flow and capacity which links with the work being undertaken by AG around purposeful admission.

PS thanked MK for referring to the personality disorder pathway and it was clear everyone was contributing to the different priorities. These were having an impact and there was good level of progress. There was now a move towards delivering on the priorities and understanding the impact. There are a draft set of outcome measures being developed which allowed the impact of the work being undertaken to be measured.

ARQ commented the BSOG had not met over the last two months due to the challenges of the Omicron. Despite this, updates were received from Executive Directors to ensure priorities were being progressed. There was lots of work happening regarding the safety agenda, despite the challenges being faced and other transformation work. ARQ felt it was important to acknowledge this and the fact there had been positive movement within the patient safety agenda.

ARQ commented one of the updates received the previous week related to the target of eliminating out of area placements. The target at this point was given as the end of January, which appeared ambitious, and the target stated in the report of March 2022 was more realistic. ARQ asked if the revised timescale would cause any problems with system expectations.

AG advised it was correct the target had shifted, but was pleased to report the Trust was on target as of today. There were 24 patients out of area as at yesterday, which was expected as the Trust moves out of the pandemic surge and can have a renewed focus. The plan for out of area placements was a system plan and there was acknowledgement there will be a level of unpredictability moving forward.

AG provided an update in relation to operations. AG advised the work undertaken before Christmas was around surge planning in preparation for Omicron. The robust plan meant the Trust did not pause or cease any services during this time, with delivery maintained throughout the period. The Trust had played a pivotal role in helping acute patients care for people at home. AG advised performance had remained stable although there has been some impact. There had been a decline in CPA reviews, which was related to staff sickness and prioritisation during the Omicron, but a recovery plan was in place. AG was happy to report the amount of areas requiring improvement had fallen.

AG identified specific areas relating to inpatient performance. For Adult / PICU occupancy was falling and was below the national average. This was impacted by some beds being closed during the pandemic, and the surge plan focused on ensuring the occupancy levels were safe. Average length of stay rose and continue to be outside the national framework. There were some outliers that have impacted, including 5.7% delayed transfers of care, however this is continuing to fall. AG reported that five patients where care had been delayed had now been transferred. The flow and capacity work project under the safety strategy would focus on delayed transfers of care regarding visibility and work around personality disorders / purposeful admissions.

TS provided an update in relation to finance. TS advised that financially, the Trust remained on target year to date and was slightly ahead of last year in terms of capital investment. This was always a challenging time of year in ensuring the delivery of year end targets, planning and budget setting. Planning guidance is emerging and the setting of operational plans / budgets for next year is underway. SS commented the Board had been kept very well briefed during this challenging period.

PS advised there had been an improved profile relating to capital spend, with 50% spent in month 9 compared to 30% at this stage last year. The Trust was confident in reaching targets because of the frequency of the Capital Planning Group and the regular release of allocations at an earlier part of the year. The membership of the group had also been enhanced and there was regular dialogue

with system colleagues. There was still more to be done as the year end approached and to plan over a longer term of around 3-5 years, which would allow a smooth level of investment across the year. TS thanked JW and ML for regular informal time to allow subjects to be explained and scrutinised.

AS commented with reference to the 3-5 year planning. There had been conversations about the fitness for repurpose review of the Trust estate. AS asked for a short update on these proposals. TS advised a 6 facet survey had already been completed, which was helping to inform the work to review the estate going forward. There was also further work commissioned regarding site utilisation, in terms of how the Trust used its sites. TS advised an updated report would be presented to the Executive Team, Finance and Performance Committee and then the Board of Directors. AS felt it would also be helpful for the People, Equality and Culture Committee to have oversight / involvement as the work around workforce models and clinical care would relate back to the estate. TS agreed and confirmed it needed to be service / operationally driven, which then drives the estates work.

ML was happy to have received assurance from TS regarding the capital programme being delivered, as it was good to have endorsement in addition to the ECFO. ML asked what the process would be for moving to final budget setting following the receipt of planning guidance. There are still a number of challenges, such as international recruitment, projects and new delivery structures and ML asked how this would move from where it is now to the 1 April 2022. TS advised this would be taken forward through the planning steering group and weekly report to the Executive Team. TS provided details of work undertaken, including the establishment of a multi-disciplinary group, communication to remind people of the importance of signing-off budgets, and informal sessions with NEDs alongside formal sign-off. TS advised there was a likely need to request delegated authority and the team are currently working through the timeline for this. The timelines were tight and challenging, but there was both internal and external support to ensure these are delivered.

NL provided an update in relation to major projects. NL advised the vaccination programme was going through a very busy period since the government announcement on the 12 December 2021 to double the capacity. NL advised the Trust had been able to achieve this by extending opening hours and opening two additional temporary centres, both within a week. The Trust had been supported by a range of partners, including the military, fire service and other voluntary agencies, which so far had allowed the delivery of over 1m vaccinations.

NL advised there had now been a rapid drop in the level of demand, but the Trust has been asked to keep centres open for the current time. The attention was now turning to 12-15 year olds and there is a very active programme across Bedfordshire, Essex, Luton and Milton Keynes. The Trust has also made significant contributions in Suffolk as the company delivering the programme was struggling to fulfil demand and had requested assistance. NL advised the situation remained busy and awaited the next steps for the programme.

SS commented that there had been interest from Governors regarding the impact on staffing caused by the mandatory vaccination requirement from the 1 April 2022. SS asked whether any indication could be given as to the level of impact on the Trust. SL advised he would cover this in his section regarding workforce.

PS commented the level of flexibility shown by staff, partners and volunteers could not be underestimated. The scale of movement over weeks has been impressive. PS asked for more detail on the future of vaccinations as there appeared to be a level of uncertainty. NL advised it was unpredictable and each time consideration is given to moving to business of usual something changes. The Trust had been reviewing sites to determine which to keep open, but the Omicron variant changed the approach in a rapid way.

SL provided an update in relation to people, culture and employee experience. SL thanked the workforce for their efforts during the pandemic. SL advised he had been nervous at the beginning of the Omicron wave in relation to staff sickness, but the Trust continued to be the lowest reported sickness rates across the region. There had been slippage with mandatory training, but a recovery plan was in place and there is confidence this will return to normal levels.

SL advised the time to hire had considerably dropped and although there had been a slight rise in December, the overall time was still 20 days lower than in October 2021. The NHS people plan shows the Trust is trending as green across the NHSE/I people strategy.

SL provided an update in relation to vaccinations being a condition of employment in the NHS, which covered the query raised earlier. SL provided details of staff at the beginning of the process requiring their vaccination status to be reviewed / validated. This had reduced significantly, however, there were still a number that required review / validation but this is reducing on a daily basis. SL provided details of the number of staff requiring validation that could affect inpatient services and this was being monitored. Calls were taking place to individuals whose vaccination status is not known and new data was being drawn from different sources where the information may be stored. He did not feel there would be a significant issue and was positive about the workforce commitment to be vaccinated.

ML thanked SL and team for the work undertaken in relation to the vaccination validation programme. This was a stressful time across the NHS and there had been staff protesting against the requirement of vaccination as a condition of employment as being a breach of human rights. ML commented the requirement would likely apply to volunteers, which was concerning considering the importance of volunteers to the Trust. SL advised the issue of volunteers was being handled in the same way, with the programme team looking at how data can be gathered for all volunteers. There was still work to do with volunteers and individuals from other organisations, but the focus at the moment had been on the workforce to ensure the Trust can continue to provide safe services. NL advised all volunteers working within the vaccination centres had been vaccinated and there is an open offer to all staff to be vaccinated. When vaccination staff attend an inpatient area to vaccinate patients, staff are invited to also receive the vaccination if they have not already.

ARQ commented on the achievement in relation to staff being vaccinated as this was contrary to what was being reported nationally regarding staff leaving the NHS. ARQ commented the report provided information regarding starters, but did not provide a lot of information about those leaving the Trust. SL suggested reviewing information about starters and leavers outside of the meeting as the number of leavers was low. ARQ agreed with this.

ARQ noted the length of suspensions had been included in the report, which was something previously requested. However, she noted the length of suspensions included 21 weeks, which appeared to be a very long time. ARQ queried whether this needed to be reviewed to see how the process was being managed. ML agreed it was an area of concern and there was a key performance indicator monitored at PECC. There would need to be a deep dive undertaken, not just about length of suspensions, but also about the impact on diversity, such as the over representation of BAME staff in those being suspended.

SL advised that when a suspension gets beyond 3-months, it usually meant there was a criminal investigation. SL advised that work had been done which had seen the length of suspension reduce and was confident those suspended for a longer time is for a reason, such as a criminal investigation. SL advised this would be closely monitored to ensure people are not remaining suspended, unless there is a good reason.

SS had picked up a comment made from the public audience which was relevant, which related to international recruitment and vaccinations. SS asked whether individuals vaccinated in their native

country will have that accepted in terms of condition of employment. SL advised work had been undertaken to ensure their vaccinations are recognised in the UK and if this is not the case, they will be quickly vaccinated to ensure they are able to work.

MK advised the Trust had recruited six international doctors and this had eased the pressure on services. There was a full cohort of junior doctors, however, there were gaps in senior trainers. The six new trainees include a senior doctor in CAMHS which would provide support in this area.

PS summarised the report in relation to the response to the vaccination programme and Omicron surge. The Executive Team had been transparent about the pressures and have been able to collectively work through these and kept members of the Board informed. PS thanked all members of the Board for their help and support during the difficult period. SS commented the response exemplified the unitary board and was impressed by the level of discussion in relation the report.

The Board of Directors received and noted the report.

008/22 PATIENT-LED ASSESSMENT OF THE CARE ENVIRONMENT (PLACE) 2021

TS presented a report providing the results of the PLACE-Lite inspections for 2021/22. TS advised the results had been presented to the Council of Governors and comments had been included in the action plan developed from the results. The action plan was in the process of being updated and refreshed. TS advised the management of PLACE was being handed over to patient experience and there was also a lessons learnt review from the process. The importance of focusing on the patient's experience of Trust environments was noted. It was important there was continuous improvement across the PLACE domains with regular oversight of this through a standing committee. SS commented the plan could be brought to a joint reflection session with Governors in the future.

AS commented she was surprised to see a decline in the results in in relation to cleanliness, especially because of the national focus in this area. AS felt this was a challenge to the Trust as it was important this area does not deteriorate. NH advised there had been increased requirements around cleanliness and was being monitored to ensure infection prevention and control (IPC) policies and guidelines are followed. The audits undertaken by the Trust have suggested cleanliness is good, so it was important to act at pace to ensure where issues with cleanliness are identified, these are rapidly resolved. TS advised there was always more that could be done in these areas, such as decluttering, cleaning practice and new technologies. These areas will continue to be a focus.

SS suggested once the NED and Quality Visits programmes are reinstated, cleanliness could be an area of focus.

RH commented the report was interesting and noted the results relating to Clifton Lodge. RH felt the results suggested the unit was trying its best, but was struggling with the environment in terms of cleanliness, privacy and dignity. RH asked what the plans were for addressing the issues. TS advised he would need to follow this up outside of the meeting and provide a briefing note to Board. RH agreed with the approach and felt it was important as there would likely be an inspection by the CQC.

The Board of Directors received and noted the report.

Action:

1. **Review PLACE-Lite results relating to Clifton Lodge and provide an update on the plans to resolve the issues. (TS).**

009/22 APPROVAL OF CHARITY ACCOUNTS 2020/21

TS presented a report providing the final Charity Annual Report and Accounts for 2020/21 for approval. TS advised the independent examination completed by the External Auditors resulted in an unqualified opinion. The accounts showed a good level of donation and an improved level of expenditure. The Board were also asked to approve the Letter of Representation for signing on behalf of the Board by the ECFO and Chair of the Audit Committee.
MK commented it was good to see innovation in spending and identifying funding.

The Board of Directors received, noted the report and approved:

1. **The final Charity Annual Report and Accounts for 2020/21.**
2. **The signing of the Letter of Representation on behalf of the Trust.**

010/22 UPDATE ON CHARITABLE FUNDS ANNUAL BIDDING PROCESS

TS presented a report advising upon the outcome of the annual general bidding process against Charitable Funds and requested the approval of two bids in excess of the Committee's delegated authority. TS advised the positive approach to identifying funds, (whatever the source had been illustrated in the report. There were two high value items requiring Board approval outside the Charitable Funds Committee delegated authority.

TS advised there had been two bids rejected, one of which had been fed into operational plans and the second had not been progressed due to safety issues identified. TS advised the report was encouraging because it reflected people requesting monies and bids progressing. AS agreed this was a positive outcome of the report.

The Board of Directors received, noted the report and approved:

1. **The bid totalling £12.5k for Clifton Lodge**
2. **The bid to be submitted to NHS Charities Together totalling £68k to be funded via a Stage 3 grant.**

011/22 BOARD ASSURANCE FRAMEWORK 2021/22

PS presented a report providing the January 2022 iteration of a refreshed Board Assurance Framework (BAF) for noting and approval of recommendations made on behalf of the Executive BAF sub-committee. PS advised there were two aspects of the report, regarding the presentation of risks and the new BAF layout, which he hoped would be more accessible.

PS advised the strategic risks had been revised to fit with the new strategic objectives, to ensure better links can be made between the strategic objectives, plans and risks. PS advised the key risks related to people, demand and capacity and there were good plans in place to ensure these improve over-time. This will be monitored via Executive Team and Board.

PS advised there was more to do and the BAF would always be developing. The next phase would be to drill down into the organisation from Board to Ward, which will be taken forward by Nicola Jones with support by the new Director of Corporate Affairs.

JW welcomed the new format and advised this had been presented to the Audit Committee to be extensively tested to ensure it was fit for purpose. JW queried the risk SR6 Cyber Attack which had been highlighted in the report. JW queried whether anything specific had happened to escalate this risk. The Audit Committee was currently looking at internal audit around this, so would be good to know if anything more needed to be done.

TS advised the Trust had been subject to a high level of care certificate notifications relating to increased adverse cyber activity. The Trust had engaged with this and had taken active steps to ensure the Trust is safe. The Trust is not alone as there had been an increased level of activity across services nationally. The Trust has Cyber Essentials Plus, but the escalation of the risk shows the Trust takes the matter seriously.

The Board of Directors received the report and:

1. **Noted the decisions made by the Executive BAF Sub-Group at its meeting in December 2021 (Section 6.0)**
2. **Noted the Board Assurance Framework Dashboard in Section 2 for December 2021 and January 2022 (Section 6.0)**
3. **Noted the risks linked to Strategic Objectives in Section 3.**
4. **Noted the key risks in Section 4.**
5. **Noted the Strategic Risks and Milestones in Section 5.**
6. **Approved the new strategic risk SR6 Cyber-Attack (Section 2 with further detailed descriptor in Section 4).**
7. **Approved increased and decreases in scores on corporate risks. (Section 2).**
8. **Approved the merger of CRR85 and CRR86 (Section 2).**

012/22 STANDING COMMITTEES

(i) Board Safety Oversight Group

ARQ provided a verbal update regarding the Board Safety Oversight Group. ARQ advised the group had not been able to meet, but assurance was provided items were still being monitored and the Group kept informed.

The Board of Directors received and noted the verbal feedback.

(ii) Charitable Funds Committee

AS presented a report providing assurance that the duties of the Charitable Funds Committee had been appropriately complied with and adhered to.

The Board of Directors received and noted assurance provided.

(iii) Finance & Performance Committee

ML presented a report on behalf of Loy Lobo providing assurance that the Finance & Performance Committee was discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objectives and impact on quality were being managed effectively.

ML highlighted the Committee had considered the award of a contract to EPUT in relation to the Lighthouse Child Development Centre. ML advised a further report would follow and assurance was needed in relation to the risks and challenges of the contract. SS confirmed a report was being presented to Part 2 due to its commercial nature of the report.

The Board of Directors received and noted assurance provided.

(iv) People, Equality & Culture Committee

ML presented a report providing details that the People, Equality & Culture Committee is discharging its terms of reference and delegated responsibilities effectively and that risks that may affect the achievement of the Trust's objectives are being managed effectively.

ML highlighted the work of patient experience and the very impressive suite of reports presented to the Committee. This included reviewing complaints, volunteer policy and driving forward recruitment for volunteers.

The Board of Directors received and noted assurance provided.

(v) Quality Committee

RH presented a report providing information relating to discussions that have taken place at the Committee, inclusive of assurance given from all accountable sub-committees, performance dashboards inclusive of challenge and mitigation against risks.

RH highlighted an approach made by Mid & and South Essex regarding having a potential representative on the Committee. This was currently being discussed.

The Board of Directors received and noted assurance provided.

(vi) Audit Committee

JW provided a verbal update in relation to the Audit Committee meeting, as the meeting had been held after the deadline for Board papers had passed. JW advised a full report would be provided at the next meeting in March 2022.

JW advised the Committee had reflected on the internal audit reports and recommendations. There were some recommendation that were long standing and the Committee agreed there needed to be a response in terms of whether the recommendation had been completed or would not be taken forward after all because of changed circumstances. It was intended the recommendations would be resolved by March to ensure the internal audit position was ready for any well-led review.

SS reflected on the Board-Lite approach and how it had been managed with the Standing Committees. It was important to ensure a good level of scrutiny and challenge was maintained during the pandemic. SS was happy the standing committees had continued to meet and were connecting with the Board. PS advised the command structure had agreed to a reduced agenda and reduced attendance, with a view that important items of risk and safety would still be taken forward. PS advised he had attended PECC and the agenda was "lite" but still covered a number of items. The Executive groups had continued to take place on a weekly basis, with more focus given to supporting during the pandemic. It was important to ensure the performance report going forward reflected the impact of the pandemic and the next report would consider the command structures in place and how these would be taken forward.

ML advised both PECC and F&P had been intensive meetings as the items had allowed a more in depth review of key issues. RH agreed and thanked sub-committees for report to the Committee, which showed the meetings were still happening as needed.

013/22 RISK ASSURANCE REPORTS

(i) Covid-19 Assurance Report

PS presented a report providing assurance in relation to action taken in response to the Covid-19 pandemic. PS advised the report was a distillation of the work undertaken throughout the pandemic and was for noting.

The Board of Directors received and noted assurance provided.

014/22 SAFETY FIRST, SAFETY ALWAYS: 12 MONTH UPDATE REPORT

NH presented a report providing 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. NH advised she was pleased to present this as a first anniversary report and noted the challenges faced over the past year as discussed during the meeting.

NH advised the report focused on the quality outcome measures presented to the Board of Directors last year and recaps the ambition set-out at that point in time, which was to be the safest organisation and live and breathe "safety first, safety always". NH confirmed the Trust had achieved the majority of urgent areas identified and there were other items still ongoing, which was as expected.

NH noted some of the improvements to staff experience, patient experience and improved outcomes, but also highlighted some of the risks, such as the increased demand in services. The pandemic had been a challenge, but it had also allowed the Trust to move at pace and innovate in a number of areas. It is not yet possible to quantify the impact of Covid-19 in the longer term.

NH noted some of the improvements highlighted in the report, which were quantified by data and the movement towards a good learning culture. The delivery of the mass vaccination programme had affected some areas, and whilst safeguarding training compliance had been maintained, there was also an increased workforce that required training. NH summarised the report noting it was the first year of a three-year strategy and therefore there was still more work to be done. The focus now was on acquiring deeper and broader data to support the strategy. NH finally summarised some of the improvements demonstrated are due to the use of quality improvement methodology, technology and the close relationship between patients and staff.

RH commented the report was well written, clear and transparent, however, there was one area regarding the reporting of preventable deaths he wanted to query. RH noted that for most of the metrics the data was up to the end of 2021, however, for preventable deaths the data was only up to March 2021. RH asked whether there was a reason behind this. NH advised the preventable death metric was driven by the mortality process, which was a lengthy process prescribed to the Trust. The process looks at certain deaths and complete investigations, await coroners outcomes etc. which creates a delay. NH advised one of the areas requiring more breadth related to the Patient Safety Incident Reporting Framework (PSIRF) which would give clearer information on outcomes and learning. The Trust is an early adopter of the framework, which means the metrics are not yet available, but once developed will give better information on safety and mortality.

ARQ commented the data and downward trends would likely be skewed by the reduced occupancy. ARQ asked whether a proportionate analysis could be undertaken to incorporate the reduced occupancy. If this was not possible, could a proviso be included in the report to note the reduced occupancy. NH agreed the longevity of the data did show peaks related to occupancy. However, Trust services were in full demand despite being reduced in some areas. Areas such as prone restraint have moved consistently downward throughout the year, despite the different challenges throughout the year. NH suggested being clearer on benchmarking against other Trusts and providers, as all would have been impacted by the pandemic. ARQ suggested the data may stay at

the same level going forward rather than continuing on the downward trend as services recover. SS suggested this should be closely monitored within the BSOG.

PS commented the report was well-written and noted the team effort in within the Trust in making improvements. The broad range of metrics illustrated contributions from all the Executive Team remits. The ESOG would continue to focus on the strategy and look at new strands of work to improve patient experiences. PS agreed there would be an impact following the pandemic, but this is not yet reflected in the report. The Trust would be looking at how the impact could be measured and including in next year's report.

MK commented the strategy brought everything together in one place and made it relatable to clinical and medical staff.

SS reflected on the key achievements noted in the report. NH advised the next steps were to communicate the achievements back to staff and ensuring these are celebrated, whilst also pushing the safety always agenda.

015/22 USE OF CORPORATE SEAL

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

016/22 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

There were no items of correspondence circulated to the Board.

017/22 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.

018/22 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

ML reflected on the diversity of the Board and showed all the influences and reflections throughout the meeting. The discussions and reports showed the focus on patient experience, with the breadth and diversity of services and service users. ML felt the equality and inclusion was fundamental to the Board, which was reflected through the agenda.

019/22 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

The Board of Directors confirmed all members remained present throughout the meeting and heard all discussions.

020/22 ANY OTHER BUSINESS

There was no other business.

021/22 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 30 March 2022, which will be held virtually via Microsoft Teams.

022/22 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.

Appendix 1: Governors / Public / Members Query Tracker (Item 022/22)

Governor / Member / Public	Query	Response provided by the Trust
John Jones, Public Governor, Bedfordshire, Luton, Milton Keynes and Rest of England (Lead Governor)	The Annual Staff Survey participation rate is 47% (see page 34), which must be one of the worst figures recorded. What plans are there in place to improve this for next year? It may be that Governors, particularly staff governors, have some thoughts	**Sean Leahy, Executive Director of People & Culture:** SL advised the more staff were surveyed this year than in previous years. There had been an expectation of a slight drop in the number of respondents, due to the survey taking place throughout the pandemic. However, the number of individuals completing the survey had increased, although the overall percentage had dropped. This would be taken forward to improve engagement with staff regarding the survey.
	ALoS figures show a target of <35, and currently run at 54. This is consistently and long term well above target. What underlying factors are the causes of this and what is being done to resolve this problem?	**Alex Green, Executive Chief Operations Officer:** AG advised this had been covered during the CEO report / quality dashboard discussion. The overarching work regarding purposeful admission and personality disorder should have an impact in this area. The level 4 impact will also have an impact, but the plan in place should bring this into line with the benchmark over a period of time. The Executive Medical Director is a co-sponsor of the plan, so there is good oversight in this area.
	May I congratulate the significant reduction in prone restraints showing in the Safety Report, currently reported as less than 5. This is a remarkable achievement and shows the value of concentrating on a particularly difficult area.	N/A
Stuart Scrivener, Public Governor, Essex Mid & South	**Agenda item 6, 2.1 continued development of MH services.** As Governors are looking at our community's issues, can we have an idea, fuller explanation, of what is on offer?	Stuart Scrivener was happy the question had been answered during the meeting.
	Agenda item 6, Mandatory Training Are NED's comfortable with the mandatory training level achieved? Safeguarding below 90% sounds like a problem to me.	**Sean Leahy, Executive Director of People & Culture:** SL confirmed mandatory training figures had dropped, but these are being monitored as part of the Trust recovery plan to ensure these improve.

Signed: …… Date: ……

In the Chair

Governor / Member / Public	Query	Response provided by the Trust
		Amanda Sherlock, Non-Executive Director: AS advised safeguarding training was one element which is reviewed as part of competency and capability. It is also looked at as a result of anything escalated via Mental Health Act Managers, incidents etc. There are mitigations in place to ensure there are staff on shift trained in safeguarding on a 24/7 basis.
Pippa Ecclestone, Public Governor, West Essex & Hertfordshire (Deputy Lead Governor)	In the CEO Report Page 10/11 EMPLOYEE RELATIONS HIGHLIGHTS: Reference to ***TEMPORARY workers….***what is meant by this term? [?agency/bank/?]	**Sean Leahy, Executive Director of People & Culture:** SL advised temporary staff refers to staff who are either bank, on a fixed term contract or agency staff.
	"Workforce Leadership chart" Temporary staff. Rated GREEN **but** figures + orange dot = *special cause of concern* since April 2021?	**Sean Leahy, Executive Director of People & Culture:** The oversight framework does not set a target for this indicator. Whilst the performance is outside of expected limits we know this is due to staffing pressures and vacancies. Internally we flag this as an item requiring improvement but for the oversight framework perspective it is not breaching any target.
	How many patients are in the 3 CAMHS wards this week?….great news that they are all open.	**Denise Cook, Director of Specialist Services:** On the 26 January 2022 the Trust had 10 beds occupied on Poplar Unit, 5 on Longview and 4 on Larkwood.
	Follow-up questions received following the meeting seeking clarity on certain aspects of the Safety Strategy report.	Meeting held with Natalie Hammond, Executive Nurse and information provided clarifying the aspects of the report.
Pippa Ecclestone, Public Governor, West Essex & Hertfordshire (Deputy Lead Governor) Paula Grayson, Public Governor, Bedfordshire, Luton,	Understand pressures on CPA. Can we have some idea of risks on patient experience and safety?	**Alex Green, Executive Chief Operations Officer:** AG advised there had a dip in performance over two-months which correlates with staff sickness and the Omicron surge. Assurance was given that this was being managed robustly, with staff proactively investigating and flagging any breaches. Deep dives are being undertaken for any services dropping below expectation.
	Understanding the pressures leading to the reduced performance on CPAs for service users who should be assisted through these, please can we have some idea of the potential	

Governor / Member / Public	Query	Response provided by the Trust
Milton Keynes & Rest of England	risks for these service users around their patient experience and safety?	Supervision of staff also identify any issues and allows dialogue with staff members. The discussion would include checking the risk assessment has been completed and any risks have been managed. The Accountability Framework also supports this process.
Paula Grayson, Public Governor, Bedfordshire, Luton, Milton Keynes & Rest of England	Earlier, Milind referred to a "Patient Forum". Please can someone elaborate on how that Forum carries out tasks and where there are examples of co-production please	**Dr. Milind Karale, Executive Medical Director:** MK advised the forums are coordinated by the Patient Experience Group and are overseen by the Patient Experience Team. One group relating to Personality Disorders has input from psychology services, but all are overseen by the Patient Experience Group.
	While accepting the need for Executive Directors and staff to be delivering outcomes during the pandemic, if all the Board Standing Committees are reduced in content, attendance and scrutiny, what assurance can we have that the governance of our activities is still proportionate and safe?	This was answered during the meeting, in relation to Standing Committees continuing to meet and ensuring no deferred items created and risk or impacted safety.
	Please can we have a little more information about the practicalities underpinning the ambition to have all our front-line staff fully vaccinated by 1 April 2022?	**Sean Leahy, Executive Director of People & Culture:** Further to the announcement by the Secretary of State on 31 January 2022, and on advice received from NHSE/I, the Trust has paused progression on the implementation of the Vaccination as a Condition of Deployment (VCOD) Regulations pending the Government consultation and Parliamentary process to review these.
Paul Walker, Staff Governor, Non-Clinical	Is it definitely confirmed that all EPUT volunteers will be required to be fully vaccinated? This did not initially seem to be the case – although I thought this would become so.	**Nigel Leonard, Director of Major Projects:** Yes if implemented this would apply to volunteers in vaccination centres We are checking and validating now. As you will recall all staff and volunteers were offered vaccinations on starting with the vaccination centres. .
	One of our long term EPUT chaplaincy volunteers has copied me in to an email to his local MP, sent on 23rd Jan, flagging up his concerns regarding being told by EPUT that he	**Sean Leahy, Executive Director of People & Culture:** The Trust values and appreciates the significant contribution of our chaplaincy volunteers.

Governor / Member / Public	Query	Response provided by the Trust
	will need a first dose by 3rd Feb and fully vaccinated by 1st April. This gentleman has been a very helpful volunteer for several years and a local service user – I am aware of at least one other volunteer who will also not be willing to be vaccinated	Further to the announcement by the Secretary of State on 31 January 2022, and on advice received from NHSE/I, the Trust has paused progression on the implementation of the Vaccination as a Condition of Deployment (VCOD) Regulations pending the Government consultation and Parliamentary process to review these. The Trust supports that vaccination is the best way to protect ourselves, our families, our colleagues and our patients from the virus and we will continue to encourage and engage with our workforce and volunteers on vaccination uptake.
	If we do have to ask former volunteers to cease due to none vaccination – could some recognition / gift be arranged?	**Nigel Leonard, Director of Major Projects:** As part of the Vaccination programme we are completing a project to capture the Trust's timeline and social history of the vaccination programme. This is at an early stage but we would aim to make this memento available to all staff. We are also preparing a draft letter for staff/volunteers who have worked on the programme.

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 26 January 2022)

Lead	Initials	Lead	Initials	Lead	Initials
Trevor Smith	TS	Sean Leahy	SL		
Trust Secretary's Office	TSO				

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

Minutes Red	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
January 008/22	Review PLACE-Lite results relating to Clifton Lodge and provide an update on the plans to resolve the issues.	TS	May 2022	**March 2022:** The results are believed to have been impacted by process issues on the day of inspection, a re-assessment has therefore been scheduled.	Closed	
November 132/21	Vulnerable Adult Service to be invited to present at a future Board of Directors Meeting.	TSO	~~January 2022~~ July 2022	**January 2022:** Item deferred due to moving to Board-Lite agenda in response to the current upsurge in the pandemic.	Open	
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.	Open	

Minutes Red	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
			April 2022	**January 2022:** Item deferred until March 2022 due to current upsurge in the Covid-19 pandemic. **March 2022:** The Engagement Strategy will be socialised at the next Board Seminar session in April.		

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 March 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 Non-Executive Directors					
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)?	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	N/A	

Purpose of the Report		
This report provides a summary of key headlines and information to be shared with the Board 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

Summary of Key Issues

The report provides information in respect of:

- Situation in the Ukraine
- Board Lite Approach
- Service Visits
- Executive Director appointment
- Visit from Independent Chair of the Herts and West Essex Integrated Care System

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	NHS England	NED	Non-Executive Director
ICS	Integrated Care System		

Supporting Documents and/or Further Reading
Main Report.

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

Agenda Item: 5
Board of Directors Part 1
30 March 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 Situation in the Ukraine

You will all be aware of and many of us will have been affected in some way by the recent events in Ukraine. A session for our staff, led by EPUT Chaplain Paul Walker and colleagues from our Faith and Spirituality Staff Network took place on 08 March, which provided an opportunity for prayer, reflection and support for all of those affected by the conflict. Richard Bannister also shared an update on his collection of goods for the Ukraine. Richard is collecting sleeping bags, nappies, female sanitary products, first aid kits and over the counter medications and many of our colleagues across the Trust have generously donated to this collection.

2.2 Board Lite Approach

Following updated NHSE guidance to NHS Trusts and Foundation Trusts in January, and as advised in my January Board Chair's report; 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 Executive Director Appointment

We look forward to formally welcoming Zephan Trent to the role of Executive Director of Digital, Strategy and Transformation in April. Zephan brings a wealth of experience from within the health care sector and a passion for the potential benefits of digital technology and innovation in the NHS.

2.5 Visit from Independent Chair of the Herts and West Essex ICS

The Chief Executive and I were delighted to welcome Paul Burstow, Independent Chair of the Herts and West Essex ICS to the Trust recently, during which he visited Brockfield House and Services at the St Margaret's site in Epping.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

3.1 Briefing On The Health and Care Bill House of Lords Report Stage: Please see link below for a copy of the briefing published on 25 February 2022. **For Information: Link**

3.2 **Health Management And Policy Alert:** Please see the link below for a copy of the social care: independent report by Baroness Cavendish published in February 2022. **For Information: Link**

3.3 **What is Compassionate Leadership:** Please see the link below for a copy of the report published on 22 February 2022. **For Information: Link**

3.4 **AI Roadmap Methodology and Findings Report:** Please see the link below for a copy of the report produced in partnership with Health Education England and Unity Insights. **For Information: Link**

4.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by
Angela Horley
PA to Chair, Chief Executive and NEDs

On behalf of
Professor Sheila Salmon
Chair

		Agenda Item No: 6
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 March 2022

Report Title:	**Chief Executive Officer 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**		**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)?	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 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 Receive and 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
Accompanying Report

Lead
Paul Scott **Chief Executive Officer**

Agenda Item: 6
Board of Directors Part 1
30 March 2022

Chief Executive Officer Report
January 2022

1.0 INTRODUCTION

This report sets out the key issues for the Board and reflects highlights from the integrated performance report.

It was with some relief that the Omicron wave earlier in the year did not reach some of the more pessimistic scenarios. Nonetheless, the wave we did experience put pressure on our teams and I would like to recognise their forward planning, flexibility and resilience that allowed us to maintain services during this period of high staff absence. I am pleased we have been able to restore some visiting for patients. I know how important visiting is to all our patients, and their family and friends and we are exploring every opportunity to fully restore this as soon as possible.

As has been widely predicted, demand for mental health services has increased to record high levels as the immediate impact of the pandemic eases. Our teams continue to focus on our recovery, investing in our workforce, improving access to our services, embracing new technologies and innovation and continuing to build on population health management and address inequalities alongside our system partners. We are working incredibly hard to support those who need it, thinking of better ways of providing care and we continue to invest in our Community Mental Health teams on top of the £20m we invested in 21/22.

Our Community Nursing Teams continue to play a vital role in making the most effective use of the resources available across health and social care. They remain relentlessly focussed on supporting people to stay home which has provided the added benefit of freeing up much needed ambulances and hospital beds. The compassion, flexibility and collaboration displayed from our community nursing teams is extraordinary, and I would like to take the opportunity to thank you for all you do, every day.

I am very pleased to report that our children's services are fully up and running again. I would like to extend huge thanks to the team who have responded so well to the challenges. Children's services across the entire health and care system are under enormous pressure, and we continue to work closely with our Local Authority partners and North East London Foundation Trust to make improvements.

We are launching our new vision, purpose and strategic objectives across EPUT at the end of March, following engagement with staff and stakeholders. The first tangible sign of the new vision will be the launch of a new, user friendly, rebranded website, changes to onsite branding across all sites as well as a new, approachable and modern visual identity for leaflets, communications, posters, social media posts etc. This follows a period of building awareness through internal communications – all staff briefs, CEO blog, Managers' One Pager and content on the intranet so that all colleagues understand the context and narrative around the new strategic direction for EPUT. Next week we will be running a dedicated manager's session so that we support all line managers in communicating the new vision to their teams, so that we really embed this, along with the purpose and strategic objectives, right

across the Trust. We have also been running focus groups with colleagues and patients so that we take their input into developing the values to support our new strategic direction – ensuring that our colleagues and the people we support can really relate to the future direction of EPUT, what it means for them and how they can contribute.

Finally, I am delighted to formally welcome our newly appointed Executive Director of Strategy, Digital and Transformation, Zephan Trent, who will be joining the organisation on 01 April 2022. Zephan brings a wealth of experience gained working across a broad range of commercial and NHS roles, including most recently in his current post of Director of Strategic Transformation at NHS England and NHS Improvement for the East of England region, and prior to this, as Deputy Director of Transformation at Imperial College Healthcare.

3.0 PERFORMANCE AND OPERATIONAL ISSUES

Operations – Alex Green, Executive Chief Operating Officer

We have continued to utilise our surge plan during this period to manage our capacity and flow across services, maximising our ability to respond to patient's needs. We delivered a reduction in the number of areas with inadequate performance, which fell from 6 to 5 during February. However, CPA reviews fell below target, compounded by the impact of COVID. Caseloads are under review with focused actions across the three system areas to recover the position. Waiting times for psychology have reduced in some areas with improvement trajectories in place to manage our backlog of referrals

Our adult mental health inpatient occupancy levels have increased reflecting demand and acuity, rising to 96.1%, and our average length of stay remains outside of the national benchmark but with an improvement in month. The Flow and Capacity Programme work is progressing and I am pleased to report that our Out of Area Elimination Plan is again on track to deliver the zero ambition for inappropriate placements by year end. The Trust is benchmarking favourably against regional partners in both its Out of Area and Delayed Transfers of Care performance.

Tier 4 Child and Adolescent Mental Health Services (CAMHS) across our region have continued to manage levels of high demand and complexity and we are taking a proactive leadership role within our local Greater Essex system to find better ways to ensure that children and young people get the support they need in the right place and time.

We are working closely with our Mid and South Essex community Collaborative partners to find longer term solutions for theatre provision to deliver podiatric surgery. There is an interim plan in place to recover waiting times in the short term.

Safety and Quality – Natalie Hammond, Executive Nurse

The Executive Safety Oversight Group (ESOG) and Board Safety Oversight Group (BSOG) meeting was introduced to provide oversight and assurance of our safety strategy and delivery plans. We have continued to do this by providing highlight updates on the safety priorities: Safe Staffing, Engagement and Supportive Observations, Inpatient Flow and Capacity, Ligature Risk and EPUT Culture of Learning. In line with good governance we have undertaken a review of the reporting cycle and process and from 1st April 2022 we will report each week under the following themes:

Week 1: Safety Priorities – Prevention of Deaths (coroner themes), Ligature Risk, ECOL, Patient Experience and Other Trust safety priorities as agreed.
Week 2: Time to Care – Staffing, Observations & Engagement, Inpatient Flow

Week 3: Performance Dashboard - Safety Priorities Key Performance Indicators.
Week 4: BSOG - Consolidation and summary of reporting weeks 1-3.

On the 31st January 2022 as part of our Inpatient Flow and Capacity priority we went live with a Mental Health Emergency Department diversion service. In its first week it successfully diverted 5 of the 33 patients seen by the Mental Health Liaison Team and early data showed that the main reasons for not transferring more patients was due to their presentation, notably managing challenging behaviour and substance abuse. We have since been working collaboratively with our Basildon & Thurrock University Hospital colleagues to address this and ensure the service is supporting effective patient flow.

Our International Recruitment programme to support our safe staffing priority is underway with the first cohort of nurses arriving in Chelmsford on Monday 21st March. These nurses will be the first cohort to receive their objective structured clinical examination (OSCE) clinical skill proficiency training in our newly renovated training space at Mountnessing Court in Billericay. The space at Mountnessing Court has been designed with optimum learning in mind to ensure these nurses have the best opportunity to progress through an intensive period of training and prepare them to work and support both our teams on our wards and our service users.

Finance – Trevor Smith, Executive Chief Finance and Resource Officer

Finances 2021/22 (Year to Date, Month 11):

The Trust is reporting:

- An operating surplus of £86k with a break-even forecast outturn.
- Capital spend Year to Date £9.7m, forecast outturn £14.4m.
- Cash balances (£85.6m) remain sufficient for trading activities.

The Trust is progressing its plans for 2022/23 with final national submission due 28/4/2022

Major Projects – Nigel Leonard, Executive Director of Major Projects

Covid-19 Vaccination Programme Update

The Trust continues to play a key 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 in excess of 1.3 million vaccinations.

Since the significant increase in footfall during the national December booster “sprint”, our centres have seen a reduction in attendances. Our sessions have predominantly provided opportunities for those who took up their vaccinations later than the national cohort openings to have their follow up doses or for first doses as part of our evergreen offer. A small number of our centres have also been offering a route for 5 – 11 year olds who were most at risk of COVID-19 or who lived with someone who is immunosuppressed to receive a vaccination should they wish to but were unable to receive it from their GP.

Whilst the centres have been quieter, we have been working with our system partners to look at innovative ways to increase vaccination opportunities for people who have yet to take up the offer of

vaccination. This has included increasing the mobilisation of our vaccination bus within areas of lower uptake, including Southend and Thurrock. Through these visits we successfully administered a good number of first doses to people who previously had not come forward. We have also worked with large employers in the area as well as major retail outlets (IKEA) to site the bus in areas of potential high uptake. In order to support making vaccination available within local communities, we have recently completed the refurbishment of a second vaccination bus which is now also in use.

We would 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 delivered a number of pop up sessions in venues across the counties particularly during the February half term holiday. All our vaccination centres have also been offering dedicated sessions for 12 – 15 year olds to be vaccinated to ensure ease of access for this cohort.

The Government recently announced the spring booster programme and this has now commenced. All our centres have increased capacity availability to enable eligible individuals to receive their booster:

- Those aged 75 years and over;
- Those in care homes; and
- Those aged 12 and over with a weakened immune system.

The Government has also announced the intention to make the vaccination available to healthy 5 – 11 year olds who wish to have it, commencing in the Easter holidays. Our centres are therefore getting ready to be in a position to offer vaccination to this cohort, including making the environment as welcoming and relaxing as possible for younger children and their parents.

Following the announcement by the Secretary of State for Health and Social Care on 31 January 2022 the Government have been consulting on removing the Vaccination as a Condition of Deployment (VCOD) Regulations from law. The consultation on VCOD received more than 90,000 responses and a parliamentary review process has been completed.

It has now been confirmed that from 15 March 2022 the VCOD Regulations have been removed from law. This also removes the requirements previously in place in care homes, as well as those due to come into force in health and social care settings on 1 April 2022.

Nationally the NHS has always been clear that our staff have a professional duty to get vaccinated and vaccination remains our best line of defence against COVID-19. As a Trust we will continue to encourage, engage with, and support our colleagues to take upCOVID-19 vaccination to help protect themselves, our patients and our local community.

I would like to express my thanks again to all those involved - our staff, volunteers and our partner organisations - in delivering this phenomenal programme of vaccination.

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

The end of this month sees the launch of our new vision, purpose and strategic objectives, and in line with our values, we continue to transform the way we attract, retain and develop our people. As well as our regular Input updates, staff bulletins and all staff updates, new internal communication

channels have been established and the launch of our new rebranded website will play a vital role in improving the way we communicate and engage with all our people.

We continue to analyse the insights we receive through our staff and pulse surveys at every level to respond to what our staff have told us. Our vacancy and turnover rates remain well within the target levels, and just last month alone we welcomed 34 new permanent and fixed term starters, as well as 59 new bank staff, having dramatically reduced our time to hire to 26 days on average in February. The Trust has led and worked in partnership with the HEIs to deliver a new placement experience for our student nurses. Working with the Private and Voluntary sectors we have delivered innovative and alternative placement experiences for our student nurses, with 30 student nurses placed in their first choice this month and a further 57 students showing interest in working for us on a permanent basis. Alongside our local recruitment initiatives, we were able to welcome our first cohort of international nurses this month, with seven nurses arriving in the UK on 21 March 2022, and look forward to welcoming further cohorts throughout the rest of the year.

Given the increased cost-of-living challenges staff are facing, including rising fuel costs, we have launched a financial wellbeing support package for our colleagues, and continue to explore further support we can offer to staff pending the NHS Staff Council review in April 2022. Alongside financial assistance, we consistently promote our wellbeing support offering that is available to colleagues in light of this as well as the ongoing conflict in Ukraine, including a staff reflection event and 24/7 support available through our award winning “Here for You” programme.

I Want Great Care launched successfully at the beginning of this year, and we have already seen a significant increase of 13% in Friends and Family Test responses. We are continuing to see an increase in volunteers joining the organisation as well as an increase in the scale and diversity of opportunities open to them, assisted through the use of the newly implemented digital platform, Kinetic. We have more Lived Experience Ambassadors within the organisation now than ever, with more paid opportunities, transforming services through co-production. The new EPUT Public Forum launched this month with great success, increasing from 2% to 62% public attendance, driving through patient led quality improvement and transformation. PALS and Complaints are continuously improving, and have recently launched a co-production project to redesign our end to end complaints process. We continue to work across all our systems in supporting and influencing patient experience and involvement transformation.

This month has seen the Trust celebrate national awareness events including Apprenticeship Week, Careers Week, International Women’s Day and Eating Disorder Week and on 28 March 2022 the Trust will be signed up as a partner in Unison’s Anti-Racism Charter.

						Agenda Item No: 7a	
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**					30 March 2022	
Report Title:	Quality and Performance Scorecards						
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer						
Report Author(s):	Jan Leonard, Director of Information Technology and Telecommunication						
Report discussed previously at:	Finance and Performance Committee Quality Committee						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**		

Risk Assessment of Report – *mandatory section*		
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. Receive and 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 11 (February 2022). The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) have reviewed performance for February 2022. Five inadequate indicators (variance against target/ambition) have been identified at the end of February 2022 and are summarised in the Summary of Inadequate Quality and Performance Indicators Scorecard. • CPA Reviews • Inpatient MH Capacity Adult & PICU • Out of Area Placements • Psychology • Sickness Absence There are two inadequate indicators which are an Oversight Framework indicator for February 2022 • Out of Area Placements • Sickness Absence There are no inadequate indicators in the EPUT Safer Staffing Dashboard for February 2022. There are no inadequate indicators within the CQC scorecard. As at the end of February 2022, there has been 1 additional internal action added meaning there is now 63 (93%) individual actions reported as complete, 5 (9%) 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 February. • 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
February 2022

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.

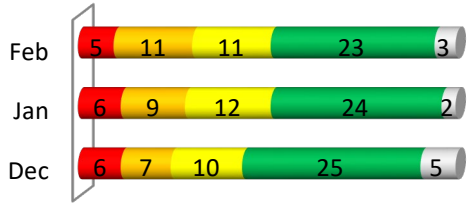
How is data presented?

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

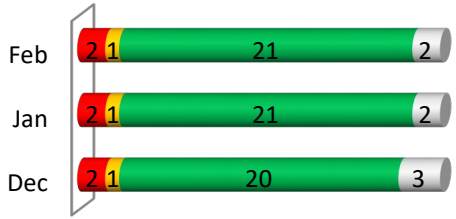


February Inadequate Performance

- CPA Reviews
- Inpatient MH Capacity Adult & PICU
- Out of Area Placements
- Psychology
- Sickness Absence

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

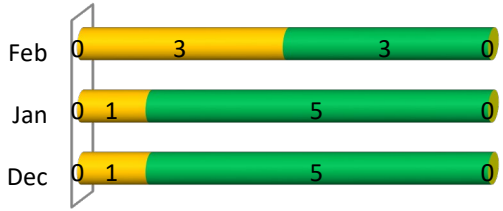
Summary of Oversight Framework Indicators



February Inadequate Performance

- Out of Area Placements
- Sickness Absence

Summary of Safer Staffing Indicators



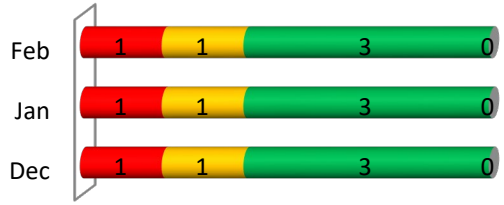
Three risks identified within the Safer Staffing section. There is currently a project underway being led by the Head of People Programmes to enhance the staffing reporting with new metrics which will enable improved monitoring and mitigation.

Summary of CQC Indicators

The CQC has undertaken an unannounced site inspection at all 3 wards for 1 day in March 2022 and are now continuing the inspection remotely.

As the end of February 2022, there has been 1 additional internal action added meaning there is now 63 (93%) individual actions reported as complete, 5 (9%) individual actions are in progress and are not yet due for completion and 0 individual actions are overdue.

Finance Summary



February Inadequate Performance

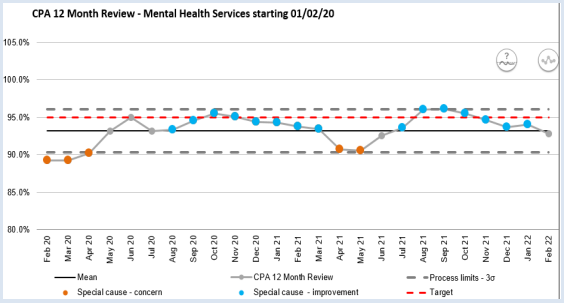
- Temporary Staffing

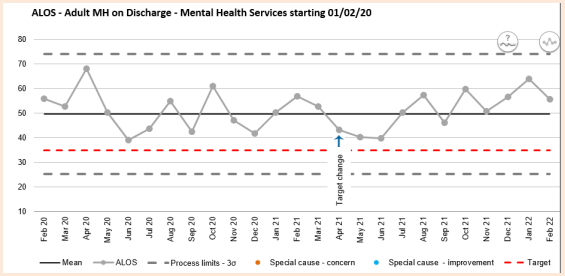
SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

<table>
<tr><th colspan="7">Effective Indicators</th></tr>
<tr><th rowspan="2">RAG</th><th rowspan="2">Ambition / Indicator</th><th colspan="2">Position M11</th><th rowspan="2">Trend</th><th rowspan="2">Nat RAG</th><th rowspan="2">Narrative</th><th rowspan="2">Recovery Date</th></tr>
<tr><th>Perf</th><th>RAG</th></tr>
<tr><td rowspan="2">2.3 CPA Review

Committee: Quality
Indicator: National
Data Quality RAG: Amber</td><td colspan="6">Inadequate
CPA Reviews has been highlighted as inadequate in February, overall performance remains below target at 92.8%, this is a reduction from the position reported in January (94.0%), three out of four areas are reporting below target.

Staffing levels and covid pressures continue to impact this performance. Reviews are being carried out on caseloads and has already identified a large number of patients to close including a large number who were not closed when they should have been. These cases are being actioned.
In addition to this staff review their cases as part of their routine supervisions and also continue to have the support of the Operation Productivity team who liaise with the staff to support with those breaching.</td></tr>
<tr><td>People on CPA will have a formal CPA review within 12 months

Target 95%</td><td>92.8%</td><td></td><td>Above Target = Good
 
</td><td></td><td>13 Teams in the South, three Teams in Mid, two Teams in NE, one Team in West and one Trust Wide Team below target.</td><td></td></tr>
<tr><td>2.9 Inpatient Capacity Adult & PICU MH</td><td colspan="6">Inadequate
Locality joint inpatient and community review and discharge planning meetings are now established in each locality offering senior oversight on progression to discharge and an escalation structure to support delay avoidance. Meetings are informed by Red to Green NHS E/I improvement methodology and address Ward and Trust level constraints. System DTOC are raised in weekly meetings with Health and Social Care commissioning. Discharge Coordination teams lead a monthly review of clinical information for all Adults with LOS 28+ days to ensure all have an active treatment plan, an allocated care coordinator, barriers to discharge are understood and that there is progression to discharge with escalation to Clinical Director, Service Manager and Associate Director for review if required. Monthly review consistently indicates clients with an extended LOS are in active treatment and extended inpatient admission is clinically appropriate.</td></tr>
</table>

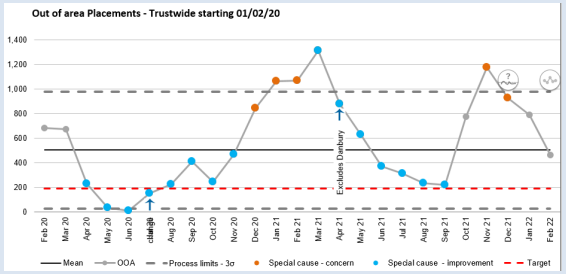
Effective Indicators							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Indicator: Local Data Quality RAG: TBC	2.9.2 Adult Mental Health ALOS on discharge less than NHS benchmark **Target: <35** (Adult Acute Benchmark 2020 35)	55.7 days	●	Below Target = Good 	●	Consistently failing target 97 discharges in February (25 of whom were long stays (60+ days)). Adult Acute 2020 benchmark EPUT result was 31, against a National mean of 35.	TBC

<table>
<tr><th colspan="8">Responsive Indicators</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M11
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td rowspan="2">4.5 Out of Area Placements

Committee: FPC
Indicator: Oversight Framework
Data Quality RAG: Amber</td><td colspan="7">February has seen a further positive reduction in out of area bed days, 464 (excluding Danbury).
Recent increases in mental health presentations to A&E and further ward closures due to COVID outbreaks had affected this indicator however performance has continued its recovery trajectory since then.
More oversight is now available on the placements to the Priory (Danbury ward) and a new contract for 7 male beds with Cygent Colchester has recently been approved. Work is in progress regarding quality and continuity principles to underpin submissions to NHSE/I for these beds to be reclassified as appropriate placements.
Placements to the Priory Danbury ward continue to be reported as appropriate and are therefore not included in these numbers.

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.

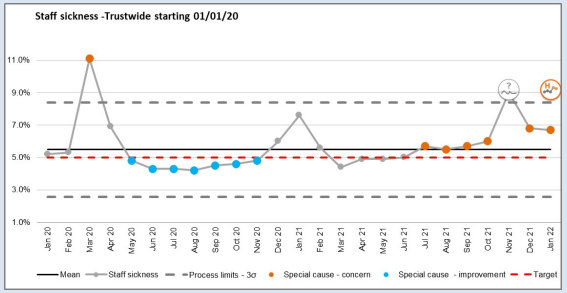
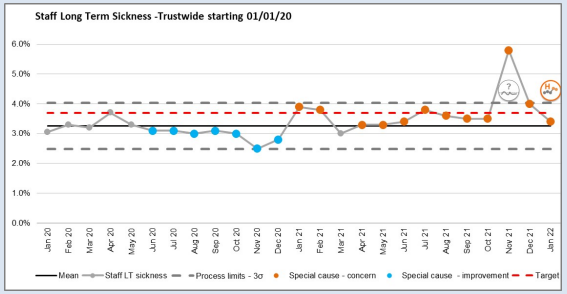
Six new clients were placed OOA in February, and following the repatriation of 13, there were 14 remaining OOA at the end of the month.</td></tr>
<tr><td>Reduction in Out of Area Placements

Target: Reduction to achieve 0 OOA</td><td>464 Days</td><td></td><td>Below Target = Good
 
</td><td></td><td>Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative.

Data excludes patients placed on Danbury Ward.</td><td>Mar 2022</td></tr>
</table>

4.10 Psychology  Committee: Quality Indicator: Local Data Quality RAG: **Blue**	4.10 Clients waiting on a Psychology waiting list	Significant work and improvements continue to be 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. In South East Essex Therapy For You+ (SE Step 4) has been commissioned with staff now in a mobilisation phase towards clinical activity. Wait list validations are taking place across all 3 localities with an average of 1 in 4 patients being identified as meeting the inclusion criteria for the new service provision of Therapy for You+. These patients will be transitioned from the Adult Community Psychology (ACP) waiting list in stages from March/April. This will reduce the number of people waiting and reduce wait times. All patients waiting for ACT and OCD groups will migrate to Therapy for You+ in March/April, clearing these group wait lists. Two PAPs who commenced at the end of February will clear those currently waiting for PAP, who will then move to the assessment phase. From January the South East ACP is fully staffed, although a small resource is currently lost due to a secondment. This underspend will be used to recruit support on bank over the summer, to bridge the gap between placement students. This ensures the robust running of the service's clinical pathway. 4 DBT groups continue to run in South East. There are additionally 2 STEPPS groups running across the area. These interventions form part of the complex needs pathway. Within South West some wait times have increased whereas others have reduced. The service has had some members of staff join who have enabled us to start more DBT and STEPPS groups. However, there have been 2 resignations of existing establishment staff which means they have had to slowly reduce down their caseloads and not pick up any new therapy cases. They have picked up additional assessments instead, which has helped to reduce some of the assessment wait times. These soon to be vacant posts are currently out to ad. The service has successfully recruited to another transformation post and the international candidate is likely to be in post in the next 2-3 months. Four new Clinical Associate Psychologists in training started with the team in late December and have begun to pick up clinical cases in line with their training needs. 1.5 WTE clinicians also started in Jan/Feb and have been/will be picking up a caseload, as well as providing supervision to junior staff. Together, this resource should start to have an impact on reducing waits and once fully recruited it is projected that waiting backlogs will be cleared within 9-12 months. Once the backlogs are cleared, ACP South West should be able to meet demand with the newly commissioned resource, if remaining fully resourced without vacancies.

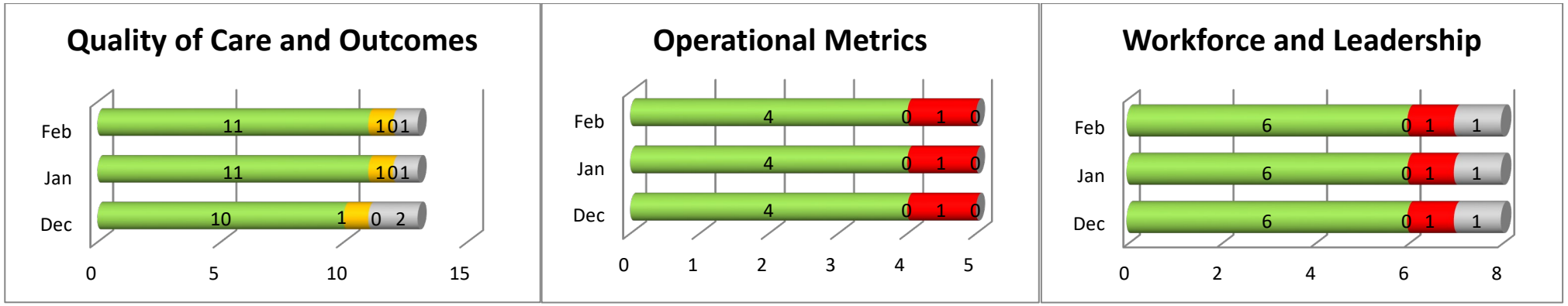
		The service is working with the CCG and the transformation project to evaluate the impact of step 4 across the South West on referrals. Risk calls are being made to those waiting (not on CPA) and to ensure any additional needs have a care plan and are documented. Wait times are as follows (February 2022): • Basildon: Individual therapy currently has the highest number of clients awaiting intervention with 50 waiting. Across all interventions, the longest waiter is 32 months and this is for individual therapy. • Brentwood: Individual therapy currently has the highest number of clients awaiting intervention with 18 waiting. Across all interventions, the longest waiter is 35 months and this again for individual therapy. • Thurrock: PAP/Assessment currently has the highest number of clients awaiting intervention with 29 waiting. Across all interventions, the longest waiter is 33 months and this is for individual therapy. • Southend: Individual psychology currently has the highest number of clients awaiting intervention with 79 waiting. Across all interventions, the longest waiter is 23 months and this is for individual therapy. • Castle Point: DBT Skills Group currently has the highest number of clients awaiting intervention with 15 waiting. Across all interventions, the longest waiter is 20 months and this is for individual therapy. • Rochford/Rayleigh: Individual psychology currently has the highest number of clients awaiting intervention with 33 waiting. Across all interventions, the longest waiter is 20 months and this is for individual therapy

Well-Led Indicators							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3 Sickness Absence Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Blue**	**Inadequate** In January sickness absence improved slightly to 6.7%, from 6.8% in December. Recent increases were expected with the current COVID level 4 incident status and the staffing pressures as a result. Long term sickness absence also improved in January to 3.4%, from 4.0% in December and is now within target.						
	5.3.1 Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**	6.7%	●	Below Target = Good 	●	The sickness figures are reported in arrears to allow for all entries on Health Roster. National data October 2021: The overall sickness absence rate for England was 5.7%. This is the higher than September 2021 (5.4%) and higher than October 2020 (4.5%). EPUT reported just above the England average at 5.9%.	
	5.3.2 Long Term Sickness Absence below 3.7% **Target 3.7%**	3.4%	●	Below Target = Good 	N/A		

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
- Staff Sickness

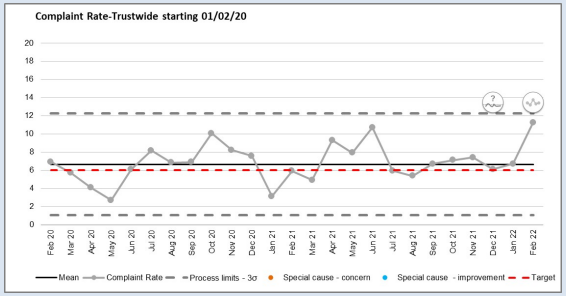
Requires Improvement

- Admissions to adult facilities of patients under 16 years old

<table>
<tr><th colspan="7">Quality of Care and Outcomes</th></tr>
<tr><th rowspan="2">RAG</th><th rowspan="2">Ambition / Indicator</th><th colspan="2">Position M11</th><th rowspan="2">Trend</th><th rowspan="2">Nat RAG</th><th rowspan="2">Narrative</th><th rowspan="2">Recovery Date</th></tr>
<tr><th>Perf</th><th>RAG</th></tr>
<tr><td rowspan="2">5.1.1 CQC Rating

Committee: FPC
Data Quality RAG: Green</td><td>Achieve a rating of Good or better</td><td>Good</td><td>●</td><td colspan="4">The CQC has rated our CAMHS service as ‘inadequate’ in 2021. A restriction has since been imposed onto the registration for the CAMHS service.
Following improvements made and assurances provided to the CQC, the CAMHS units can take admissions with no more than 2 per week.</td></tr>
<tr><td>No action plans past timescale</td><td colspan="2">●</td><td colspan="4">The CQC has undertaken an unannounced site inspection at all 3 wards for 1 day in March 2022 and are now continuing the inspection remotely.
As at 22nd February 2022, there has been 1 additional internal action added meaning there is now 63 (93%) individual actions reported as complete, 5 (9%) individual actions are in progress and are not yet due for completion and 0 individual actions are overdue.</td></tr>
<tr><td>4.1.1 Complaint Rate

Committee: FPC
Indicator: Oversight Committee
Data Quality RAG: Green</td><td>4.1.1 Complaint Rate
OF Target TBC

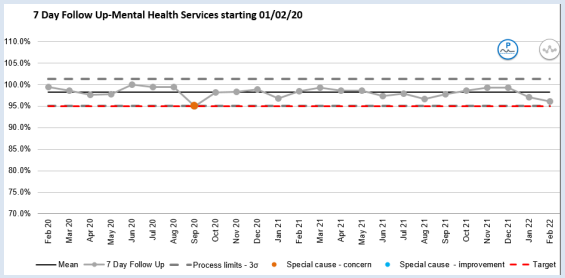
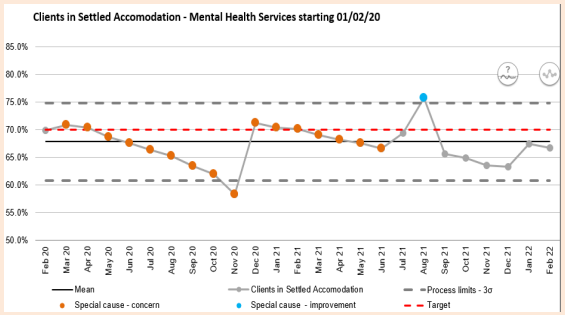
Locally defined target rate of 6 each month</td><td>11.2</td><td>●</td><td>Below Target = Good
 
</td><td>●</td><td>A sharp rise noted for February.
This increase has been noted across most areas with the most significant rise in the Mid & South STP.</td><td>N/A</td></tr>
<tr><td rowspan="2">5.6 Staff FFT

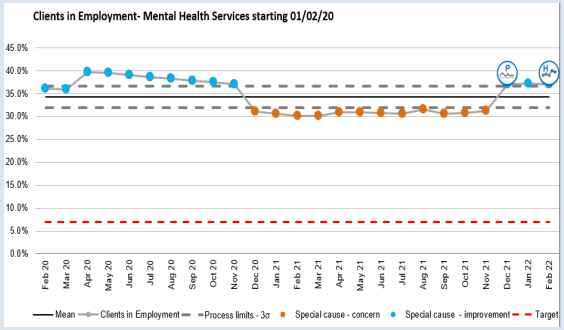
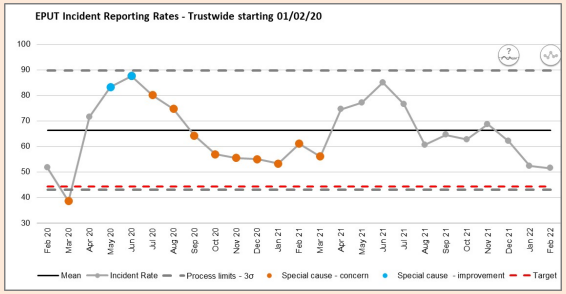
Committee: FPC
Data Quality RAG: Green</td><td>5.6.1 Staff FFT recommend the Trust as place to work

Target 63%</td><td colspan="5" rowspan="2">The Staff FFT has been replaced with the National Quarterly Pulse Survey. This launched on the 4th January and closed on the 31st January. Results will be provided once published.</td><td></td></tr>
<tr><td>5.6.2 Staff FFT recommend the Trust as a place to receive treatment

Target 74%</td><td></td></tr>
</table>

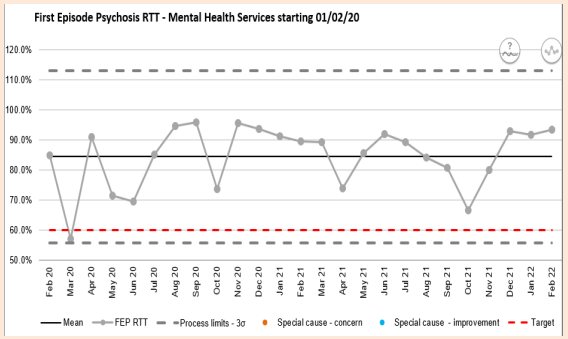
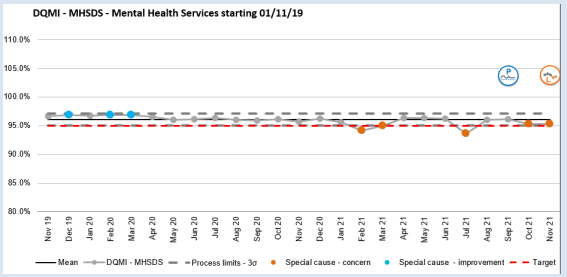
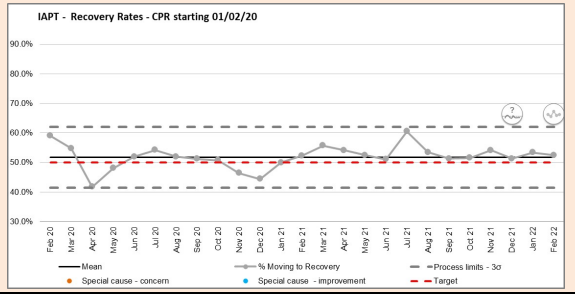
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
1.1 Never Event Committee: Quality Indicator: OF Data Quality RAG: **Blue**	0 Never Events **2019/20 Outturn 0**	0	●	Year to Date 0	●		N/A
1.6 Safety Alerts Committee: Quality Indicator: OF Data Quality RAG: **Green**	There will be 0 Safety Alert breaches **2020/21 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 2021 survey when compared with other Trusts.				N/A	Positive Results from CQC MH Patient Survey

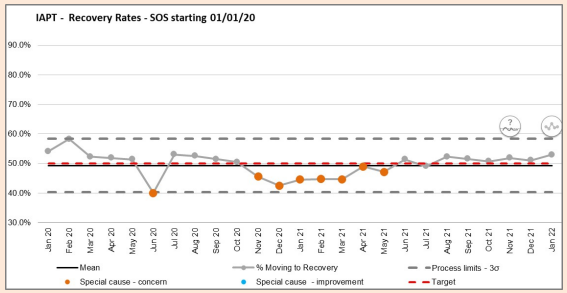
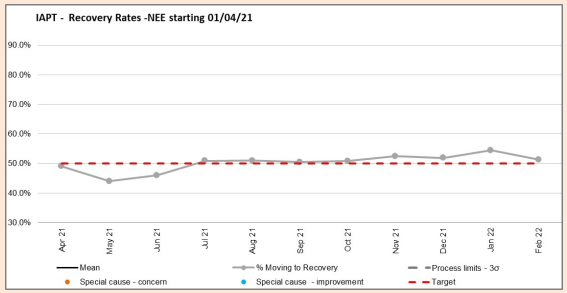
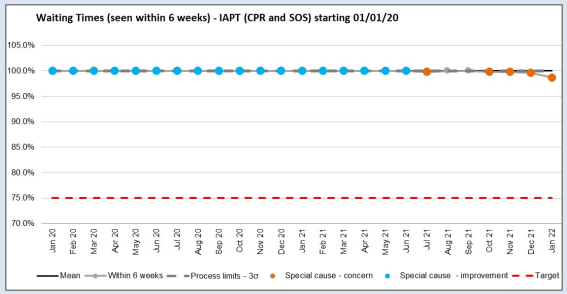
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
3.3 Patient FFT Committee: Quality Data Quality RAG: **Green**	3.3.1 Patient FFT MH response in line with benchmark Target = 88% (Adult Acute 2020 Benchmark 88%)		●	I Want Great Care has been rolled out across the Trust from 23rd January 2022. We are awaiting the result for February.	●	Awaiting result.	
	3.3.2 Patient FFT CHS response in line with benchmark Target = 96%		●		●	Awaiting result.	
2.8.1 Mental Health Discharge Follow up Committee: Quality Data Quality RAG: **Blue**	Mental Health Inpatients will be followed up within 7 days of discharge **Target 95%** **Benchmark 98%** (Adult Acute 2020 Benchmark 98%)	96.1%	●	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	We will support patients to live in settled accommodation **Target 70% (locally set)**	66.7%	●	Above Target = Good 	●	February performance : Paris 62.8% Mobius 79.6% Additional operational work continues to help improve performance going forward.	N/A

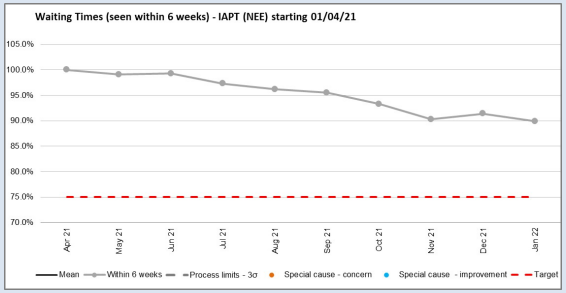
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG **Green**							
2.5 MH Patients in Employment Committee: Quality Indicator: Oversight Framework Data Quality RAG: **Green**	We will support patients into employment **Target 7% (locally set)**	37.1%	●	Above Target = Good 	●	February performance : Paris 42.9% Mobius 18.4% 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	51.4	●	Above Target = Good 	●	This is above target for February, with the EPUT total at 51.4. Staffing pressures are impacting on the time available for staff to sign off all incidents. This data is also extracted very early in the month due to reporting timescales and does usually improve on refresh.	
1.15 Admissions to Adult Facilities of under 16's Committee: FPC Indicator: Oversight Framework	0 admissions to adult facilities of patients under 16	1	●	One admissions in February Two year to date.	N/A	One patient under the age of 16 was admitted to an Adult ward in February (Ardleigh), patient transferred from a care placement in Scotland when behaviour escalated to a point they could not safely care for them. Transferred to the HBPoS at The Lakes as there were no available CAMHS beds. The CAMHS team are aware and supporting the patients care.	N/A

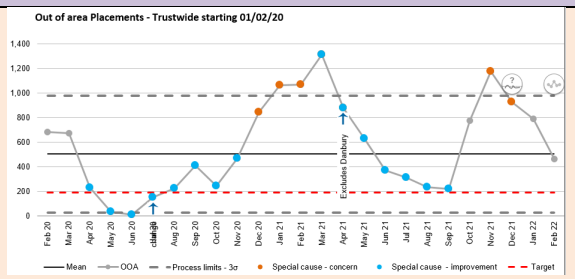
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Green**							

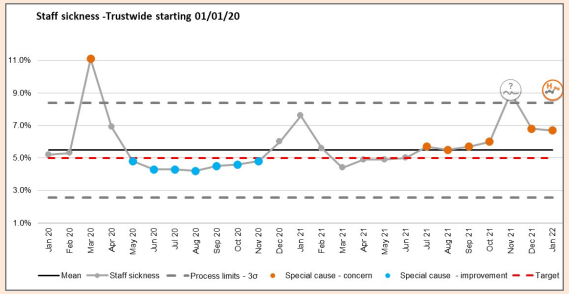
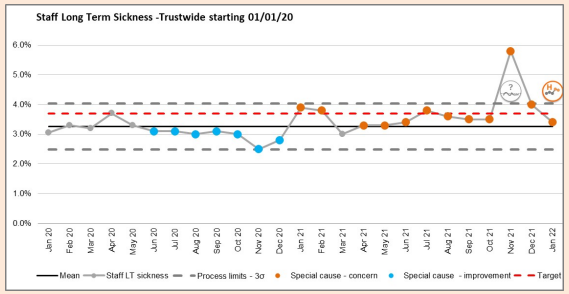
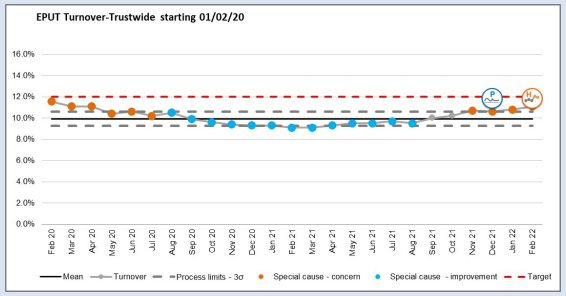
Click here to return to Summary

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M11**		**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%**	93.5%	●	Above Target = Good 	●	February performance represents: 21 / 29 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%**	95.3%	●	Above Target = Good 	●	Latest published figures are for November 2021	
2.16.4/5/6 IAPT Recovery Rates Committee: FPC Indicator: National	2.16.4 IAPT % Moving to Recovery CPR **Target 50%**	52.5%	●	Above Target = Good 	●	Slight decrease in performance since January, still above target.	

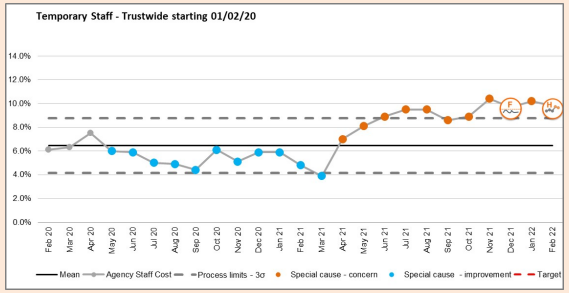
Operational Metrics							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Green**	2.16.5 IAPT % Moving to Recovery SOS **Target 50%**	51.5%	●	Above Target = Good 	●	Slight decrease in performance since January, still above target.	
	2.16.6 IAPT % Moving to Recovery NEE **Target 50%**	51.3%	●	Above Target = Good 	●	Slight decrease in performance since January, still above target.	
2.16.7/8 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.7 % Waiting Time to Begin Treatment – 6 weeks CPR & SOS **Target 75%**	100%	●	Above Target = Good 	●	Consistently above target.	

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.16.8 % Waiting Time to Begin Treatment – 6 weeks NEE **Target 75%**	93.4%	●	Above Target = Good 	●	Consistently above target.	
2.16.9/10 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.9 % Waiting Time to Begin Treatment – 18 weeks CPR & SOS **Target 95%**	100%	●	Above Target = Good	●	This measure is consistently 100%.	
4.5 Out of Area Placements ● Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Amber**	February has seen a further positive reduction in out of area bed days, 464 (excluding Danbury). Recent increases in mental health presentations to A&E and further ward closures due to COVID outbreaks had affected this indicator however performacne has continued its recovery trajectory since then. More oversight is now available on the placements to the Priory (Danbury ward) and a new contract for 7 male beds with Cygent Colchester has recently been approved. Work is in progress regarding quality and continuity principles to underpin submissions to NHSE/I for these beds to be reclassified as appropriate placements. Placments to the Priory Danbury ward continue to be reporetd as appropriate and are therefore not included in these numbers. 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. Six new clients were placed OOA in February, and following the repatriation of 13, there were 14 remaining OOA at the end of the month.						
	Reduction in Out of Area Placements	464 Days	●	Below Target = Good	●	Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative.	Mar 2022

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	Target: Reduction to achieve 0 OOA					Data excludes patients placed on Danbury Ward.	

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3.1 Staff Sickness Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Blue**	**Inadequate** In January sickness absence improved slightly to 6.7%, from 6.8% in December. Recent increases were expected with the current COVID level 4 incident status and the staffing pressures as a result. Long term sickness absence also improved in January to 3.4%, from 4.0% in December and is now within target.						
	5.3.1 Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**	6.7%		Below Target = Good 		The sickness figures are reported in arrears to allow for all entries on Health Roster. National data October 2021: The overall sickness absence rate for England was 5.7%. This is the higher than September 2021 (5.4%) and higher than October 2020 (4.5%). EPUT reported just above the England average at 5.9%.	
	5.3.2 Long Term Sickness Absence below 3.7% **Target 3.7%**	3.4%		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%**	11.1%		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

<table>
<tr><th colspan="7">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M11
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td>5.7.3 Temporary Staffing (Agency)

Committee: FPC
Indicator: Oversight Framework Indicator
Data Quality RAG: Green</td><td>5.7.3 Proportion of temporary Staff (Provider Return) No Oversight Framework Target</td><td>9.8%</td><td></td><td>Below Target = Good
 
</td><td>N/A</td><td>The COVID directorate currently has the highest percentage of agency staff at 36%.</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>

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M11** **Perf** / **RAG**	**Trend**	**Nat RAG**	**Narrative**		**Recovery Date**

• % agreeing that their team often meets to discuss the team's effectiveness

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

Trusts in lowest third across the sector will represent a concern

Inclusion (1) Average of

• % staff believing the trust provides equal opportunities for career progression or promotion

• % experiencing discrimination from their manager/team leader or other colleagues in the last 12 months

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

SECTION 4 – Safer Staffing Summary

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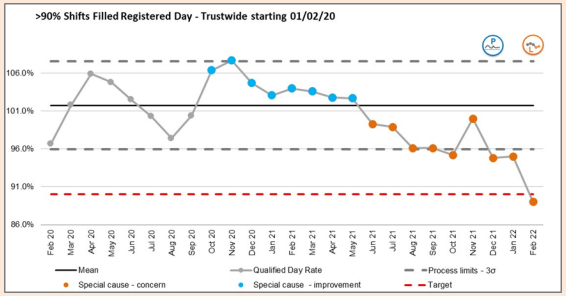
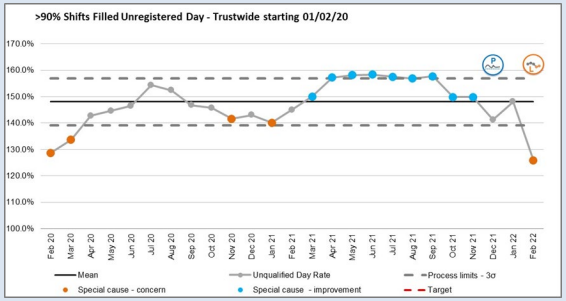
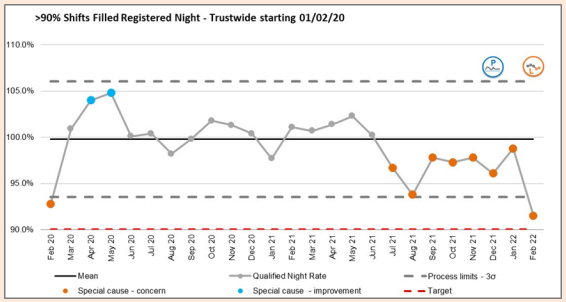
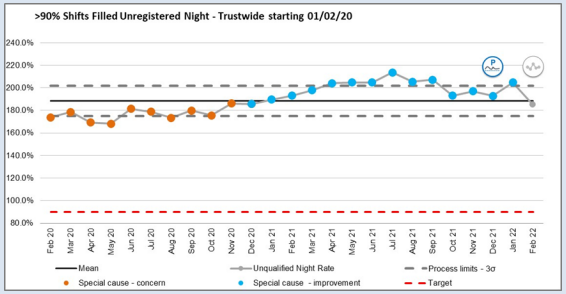
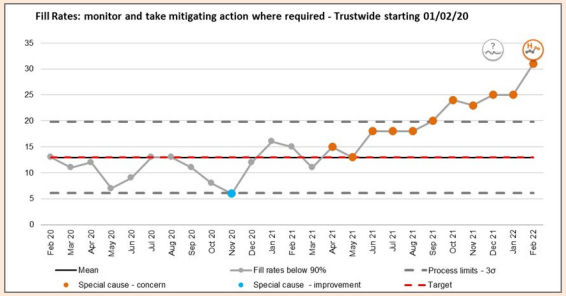
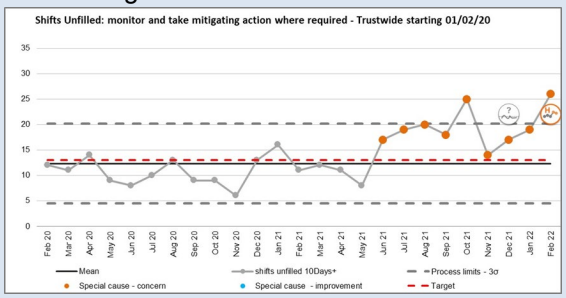
Safer Staffing							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards. From February this data is being extracted from SafeCare. There is currently a project underway being led by the Head of People Programmes to enhance the staffing reporting with new metrics. Safe staffing performance continues to be monitored by the Quality SMT.							
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	89.0%		Trend above target = good 		The following wards were below target in February: Nursing Home: Rawreth Court, Specialist: Alpine, Dune,Fuji,.Edward House, Rainbow, Lagoon Adult: Ardleigh, Willow, Finchingfild, Galleywood, Gosfield, Kelvedon. Cherrydown Adult – Assessment: Peter Bruff, Basildon MHAU CAMHS: Longview, Larkwood Older: Beech, Ruby , Tower CHS: Beech(SMT), Cumberledge, Poplar(SMT)	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	125.9%		Trend above target = good 		The following wards were below target in February: Specialist:, Aurora, Rainbow, Fuji LD: Woodlea Clinic Nursing Home: Rawreth Court CHS: Cumberlege Older: Topaz Adult: Finchingfield, Gallewood,	N/A

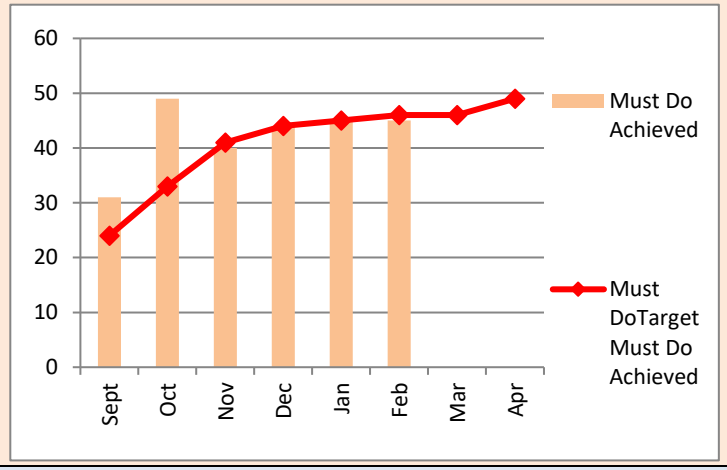
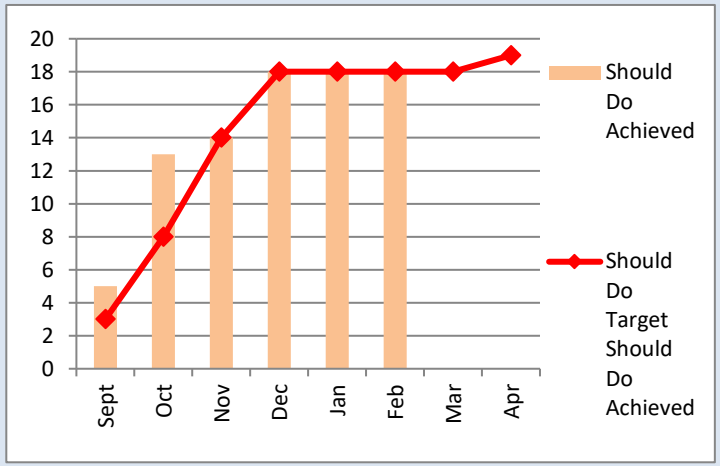
Safer Staffing							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	91.5%		Trend above target = good 		The following wards were below target in February: Adult – Gosfield, Cedar CAMHS: Longview, Larkwood, Poplar - Rochford Nursing Home: Rawreth, Clifton Older: Beech, - Rochford, Tower, Gloucester, Topaz CHS: Cumberlege, Avocet Specialist: Fuji, Edward House, Rainbow	N/A
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts filled	184.9%		Trend above target = good 		The following wards were below target in February: CHS: Beech (SMT), Cumberlege Specialist: Rainbow	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required	31		Below Target = Good 		The following wards had fill rates of <90% in February: Adult:, Ardleigh, Cedar, Willow, Finchingfield, Galleywood, Gosfield, Kelvedon, Cheerydown Adult Assessment: Basildon MHAU, Peter Bruff Older Adult: Topaz, Tower, Beech – Rochford, Gloucester Nursing Homes: Rawreth Court, Clifton Specialist: Dune, Edward House, Fuji, Rainbow, Lagoon	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
						CHS:Avocet, Beech (SMT), Cumberlege, Poplar	
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	26		Below Target = Good 		The following wards had more than 10 days without shifts filled in February: Adult: Ardleigh, Cedar, Chelmer, Galleywood, Cherrydown, Gosfield, Willow, Kelvedon Adult-Assessment: Peter Bruff, Basildon MHAU CAMHS: Longview, Larkwood, Poplar - Rochford Older Adult: Beech-Rochford, Tower, Henneage, Ruby, Meadowview Nursing Homes: Rawreth Court, CHS:Avocet,Cumberlege, Beech(SMT), Specialist: Rainbow, Lagoon PICU: Christopher Unit, Hadleigh Unit	N/A

Click here to return to summary page

SECTION 5 – CQC

Click here to return to summary page

RAG	Ambition / Indicator	Position M11	Trend (above target = good)	Narrative
CQC Must do Actions	There will be 0 CQC Must Do actions past timescale	At the end of February 0 actions were past timescale	Achieve target = good performance 	0 CQC Must Do actions are past timescale at the end of February 2022
CQC Should do Actions	There will be 0 CQC Should Do actions past timescale	At the end of February 0 action were past timescale	Achieve target = good performance 	0 CQC Should Do actions are past timescale at the end of February 2022

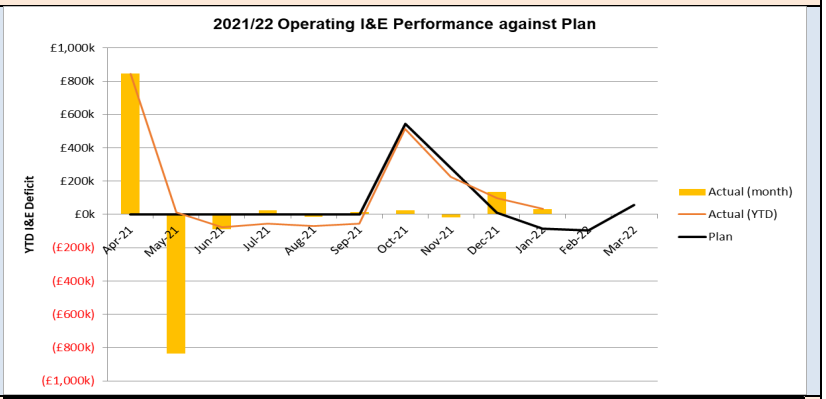
SECTION 6 - Finance

Click here to return to summary page

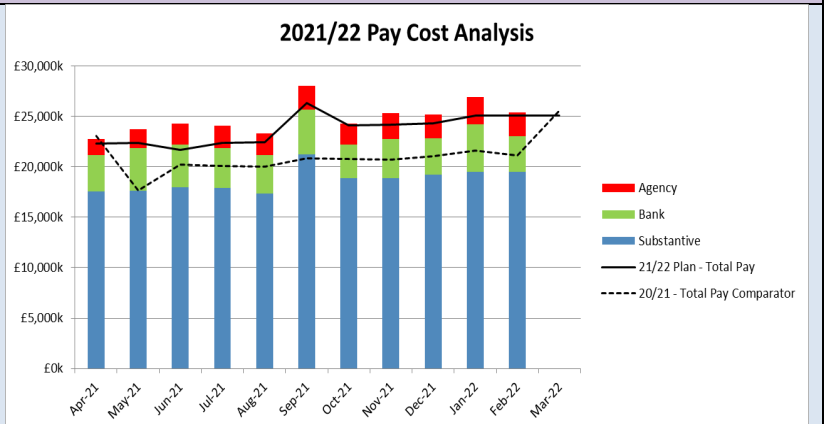
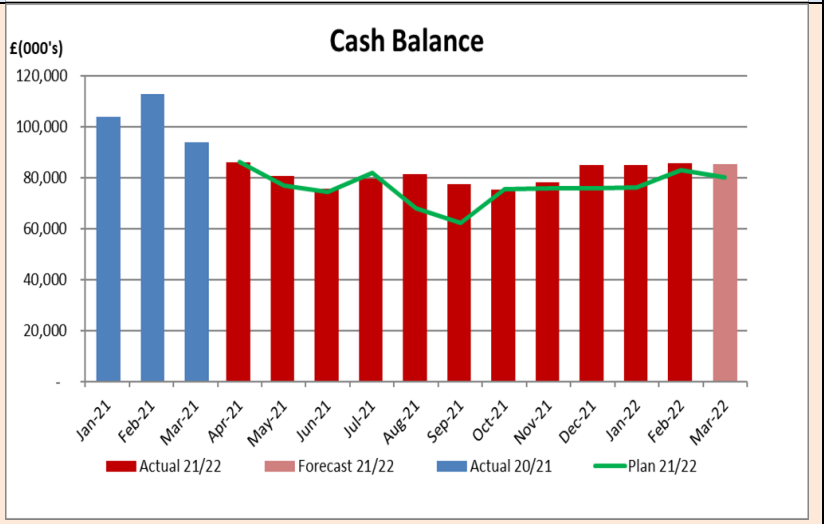
RAG	Ambition / Indicator	Position	Trend
Capital Expenditure	Maximising Capital Resources	The Trust has incurred capital expenditure of £9.7m against the annual £14.4m programme. The Capital group and sub working groups continue to monitor spend and address any emerging high priority requirements.	
Trust I&E 2020/21	Operating Income and Expenditure	The year to date position is a £0.1m actual which is £0.2m favourable to plan.	
Efficiency Programmes	Planned improvement in productivity and efficiency	YTD reported position is £8.2m, being £0.4m behind plan. £4.8m of the delivered efficiencies are recurrent. As part of the 22/23 planning the Trust is currently working on development of efficiencies and has identified £9.5m of potential schemes.	

Capital

	Annual Plan £000	Year to Date Plan £000	Year to Date Actual £000	Year to Date Variance £000
ICT (including ePrescribing)	2,428	2,198	1,453	745
MEMS / Other equipment	200	160	116	44
Safety & Ligature	1,942	1,698	1,850	(152)
Backlog Maintenance	2,349	1,601	1,232	369
Health & Safety	1,000	881	380	501
Strategic Schemes:				
Dormitory Project	2,159	1,847	588	1,259
Other	1,085	1,001	795	206
Charge against Capital Allocation	**11,163**	**9,386**	**6,414**	**2,973**
DHSC Dormitory Project	3,080	3,080	3,080	0
TIF Podiatric Surgery	0	0	90	(90)
PFI Residual Interest	109	100	100	0
Net CDEL	**14,352**	**12,566**	**9,684**	**2,883**



	Efficiencies	YTD Plan	YTD Delivery	YTD Variance
	£m	£m	£m	£m
H1	3.5	3.5	2.1	1.4
H2	6.3	5.1	6.1	(1.0)
EPUT Total	**9.8**	**8.6**	**8.2**	**0.4**

RAG	Ambition / Indicator	Position	Trend
Temporary Staffing	Level of Temporary Staffing Costs	In month temporary staffing was £5.9m (£7.4m in M10). The decrease between months reflecting higher temporary staffing usage due to the impact of COVID outbreaks across operational services.	
Cash Balance	Positive Cash Balance	Cash balance as at end of M11 was £85.6m above plan by £2.4m (M10 £8.9m) largely due to net receipts being higher than plan.	

END

		Agenda Item No: 7b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 March 2022**

Report Title:	Learning from Deaths – Mortality Review Summary of Quarters 2 & 3 2021/22 information					
Executive/ Non-Executive Lead:	Professor Natalie Hammond / Dr Rufus Helm					
Report Author(s):	Michelle Bourner, Project Coordinator					
Report discussed previously at:	Mortality Review Sub-Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
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)?	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.	Not applicable	
Describe what measures will you use to monitor mitigation of the risk	Not applicable	

Purpose of the Report		
This report presents to the Board of Directors: • Information relating to deaths in scope for mortality review for Q2 and Q3 2021/22 (1st July – 31st December 2021) together with updated information for Q1 2021/22, 2020/21, 2019/20 and 2018/19; and • Learning that has been identified within the Trust as a result of mortality review undertaken since the last report to the Board of Directors.	**Approval**	
	Discussion	
	Information	✓

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

Summary of Key Issues

1. This report presents information that the Trust is nationally mandated to report to public Board meetings on a quarterly basis – i.e. the number of deaths in scope, the number reviewed and the assessment of problems in care; as well as the learning realised from mortality review. Additional information is routinely included within quarterly reports to provide additional assurance / information on inpatient / nursing home deaths and on the timeliness of mortality review processes within the Trust.

2. There were **48** deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in Q2 and **52** deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in Q3. These are in line with quarters not impacted by COVID-19 in previous years.

3. Of the 48 deaths in Q2, 3 were inpatient deaths and 7 were nursing home deaths. All of these deaths have been confirmed as being due to natural causes. Of the 52 deaths in Q3, 9 were inpatient deaths and 10 were nursing home deaths. 5 of the 9 inpatient deaths and all 10 of the nursing homes deaths have been confirmed as due to natural causes. The remaining causes of death, with the exception of one, are currently under determination. There was one inpatient death which was due to unexpected unnatural causes and this death is subject to a serious incident investigation.

4. The attached report includes details of the grade of review to which deaths are being subjected and the timeliness of completion of those reviews. It indicates that the improvement in the timeliness of consideration via the Deceased Patient Review Group has continued. It also indicates that the significant majority of deaths continue to either be closed at Grade 1 desktop review by the Deceased Patient Review Group or investigated at Grade 4 serious incident investigation, with limited use of the Grade 2 case note review option. This will be addressed via the current implementation of the national Patient Safety Incident Response Framework (PSIRF) and the new learning from deaths processes that are being implemented from 1st April. Further details are included in Section 9 of the attached report.

5. The attached report also includes details of the profile of problems in care scores assigned to deaths in scope. This indicates that the significant majority of deaths have been assessed as having no problems in care (score 6).

6. The Mortality Review Sub-Committee also oversees a dashboard of information on deaths of substance misuse service users who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death. This information will be considered by the Sub-Committee to ensure an overview of such deaths. There are no issues of concern to report.

7. Details of learning from mortality review since the last report to the Board of Directors are included in the attached report, together with examples of actions taken in response to learning themes.

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 £**			N/A
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

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

Supporting Documents and/or Further Reading

Attached - Report on Mortality Information and Learning from Deaths for Q2 & Q3 2021/22
Appendix 1 – Flow chart of new learning from deaths process to be implemented 1st April

"National Guidance on Learning from Deaths" *Quality Board March 2017*
https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf
"Implementing the Learning from Deaths framework: Key requirements for Trust Boards" *NHS Improvement July 2017*
https://improvement.nhs.uk/uploads/documents/170720_Implementing_LfD_-_information_for_boards_proofed_v2.pdf

Lead
 Professor Natalie Hammond **Executive Nurse**

EPUT

LEARNING FROM DEATHS – MORTALITY REVIEW PUBLICATION OF MORTALITY DATA AND LEARNING QUARTERS 2 & 3 2021/22

1.0 PURPOSE OF REPORT

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

- Information relating to deaths in scope for mortality review for Q2 & Q3 2021/22 (1st July – 31st December 2021);
- Updated information relating to deaths in scope for mortality review in Q1 2021/22, 2020/21, 2019/20 and 2018/19; and
- Learning that has been identified within the Trust as a result of mortality review since the last report to the Board of Directors.

2.0 BACKGROUND AND CONTEXT

2.1 The effective review of mortality is an important element of the Trust's approach to learning and ensuring that the quality of services is continually improved. "National Guidance on Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care" (National Quality Board March 2017) set out extensive guidance for Trusts in terms of approaches to reviewing mortality, learning from deaths and reporting information. The Trust subsequently implemented a Mortality Review Policy and agreed its approach to reporting mortality data. This Policy has been reviewed and new learning from deaths processes aligning to the new Patient Safety Incident Response Framework (PSIRF) arrangements are being implemented from 1st April. Further details are included in Section 9.

2.2 In line with national guidance, quarterly reports of the nationally mandated information are presented to the Trust Board of Directors outlining mortality data and learning from deaths. This report presents data for Q2 & Q3 2021/22 (and updated data for previous quarters / years) as at the day the report was prepared (i.e. 22nd March 2022).

3.0 SCOPE OF DEATHS INCLUDED IN THIS REPORT

3.1 The scope of deaths included within this report is in line with the scope defined in the Trust's Mortality Review Policy applying in Q2 & Q3. Deaths "in scope" include expected deaths due to natural causes as well as unexpected deaths.

3.2 The Mortality Review Sub-Committee also monitors the deaths of patients who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death. The data for Q2 & Q3 has been considered by the Mortality Review Sub-Committee and there are no issues of note or concern to report.

4.0 TOTAL NUMBER OF DEATHS IN SCOPE FOR REVIEW

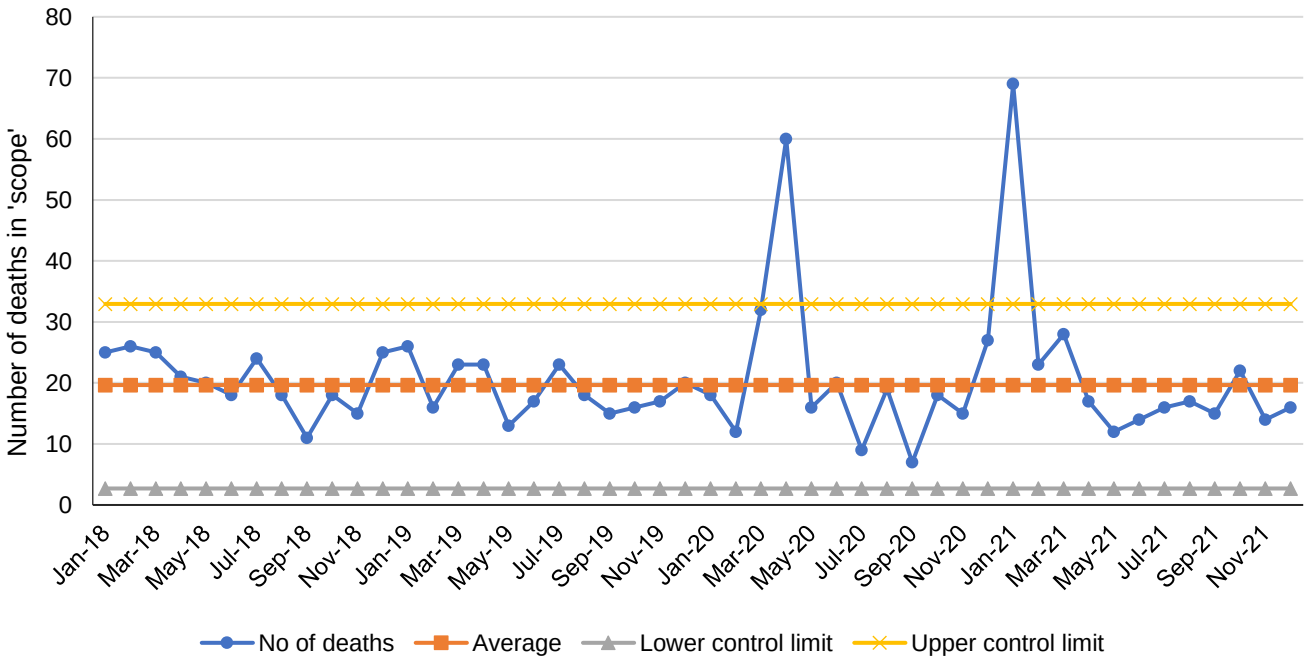
4.1 There were **48 deaths** which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in **Q2 2021/22** and **52 deaths** which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in **Q3 2021/22**. These figures are in line with quarters not impacted by COVID-19 in previous years.

Table 1: Breakdown of total deaths in scope for review

Period	Total 2018/19	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	Total 2019/20	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	Total 2020/21	2021/22 Q1	Jul 2021	Aug 2021	Sep 2021	2021/22 Q2	Oct 2021	Nov 2021	Dec 2021	2021/22 Q3	2021/22 YTD
Deaths in scope	235	53	56	57	62	228	96	35	60	120	311	43	16	17	15	48	22	14	16	52	143

4.2 Figure 1 below shows the total number of deaths that fell within the scope of the policy each month in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2017 – November 2018). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. Figure 1 below indicates that the number of deaths in scope in Q2 & Q3 fall within control limits.

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



4.3 The significantly higher levels of deaths in April 2020 and January 2021 were directly impacted by the COVID-19 pandemic. Explanatory information was included in the Q1 and Q4 2020/21 reports to the Board of Directors. The data for Q2 - Q3 2021/22 indicates a continuation of the return to levels of deaths consistent with periods pre-pandemic.

4.4 Given the nature of the services provided by the Trust, there will be a number of deaths that occur on in-patient wards and in nursing homes which will be expected and which will be due to natural causes. Of the 48 deaths in **Q2**, 3 were inpatient deaths and 7 were nursing home deaths. All of these deaths have been confirmed as due to natural causes. Of the 52 deaths in **Q3**, 9 were inpatient deaths and 10 were nursing home deaths. 5 of the 9 inpatient deaths and all 10 of the nursing homes deaths have been confirmed as due to natural causes. The remaining causes of death, with the exception of one, are currently under determination. There was one inpatient death which was due to unexpected unnatural causes and this is subject to a serious incident investigation.

5.0 GRADE AND PROGRESS OF REVIEWS / INVESTIGATIONS

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

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

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

Grade of review / investigation	2018/19 total	2019/20 total	2020/21 Total	2021/22 Q1 total	2021/22 Q2 total	2021/22 Q3 total	2021/22 Total YTD
Grade 1 Deceased Patient Review Group	148	144	215	30	22	22	74
	63%	63%	69%	70%	46%	42%	52%
Grade 2 Case Note Review	18	17	7	0	0	0	0
	8%	7%	2%	0%	0%	0%	0%
Grade 3 Critical Incident Review	0	1	0	0	0	0	0
	0%	1%	0	0%	0%	0%	0%
Grade 4 Serious Incident Investigation	69	65	72	12	10	15	37
	29%	28%	23%	28%	21%	29%	26%
Final grade under determination	0	1	17	1	16	15	32
	0%	1%	5%	2%	33%	29%	22%
TOTAL	235	228	311	43	48	52	143

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

- closed at Grade 1 desktop review by the Deceased Patient Review Group (ranging from 63% to 69% in previous years); or
- being investigated as Grade 4 serious incident investigations (ranging from 23% to 29% in previous years).

This trend has continued into 2021/22, with 52% being closed at Grade 1 thus far and 26% being investigated at Grade 4.

5.3 There has been limited use of the Grade 2 clinical case note review option (ranging from 2% to 8% in previous years). This has been kept under review and has been taken into account in implementation of the national Patient Safety Incident Response Framework (PSIRF) arrangements put in place across the Trust.

5.4 Positive progress has continued since the last report to the Board of Directors in terms of the timely consideration of deaths via mortality governance processes, with only 22% of deaths in 2021/22, 5% of deaths in 2020/21 and 1% of deaths in 2019/20 requiring the grade of review to be determined.

5.5 There has been good progress with completing Case Note Reviews and investigations under the new Patient Safety Incident Response Framework (PSIRF) arrangements since the last report to the Board of Directors. This has included the completion and approval by the Deceased Patient Review Group of five Case Note reviews; and completion and approval of 22 investigations under PSIRF.

5.6 The following table details progress in terms of completion of mortality reviews by year:

Year	Reviews complete	Reviews in progress	Comments
2018/19	234	1	Case Note Review (recommissioned due to staff turnover of reviewers)
2019/20	226	2	1 x Case Note Review (recommissioned due to staff turnover of reviewers) and 1 x awaiting closure by DPRG
2020/21	292	17	3 x Case Note Reviews and 14 x awaiting closure by DPRG
2021/22	97	46	13 x PSIRF investigations in progress; 33 x awaiting closure by DPRG

5.7 The main reason for deaths requiring a grade of review still to be determined is where they are awaiting presentation to the Deceased Patient Review Group (DPRG) or where the Deceased Patient Review Group has requested additional information prior to making a final decision. Given the COVID-19 Level 4 response it was unfortunately necessary to cancel the DPRG meeting scheduled for February 2022 due to capacity pressures.

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

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

Score	2018/19 (Number)	2018/19 (as a %)	2019/20 (Number)	2019/20 (as a %)	2020/21 (Number)	2020/21 (as a %)	2021/22 YTD (number)	2021/22 YTD (as a %)
6 - definitely less likely than not	191	81%	170	75%	235	76%	74	52%
5 - slight evidence	22	9%	29	13%	22	7%	1	2%
4 - not very likely	11	5%	15	7%	8	3%	0	0%
3 - probably likely	6	3%	4	2%	0	0%	0	0%
2 - strong evidence	1	1%	0	0%	0	0%	0	0%
1 - definitely more likely than not	0	0%	0	0%	0	0%	0	0%
Under determination	4	2%	10	4%	48	15%	46	32%
PSIRF not scored	N/A	N/A	N/A	N/A	N/A	N/A	22	15%
TOTAL	235	-	228	-	311	-	143	-

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

6.3 Scores for those deaths for which the review has been closed but no score yet allocated (where a score is required) are being followed up.

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

6.5 Under the new Patient Safety Incident Response Framework (PSIRF), investigations focus on quality learning outcomes and no "score" is allocated. This is reflected in the 2021/22 column in the table above.

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

7.1 Assurances can be given that all deaths meeting the criteria for referral to the LeDeR programme have been referred. There is one additional death on the EPUT mortality dashboard for Q1, not included in the LeDeR referrals total. This is due to the specific diagnosis and, as yet, whilst this has been reported to the LeDeR Steering Group, there is no reporting facility in place nationally to accommodate this. The reporting abilities are being pursued nationally.

8.0 LEARNING FROM MORTALITY REVIEW OF DEATHS

8.1 The Trust continues to ensure that identified learning from investigations and reviews lead to improvements in practice. Examples of actions taken in response to learning include:

8.1.1 **Tailgating and absconding** - A review was recently undertaken of incidents where patients have attempted to abscond from inpatient units and themes in terms of learning identified. Actions arising from the review now include a time limited period for the multi-disciplinary team to identify mitigations for the risk and key lessons for the service, increase awareness among staff, mailshot to all services as well as presenting findings and action at the Quality & Safety Group meetings and Learning Oversight Sub-Committee.

8.1.2 **Disengagement protocols** – The new protocols have now been in place for a year and a review is currently underway. Further changes are to be made to the protocols to reflect learning from their implementation over the past year.

8.1.3 **Handover guidance** – Similarly, the new guidance for handover has been in place for a year. An audit of handover approaches has recently been undertaken and the outcomes of the audit are being worked through to determine how to further strengthen and standardise approaches across the Trust to learn from best practice in all areas.

8.1.4 **Clinical notes guidance** – A review has been undertaken of the clinical notes guidance implemented. Feedback has been gathered from a range of staff in this review. In response to this feedback, action is now being taken to develop separate guidance for staff working in the community and staff working in an inpatient setting with a view to strengthening record keeping approaches in different settings.

8.1.5 **Observation and engagement** – A Task & Finish Group has reviewed the policy, procedural guidelines and record keeping forms. Refinements have been made to the record keeping forms to localise for each individual ward environment and to ensure recording of exact timings of observations. Two patient safety videos on observation and engagement have been

produced by the Trust and a third is currently nearing completion. Once all are completed, these will be launched as a development tool to strengthen practice.

8.1.6 **Clinical dashboards** – Clinical dashboards have been introduced across the Trust. These allow, at a glance, identification of any care plans or risk assessments that are out of date and require updating – thus directly addressing learning themes emerging relating to risk assessment and documentation.

8.1.7 **Approach to implementing learning into the future -** In recognition of the importance of identifying learning and embedding improved practice as a result of such learning, the Trust is implementing new structures and ways of working to strengthen outcomes. A significant strand of this will be the continuation and strengthening of assurance testing following implementation to ensure that the changes have been embedded and that practice has changed as a result.

9.0 NEW LEARNING FROM DEATHS POLICY AND PROCEDURAL GUIDELINES

9.1 Significant work has been undertaken over the past 6 months to develop and consult across a range of clinical and governance staff on new processes for learning from deaths, based on national guidance and staff experiences of mortality review since implementation of the current Policy in 2017.

9.2 The outcome is a new Learning from Deaths Policy and accompanying Procedural Guidelines. These have recently been approved by the Quality Committee and will launch on 1st April. The new procedures simplify the existing mortality review processes, strengthen the focus on learning outcomes and directly align with the Patient Safety Incident Response Framework arrangements.

9.3 Under the new processes, a Stage 1 review will be undertaken of all deaths reported on our incident management system, Datix, via completion of a new form by the manager signing off the death report. The new form is simple to complete and enables identification of any immediate learning and any deaths that need a referral, by the Patient Safety Incident Management Team, to a reviewer for a more detailed Stage 2 Clinical Case Note Review.

9.4 Monitoring the review of deaths will move from a central corporate Group to Directorate Quality and Safety Groups, bringing ownership of the process and learning closer to front line services. Over the coming weeks, our Mortality Project Co-ordinator will be attending Quality and Safety Group meetings to discuss the new processes and their role within them.

9.5 Attached at **APPENDIX 1** is a flow chart summarising the new processes.

10.0 CONCLUSIONS AND FUTURE ACTIONS

10.1 This report provides assurances that all deaths in Q2 & Q3 which were within scope for mortality review have been reviewed / investigated or are in the process of being reviewed / investigated. The report also provides assurances that the overarching aim of mortality review – i.e. learning from deaths - is being achieved with examples of the learning themes being acted upon.

11.0 ACTION REQUIRED

11.1 The Board of Directors is asked to:

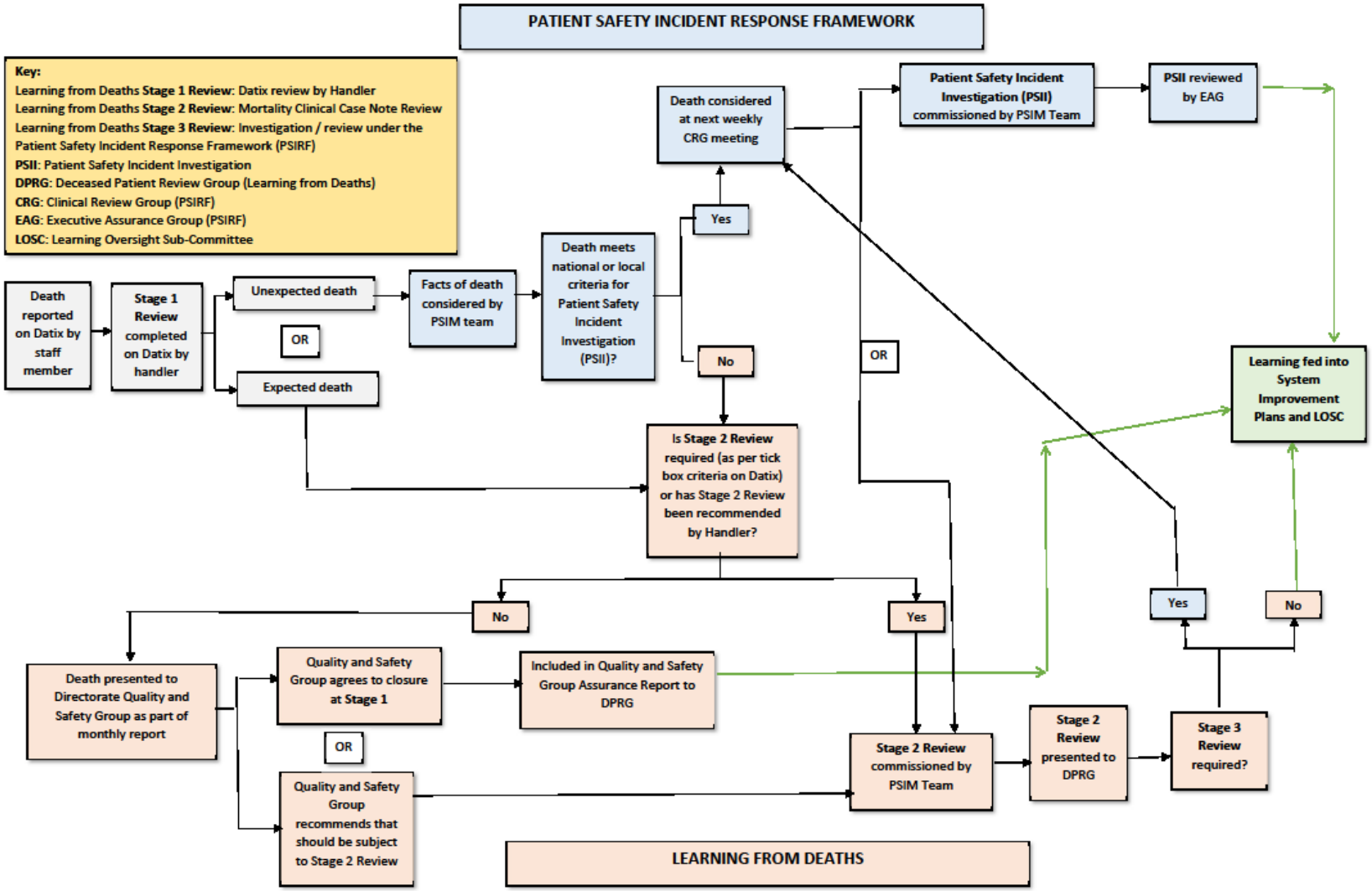
- Note the information contained within the report; and
- Request any further information or action.

Report prepared by:
Michelle Bourner, Project Co-ordinator

On behalf of:
Prof Natalie Hammond, Executive Nurse

March 2022

APPENDIX 1: NEW LEARNING FROM DEATHS ARRANGEMENTS AND ALIGNMENT TO PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) ARRANGEMENTS



		Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 March 2022

Report Title:	**Views of Members and Governors Report**					
Executive/Non-Executive Lead:	Professor Sheila Salmon, Chair of the Trust					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Council of Governors					
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)?	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		
The report provides details of the current membership metrics and details of any membership engagement events undertaken by the Trust.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: 1 Receive the report.

Summary of Key Issues

The Foundation Trust Code of Governance (Section E.1.3 – E.1.4) provides for:

- The chairperson should ensure the views of governors and members are communicated to the Board as a whole. The chairperson should discuss the affairs of the NHS foundation trust with Council of Governors.

- Non-executive directors should be offered the opportunity to attend meetings with the Council of Governors and should expect to attend them if requested to by governors. The senior independent director should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.

The report provides details of the mechanisms in place to meet this requirement.

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
Professor Sheila Salmon **Chair of the Trust**

Agenda Item: 7a
Board of Directors Part 1
30 March 2022

VIEWS OF MEMBERS AND GOVERNORS REPORT

1.0 PURPOSE OF THE REPORT

The report provides details of the current membership metrics and details of any membership engagement events undertaken by the Trust.

2.0 VIEWS OF MEMBERS AND GOVERNORS

The information below sets-out the mechanisms in place during 2021/22 to ensure the views of Governors and Members are shared with the Board of Directors.

2.1 Council of Governors

One of the general duties of the Council of Governors is to represent the interests of the members of the Trust and interests of the public. The Council of Governors meeting is held on a quarterly basis and has been held met on four occasions during 2021/22:

- 28 May 2021
- 1 September 2021
- 8 December 2021
- 21 March 2022

All members of the Council of Governors are expected to attend these meetings and in the case of Public and Staff Governors are elected by members of their constituencies to represent their views.

Appointed Governors are nominated to represent the views of their organisations. The table below provides the composition of the Council of Governors as at 22 March 2022:

Constituency	No. of Governors	Vacancies
Public Governors		
Essex Mid and South	8	1
North East Essex and Suffolk	2	1
Milton Keynes, Bedfordshire, Luton and the Rest of England	2	0
West Essex and Hertfordshire	4	1
Staff Governors		
Clinical	3	1
Non-Clinical	2	0
Appointed Governors		
• Essex County Council • Southend-on-Sea Council • Thurrock Council • Anglia Ruskin / Essex Universities • Council for Voluntary Services (CVS) Essex	3	2
Total	**30**	

The next elections for Public and Staff Governors will be held in June 2022 and will incorporate all vacancies.

The Council of Governors have further opportunities to meet with members of the Board of Directors through the following meetings:

Meeting	Frequency	Detail
Chair and Lead / Deputy Lead Governor Meeting	Quarterly	The Chair and Lead / Deputy Lead Governor meet to discuss the upcoming business for the Council of Governors and raise any items directly with the Chair of the Trust.
Chief Executive Officer Briefing	Quarterly	The Chief Executive Officer (CEO) briefs the Council on any operational matters and provides an opportunity for any items queries or clarifications prior to the Council of Governors meeting.
Chair of Sub-Committee Meetings	Quarterly	The Vice Chair and Chairs of the Council of Governors Sub-Committee meetings discuss items arising from these meetings and share learning.
Non-Executive Director / Governor Informal Meetings	Quarterly	Informal sessions providing an opportunity for relationship building between the Non-Executive Directors and Council of Governors and provides an opportunity for broader discussion on any topics.
Constituency Meetings	Quarterly	Non-Executive Directors and Governors meet by constituency to discuss any topics specific to their own constituency. Operational Service Managers / Directors also attend where possible to provide information about local services.
Joint Board Seminar Sessions	Twice-yearly	The Board of Directors and Council of Governors meet together to discuss strategic items and provide views for consideration as part of the strategic development.

The Governors are able to contact the Trust Secretary's Office to raise any concerns or queries which are then directed to the relevant member of the Board of Directors for response.

2.2 Membership

The Trust maintains a Membership Database which contains a list of all members currently registered with the Trust. The database is used to ensure communication with members is maintained and can provide certain metrics, based on information available. The metrics were presented to the Council of Governors Membership Committee for the first time in January 2022 and will be used going forward to note any changes and track impact of actions taken.

The following metrics provide details of the current membership composition as at January 2022 when the Committee last met. The information will be updated for each report and any changes will be advised. In addition, more metrics are being explored to provide further information on the composition of Trust membership:

	Current Membership as at January 2022
Total Membership	10,978
Public Members (45%)	4,989
Staff Members (55%)	5,989
By Constituency	
Essex Mid & South	1,955
Milton Keynes, Bedfordshire & Rest of England	1,702

	Current Membership as at January 2022
West Essex & Hertfordshire	709
North East Essex & Suffolk	606
By Gender	
Male (17%)	1,913
Female (28%)	2,975
Not Stated (55%)	6,090

The Trust Secretary's Office is currently liaising with Civica to understand the data relating to communicating with members. This will allow future reports to provide metrics relating to any communication circulated via the database, including postal members.

The Trust completed a baseline survey using the Membership database in October 2021.The survey sought views of Public Members of their current involvement and the level of communication with the Trust. The survey was circulated to 4,128 members with a valid email address and was opened by 40% of the recipients, with 9.1% completing the survey. The results of the survey were communicated to the Council of Governors Membership Committee and action is being undertaken to promote Trust membership and communicate with members outside of the Membership database, such as via social media.

2.3 Your Voice Meetings

The Trust holds public members meetings (Your Voice) which is an opportunity for the Trust to share information on certain topics and Governors to liaise directly with the membership. There have been two Your Voice Meetings held in 2021/22 (May 2021 and December 2021). Both meetings were held virtually for all members to attend.

The meeting on the 18 May 2021 focused on West Essex Out of Hospital Care and First Episode Rapid Early Intervention for Eating Disorders (FREED). Attendance data was not collected for this session.

The meeting held on the 1 December 2021 focused on Oxehealth which is a non-contact monitoring technology to support staff caring for patients by monitoring certain vital signs and movements and a service user providing feedback of their experiences accessing Trust services. The meeting was attended by 62 individuals and the table below provides a breakdown of the attendee group:

Attendee Group	No. of Attendees
Public Member	29
Governor	15
Staff Member	14
Non-Executive Director	3
Executive Director	1
Total	**62**

Feedback from the meetings were both informal and via a feedback form and was positive in terms of content and discussion provided. The Membership Committee considered the feedback for both sessions and highlighted the positive comments and considered improvements for future sessions.

The next Your Voice meeting is planned for 31 March 2022 and will be chaired by Mark Dale (Public Governor) and will cover the Crisis Line (111 Option 2) and a person with lived experience will share their experiences of our services.

2.4 Annual Members Meeting

The Trust held its Annual Members Meeting (AMM) on the 1 November 2021 via Microsoft Teams and included:

- A reflection on the last 12-months, including changes to the Board of Directors, inspections by the Care Quality Commission, key challenges and a celebration of the workforce over the last year.
- The Trust Annual Report and Accounts, including the outcome of external audit.
- A report from the Council of Governors, including details of what the Council does and key achievements over the last 12-months.
- A focus on Workforce engagement, including Here for You, staff wellbeing and future plans.
- Details of the Covid-19 mass vaccination programme delivered by the Trust.
- Details of Quality Priorities in relation to improvement, transformation, innovation and the Safety First, Safety Always Strategy developed by the Trust.

The meeting ended with a Question and Answers session, with members and Governors invited to ask any questions of the Board of Directors present at the meeting.

3.0 ACTION REQUIRED

The Board of Directors is asked to:

1 Receive the report.

Report prepared by:
Chris Jennings
Assistant Trust Secretary

On behalf of:
Professor Sheila Salmon
Chair of the Trust

		Agenda Item No: 8a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 March 2022

Report Title:	**Board Assurance Framework 2021/22 March 2022**					
Executive/Non-Executive Lead:	Denver Greenhalgh, Senior Director of Governance and Corporate Affairs					
Report Author(s):	Susan Barry, Head of Assurance					
Report discussed previously at:	Executive BAF Sub-Committee February 22 Executive BAF Sub-Committee March 22					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
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)?	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	N/A	

Purpose of the Report		
This report provides the Board of Directors (Part 1) with the March 2022 iteration of the 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 February 2022 Note the Board Assurance Framework Dashboards in Section 2 for February and March 2022

2. Note the risks linked to Strategic Objectives in Section 3
3. Note the key risks in Section 4
4. Note the Risk Movement and Milestones in Section 5
5. In relation to risks CRR90 Management of Covid-19 and CRR85 Mass Vaccinations approval of decreases in scores on corporate risks in Section 2

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)

There are currently six strategic risks each with underpinning strategies. SR3 (Systems/ Processes and Infrastructure) now has a Finance and Resources Directorate focus with work ongoing to move relevant parts into SR2 People and SR4 Demand and Capacity. The aim is to ensure appropriate Executive leadership. There are a number of strategic choices, prioritisation and cases for funding to be made in relation to SR3 going forward.

In relation to SR1 (Safety) further work will strengthen the narrative and actions as well as identify any gaps. Work is ongoing to scope risks around record keeping as part of the safety first, safety always strategy.

There are a breadth of issues and potential measures within SR2 (People) made up of more than one risk and we will take actions to ensure robust controls are detailed for the future.

Corporate Risks (Section 2.0)

No new identified risks added to Corporate Risk Register in the period. All risk reviews have taken place.

There are 14 corporate risks following three de-escalations in February 2022 to Directorate Risk Registers, namely CRR48 Medical and Consultant Vacancies, CRR74 Airlocks, and CRR84 Purposeful Admissions (the focus of a flow and capacity work

stream). One risk closed in February 2022, that being CRR87 Mass Vaccinations 12-15 age group Suffolk.

Risk owner for CRR11 (Suicide Prevention) and CRR34 (Suicide Prevention Training) is now Dr Milind Karale.

A reframing of risks CRR82 (Efficiencies) and CRR83 (Financial Plan) will take place as we go into the new financial year 2022/23 with a review of risk scores.

CRR90 Management of Covid-19 recommended to reduce in score to 5 x 2 = 10 (threshold).

Key Risks (Section 4.0)
There are seven 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
- 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

Supporting Documents and/or Further Reading

Appendix 1 Board Assurance Framework February - March 2022

Lead

Denver Greenhalgh
Senior Director of Governance and Corporate Affairs

EPUT Board Assurance Framework (BAF)
March 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.

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 key strategic risks, linked to the strategic objectives. All of these risks have/ will have a strategy underpinning them that focus on the enormity 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 Board may assign Strategic risks to a specific Committee for overview and scrutiny.

The Board Assurance Framework had its first public outing at the January 2022 Board of Directors meeting and received with approval. We are now live in Radar and working on populating strategic and corporate risks. Corporate Directorates will follow in April and Operational Directorates in May 2022. A standard operating protocol is in place for the Assurance Team initially and this will be adapted as we move forward.

2.0 BAF Dashboard February/ March 2022

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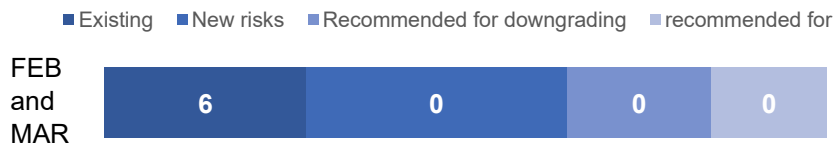
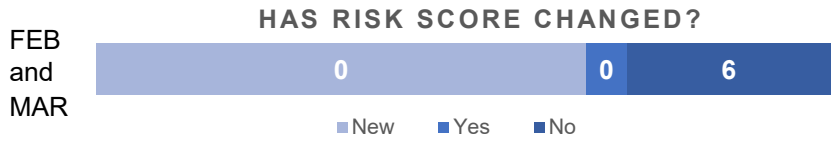
Strategic Risks

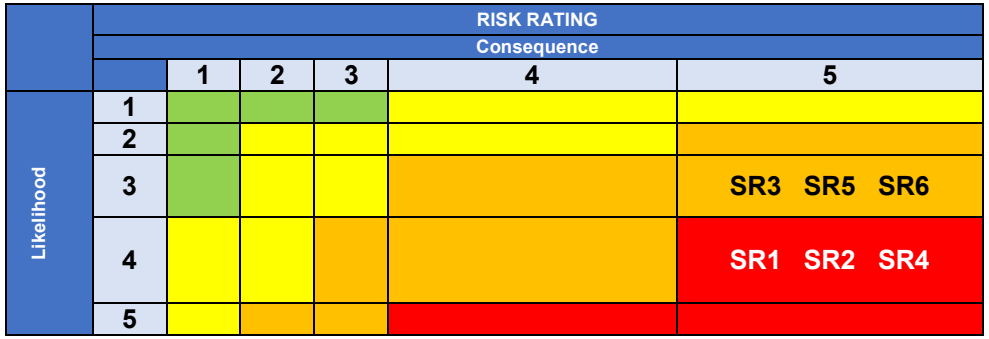
Risks to Strategic Objectives



Risk Score Movement



Risk Score Profile

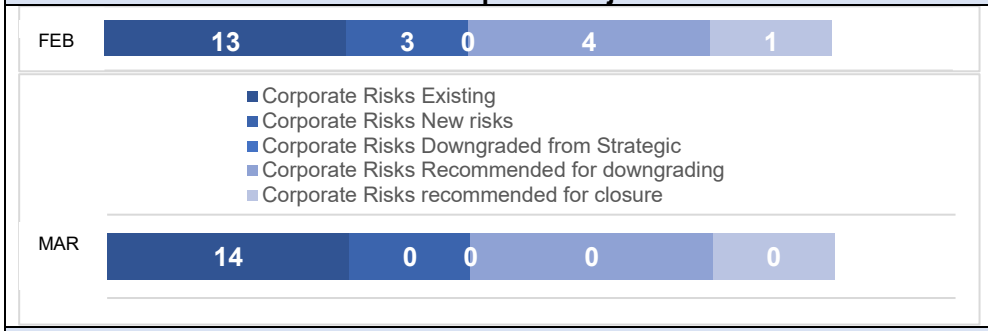


% risks reviewed by risk owners	Number of risks not reviewed	No movement 12 months	On RR more than 12 months	% risks with controls identified	% risks with assurance identified	% risks with actions overdue
100% ●	0 ●	0 ●	2 ●	100% ●	100% ●	0% ●

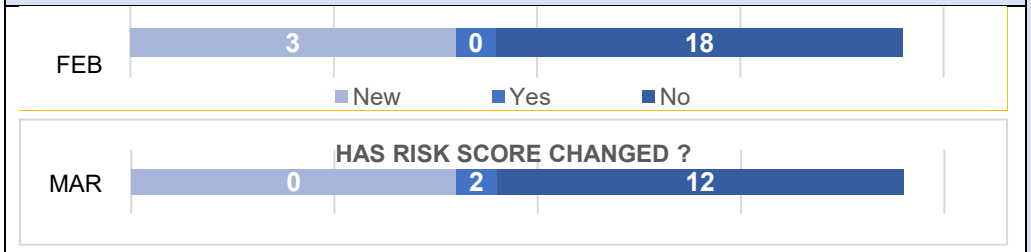
ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Comments
Existing risks								
SR1	1	**Safety**	Safety, Compliance, Service Delivery, Experience, Reputation	NH	5x4=20	20 20 20	Rising demand for services; Government Mental Health Recovery Action Plan; Covid-19; Challenges in Children & Adolescent Mental Health Services and complexities; Systemic workforce issues in the NHS	Safety First, Safety Always Strategy in situ. Regular progress reports are received at Executive and Board Safety Oversight Groups (ESOG and BSOG)
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	A People Plan is in place with a number of focused programmes overseen by People Equality and Innovation Committee
SR3	All	**Systems and Processes/ Infrastructure**	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x3=15	15 15 15	Functionality of Systems, processes and infrastructure across Estates, Facilities, Finance and procurement to optimise support to frontline services	The focus of this risk is now Esates, Facilities, Finance and Procurement Directorate. Overseen byFinance & Performance Committee. .
SR4	All	**Demand and Capacity**	Safety, Compliance, Service Delivery, Experience, Reputation	AG	5x4=20	20 20 20	Covid-19. Long-term plan. The Integration White Paper. Transformation and innovation National increase in demand on services Need for credible inpatient clinical model linked to community to drive service flows.	Executive Chief Operating Officer (ECOO) Service Delivery Model/ Strategy in implementation with clear road map for portfolio service areas. Directorate Operational structure well underway.
SR5	1	**Independent Inquiry**	Compliance, Reputation	NL	5x3=15	15 15 15	Government led independent inquiry into mental health services in Essex.	Inquiry Terms of Reference now published. Methodology for dealing with the Inquiry developed
SR6	All	**Cyber Attack**	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x3=15	15 15 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	Escalated to strategic risk register by Executive Board Assurance Framework Sub-Committee (EBAF) January 22 with increased score.

Corporate Risks

Risks to Corporate Objectives



Risk Score Movement



Risk Score Profile March

		RISK RATING				
		Consequence				
		1	2	3	4	5
Likelihood	1					
	2				85↓	90↓
	3				11 82 83 92	34 81 91 93
	4				45 77 79	94
	5					

% risks reviewed by risk owners	Number of risks not reviewed	No movement 12 months	On a RR more than 12 months	% risks with controls identified	% risks with assurance identified	% risks with actions overdue
85% ●	2 ●	4 ●	8 ●	100% ●	100% ●	0% ●

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Comments
CRR11	Suicide Prevention	Safe	MK	4x3=12	12 12 12	Implementation of suicide prevention strategy	Level 1: Suicide Prevention Group Level 2: Mortality Sub-Committee/ ESOG and BSOG Strategy implementation plan in place
CRR34	Suicide Prevention - training	Safe	MK	5x3=15	15 15 15	Implementation of suicide prevention strategy	Level 1: Suicide prevention group Level 2: Mortality Sub-Group and ESOG and BSOG 95% of staff have completed the suicide awareness training
CRR45	Mandatory training	Safe	SL	4x4=16	16 16 16	Training frequencies extended over Covid-19 pandemic with a need for recovery	Level 1: Training Tracker Level 2: Training Reporting via performance report Level 3: Information Governance Data Security & Protection Toolkit (IGDSPT) Recovery plan in place. Therapeutic and Safe Interventions (TASI) is the main area of concern and an increasing of resource discussions is taking place
CRR77	Medical Devices	Safe, 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

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Comments
							Level 3: Internal Audit – Design Moderate Effectiveness Limited
CRR79	Seasonal flu	Service Delivery	NH	4x4=16	16 16 16	Annual Flu vaccination programme	Level 1: Flu project group; Platform to collect data on flu uptake Level 2: Clinical Governance and Quality Planning for Winter 2022/23
CRR81	Ligature	Safe, 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 Ligature Risk Reduction Group (LRRG) Level 3: Internal Audit by BDO 2021/ East London Foundation Trust (ELFT) Independent Review 2021
CRR82	Efficiencies 21/22	Financial	TS	4x3=12	16 12 12	National deflator and local efficiency requirements.	Level 1: Board Level 2: Regional, Integrated Care System (ICS) and service efficiency groups Reframe risk for 2022/23
CRR83	Covid-19 Financial	Financial	TS	4x3=12	12 12 12	Financial regime during Covid-19 and reducing allocations	Level 1: F&PC EOSC BOD Level 2: Integrated Care System (ICS) sustainability exercise Reframe risk for 2022/23
CRR85	Mass Vaccination	Service Delivery	NL	4x2=8	12 12 8	Covid-19 pandemic	Mass Vaccination project in place 1,250,000 vaccinations given Recommendation to reduce this score to threshold at the current time as all plans are in place for responding to next wave vaccination programmes and the programme is now integrated. Maintain regular review.
CRR90	Management of Covid-19	Service Delivery	NL	5x2=10	20 20 10	Covid-19 pandemic	Level 1: Project management board Level 2: Command Structure and system monitoring Recommendation to reduce this score to threshold as we maintain everything in place to deal with Covid-19 going forward
CRR91	CAMHS Tier 4 System Bed Pressures	Safety, Compliance	AG	5x3=15	15 15 15	CQC Section 31 System bed pressures/ lack of specialist CAMHS beds	Intensive Support Group and daily escalations Managers Assurance report to ESOG CQC re-inspection taking place
CRR92	Addressing Inequalities	Experience	SL	4x3=12	12 12 12	Risk was escalated from Corporate Risk Register to the BAF in March 2021 – de-escalated November 21	Overseen by Equality & Inclusion Sub-Committee (E&ISC) EDS2 2020/21 scored positively by stakeholders, EDS2 2021/22 approved by stakeholder focus group and E&ISC
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 aiming for July 22 to become business as usual for this Overseen by ESOG Framework for Public Health Service Ombudsman (PHSO) and Care Quality Commission (CQC) action plan testing
CRR94	Engagement and supportive observation	Safety, Compliance	AG	5x4=20	20 20 20	CQC found observation learning not embedded	Observation is a key priority project Overseen by ESOG and BSOG Increased score in Dec 21

3.0 Strategic Objectives

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

Risk Summary

There are 17 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. No risk score changes for 3 months.
- CRR11 Suicide prevention, risk score 4x3=12. Risk score unchanged in last 3 months.
- CRR77 Medical devices, risk score 4x4=16. No risk score changes in last 3 months.
- CRR81 Ligature reduction, risk score 4x3=12. No risk score changes in last 3 months. De-escalated from SRR.
- CRR82 Efficiencies, risk score 4x3=12. No risk score changes 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.
- 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.
- CRR79 Seasonal flu, risk score 4x4=16. No risk score changes in last 3 months.
- CRR92 Addressing Inequalities, risk score 4x3=12. No risk score changes 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 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 Programme, recommend risk score reduction from 3x4=12 to 4x2=8 (Nigel Leonard). Risk score decreased in last 3 months. Managed by Mass Vaccination Project. Recommendation to reduce this score to threshold at the current time as all plans are in place for responding to next wave vaccination programmes and the programme is now integrated. Maintain regular review.
- CRR90 Management of Covid-19, risk score increased in last 3 months. Managed by Command Structure overseen by Executive Team. Recommended for a reduction in score to threshold 5 x 2 = 10 (NL). Recommendation to reduce this score to threshold as we maintain everything in place to deal with Covid-19 going forward

4.0 Key Risks

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The tables below highlight all risks with a score of 20 or above

4.1 Table 1 – Strategic Risks 20 or above

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 *Reduction in sexual safety incidents, reduction in use of restrictive practice Delivery of National Zero Suicide Ambition Improved patient safety across all key*	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	Project Management Office (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	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 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*	Safety First, Safety Always Strategy Quality Committee Strategy Overall Portfolio Status Report including Safety Priorities – inpatient flow, safe staffing, engagement and supportive observations, culture of learning, ligature risk reduction/ environmental actions – all on track Culture of learning progress report ESOG Minutes BSOG Minutes	None

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
	theme trajectories March 24 5 x 2 = 10			insight into wellbeing support for via structured feedback Wellbeing offer including 'Here for you' confidential staff support Innovation EPUT (Trust) Lab, Quality Academy and partnership initiatives Executive Safety Priority – Flow and Capacity with five work streams: personality disorders, community flow, flow processes, out of area placements and inpatient modelling Intensive clinical support groups in MH acute and CAMHS – guidelines reviewed in relation to handover, observation and engagement, sexual safety and restrictive practice Reviews of component factors to support implementation and review, including co-production, reflective supervision and practice, continuous learning and improvement, learning lessons and sharing and celebrating good practice. Agenda embedded into induction and all management development programmes	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	Overall plan of all projects, inclusive of in-flight and planned projects and programmes over next 24 months – updates to ESOG and BSOG Updates on Quality Priorities to Quality Committee	

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
				12 nurses completed Nurse Advocate Programme RISE leadership programme commenced Lunchtime learning events, 5 key messages and presentations to QI Hubs 2 Patient Safety Co-ordinators employed by Estates Team to improve comms and measure performance in all (estates) areas of patient safety. Includes risk stratification process and triage. Visible improvements.			
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	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	SafeCare to provide more reliable staffing information 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	Corporate business partnering 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'	People and Culture Committee (PECC) Safer staffing data Patient safety incidents Project updates to ESOG and BSOG PECC Committee papers February 22	Delivery of elements of the proposed People Strategy (see gaps in controls) – dates to be added

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
	5 x 2 = 10		Mandatory vaccinations from 1 April 22 Recovery from HSE and Covid-19 NHS People Plan	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 Patient Engagement Strategy presenting to PECC Feb 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 Feb 22 – includes international recruitment establishment Retention task and finish group in place Links to culture of learning project through engagement	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) **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**		

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
				HR drop in surgeries Delivery of VCOD Regulations Launch of new disciplinary procedure that promotes just learning and restorative culture 'Here for you' fully embedded in Trust Appointment of Director of Health and Wellbeing ER activity reported to all staff networks Therapy apprenticeships in place Health Care Support Worker recruitment programme ESR and EFIN alignment complete Appraisal process includes talent mapping process using Pen Plan Placement capacity expanded to support grow your own strategy Long Covid Support Group Menopause Support Group Burnout sessions Mindfulness Wellness plans linked to appraisals Work-life balance and bespoke individual and team level support implemented Domestic abuse support Monthly Engagement Champion network events	R&R strategy, identifying future EPUT needs, talent gaps, population we serve Workforce action plan requires broadening (AH) **People Plan** Review long-term strategy for home working Review the dignity, respect and grievance policy and procedure with focus on just learning and restorative culture Undertake targeted recruitment campaigns for underrepresented groups Review all recruitment literature to ensure diversity captured Work towards fully embedding just learning and restorative culture – task and finish group March 22 Undertake review of healthcare support worker induction programme Develop proposal to maximise flexible working across Trust following completion of NHS Flex for the Future programme Pilot centralised rostering in specialist services Undertake a review and mapping process of people systems Implement ESR management self-service Staff Survey Results Framework for health and wellbeing offer		

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
				Launch of Monthly Engagement and Wellbeing Newsletter Festival of Wellbeing Draft KPI Dashboard – Staffing – Time to hire (working days) SafeCare completion rate Substantive registered clinical staff vacancy rate Substantive unregistered clinical staff vacancy rate			
SR4 All SO's Lead AG Standing Committee: PECC	**DEMAND/ CAPACITY** 20 > 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	All integrated Director posts covering mental health and physical health have now been appointed to across EPUT – commencement of evolution of care groups with early discussions on operational structures **Operational Directors** accountable for service delivery through accountability and governance frameworks 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	**ECOO Service Delivery Model/ Strategy** aligned with – **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 July **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 Clinical and service strategies for each area to be developed	F&PC Board ESOG System Oversight and Assurance Groups Accountability meetings	None Developing KPIs for flow and capacity Workstream – inpatient modelling community flow purposeful admissions and out of area placements Reduce Inappropriate our of area placements by end March MH inpatients

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
			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	opportunities to deliver improved outcomes Draft KPI dashboard developed – Inpatient Flow & Capacity % of end of month out of area placements versus trajectory % of end of month Delayed Transfers of Care versus trajectory % of patients staying longer than national benchmark days with a clear treatment plan	**Facilitating partnerships** including social care and voluntary sector as well as service user voice Advent of provider collaboratives – resilience and mutual aid/ support. Commonality in service delivery. MSE community, EoE provider collaborative and MH collaborative are part of this strategic solution **Progressing for Inpatient Adult Mental Health:** Inpatient modelling with bed capacity that supports demand Inpatient modelling developing through flow and capacity, a safety priority under ESOG. Raising profile of flow and capacity leadership in EPUT. 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 **Diagnostics** All systems (EPUT leadership support in place NEE)		

4.2 Table 2 – Corporate Risks 20 or above

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
CRR94 SO1 Lead AG Quality Committee	**Engagement and Supportive Observations** 20 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 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	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 Incidence of harm Task and Finish Workstreams in train – policy refresh, clinical audit, e-observations, training and armbands Phase 4 documentation underway for E-observations paused due to tech reasons Upload new policy to InPut and share comms Align online training to new policy and release by end Feb comms Review training videos by end Jan	Level 1: Perfect Ward Audits ESOG BSOG Accountability Framework Implementation Plan	Perfect Ward audit results Annual audit using data from PerfectWard Follow up clinical audit in Q2 Bring into line with developed KPIs

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
				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 Phase 3 parallel digital and paper trial concluded at Peter Bruff, Ardleigh and CAMHS. Digital protocol is as safe as paper. Functionality and ease of use positive. On line training being reviewed by Deputy Director of Quality Transformation Intensive Clinical Support Groups have reviewed guidelines relating to observation and engagement Draft KPI Dashboard – Engagement and Observation –	and incorporate into revised online training by end Feb Onsite ward activities to recommence 07/02		

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
				% of patients on level 3 & 4 observations who have been on that level for over two weeks % of wards with improved clinical audit results (reported once a year)			

5.0 Strategic and Corporate Risk Movement and Milestones – two-year period April 2020 to March 2022

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5.1 Strategic Risk Movement

Risk ID	Initial Score	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	Feb 22	Mar 22	Risk ID
SR1	20																			New	20	20↔	20↔	20↔	20↔	SR1
SR2	20																			New	20	20↔	20↔	20↔	20↔	SR2
SR3	15																			New	15	15↔	15↔	15↔	15↔	SR3
SR4	20																			New	20	20↔	20↔	20↔	20↔	SR4
SR5	20								New	20	20↔	20↔	20↔	20↔	15↓	15↔	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↔	15↑	15↔	15↔	SR6

5.2 Strategic Risk Milestones

Risk ID	Initial Score	Time on SR/ old BAF	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	Feb 22	Mar 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																					CRR	15			SR6 (CRR40)

5.3 Corporate Risk Movement

Risk ID	Initial Score	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	Feb 22	Mar 22	Risk ID
CRR11	16	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	8↓	12↑	12↔	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↔	15↑	15↔	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↔	SR				CRR40
CRR45	12	12↔	12↔	12↔	12↔	16↑	16↔	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	16↓	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	DRR		CRR48
CRR53	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↔	DRR		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↔	16↔	16↔	CRR77
CRR78	9																New	9	9↔	9↔	9↔	6↓closed				CRR78
CRR79	16																	New	16	16↔	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↔	De-esc				CRR80
CRR81	12	20↔	15↓	15↔	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↔	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↔	12↔	12↔	CRR83
CRR84	15														New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	DRR		CRR84
CRR85	20							New	20	20↔	20↔	15↓	15↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	20↑	12↓	12↔	8↓	CRR85

Risk ID	Initial Score	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	Feb 22	Mar 22	Risk ID
CRR86	16																			New	16	20↑	Merged			CRR86
CRR87	20																			New	20	16↓	16↓	Close		CRR87
CRR88	20																			New	20	De-esc				CRR88
CRR89	15																			New	15	Closed				CRR89
CRR90	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	10↓	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	20↑	20↔	20↔	12↓	CRR90
CRR91	20																New	20	20↔	20↔	20↔	15↓	15↔	DRR		CRR91
CRR92	20											New	20	20↔	16↓	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	CRR92
CRR93	15												New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR93
CRR94	16																New	16	16↔	16↔	16↔	20↑	20↔	20↔	20↔	CRR94

5.4 Corporate Risk Milestones

Risk ID	Initial Score	Time on CRR or old BAF	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	Feb 22	Mar 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															DRR		CRR48
CRR53	12	> 2 years																					De-esc	DRR			CRR53
CRR68	16	> 1 year					16																De-esc	DRR			CRR68
CRR72	12	> 1 year								12													Closed				CRR72
CRR74	15	> 1 year									15														DRR		CRR74
CRR76	20	>6 months												20		15				10			Closed				CRR76
CRR77	16	>6 months														16											CRR77
CRR78	9	<6 months																	9				Closed				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								DRR		CRR84
CRR85	20	> 1 year							New	20			15		12								20	12		8	CRR85
CRR86	16	<6 months																				16	20	Merged			CRR86
CRR87	20	<6 months																				20	16		Closed		CRR87
CRR88	20	<6 months																				20	De-esc	DRR			CRR88
CRR89	15	<6 months																				15	Closed				CRR89
CRR90	15	> 2 years								10													20			12	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

6.0 Recommendations to the Board of Directors

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1. Note the decisions made by the Executive BAF Sub-Group at its meeting in February 2022 Note the Board Assurance Framework Dashboards in Section 2 for February and March 2022
2. Note the risks linked to Strategic Objectives in Section 3
3. Note the key risks in Section 4
4. Note the Risk Movement and Milestones in Section 5
5. In relation to risks CRR90 Management of Covid-19 and CRR85 Mass Vaccinations approval of decreases in scores on corporate risks in Section 2

Please see table below for summary of changes in February and March 2022:

February 2022 Decisions
New Strategic Risks
None
Strategic Risks recommended for de-escalation to Corporate Risk Register
None
Strategic Risks recommended for closure
None
New Corporate Risks
None
Corporate Risks increased in score
None
Corporate Risks decreased in score
None
Corporate Risks de-escalated to Directorate RR(s)
CRR48 Medical and Consultant Vacancies – Medical DRR
CRR74 Airlocks – Estates DRR
CRR84 Purposeful Admissions – Inpatients DRR
Corporate Risks closed
CRR87 Mass Vaccinations 12-15 Age Group Suffolk

March 2022 Decisions
New Strategic Risks for Approval
None
Strategic Risks recommended for de-escalation to Corporate Risk Register
None
Strategic Risks recommended for closure
None
New Corporate Risks for Approval
None
Corporate Risks recommended for increase in score
None
Corporate Risks recommended for de-escalation
None
Corporate Risks recommended for decrease in score
CRR90 Management of Covid-19 (decreased to 10 as all plans are in place for responding to next wave vaccination programmes and the programme is now integrated. Maintain regular review.)
CRR85 Mass Vaccinations (decreased to 8 recommendation to reduce this score to threshold as we maintain everything in place to deal with Covid-19 going forward)
Corporate Risks recommended for closure
None

		Agenda Item No: 8bi
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 March 2022

Report Title:	**Audit Committee Assurance Report**					
Executive/ Non-Executive Lead:	Janet Wood, Chair of the Audit Committee					
Report Author(s):	Carol Riley, Audit Committee Secretary					
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	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)?	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 assurance to the Board that the duties of the Audit Committee, which include Governance, Risk Management and Internal Control, have been appropriately complied with.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Receive and note the contents of the report
2 Confirm acceptance of assurance given in respect of risks and actions identified

Summary of Key Issues

Details are provided of the discussions held at the Audit Committee meetings held on the 21 January 2022 and 18 March 2022.

The meeting held on the 21 January 2022 considered:

- Internal Audit
- Update from Local Counter Fraud Specialists (LCFS)
- External Audit
- Final Charitable Accounts 2020/21

- Draft Interim Risk Management and Assurance Framework
- Governance Development Plan
- Finance Procedures
- Losses and Special Payments
- Waiver of Standing Orders
- Statement of Financial Position Write Offs/Impaired Debt Write Offs
- IFRS 16

The meeting held on the 18 March 2022 considered:

- Internal Audit
- Update from LCFS including the Annual Work plan and Strategy and the Counter Fraud Functional Standard Return 2020/21
- External Audit
- Draft Interim Risk Management and Assurance Framework
- Joint Assurance Report on Process around Whistleblowing and Freedom to Speak Up
- Fire Safety Update
- Audit Committee Self-Assessment Checklist
- Annual Review of Audit Committee Terms of Reference
- Audit Committee Work plan
- Non Consolidation of Charity Accounts 2021/22
- Losses and Special Payments
- Waiver of Standing Orders
- Statement of Financial Position Write Offs/Write Backs/Impaired Debts Write Offs
- Finance Procedures
- 2022/23 Budget 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			

Supporting Documents and/or Further Reading
Main Report

Lead

Janet Wood
Non-Executive Director
Chair of Audit Committee

Agenda Item: 8bi
Board of Directors Part 1
30 March 2022

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE AUDIT COMMITTEE CHAIR

1.0. PURPOSE OF THE REPORT

This report provides the Board of Directors with assurance to the Board that the duties of the Audit Committee, which include Governance, Risk Management and Internal Control, have been appropriately complied with.

2.0. EXECUTIVE SUMMARY

Audit Committee Meeting 21 January 2022 & 18 March 2022

The Audit Committee met on the 21 January 2022 and the 18 March 2022. The meeting held on the 21 January 2022 approved the minutes of the 9 November 2021 meeting. The meeting held on the 18 March 2022 approved the minutes of the 21 January 2022 meeting subject to minor amendments. These minutes are available to Board members on request.

At the meeting held on 21 January 2022 the following matters were discussed:

1. **Internal Audit**

1.1 **Internal Audit Progress Report 2020/21 -** The following reports have been finalised:

- Clinical Audit
- Trust Accommodation – Limited assurance

1.2 **Local Counter Fraud Service Progress Report:**

Referrals - The Committee received an update on the current investigations/referrals.

Fraud Awareness Week 14-20 November 2021 - Members were informed and agreed that this would be promoted via Communications.

2. **External Audit - External Audit Plan**

External Audit Plan to be presented to the Audit Committee in March 2022.

3. **Charitable Fund Accounts 2020/21**

Members approved the above and agreed that the accounts would be presented to the January 2022 Board of Directors.

4. **Draft Interim Risk Management and Assurance Framework**

The above was discussed and noted.

5. **Losses and Special Payments**

As at the end of Month 9, the Trust is reporting losses and special payments of £4.9k.

6. **Waiver of Standing Orders**

During the period from 1 November 2021 to 31 December 2021, standing orders for competitive quotations were waived on eighteen occasions to the value of £540,260.38 (including VAT). Of these, six relate to the mass vaccination programme to the value of £253,091.07.

For the same period, standing orders for competitive tenders were waived on two occasions to the value of £346,800.

The total value of waivers for 2021/22 YTD is £7,121,574 including £2,600,000 for security services at the vaccination centres (approved by Board in July 2021).

7. **Statement of Financial Position Write Offs/Write Backs/Impaired Debts Write Offs**

The debts and ledger balances as at 31 December 2021 and has identified amounts to be written off totalling £99,466. Of this total amount, £44,441 has previously been provided for within earlier financial years, thereby reducing the charge to the 2021/22 financial year to £55,025.

8 **IFRS16**

NHS organisations are required to implement IFRS 16 Leases for FY 2022/23. This will result in the majority of leased assets, and the associated lease liability, being recognised on the Trust's Statement of Financial Position (SoFP).

It has been identified that 55 leases will be brought onto the Trust's Statement of Financial Position (SoFP) as Right of Use (RoU) assets, increasing both asset and liabilities by £43.2m.

The 2022/23 financial impacts are estimated as additional costs of £186k against revenue budgets, and £877k additional capital costs. Formal confirmation regarding the level of central financial support remains outstanding. Further guidance is expected as part of the 2022/23 plan submission arrangements. The forthcoming planning submissions for 202/223 will collate the impact of the IFRS and it is expected this will be used to inform NHS capital and revenue allocations for 2022/23.

It was noted that the accounting arrangements are predominantly the same as under the previous standard.

At the meeting held on 18 March 2022 the following matters were discussed

1**. Internal Audit**

1.1 **Internal Audit Progress Report 2021/22** - The following report has been finalised:

- Site Visits – Limited assurance
- Medical Devices Management – Limited assurance

1.2 **Local Counter Fraud Service Progress Report -**

Referrals - The Committee received an update on the current investigations/referrals.

LCFS Annual Work plan and Strategy 2022/23 - The Committee approved the plan.

Draft Counter Fraud Functional Standard Return 2020/21 - The above return is due in May 2022.

2. **External Audit**

Provisional Audit Plan - The Committee approved the provision plan.

3 **Draft Interim Risk Management and Assurance Framework**

The above was discussed and noted.

4. **Joint Assurance Report on Process around Whistleblowing and Freedom to Speak Up**

The above was discussed and noted.

5. **Fire Safety Update**

Assurance was provided by the Senior Director of Estates and Facilities that the two fire risks highlighted within the fire compartmentation programme are due to be mitigated by the 31 March 2022 at Rochford Hospital.

The Basildon Assessment Unit compartmentation will not be mitigated until May 2022 due to labour and material shortages.

6. **Audit Committee Self-Assessment Checklist**

The above was discussed and noted.

7. **Annual Review of Terms of Reference – Audit Committee**

The terms of reference were approved.

8. **Audit Committee Work plan**

Subject to minor amendments the above was approved.

9. **Non Consolidation of Charity Accounts 2021/22**

The above was approved.

10. **Losses and Special Payments**

As at the end of Month 11, the Trust is reporting losses and special payments of £5.6k.

11. **Waiver of Standing Orders**

During the period from 01 January 2022 to 28 February 2022 competitive quotations were waived on nineteen occasions totalling £632k (including VAT). Of these, five items relate to the mass vaccination programme (£98k).

For the same period one competitive tender was waived which totalled £115k.

The total value of waivers for 2021/22 YTD is £7,869k including £2.6m for security services at the vaccination centre (approved by Board in July 2021).

It was noted that following October 2021 the SFIs have been strengthened to ensure completeness of capture of waivers. Therefore an increase in reported waivers has occurred. The capture process now includes waivers where EPUT acts as a pass through agent for some services.

12. **Statement of Financial Position Write Offs/Write Backs/Impaired Debts Write Offs**

The debts and ledger balances as at 31 March 2022 and has identified amounts to be written off totalling £41,216. Of this total amount, £19,957 has previously been provided for within earlier financial years, thereby reducing the charge to the 2021/22 financial year to £21,259.

13. **Finance Procedures**

The following procedures were approved:

- Leases (FP05/11)
- Efficiency Improvement Procedure (FP09/17)
- Purchase Card Procedure (FP10)

14. **2022/23 Budget Process**

It was noted that the above is due to be presented to the Board Seminar on the 27 April 2022 followed by the final submission on the 28 April 2022. The above plan was discussed and noted.

3.0. MANAGEMENT OF RISK

The Audit Committee is not responsible for managing any of the Trust's significant risks (as identified in the Board Assurance Framework).

4.0. NEW RISKS

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

5.0 ACTION REQUIRED

The Board of Directors is asked to:

1 Receive and note the contents of the report
2 Confirm acceptance of assurance given in respect of risks and actions identified

Janet Wood
Non-Executive Director
Chair of Audit Committee

Agenda Item No: 8bii

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	30 March 2022

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

Risk Assessment of Report		
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 thatthe Finance and 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 Receive and note the contents of the report
2 Confirm acceptance of assurance provided
3 Request any further information or action

Summary of Key Issues

Please note this assurance report for the Board is a bi-monthly report and will cover items discussed in February and March.

Performance Report

This report covers the position for month 10 and month 11.

In February 2022 there were 5 areas of inadequate performance (6 in January).

The Executive Director of Operations outlined each inadequate indicator along with the pressures impacting on these and what mitigating actions are in place. The Executive Director of Operations assured members that EPUT continues to work collaboratively with system partners and NHS England / Improvement on the challenges being faced by the Trust.

During the March meeting the Director of Mental Health Urgent Care & Inpatient Services attended to provide a spotlight presentation on flow and capacity within the inpatient units.

During the February meeting the Executive Director of Operations and the Chief Finance and Resources Officer provided an update covering progress with the Accountability Framework meetings.

Committee members thanked those who presented for bringing to life the performance within the Trust with a full and comprehensive update.

Financial Update – Month 11

The Director of Operational Finance reported to the committee the current updates for revenue and capital.

The Trust continues to forecast a year end breakeven position and the committee noted that the Trust is dealing with a greater number of year end issues than usual. The Director of Operational Finance gave assurance to members that the Trust continues to forecast delivery of the capital plan.

The committee members noted their praise for the work being carried out by the finance team and for the presentation given.

Contracting Update

The Director of Contracting and Business Development presented an update of the status of Contracting and Business Development activities, along with the primary issues. This included updates for the Lighthouse and School Aged Immunisation services.

The Chair of the committee thanked the Director of Contracting and Business Development for their update and reassurance of the Lighthouse Child Development Centre Service progress.

22/22 Planning (Revenue & Capital)

The Director of Commercial Finance supplied an update on the draft activity and workforce financial plan which has now been successfully submitted. EPUT submitted a balanced plan and continues to work closely with all three system partners. The final plan is due for submission in April.

Members of the committee praised the achievement of submitting this within timescale and for keeping the members well briefed. The committee has agreed to adopt the draft plan as an interim budget proposal.

Q3 Board Assurance Framework

The Senior Director of Governance and Corporate Affairs gave a brief update on the Board Assurance Framework progress and which risks are aligned to this committee. Three risks have been either closed or de-escalated since the last report provided.

The committee thanked the Senior Director of Governance and Corporate Affairs for providing this update.

Estates & Facilities Restructure Proposal

In February, the Transformation Director of Estates and Facilities presented the restructure proposal which has been supported by the Executive Team.

Members of the committee noted the "work in progress" list is long and have asked for more assurance on prioritisation and progress. The Transformation Director of Estates and Facilities has agreed to bring this item back to the committee on a quarterly basis.

Policy Extension & Approval Requests

In March, the Committee approved the extension of the policy & procedure listed below:

- Fit & Proper Persons

There were no policy extension requests in February.

Any Risks or Issues

There were no risks identified as requiring addition to the risk register.

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
Accompanying Report

Lead
Loy Lobo **Non-Executive Director**

Agenda Item 8bii
Board of Directors Meeting Part 1
30 March 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 10 January 2022 and month 11 February 2022.

The Finance and Performance Committee (FPC) is constituted as a standing committee of the Board of Directors. The Board of Directors has delegated responsibility to this committee for the oversight and monitoring of the Trust's financial, operational and organisational performance in accordance with the relevant legislation, national guidance, the Code of Governance and current best practice from 1 April 2017.

The Committee is required to ensure that risks associated with the performance and governance arrangements of the Trust are brought to the attention of the Board of Directors and/or to provide assurance that these are being managed appropriately by the Executive Directors.

2.0 Quality and Performance Report

This report covers the position for month 10 and month 11.

In February 2022 there were 5 areas of inadequate performance (6* in January):

- CPA Reviews
- Inpatient MH Capacity (Adults)
- Out of Area Placements
- Psychology
- Sickness Absence

*Clients not seen for 12 months is no longer inadequate. The medical elements of this indicator have been downgraded whilst the target is being reviewed.

The Executive Director of Operations outlined each inadequate indicator along with the pressures impacting on these and what mitigating actions are in place. The Executive Director of Operations assured members that EPUT continues to work collaboratively with system partners and NHS E/I on the challenges being faced by the Trust.

During the March meeting the Director of Mental Health Urgent Care & Inpatient Services attended to provide a spotlight presentation on flow and capacity within the inpatient units. The Chair of the committee gave thanks for the report and the great insights that are being captured and presented.

During the February meeting the Executive Director of Operations and the Chief Finance and Resources Officer provided an update covering progress with the Accountability Framework meetings. The committee fed back praise for the performance report created for this and operational colleagues advised the groups have been very supportive and beneficial.

Committee members thanked those who presented for bringing to life the performance within the Trust with a full and comprehensive update.

3.0 FINANCIAL POSITION – MONTH 11

The Director of Operational Finance reported to the committee that the revenue position for month 11 is breakeven, year to date there is a surplus of £0.1m, and is £0.2m better than planned.
The Trust continues to forecast a year end breakeven position and the committee noted that the Trust is dealing with a greater number of year end issues than usual.
The capital year to date actual spend is £9.7m compared to an annual plan of £14.4m. The Director of Operational Finance gave assurance to members that the Trust continues to forecast delivery of the capital plan.

The committee members noted their praise for the work being carried out by the finance team and for the presentation given.

4.0 CONTRACTING UPDATE

The Director of Contracting and Business Development presented an update of the status of Contracting and Business Development activities, along with the primary issues. This included updates for the Lighthouse and School Aged Immunisation services.

The Director of Contracting and Business Development updated the committee on the current position with the Lighthouse Child Development Centre Service and gave assurance that there will be a post mobilisation review by the end of April. This will be fed back to the committee at that point.

The Chair of the committee thanked the Director of Contracting and Business Development for their update.

5.0 22/23 PLANNING (REVENUE & CAPITAL)

The Director of Commercial Finance supplied an update on the draft 22/23 activity and workforce financial plan which has now been successfully submitted and has met all National and ICS deadlines. EPUT submitted a balanced plan with a current requirement to deliver £19.5m (4.1%) of efficiencies, of which £9.5m schemes have been identified. Key risks noted by the Director of Commercial Finance are the development and delivery of the efficiency programme and management of COVID costs within allocations. The final plan is due in April and the Trust continues to work closely with all three system partners.

Members of the committee praised the achievement of submitting this within timescale and for keeping the members well briefed. The committee has agreed to adopt the draft plan as an interim budget proposal.

6.0 Q3 BOARD ASSURANCE FRAMEWORK

The Senior Director of Governance and Corporate Affairs gave a brief update on the Board Assurance Framework progress and which risks are aligned to this committee. Three risks have been either closed or de-escalated since the last report provided.

A mapping exercise will be taking place to assess how these reports sit in the organisation and are escalated to different committee's.

The committee thanked the Senior Director of Governance and Corporate Affairs for providing this update.

7.0 ESTATES & FACILITIES RESTRUCTURE PROPOSAL

In February, the Transformation Director of Estates and Facilities presented the restructure proposal which has been supported by the Executive Team. The plan outlines the long-term strategy with focus on succession planning and quality.

Members of the committee noted the “work in progress” list is long and have asked for more assurance on prioritisation and progress. The Transformation Director of Estates and Facilities has agreed to bring this item back to the committee on a quarterly basis.

8.0 Policy Extension Requests

In March, the Committee approved the extension of the policy & procedure listed below:

- Fit & Proper Persons

There were no policy extension requests in February.

9.0 Any risks or issues

There were no risks identified as requiring addition to the risk register.

10.0 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

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 8biii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 March 2022

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:	Not previously discussed.					
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 the Board of Directors with assurance on actions being taken by Sub-Committees to progress key aspects of the quality agenda and identify any risks associated with the current COVID-19 Pandemic and the associated pressures on services.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Receive and note the contents of the report

2 Confirm acceptance of assurance given in respect of actions identified tomitigate 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. It is to be noted, however, that due to capacity issues not all sub-committee assurance reports were received for the March 20022 Committee meeting but verbal assurance and other elements were provided.

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
Accompanying Report

Lead
Rufus Helm Non-Execuvie Director Chair of the Quality Committee

Agenda Item: 8biii
Board of Directors Meeting Part 1
30 March 2022

QUALITY COMMITTEE ASSURANCE REPORT

1 PURPOSE OF REPORT

This report provides the Board of Directors with assurance on actions being taken by Sub-Committees to progress key aspects of the quality agenda and identify any risks associated with the current COVID-19 Pandemic and the associated pressures on services.

2 EXECUTIVE SUMMARY

2.1 Minutes of previous meetings

The minutes of the Quality Committee meetings held on 10 February 2022 and 10 March 2022 were approved as correct accounts of the meetings.

Summary of discussions and issues identified as well as assurances provided at the October and November meetings:

2.2 <u>10 March 2022</u>

2.2.1 Quality Account: The Committee received a verbal update of progress being made against the Quality Account. All area Leads have been requested to write their sections and a long list of potential quality priorities for 22/23 was being compiled that would be circulated to stakeholders in the form of a ballot.

2.2.2 Work Plan: The Committee were advised that in light of the ongoing review of governance arrangement and committee structures the work plan would be reviewed for 2022/23 and brought back to the next meeting for approval.

2.2.3 Combined Sub-Assurance Report: The Committee received the combined sub-assurance but noted that there were a number of gaps with committees' not supplying reports. The Committee acknowledged the pressure staff were under but expressed some concerns that without update reports they did not have assurance that structures were mitigating risks. It was agreed that the newly appointed Director of Governance would review reporting arrangements for the May report. Concern was expressed that cumulatively the number of risks were increasing and this should be escalated. The Committee also noted the challenges faced by the safeguarding team with an increase in referrals across all categories. It was agreed that this was a risk and should be escalated to the Executive Committee in order that an informed decision can be made in relation to resourcing and support. Non-Executive Directors agreed to review potential risks whilst taking part in their visits across Trust services.

2.2.4 Quarterly Quality/Patient Safety Strategy: The Committee received an updated report that showed progress against the seven themes embedded within the Patient Safety strategy and the impact this work was having against quality outcomes. Feedback was sought on how the Board and Quality Committee would receive visibility and assurance around lessons learnt ensuring they were embedded within practice. The Committee were advised that a report was being drafted that looks at learning from the first year of the Patient Safety Incident Response Framework. This was inclusive of a review of incidents, thematic review of those incidents and the priorities to take forward in system improvement plans. The outcomes documented in this report will be supported by the culture of learning work led by the Director of

Patient Safety. It was agreed that further discussions would be held with senior leads to ensure that the report contacted the level of assurance expected. A learning lessons team was being established and that team will lead on the provision of assurance in relation to changes in practice. The importance of the governance process around the implementation of PSIRF and assurance was given that delivery sits in the target operating model ensuring clinicians and operating leadership teams have oversight assurance with corporate support to deliver. It was noted that the Trust would need to be mindful of the national implementation of Medical Examiner Officers in acute hospitals, and how we build links. It was agreed that the review paper would be considered by the Quality Committee.

2.2.5 **Care Quality Commission (CQC) Assurance Report:** The Committee were assured that EPUT is fully registered with the CQC and continues to have restrictions imposed on registration with regard to Child and Adolescent Mental Health Services (CAMHS). An application was made and approved in relation to a change in registered manager at Rawreth Court. An Adult Social Care Provider Information Return (PIR) was received in respect of Clifton Lodge nursing home. The PIR was completed and returned to the CQC within the deadline set.

The Committee advised that the CQC commenced inspection of EPUT CAMHS Wards on 1 March 2022. Assurance was given that CQC Preparation and action plan testing continues.

2.2.6 **Ligature Risk Update Report:** The Committee received an overview of the action that is underway and planned to continue to mitigate the potential risk associated with ligature from a fixed point within the Trusts inpatient estate. It was noted that independent assurance had been undertaken by the Trust's internal auditors (BDO) carrying out an audit in May 2021 and it was noted that all actions in relation to the internal audit are now complete.

A review of the Ligature Risk Reduction Group Terms of Reference is currently taking place to ensure the group remains effective with the current membership and reporting structures. Assurance was given that Ligature Environmental Risk Assessments of all Mental Health and Learning Disability wards continue to be undertaken annually with a 6 month follow up review which focuses on clinical risk management. Enhancements continue to be made in relation to risk management arrangements and continuous learning from ligature incidents and that this being embedded across the Trust.

2.2.7 **BAF Action Plan**: The Committee received an update on the Board Assurance Framework and the Strategic and Corporate Risk Register covering the period up to March 2022. The report identified a risks closed or de-escalated since the last update as follows:

- CRR53 Dormitory Elimination (DRR)
- CRR76 Quality of Linen (closed)
- CRR78 Blood collection tubes (closed)
- CRR80 Fire Safety (DRR)
- CRR84 Purposeful Admissions (DRR)
- CRR86 Mass Vaccinations 12-15 age group (merged into CRR85)
- CRR87 Mass Vaccinations 12-15 age group Suffolk (closed)
- CRR88 Diabetes Service (DRR)
- CRR89 Defibrillator pads (closed)

2.2.8 **Emergency Prevention, Preparedness and Response (EPPR):** The Committee received a report providing assurance of the quarter 3 update on EPPR position across the Trust and the current Covid-19 position. It was noted that NHS incident response level was at Level 4 and during Q3 there was a considerable increase in

prevalence and significant increases in hospital admissions due to the Covid-19 Omicron Wave. During the period it was noted that the Trust had experienced significant staffing challenges. Challenges were due to multiple factors including increased Covid-19 sickness (in line with national experiences), increased Covid-19 isolation absence and the festive leave period. In addition at its height EPUT had 29 open Covid-19 outbreaks. It was noted that in anticipation of the surge an inpatient surge plan had been developed that was monitored through the command and control system.

2.2.9 **Patient Story:** The Committee heard a patient story that highlighted staff reflection following a patient safety incident. The story involved a patient who presented to the emergency department in July 2021 expressing suicidal ideation. Following assessment she was admitted to an adult acute mental health ward. The patient was placed on level 2 observations but there was minimal response. Twelve hours after admission the patient was found unresponsive and an ambulance was called. She received treatment for an overdose from which a full recovery had been made. Following the incident an After Action Review was undertaken in order to ascertain how the individual had access to the amount of medication she taken to overdose. It was confirmed that the patient had been thoroughly searched on admission in line with Trust policy. The patient informed the ward doctor that the medication had been obtained via the internet and had been concealed in her underwear. Reflection identifying pressure on the ward due to Covid-19 , the reason for the admission and the lack of engagement and the context of Covid-19 isolation the patient may have benefitted from a period of level 3 observation. Learning from the incident has been shared.

2.2.10 **Infection Prevention and Control Board Assurance Framework:** An update following the previous report was submitted to give assurance on the Trust position regarding infection, prevention and control during the Covid-19 Pandemic. It was noted that following the first presentation, the assurance template has been updated nationally in response to emerging Covid-19 evidence and the effective infection prevention and control measures. It was noted that Version 1.8 has now been received and actions are being taken to ensure the framework is a live and dynamic collection of evidence, risks, gaps and mitigation.

2.3 **10 February 2022**

2.3.1 **Quality Performance Report:** The Committee received the report that gave an updated position as at August 2021. The report incorporates 53 performance/ quality indicators with 32 identified as Indicators for review by the Quality Committee. In addition, five physical health indicators reported to commissioners were included.

There were 20 indicators within target and 4 areas of inadequate performance:

- CPA 12 Month Reviews – Overall performance remains at 93.3%. Performance continues to be aligned with the increased peak in Covid cases.
- Inpatient MH Capacity (Adults & PICU) – With the closure and opening of beds on a daily basis due to Covid-19 outbreaks, the Committee were advised that it has been increasingly challenging to acquire accurate bed occupancy information. Work is being undertaken by the Director of Nursing & 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 required to complete this work due to pressure on resources.
- Clients not seen for 12 Months – It was noted that improving trends have been witnessed in recent months across all medical and non-medical indicators. Work remains ongoing to continue this improvement.

- Psychology - Significant work and improvements are being made across the Adult Community Psychological Service in the south with continued scrutiny being invested to best utilise available resources.

Positive trends were noted in relation to a sustained reduction in pressure ulcers since April 2021 and ligatures.

The Committee were advised that across all services staffing pressures continue. This is largely as a result of sickness and the requirement to isolate in addition to the vacancy factor. A programme of work was in place with the aim of securing additional staffing and supporting health and wellbeing of the workforce.

Discussions took place in relation to the criteria for recording length of stay. It was confirmed that length of stay ended at discharge and it was noted that individuals with long lengths of stay would impact on data averages. The Committee were advised that twice daily situation report meetings focused on staffing alongside flow and capacity work streams were held. A request was made for further information in relation to average length of stay.

It was observed that whilst the data was showing a reduction in ligature incidents this may have been impacted by the reduction in CAMHS beds and consequently it was noted that figures may rise once beds were reopened.

It was noted that since putting increased focus on specific key performance indicators there had been increased success in some of the trajectories.

2.3.2 CQC Exception Report: The Committee received confirmation that the trust is fully registered with CQC and has restrictions imposed on registration of CAMHS. It was noted that the CQC has set out 3 main areas of concern regarding staffing, observation & engagement and learning, all of which align with Trust-wide strategic priority focus areas. The Trust has identified one additional area of concern in relation to young people awaiting specialist placements. The CQC has requested fortnightly update reports and to date all reports have been submitted in line with the timescales.

The Committee was advised that the CQC has given permission for all three CAMHS wards to take new admissions and assurance was given that all wards were utilising the daily risk assessment tool to assist with admission decisions.

Assurance was given that at 28 January 2022, 94% of actions from the CQC action plan had been completed.

A Provider Information Return has been received in relation to Rawreth Court and is currently being completed by the registered manager and while be completed within the required timescales.

2.3.3 Quality Account Timetable: The Committee received the draft timetable for development of the Trust's Quality Account that is due for submission on 30 June 2022. It was noted that further detailed guidance had not been received and the process would follow in the steps of last year's collation and consultation process. The Committee approved the timelines included within the report.

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2.3.4 Patient Story: The Committee received a report that demonstrated the progress of a patient with complex needs within secure services. The patient was admitted on a low secure female ward under Section 3 of the Mental Health Act in January 2021. She had a history of substance misuse and of not being compliant with her medication regime. Due to an increasing ward. Due to refusal to take medication her condition further deteriorated and she was subject to multiple restraints and episodes of

seclusion.

Following interventions with the medical team, Pharmacy, the Ethics Committee and a SOAD (Second Opinion Appointed Doctor) and advice from the TASID team the unusual step of utilizing IM clozapine was introduced. The patient was accepting of IM Clozapine without the requirement for restraint. She has made significant progress with reduced level of aggression, no episodes of seclusion, development of more insight and generally a much improved mental state. The Committee discussed the learning from this patient story and were assured that the nursing team were offered group discussion and supervision from psychology to support them in managing their own anxiety regarding the ethical concerns surrounding the patients care and treatment.

2.3.5 Clinical Audit Internal Audit Report: This report set out a summary of findings about an internal audit carried out against the Trust's clinical audit processes and provided assurance that all recommendations in the report were being addressed.

It was noted that it was important to align the audit programto where changes are being made in relation to clinical procedure as the first call of assurance. The Committee queried whether the coverage was broad enough and whether there were adequate resources to ensure completion. It was confirmed that this draft report had been produced by the Audit Team based on the current resources available, but steps would be taken to review further and ensure there is alignment and triangulation. It was noted that the Audit Team have looked at key priorities in terms of requirements for clinical audit in the first instance. It was agreed that the report would be reviewed with a further draft to be considered by the Committee**.** .

2.4. Policies and Procedures

The Committee approved the following policies and procedures:

- Clinical Audit Policy
- Learning from Deaths Policy
- Mental Health Operational Procedure
- CLP84 Safe Staffing Inpatient Policy
- RM01 Corporate Health & Safety Policy
- RMPG11 General Workplace Risk Assessment Policy
- CP75 Ligature Risk Assessment & Management Policy
- MHAPG30 Community Treatment Order Procedure
- MHA1 Administration of MHA 1983 Procedure
- CPG50F Text Messaging to Service Users

Policy extensions were agreed for the following:

- SLP34 Missing Persons Policy
- CLP51 Hospitality and Sponsorship Policy (Pharmaceutical Industry)
- CP36 Communicating Patient Safety Incidents Being Over Policy
- CPG50B Email, Intranet, Internet Access and Use Procedure
- CPG50H NHS Mail Usage Procedure
- MHA20 Section 136 Policy
- CP3 and PRG3 Adverse Incident Policy and Procedure

2.5. Risks/Hotspots:

The Committee identified:

- No risks to be escalated to the corporate risk register

- No risks or issues to be raised with other outstanding committees
- No recommendations to the Audit Committee linked to the internal audit programme

3. RECOMMENDATIONS / ACTION REQUIRED

The Board of Directors is asked to:

1 Receive and note the contents of the report
2 Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3 Request any further information or action.

Report prepared by:
Gill Mordain, Strategic Advisor

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

		Agenda Item No: 8biv
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 March 2022

Report Title:	**People, Equality and Culture Committee**					
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:	Not previously discussed.					
Level of Assurance:	**Level 1**		**Level 2**	✓	**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 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.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Receive and note the contents of the report

2 Accept the Assurance provided

Summary of Key Issues

The People, Equality and Culture Committee (PECC) met on the 24 February 2022 as a Part 1 meeting, with a short Part 2 session to approve the minutes from January 2022. The January 2022 Committee meeting outcomes were reported in the open Part 1 Board Meeting.

The continuing pressures upon staff resulting from the Level 4 incident related to the Covid-19 pandemic meant the February 2022 PECC was in shortened form pursuant to the Trust-wide "Governance-Lite" expectations. A comprehensive slide deck covering the substantive agenda topics and a video from the Director of Marketing and Brand covering website developments supported the meeting.

The Governor Observer was unable to attend the meeting.

Committee Future Topics

The action log was discussed and it was recognised that the meeting slide deck covered a number of items that could now be closed. Deep dives into Equality, Diversity & Inclusion and Learning & Development were identified as required for the April meeting.

Workforce Strategy (Provisional)

A provisional (draft) strategy was shared for feedback on the principal elements covering the background to the strategy, equality diversity and inclusion, staff engagement, health and wellbeing and employee experience. It was proposed that reward and recognition, and the development of a "one team" approach would complete the strategy package headings.

There was general support for the proposed strategy with an expectation that the final document would be outcome focussed and have a greater element relating to learning and development. A strengths, weaknesses, opportunities and threats (SWOT) analysis would assist with focussing on the areas of greatest shortfall. There was agreement that the strategy should reflect a requirement that there be a two way "employee contract" relationship with staff, setting out the expectations the Trust had from its workforce in return for what the Trust would be providing. There was a role for staff and a responsibility upon them to create a high performing culture. It was agreed that a final version would be returned to the June 2022 Committee meeting.

Time to Care / Time to Manage

The Committee discussed the Newton Workforce Transformation Phase 2 initiative noting that discussions were ongoing with Newton to refine the detail and depth of the proposed partnership working to ensure the maximum definition, benefit and value for money from the anticipated investment. This would not be confined to financial measures but on the more important quality benefits to staff and patients from a better work environment. There would be no formal agreement with Newton until everything was in place to the satisfaction of the Trust and the caution being displayed was encouraged. The governance package and pathway agreed by the Board of Directors surrounding any contract being finalised was reconfirmed.

In discussion the benefits of learning from any similar work elsewhere and in having measurable outcomes was emphasised, along with being able to distinguish what added value there would be from the Time to Care initiative separated from developments that would have happened anyway. It was recognised that time was required to ensure the project was able to progress in the right way.

Resourcing

Details were provided on the progress made and staff secured through the recruiting initiatives relating to Health Care Assistants (HCA's), Trainee Nurse Associates, the Lighthouse Child Development Centre TUPE process, Student Nurses, Allied Health Professionals and Bank New Starters. Data relating to starters and leavers with the Trust was provided to the Committee.

The International Recruitment outcomes were provided to the Committee, with details on the number of staff successfully recruited and plans for the further recruitment. The Committee were provided with information on lessons learnt during from the initial international recruitment phase and would be incorporated into the next cycle of recruitment.

Emerging Communications and Marketing Update

The Committee received details and rationale in relation to the new Communications Strategy, focusing on the priorities going forward. Details of the approach to be adopted in relation to internal and external communications was shared along with the current focus and progress on establishing communication channels and refining content and messaging.

The Committee received details of the brand relaunch and details of how this would be launched alongside the new website. The ongoing development and functionality of the new website was demonstrated. The Committee discussed the content and advised to ensure good stakeholder engagement was maintained.

Committee Business

The Committee noted progress on the initiatives within the People and Culture Directorate with reference to a slide deck summarising HR services, progress against the NHS people plan, equality diversity & inclusion, staff engagement and wellbeing and safe staffing.

Policy Extensions and Approval

The Committee approved the Social Media Policy and extensions to two policies.

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			
TUPE	Transfer of Undertakings (Protection of Employment) Regulations		

Supporting Documents and/or Further Reading
None

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

		Agenda Item No: 8c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 March 2022

Report Title:	**Board Safety Oversight Group Report – March 2022**					
Executive/Non-Executive Lead:	Alison Rose-Quirie, Non-Executive Director					
Report Author(s):	Richard James, Director of Transformation					
Report discussed previously at:	Executive Safety Oversight Group Board Safety Oversight Group					
Level of Assurance:	**Level 1**		**Level 2**	✓	**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)?	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 an update on the progress of projects and programmes linked to the safety priorities within the Safety First Safety Always strategy.	**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 projects and programmes linked to the safety priorities within the Trust Safety Strategy are:

- Safe Staffing
- International Recruitment
- EPUT Culture of Learning
- Ligature Risk Reduction
- Engagement & Supportive Observations
- In-patient Flow and Capacity

Since our last update in November 2021 the Board Safety Oversight Group (BSOG) has continued in its role to provide assurance that the safety strategy is being delivered to the agreed time, cost and quality parameters.

This report has been provided as assurance for the Board of Directors on the continued progress of projects and programmes that are linked to the safety priorities within the safety strategy.

Safe Staffing

The Safe Staffing programme has been running since April 21 and is now preparing to transition into business as usual.

A critical element of this programme has been the conversion of flexible workers into substantive posts, and following a successful 'New Year, New Role' communications campaign in the early part of 2022 we have successfully converted a further 62 flexible workers, with the total now converted at 94.

We have also completed the migration from the previously used Safer Staffing system to Safecare. Safecare gives us a real time view of staffing levels across our inpatient settings which means our staff are able to make informed decisions on patient care based on patient numbers, acuity and dependency. Safe Staffing could only record the number of registered and unregistered staff working for each shift whereas, Safecare gives us the ability to respond in real time to roster changes, have visibility of any staffing changes and understand the impact that will have on patient safety. On average 41 of our 45 wards have a Safecare completion rate of over 70% with remaining wards supported by the team on a targeted basis to raise completion rate to 100%.

To further maximise the benefits of Safecare, we are completing a review of the minimum skillset required for inpatient wards which will be uploaded onto HealthRoster and be visible in Safecare.

A Safe Staffing Working Group has been established which will enable ward managers and matrons to discuss staffing issues. A refreshed escalation process has been launched which now clearly defines clear steps to be taken to manage staffing shortages on inpatient wards. A safe staffing policy has been developed and a safe staffing intranet page has been created which is now live on Input. This intranet page includes information on policies, staffing escalation processes, how to use SafeCare and staff vacancies.

International Recruitment

In 2021, we completed a pilot programme with Mid and South Essex to recruit 10 nurses from India. These nurses arrived in 3 cohorts throughout November and December 2021. The nurses have been progressing well through their objective structural clinical examination (OSCE) training programme and 4 have already passed their OSCE exam and received their Nursing and Midwifery Council (NMC) pin. The remaining 6 from the pilot scheme are due to take their exam before the end of March 22.

Following the submission of two international nurse recruitment bids we were successfully awarded funding from NHSE/I to support the arrival of a further 185 nurses by the end of December 2022.

To kick start our campaign we engaged with 5 specialist overseas recruitment agencies and have to date completed interviews for 93 nurses, made offers to 62 with 49 accepting positions with EPUT. The candidates are now progressing through visa checks with 5 nurses having arrived on the 21 March 22 and a further 2 are arriving on the 27 March 22.

The cohort arriving in March will be living in Chelmsford and starting their OSCE training on Monday 28 March 22 in a newly established training school at Mountnessing Court.

To ensure its success, a delivery team is being recruited to provide specialist recruitment capabilities, pastoral care and support, OSCE training and further development.

EPUT Culture of Learning (ECOL)

One of the key objectives of the proposals in the culture of learning project is the review and analysis of a range of data available in the Trust and the use of the intelligence drawn from multiple sources as an early warning system serving as a deterrent for the likelihood of a repeat of a similar incident occurring in the organisation.

Recruitment of the Lessons Leant team is nearing completion and specialist training for these individuals is being prepared by the externally sourced consultancy team who are experts in the methodology and process' the team will need to implement. A newly scoped Patient and Safety Champions role has been approved and socialised and in an effort to learn lessons from previous Champions initiatives, invites have been sent to over 100 recognised Quality Champions to attend workshops.

The ECOL team have identified Datix as a suitable way to record lessons learned and are working in conjunction with the Ligature Risk Reduction group as any proposed system changes on Datix from either project could impact the other.

ECOL now forms part of the corporate induction and is being delivered to all new starters to the Trust.

Case Study into Culture of Learning

A review of absconsion and tailgating from January 2020 to January 2022 identified that 21 incidents had been recorded on DATIX incident reporting system.

Further analysis of these revealed that the hot spot area for these incidents was the Linden Centre. It was agreed at the EPUT Culture of Learning Project Group that a joint visit would be conducted at the Linden Centre, to gain an in-depth understanding of the site, as well as working with operational colleagues to understand their lived experience of these types of incidents and their view on how these could be minimised.

Using the data gathered the initial key area of focus was the use of the air lock door system, which upon inspection appeared to be working with no issues identified or reported.

Lesson identified

The site inspection identified that the majority of the absconding incidents occurred when staff were responding to an emergency call from another ward. The absconsion took place when staff were

exiting the back of the unit to assist colleagues on the other ward, as their primary focus was on supporting colleagues in need of assistance.

Action required

Following this a number of actions have been identified and implemented:

1. Security Training to improve staff awareness

2. Installation of an airlock system in the exit point at the back of the hospital that is used to gain access to the unit by staff during an emergency rapid response

3. Generation of an infographics for dissemination of information to the leads of the target services

4. Present findings at the Inpatient Quality and Safety Meeting on 7 April 22 and discuss at the Learning Oversight Sub Committee on 5 April 22

5. To replicate the assurance review process across other high risk inpatient areas identified from the DATIX report

Further assurance testing has been scheduled for 30 May 22, which will focus on gathering evidence of cascading a review of Inpatient Quality and Safety Meeting minutes and Learning Oversight Sub Committee Meeting and Operational Team meeting minutes for evidence of discussion with the team.

Ligature Risk Reduction

The reduction of ligature risks across our wards remains of key importance to the Trust with a key aspect being the analysis of historic environmental action plan data.

In December 2021 we reported circa 60 open environmental actions and through the work we have been undertaking significant progress has been made and there are now only 12 that remain open. The team are working in collaboration with the Patient Safety Incident Management Team to review some of these remaining open actions.

Concerns were highlighted following analysis of the historical data and a decision was made to revise the approach to environmental ligature risks and strengthen the project team. Work is underway on this new approach and has resulted in an up-to-date ligature risk data set incorporating information from the historic action plans, Datix and 3i. An Initial scope of works for a revised process flow involving changes to our systems has also been produced outlining the problems, assumptions and proposed changes.

We have implemented a Technical Solutions Group who will provide a centrally coordinated approach for the management of environmental ligature risks in an actionable and reportable format. A priority action plan is in place to review the current systems and processes for reporting environmental ligature points throughout the Trust. The wider aim is to develop a single source of data with clear timelines and defined accountability.

The Technical Solutions Group have already been able to implement some Interim fixes on Datix, in particular the outcome/progress field for actions was made mandatory to encourage handlers to provide assurance of the action taken.

An update on related estates work will be presented in Part 2 of this meeting. Further information is provided in Appendix 1: Ligature Risk Management Q3 Report.

Engagement & Supportive Observations

EPUT is engaged in a national piece of work to develop Care Quality Committee (CQC) standards for inspections in relation to observation and engagement.

The project group has been providing technical and clinical support on e-observations to ward staff in order to identify what works well and what needs to be addressed. They have then liaised with Oxehealth to escalate actions, upload observation records to the Electronic Patient Record, plan for future Electronic Patient Record integration, and recommend feature enhancements.

A revised policy has been shared in the communications e-mail circulated each Wednesday to the entire Trust and a structured summary of the policy, highlighting the 5 key changes, was published in the Quality Matters newsletter on Input. A targeted comms plan is now being developed by the Quality Governance Lead and Communications colleagues to help embed new policy changes in practice.

Training videos have been storyboarded by the project team and include clinical staff talking through the new Engagement and Supportive Observations policy. This will explain any changes and updates. There are four videos in production with the first three now completed. The fourth video is in final production and is anticipated to be ready by the end of March. These videos will form part of the revised on-line training and will be uploaded to Input.

Inpatient Flow and Capacity

A focus on Inpatient Flow and Capacity was added as a fifth safety priority in November 2021 and work is underway with system partners to maximise flow, supported by discharge/winter funding.

We have made progress in the following key areas:

Delayed Transfer of Care reduction (DTOC)
We are maintaining a good position in the East of England by introducing multi-agency discharge events (MADE) and weekly system meetings. Daily sit reps are now in place to focus on patients who require admission, transfer and discharge which have enabled EPUT to remain at Operational Pressures Escalation Level (OPEL) 3 despite surge pressures.

Out of Area Placements (OoAP)
Our trajectory is on target with 12 inappropriate OoAPs at the end of February reduced to 6 inappropriate on the 22nd March 2022. The 6 remaining all have discharge/transfer plans in place. Additional contracted beds with Essex providers (Priory & Cygnet) are in place underpinned by joint quality and continuity principles.

Purposeful admissions
Work has been progressing around the rollout of a safer care bundle (a practical tool to reduce delays for patients in inpatient wards using five elements – senior review, all patients, flow, early discharge and review) and an emotionally unstable personality disorder pathway to support a reduction in average length of stay.
Patient data collected on the number of patients with a personality disorder diagnosis, patients with a personality disorder in each locality, the case load in each locality and the number of patients diagnosed with personality disorder that have been discharged within the last 6 months will inform what resources are required to ensure we have appropriate staff in place. Additionally we have undertaken recruitment of activity coordinators to be part of an Allied Health Professional/Occupational Therapy team focused on supporting therapeutic activities.

Basildon Emergency Department Diversion/ Mental Health Emergency Department
Our diversion service has been operational since end of January, supporting a reduction in Mental Health Emergency Department waits. Work is underway on a full Mental Health Emergency Department which is due to be operational in readiness for winter 2022/2203. The Mental Health Emergency Department will provide timely assessment of patients by specially trained staff in a suitable environment, improve patient satisfaction, reduce admissions to the MH Assessment Unit and reduce the need for a referral to a GP following an emergency/crisis.

Section 135/136
An Essex wide multi-agency workshop (Crisis Concordat) was held on the 18th March to review best practice/policies.

Discharge funding
Collaborative working with voluntary sector has enabled us to establish and embed schemes to support admission avoidance by providing intensive home treatment which can be an alternative to admission dependant on risk and presentation and earliest safe discharge.

Key Performance Indicators

In order to provide further assurance that the work being completed around the 5 safety priorities is effective, the Transformation PMO have been working with the Executive team to develop KPIs for each of the safety priorities. Whilst a number of these KPIs are already reported through other governance forums, e.g. accountability framework meetings, some are new and will require engagement with the relevant teams (e.g. Information Team) to produce the data over the coming weeks. The new dashboard will start to be reported through the Executive Safety Oversight Group and Board Safety Oversight Group from April onwards.

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			
ECOL	EPUT Culture of Learning	OPEL	Operational Pressures Escalation Level
DTOC	Delayed Transfers of Care	OoAP	Out of Area Placement

Supporting Documents and/or Further Reading
Appendix 1: Ligature Risk Management Q3 Report

Lead

Alison Rose-Quirie
Non-Executive Director

Appendix 1

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

LIGATURE RISK MANAGEMENT – Quarter 3

1.0 INTRODUCTION

This report provides an update of the action that is underway and that which is planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate. The report aims to assure members that the focus on mitigating this potential risk continues to be a priority.

The Trust is committed to continuously improving systems and processes that facilitate robust risk identification and management, carrying out patient safety improvement works to create safer physical environments and to creating a risk aware culture.

The Board of Directors has identified the potential risks associated with this agenda as one of the most significant risks that may prevent achievement of the Trust strategic objectives. This risk is therefore recorded in the Corporate Risk Register (CRR81). An action plan is in place to mitigate the risks. Reports on the action that has been taken are provided regularly to the Board of Directors.

Whilst this report confirms that the focus on mitigating risk continues to be strong and progress continues to be made, members are reminded that managing ligature risk associated with the physical environment must be considered in the wider context of care provision that includes staffing, security, patient risk assessment, observation and care planning. It also has to be recognised that the Trust's inpatient environments, consistent with many providers of mental health services, will rarely be entirely free of fixed ligature points. This is because most services were not designed to mitigate the potential risks being identified currently, and/or there are no design solutions to eliminate identified potential risk entirely from all infrastructure, fixtures and fittings.

2.0 INDEPENDENT ASSURANCE

Internal Audit

Following the Trust's internal auditors (BDO) review undertaken between the 10 and 20 May 2021, an action plan was developed that addressed each of the recommendations. The progress of the plan was monitored by the Ligature Risk Reduction Group (LRRG) and is now complete with all the actions having been fully addressed.

Care Quality Commission (CQC) New Inspection Criteria

The CQC are yet to publish a revised briefing guide for inspection teams that will include Ligature anchor points, ligatures and other means of self-harm using fixtures & furniture.

As previously reported, the CQC highlight that the care provided, including trust and engagement between staff and patients, and effective treatment of mental health needs, is the core of preventing self-harm and suicide. Complementing the clinical interventions and by making the physical environment of mental health units, including buildings, fixtures, fittings and furniture as safe as possible, is vital.

In the absence of the revised/updated CQC briefing guides a review of previous criteria is being undertaken to ensure compliance remains. As soon as the revised guidance is available, a review against any new criteria will be undertaken to provide assurance of the trust position against meeting the new or updated criteria.

East London NHS Foundation Trust (ELFT) Review

As previously reported, EPUT has been working with East London NHS Foundation Trust (ELFT)

to undertake peer reviews. The purpose being to identify improvements that could be made to EPUT ligature processes through shared learning with ELFT. The draft report was received and checked for factual accuracy, however, the final report has not been received as yet.

An action plan has been developed against the draft recommendations, covering the following:

1. Governance and working practice - reviewers found that the governance structures of the Trust were appropriate and effective they recommended a simplified document giving the outcome of ligature inspections and more detail in the Trust ligature procedure to assist staff.
2. Environment –reviewers suggested an updated timeline for completion of works to assist clinicians on the wards.
3. Workforce –reviewers suggested increasing assurance for new staff being inducted to the ligature process.
4. Training and Learning - reviewers recommended additional training on ligature cutters and consideration to be given to holding workshops to enhance staff awareness of suicide prevention strategy.

The action plan is monitored bimonthly by the LRRG.

3.0 GOVERNANCE

The Trust continues to hold a Ligature Risk Reduction Group (LRRG) each month; chaired by the Executive Chief Operating Officer (COO). The Group reports to the Health Safety and Security Committee and provides a monthly assurance report to the Executive Safety Oversight Group (ESOG) to ensure:

- Ligature risk assessment inspections are robust with appropriate control measures in place
- The Trust remains compliant with all regulatory or legislative requirements and Safety Alerts
- Risks that are identified are managed and escalated as required.
- Governance structures of the Trust are appropriate and effective.

A review of the LRRG Terms of Reference is currently underway to ensure the Group remains effective with the correct membership and reporting structures. The review will also seek to move focus towards clinical management of ligature risk rather than environmental focus which is undertaken by the Estates Expert Reference Group.

The Estates Expert Reference Group, oversees a wide range of environmental patient safety improvement works identified as a result of ligature risk assessment and setting of agreed standards by the Ligature Risk Reduction Group.

4.0 CONTINUOUS LEARNING

The Trust's approach to identifying and mitigating any potential risk remains subject to reflection and review. This is constantly informed by undertaken independent reviews, incident data, internal scrutiny and national guidelines.

The Ligature Risk Reduction Group continues to receive incident analysis to identify learning and review national and local safety alerts.

The Compliance team are in the process of setting up a local area ligature forum with other trusts and are in the process of identifying leads from neighbouring trusts to enable wider learning and sharing of ligature awareness.

5.0 POLICY AND PROCEDURE IMPLEMENTATION

The previously agreed change in the Ligature Risk Assessment procedure continues to be implemented. Inspections are completed within 12 months for all inpatient areas and a six month review also undertaken. The six-month review is being used to:

- Coach, support and educate staff regarding ligature
- Follow up outstanding actions from ligature inspections
- Audit compliance with the policy, procedure and appendices
- Identify good practice and ideas for improvement

The expected strengthening of the ligature assessment process and arising opportunity to enhance staff understanding and implementation of policy requirements, will be reviewed and monitored by the LRRG through quarterly reporting of findings. Compliance checks within the risk team continue to ensure all ligature risk assessment tools and reports are completed correctly and in line with policy.

6.0 ENHANCING ENVIRONMENTS

Setting Environmental Standards
The LRRG continues to develop agreed risk reduced environmental standards that inform the Trust's investment and patient safety improvement works programme. The environmental standards have been updated to take into account all known safety alerts and ligature learning. The trust has instigated a project team looking at the trust standards and how these can be applied universally across the inpatient estate.

Ligature Project
The trust Ligature project is continuing with a clear project plan monitored by the Executive Safety Oversight Group. The decision was made to further strengthen the project team. The revised approach will create an up-to-date ligature risk data set, incorporating information from the historic action plans, Datix and 3i. Twice weekly review meetings have been scheduled with relevant stakeholders to ensure the actions are driven in a timely manner and the work is scheduled, approved and completed to the required specifications.

7.0 CULTURE – STAFF TRAINING

All staff working within a mental health/LD inpatient settings are required to complete the ligature awareness on-line training package "Preventing Suicide by Ligature" on an annual basis.

Overall trust compliance with training as of the end of December 2021 was 93%.

The trust continues to provide the bespoke TIDAL ligature risk assessment training for EPUT staff who undertake ligature risk inspections within our mental health wards. This was previously aimed at Band 6 and above staff however it was agreed at LRRG to extend the training to now include those of a Band 4 and above to increase ligature awareness of our staff across the inpatient mental health wards. The training is delivered over 2 full days by TIDAL training; attendees include clinical staff, members of the risk team and estates staff who undertake ligature risk assessments. To date 71 staff have been trained as follows:

- 51 Ward Staff Agenda for Change Band 6 and above
- 12 Estates staff
- 8 Corporate/Risk Staff

The overall aim of the sessions is to equip and skill staff members to be confident in identifying ligature risks and to continue to monitor and update risk assessments for their individual work areas.

The uptake of the training is monitored via LRRG where operational leads are advised of the need to ensure more staff enrol on the training. It was agreed that TIDAL training be paused over the summer months to account for a potential increase in annual leave being taken. The next TIDAL training session is booked for January 2022.

8.0 CONCLUSION

The summary of information provided in this report is by its nature only potentially a snapshot of the work that is taking place by frontline clinical staff, risk and estates specialists and the wider leadership team.

It is intended that the information provides sufficient assurance that the Trust continues to take action and mitigating the risk of ligature seriously.

9.0 ACTION REQUIRED

The Board of Directors are asked to:

1 Note the contents of this report

2 Confirm acceptance of assurance given in respect of actions identified to mitigate risks

3 Request any further information or action

Report Prepared By:
Jane Cheeseman
Head of Compliance and Emergency Planning

On behalf of:
Paul Scott
Chief Executive Officer

		Agenda Item No: 9ai
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 March 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:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	High number of outbreaks and staff sickness due to Covid-19. 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	N/A	

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 Receive and note the content of this report.
2 Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3 Note the Covid 19 Gold risk register and summary mitigations (Appendix 1)
4 Request any further information and or action

Summary of Key Issues

Background / Current Context

- The country continues to deal with the corona virus pandemic and the emergence of additional variants.
- The NHS remains at its highest level of emergency preparedness- Incident Level 4.

Current Impact

- The organisation continues to experience challenges due to the new Omicron variant, which emerged in December 2021.
- There are currently 10 reported outbreaks within the trust, since the last report of 29.
- There has been 1 further reported patient death due to the patient having tested positive in the proceeding 28 days prior to their death.
- At time of writing we have a total of 167 staff off sick due to Covid-19 and there are 25 Covid-19 confirmed in-patients.
- It should be noted that whilst the number of outbreaks has steadily deceased we have seen a number of areas that had previously been closed to outbreak status, reopened highlighting the need to continue adherence to IPC guidance PPE requirements and regular lateral flow testing.
- Considerable national guidance changes have been received as we remain at incident level 4.

Risks

The Trust's Covid Risk Register (Covid RR), summary attached as Appendix 1, remains a live document with monthly updates that reflect the changing environment. There are two extreme risks open on the Covid 19 Risk Register.

1. 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.
2. Management of Covid 19 (emergency planning risk) as detailed below in the Corporate Risk Register (CRR).

In addition there are 5 risks on the Corporate Risk Register (CRR) relevant to Covid-19, one of which is extreme:

- 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.

Learning

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

- Establishment of a recovery plan identifying 5 key milestones and trajectories
- IPC live event on lessons learnt from outbreaks
- Understanding impact of 'Long Covid' on colleagues and putting in place a range of health and wellbeing offers of support that can be accessed by staff with long covid and managers in supporting staff.

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

Supporting Documents and/or Further Reading
Covid Assurance Report 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, the NHS remains at its highest level of emergency preparedness being at Incident Level 4.

The Omicron Variant has had significant impact on the NHS including EPUT from December 2021.

On the 24th February 2022, the government ended the domestic legal restrictions in England. However, the global pandemic is not yet over as such but transitioning from managing Covid-19 to 'Living with Covid-19'. The Living with COVID plan (published February 2022) sets out how England will move into a new phase of managing the virus. Encouraging safer behaviours through public health advice, in common with longstanding ways of managing most other respiratory illnesses.

Compared to last reporting the national growth rate had remained relatively stable although we are starting to see signs of an incline. The Trust's arrangements continue to be in place, regularly reviewed in line with national guidance and working effectively. For the NHS 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 separate Gold, Silver and Bronze command structures remain in place and have reduced in frequency to now holding separate once a week meetings. This frequency remains flexible in regards to reducing/ increasing dependent on COVID-19 activity/risk. Bronze command meetings continue to mirror the Silver and Gold commands to ensure decisions and information received continues to cascade through the organisation at pace, and that we are responsive to any 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 continues to be covered by the Compliance and Assurance Directorate with the additional help at the weekends of a bank Band 6 Emergency Planning Support Officer 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 requirements.

The regular situation report submissions required by the Centre continue, namely the National Covid daily sitrep, Community discharge daily sit rep, (inclusive of 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 wider remit of information sharing. The continued monitoring of the inbox ensures that should anything of urgency come through or stood up we are able to remain responsive.

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.

The ethics committee remains in place 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 January 2022 there has been a decrease in our reporting of Covid-19 positive cases although we are starting to see this rise over recent weeks. At time of writing, we currently have 25 Covid-19 confirmed patients within our services (previously 58) and a total of 167 staff off sick not working due to Covid-19 related illness which is a decrease from 197 at last report.

We have reported one death onto the Covid-19 Patient Notification System (CPNS) (March 2022) due to the patient having tested positive in the proceeding 28 days prior to their death.

Since last reporting, we now have 10 outbreaks currently declared to UK Health Security Agency (UKHSA) formerly known as Public Health England, this is a significant reduction from the 29 reported at the height of the Omicron wave. The 10 open outbreaks relate to 3 CHS and 7 MHS and continue with consistent 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.

It should be noted that whilst the number of outbreaks has steadily deceased we have seen a number of areas that had previously been closed to outbreak status, reopened. This highlights the need to continue to learn from previous outbreaks and our adherence to the IPC Guidance, PPE requirements and the regular lateral flow testing of both our patients and staff across the trust. The trust has reiterated this message via the fortnightly live events and Wednesday weekly publication.

5. Trust wide Response

The significant staffing challenges that was experienced over the December period continued into January, February and March. Challenges were due to multiple factors including increased Covid sickness (in line with the national experiences) and increased Covid isolation absence which required enactment of our surge plans to redeploy staff, offer incentives; reduce meetings and mandatory training particularly the face to face courses.

As we start to get back to business as usual and move into more of a recovery phase we are working on agreeing the key impacts and the trajectory and recovery plan for each key impact with the following 5 themes currently identified;

- Workforce Resilience
- Inpatient Capacity and Flow
- Mandatory/ Essential Training, Supervision and Appraisal compliance rates
- Community patient experience – waiting times and face to face activity; Dementia Diagnosis
- Governance Lite – reduced meetings and agendas; Policy extensions

Visiting was paused for all inpatient wards at the point in time where the Trust was experiencing significant outbreaks. This is reviewed weekly and at significant points of change by Silver Command and takes into account the fact that inpatient in healthcare settings can be more vulnerable and as such facilitating visits needs to be undertaken in a risk managed way. The contribution that visiting makes to the well-being of patients is widely recognised and in line with recent guidance EPUT visiting policies have been reviewed to ensure that we reflect the balance of risk and that we are living with Covid in general circulation.

On 31 January 2022 the Government announced that the legislation to make the Covid-19 vaccination mandatory for health and social care workers from 1 April 2022 (VCOD Regulations) was under review

with a public consultation carried out in February. On 1st March 2022 the government published the consultation responses and confirmed that the vaccination as a condition of deployment policy would be revoked as from 15 March. This will remove the requirements already in place in care homes, in addition to those that were due to come into force on 1 April 2022.

We continue to receive considerable national guidance changes that are taken through the EPUT Command structure for consideration and changes made to local guidance where necessary.

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 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, and remains a live document with monthly updates that reflect the changing environment. There are currently 11 live stand-alone Covid risks made up of 2 extreme, 7 high and 2 medium. The extreme risks were both new risks as of December 2021:

- (1) 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.

- (2) management of Covid 19 (emergency planning risk) as detailed below in the Corporate Risk Register (CRR)

In addition there are 5 risks on the Corporate Risk Register (CRR) relevant to Covid-19, made up of 1 extreme and 3 high risks and 1 medium. The extreme risk is:

- (1) 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.

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.

The NHS remains at Level 4 incident in the Omicron wave and we continue to develop our recovery plans incorporating learning, decision benefits and impacts from a review of command decisions up to mid - January 2022 which identified 5 key areas for recovery.

A Recovery Plan Group has been established and to date has met on 3 occasions to identify key milestones and trajectories in the 5 key areas identified in section 5 of this report.

The Trusts Infection Prevention and Control team held a live event on lessons learnt from outbreaks for staff to attend which reminded staff of the infection control measures to maintain the safety of patients, staff and visitors. The presentation covered what happened and why, what actions the Trust

has taken in response to this, what the Trust are doing well and key areas of learning from this as detailed below:

- An outbreak is easier to manage when we are able to isolate the affected patients as spread of infection is reduced.
- Adherence to the IPC policies at all times by all staff helps to reduce spread of the infection.
- Regular testing of our patients and staff helps early detection of cases.
- Accurate patient information prior to admission supports safer transfer from other inpatient units.
- Robust COVID-19 risk assessment on admission supports safer decision-making.
- Importance of ensuring all staff understand and adhere to IPC policies and procedures - in particular those who work on multiple sites.
- Good communication with all teams across the wider care system is a key part of outbreak management.
- The isolation of contacts may negatively impact the rehabilitation of some patients – this must be taken into consideration.

We now understand more about the signs and symptoms that continue or develop after acute COVID-19 defined as 'long COVID' and how we can support colleagues who are experiencing this and have in place a range of health and wellbeing offers of support that can be accessed by staff with long Covid and managers in supporting staff.

9. Action Required

The Board of Directors are asked to:

1. Receive and 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)

Report compiled by:
Jane Cheeseman,
Head of Compliance and Emergency Planning

On Behalf of

Paul Scott
Chief Executive Officer

Appendix 1

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

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

The table below lists the stand-alone Covid-19 risks and current controls

Risk and Objective ID	Summary	Potential Risk	Key Controls
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 Target Risk Score 4 x 2 = 8 Timescale 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 • IPC BAF updated March 22 and submitted to Quality Committee 10 March 22 • Silver Command monitoring of Outbreaks
CVG37 SO1 Lead: DG Committee: Quality	**Covid Secure Risk Assessments** 12 12 12 Current risk score 4 x 3 = 12 Timescale March 22 Target Risk Score 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 • Weekly position report listing all buildings and Covid risk assessment status • Part of H&S inspection process for BAU • Certificates no longer need to be displayed
CVG10 SO1	**Capital Programme** 9 9 9	If EPUT is unable to maintain its planned capital programme through lack of contractor access then delays or deferments may occur	• Capital projects continuously under review • Building contractors have returned to BAU • No delay identified and no significant risk to future programme

Risk and Objective ID	Summary	Potential Risk	Key Controls
Lead: TS Committee: F&PC	Current risk score 3 x 3 = 9 Timescale Ongoing Target Risk Score 3 x 2 = 6	resulting in increased pressure on the capital programme in recovery	• Situation continues to be managed including managing contractors on care home sites
CVG55 SO1 Lead: AG Committee: Quality	**Outbreaks** 10 10 15 Score increased to 5 x 3 = 15 by Silver Jan 22 Timescale June 22 Target risk score 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
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 Timescale Ongoing Target risk score 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 • Focus on recruitment to vacancies • Wellbeing incentives and support on offer promoted in Wednesday weekly – includes resilience and mental health webinars
CVS32 SO2 Lead: SL Committee: PECC	**Staffing Pressures** 20 20 20 New risk Dec 21 Initial risk score 5 x 4 = 20	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 and breaches in working time regulations	• 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 • Corporate clinical staff redeployments to clinical areas • Surge Plans in place

Risk and Objective ID	Summary	Potential Risk	Key Controls
	Target date and score March 22 5 x 2 = 10		

The following is an extract from the current Corporate Risk Register including all Covid-19 related risks and current controls.

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)
CRR45 SO2 Lead SL PECC	**Mandatory training** 16 16 16 Initial Risk Score 4 x 3 = 12 Current Risk Score 4 x 4 = 16 Target March 22 4 x 2 = 8	If EPUT does not achieve mandatory training policy requirements then patient and staff safety may be compromised resulting in additional scrutiny by regulators and not meeting the IG Toolkit requirements	Training frequencies extended over Covid-19 pandemic leaving need for recovery	Local trajectory in place for safety focused and IG mandatory training as a priority Monthly reporting to ET National OLM issue resolved
CRR83 SO1 Lead TS F&PC	**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 YTD surplus M10 £118k YTD other operating income £3.5m above plan Non-recurrent benefit associated with resolution of PropCo dispute has been accounted for Discussions on funding options for yearend continues with Commissioners and NHSE/I System Covid planned allocation reduces for 2022/23, continued reporting and close monitoring of Covid costs to continue
CRR85 SO4 Lead NL	**Mass Vaccination** 12 12 8 Current risk score decreased to threshold subject to EBAF approval 4 x 2 = 8 Mar 22	If EPUT does not effectively direct and implement the entire mass vaccination programme during challenging times then it may not meet level 4 deliverables and timescales	Covid-19 pandemic Mass Vaccination programme is nationally driven	• 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

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)
Quality Committee	Initial Risk Score 5 x 4 = 20 Target Ongoing 4 x 2 = 8	resulting in a compromise to the programme		• All costs passing through NHSE and laptop costs 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 • Expanded 12-15 age group appointments • Workforce stable • Security risk at threshold
CRR90 SO4 Lead NL Quality Committee	**Management of Covid-19** 10 20 10 Initial Risk Score 5 x 3 = 15 Current risk score decreased Mar 22 to 5 x 2 = 10 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

Table 2 – Heat Map against 5 x 5 scoring matrix

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2				CRR85↓	CRR90↓
	3			CVG10	CRR83 CVG37 CVS30↑ CVG19	CVG55
	4				CRR45 CVG59 CRR79	CVS32
	5					

NHS
Essex Partnership University
NHS Foundation Trust

EPUT NHS People Plan 2021/2022 Priorities Progress To Date March 2022

Prepared by Sean Leahy & Kelly Gibbs

Delivering the National NHS People Plan

The EPUT People plan actions and delivery align to the commitment of the **We are the NHS: People Plan for 2020/2021 – action for us** :

Looking after our people

Sets out our People Promise to everyone who works in the NHS. This will help make the NHS a better place to work by ensuring staff are:

- **Safe and healthy**
- **Physically and mentally well**
- **Able to work flexibly**

New ways of working and delivering care

COVID-19 compels us to be **flexible** and make **best use** of skills and experience. We will continue to enable working differently:

- **Upskilling** staff
- Expanding **multi-disciplinary teams**
- Supporting **volunteers** in the NHS and expanding routes into health and care careers
- Supporting staff **learning and development (**access to CPD and greater access to online learning)

Belonging in the NHS

Action to ensure the NHS is **inclusive and diverse** and a place where discrimination, violence and bullying do not occur. This Includes:

- Overhauling **recruitment practices** to improve representation
- **Health and wellbeing conversations**
- Confidence to **speak up** and empowering staff to **use their voice** to inform learning and improvement
- **Inclusive, compassionate leadership**

Growing for the future

We want to capitalise on **unprecedented interest** in NHS careers and higher **numbers of applications** to education and training. We will do this through:

- **Recruiting** into entry-level clinical and non-clinical roles
- **Return to practice**
- **Training places** in shortage professions
- **International recruitment**
- **Retaining more people** in the service

We are 1.3 million strong. We are all walks of life, all kinds of experiences. We are the NHS.

EPUT Action Plan

The EPUT People plan: 9 Work streams aligned to the 4 people plan areas

Looking after our people

- **Health & Wellbeing – 23 Actions**
- **Flexible working – 6 Actions**

New ways of working and delivering care

- **Talent, Leadership & Culture – 8 Actions**
- **Digital & Technology – 6 Actions**
- **New ways of Working – 5 Actions**

Belonging in the NHS

- **Equality, Diversity & Inclusivity – 8 Actions**
- **Talent, Leadership & Culture – 8 Actions**

Growing for the future

- **Recruitment – 4 Actions**
- **Retention – 6 Actions**
- **Recruitment & Deployment across systems – 4 Actions**

March 2022

PROGRESS TO DATE

- 9 Work Streams
- 70 actions to be delivered for 2021/2022
- 57 actions completed
- 13 Actions in delivery

Recent Key Deliverables

Looking After Our People

- Delivery of VCOD Regulations – 98% of all workers in scope have received 1st dose of vaccination. 92% of workers in scope are fully vaccinated
- Launch of new disciplinary procedure that promotes just learning and restorative culture
- Individuals Staff wellness plans implemented
- “Here for you” fully embedded within Trust
- Appointment of Director of Health and Wellbeing
- Drafted Civility, and Respect (Grievance) Policy
- Completed Flex for Future Programme
- Window for selling annual leave completed

New Ways of Working

- Therapy apprenticeships in place
- Health Care Support Worker recruitment programme
- ESR and EFIN alignment completed improved reporting on vacancies

Belonging in The NHS

- ER activity reported to all staff networks – continuation in reviewing ways in which the Trust can eliminate the ethnicity gap for workers entering disciplinary procedures
- Completed Mersey Care Just Learning and Restorative culture Module to bring learning back into organisation
- Rise programme in delivery
- Development of Workforce Data dashboard

Growing for the Future

- Launch of appraisal process includes a talent mapping process using the Pen Plan method
- Retention Task and Finish Group launched
- International Recruitment programme underway
- Placement Capacity expanded to support grown your own strategy
- International Fellowship Programme launched
- Workforce Planning Cycle completed
- Healthcare Support worker recruitment programme underway

PLANNED NEXT PERIOD

- To review the long term strategy for home working
- To review the dignity, respect and grievance procedure with a focus on just learning and restorative culture and behaviour toolkit
- Undertake targeted recruitment campaigns for under represented groups
- Review all recruitment literature to ensure captures diversity
- Work towards fully embedding the just learning and caring culture – Task and Finish group to commence in April 2022
- To undertake a review of the healthcare support worker induction programme
- To develop proposal to maximise flexible working across the Trust following the completion of the NHS Flex for the future programme
- Pilot centralised rostering in specialised services
- Undertake a review and mapping process of people systems
- Implement ESR management self service
- Staff Survey and pulse survey results
- Enhance and expend current Trist internal mediation service
- Violence and Aggression Task and Finish Group being set up – review zero tolerance procedure – Working with LSMS on implementing violence prevention and reduction strategy
- New employee relations reporting
- New trust website to launch April 2022
- Completion of pen appraisals by May 2022
- Completion of medical rostering roll out
- Review benefits of AHP job planning via rosters

		Agenda Item No: 10b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 March 2022

Report Title:	**Mental Health & Community Health Services Transformation**					
Executive/ Non-Executive Lead:	Alex Green, Executive Chief Operating Officer					
Report Author(s):	Mark Travella, Associate Director Business Development & Service Improvement					
Report discussed previously at:	Not previously discussed.					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	Workforce remains the biggest challenge to delivery of transformational change. There is a national shortage of all clinical professional groups. This is mitigated by national and international recruitment campaigns, working alongside Voluntary, Community and Social Enterprise (VCSE) organisations as colleagues, apprenticeships and development and support for peer support workers and unqualified staff.	
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	Workforce and recruitment monitoring. Whole systems People's Board oversight	

Purpose of the Report		
This report provides the Board of Directors with an update on transformational work that has taken place 2021/22 and highlights of transformational plans for 2022/23	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Receive and note the contents of the report
2 Request any further information or action.

Summary of Key Issues

- Transformation work is evolving to create a new operational capability from a secondary care model to a whole system model that supports Primary Care Networks and joins up mental health and physical care community services.
- Significant mental health investment continues in 2022/23 to support whole systems transformation to deliver the aspirations of the NHS Long Term Plan.
- Workforce remains the biggest challenge to delivery of transformational change. There is a national shortage of all clinical professional groups. This is mitigated by national and International recruitment campaigns, working alongside Voluntary, Community and Social Enterprise (VCSE) organisations as colleagues, apprenticeships and development and support for peer support workers and unqualified staff.
- System interoperability solutions demand is increasing as EPUT evolves to deliver multi provider services as fully integrated care pathways. Plans to achieve this are being developed.
- Service user and carer involvement is now a high priority for transforming services, ensuring that going forward there is good stakeholder engagement but also co-production. This ensures that the people that receive our services are equal members of the teams that create new capability.

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**	NA

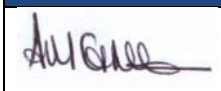
Acronyms/Terms Used in the Report

VCSE	Voluntary Community Social Enterprise	PCN	Primary Care Network

Supporting Documents and/or Further Reading

Main Report

Lead



Alex Green
Executive Chief Operating Officer

Agenda Item: 10b
Board of Directors Part 1
30 March 2022

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Mental Health & Community Health Services Transformation

1.0 PURPOSE OF REPORT

This report provides the Board of Directors with an update on transformational work that has taken place 2021/22 and highlights of transformational plans for 2022/23.

2.0 EXECUTIVE SUMMARY

Mental health and community services transformation has progressed at pace over the last two years despite the restrictions with Covid-19 and associated staffing challenges.

EPUT clinical services took the approach that they would be needed more than ever because of Covid-19 and services adapted and continued to develop. For example, the Mental Health 24/7 111 crisis services were launched in April 2020 and have continued to develop when many areas of the UK paused their plans. Similarly, older people's community mental health services and the Out of Hospital transformation plans adapted but did not stop.

Local people have continued to receive a high quality service, and are beginning to experience safer and more responsive services as transformational capability is improved.

Drivers for change that have been supported by additional investment include:

- The NHS Long Term Plan that set the ambition for 'new and integrated models of primary and community care' for both mental health and community health services.

- The Community Mental Health Framework that set out a vision to provide 'place based community mental health delivered at PCN level and also announced 12 Early Implementer Sites, West Essex being one of them.

- The Aging Well programme with the aim to develop patient centred services that enable people to age well.

- Essex Local Alliance Strategy that seeks to bring local organisations together to better use their resources to deliver evidence based high quality care.

This paper summarises the work that has taken place over the last year and sets out the plans for the next.

3.0 MENTAL HEALTH SERVICES ACROSS ESSEX

Essex Mental Health Services have undergone a themed review starting in late 2020 under the Essex Taskforce with the final report being published in March 2022. The Taskforce primary focus was the review of commissioner quality assurance systems, processes and contractual mechanisms applied to regulate the quality and safety of mental health services. A number of clinical services were reviewed e.g. Perinatal and Eating Disorders Services. EPUT supported the process as the main mental health provider in Essex. The final report is

positive and demonstrates closer working relationships and trust between commissioners and local providers. There was evidence of improving clinical services related to transformation over the last year. This provides a foundation of greater collaboration, less variability and both safer and higher quality services for the people of Essex going forward.

Mental Health Transformation is complex with three Integrated Care Systems (ICSs), 7 Clinical Commissioning Groups (CCGs) and three local authorities and a large number of voluntary community and social enterprise organisations (VCSE) trying to align their strategic aims to review and redesign clinical services together. Nearly 300 EPUT mental health posts have been recruited to in the last year to deliver these transformed services, itself an enormous task for busy operational colleagues and the support services that work along-side them. Local systems have employed many more.

A summary of the work delivered in 2021/22 is shown below:

- A new integrated primary and community Mental Health care model is being implemented. This brings together local mental health, social care and VSCE staff and the organisations they represent as one, to deliver timely integrated needs led care. Across Essex most Primary Care Networks (PCNs) now have a MH presence, while many have introduced integrated team working.

- A sustainable offer for psychological services for people with Severe Mental Illness (SMI). This provides an additional layer of integrated (multi organisational) staff providing a range of therapies to address long waiting lists and bridge the gap between primary and secondary care.

- At Risk Mental State (ARMS) and Early Intervention in Psychosis services development. This includes stricter maximum waiting times of two weeks. These services are developing against national standards and greatly improve the outcomes for people with a serious mental illness.

- Health Checks for people with serious mental health problems. This supports PCN targets of achieving 60% of people on an SMI register having a physical health check. Essex has some of the UKs highest rates of achievement.

- Perinatal Service development across Essex continues at pace with Essex having one of the most developed perinatal mental health services in the UK. Recruitment has been excellent, and access has increased. The service is on track to achieve and surpass the national performance target of 8.6% for 21/22 with some areas on track to achieve 22/23 targets.

- A personality disorders steering group oversees the development of an integrated personality disorders service. This reflects three business cases and a more recent major piece of work with in-patient services to improve the care pathway for people with personality disorder.

- Roll out of the south west Essex treatment resistant depression service across Mid and South Essex.

- Older peoples service continue to develop robust community services having closed two dementia wards in the last two ears and developed a very successful admission avoidance model. They are starting a new home treatment service in Mid and South Essex that will link in with the frailty service for truly integrated mental health and community health services. Next year this will link in with the virtual frailty wards model.

This model was developed in south east Essex and roll out plans across Essex as well as other parts of the UK are planned by other systems. North East Essex older people's transformation is on-going as a complex piece of work that incorporates the re-provision plans of Clacton Hospital. A local system steering group has been set up to oversee this work and its relationship with other clinical services as part of the north east Essex health and wellbeing alliance.

- An Essex accommodation steering group has started that will oversee the review and improvement of all local system mental health beds use including in-patient beds, supported accommodation, crisis beds and the links with homelessness and independent living.

- A new and for Essex its first crisis house is due to open shortly to provide an alternative to an admission. This will be provided by Mind but has been supported by EPUT.

- West Essex continues its transformation as an early implementer site and is advanced in its work to transform the secondary care model into a comprehensive place based mental health service seamlessly linking to its PCNs. In particular it is focussing on:

    - Community Pharmacy
    - 18-25 pathways
    - Personality Disorder
    - Eating Disorders community model.

A summary of the Mental Health Transformation work planned for 2022/23 is shown below, much of which includes progressing the work detailed above.

- North East Essex are developing a new Mental Health maternity service and commencing a review redesign and implementation phase.

- All areas will complete their delivery of Integrated Mental Health Teams within PCNs. Thurrock is due to complete first with the placement of Consultant Psychiatrists to run clinics and general support and training to primary care colleagues.

- System interoperability work will continue to support local system integration, so that as multi-provider care pathways are developed, shared records support this.

- A new care plan is being developed with an inbuilt outcome measure to demonstrate significant clinical change. This major quality initiative will improve collaborative care planning with a longer-term aim of supporting integrated care planning not only across multi providers but also mental health and physical community health services.

- Development of a new A&E diversion service. This will provide a high quality safe and more appropriate place for people with mental health problems that have attended a hospital site to be assessed and supported as an alternative to A&E where this is not required.

- Review and redesign of the mental health community model. This will transform secondary care community mental health teams into a multi-provider care pathway model and link in with the integrated Mental Health PCN teams. West Essex is leading the way in this joined up approach. This work links in with the new care plan work and the phasing out of the care programme approach as new treatment and care management models are developed.

- Roll out and development of the family group conferencing model.

- Further developmental work and delivery of the personality disorder model across Essex local systems.

- Scoping of a new initiative to introduce non-medical approved and responsible clinicians into mental health services across Essex.

- Introduction/roll out of Maternal Mental Health Clinics by 22/23 a psychological intervention service integrated with maternity for women experiencing baby loss and for Perinatal services extending the range of psychological interventions available.

4.0 SOUTH EAST ESSEX COMMUNITY HEALTH SERVICES (SEECHS) TRANSFORMATION

There are a number of major transformation work streams in south east Essex community services. These include:

- Considerable work and support to develop the MSE Community (Provider) Collaborative (MSECC) has taken place over the last year. The MSECC sees the coming together of the MSE community providers (EPUT, NELFT and PROVIDE CIC), to work together to plan, deliver and transform services.
  By working together effectively at scale, the MSECC is providing opportunities to tackle unwarranted variation, make improvements and deliver the best care for patients and communities across MSE. An example is the Urgent Community Response Team (UCRT) and EPUT hosted Mid and South Essex Single Point of Access: - Accelerated by pandemic and a key NHS Long Term Plan priority, the senior team at South East Essex Community Health Services (SEECHS) have directed and overseen the development of a standardised UCRT (2 hour community response) across the MSECC.

- Community Coordination Centre (Admission Avoidance and Discharge to Assess): SEECHS streamlined its (patient and professional) urgent access and improved overall care coordination through the development of its Community Coordination centre (CCC) operational since December 2020. The new CCC benefits from improved call handling and telephony functioning and triage including UCRT, unplanned nursing and intermediate care (supporting acute discharge)

- Community Beds (intermediate Care and Stroke): The Mid and South Essex CCG is overseeing a consultation process that will determine the future Mid and South Essex community bed configuration for both Intermediate care and stroke beds.

- Children's' Services Expansion (The Lighthouse Child Development Centre): On 1st March 2021, EPUT took on a new Children's' contract, and expansion to its offer for children and families in South East Essex, when the 'Lighthouse' (Children's neuro-development assessment and treatment service) transferred from MSE FT. This is an exciting opportunity to create a comprehensive integrated consultant-led children's community services in the South East Essex place.

- Focus on 'Frailty' (including Virtual Wards): SEECHS is developing a comprehensive community offer for frailty in South East Essex. The offer includes a Frailty Care Coordination Centre and development of a Mid and South Essex Frailty Register.

- Frailty Virtual Ward – Under development as a 2022/23 Operational Plan priority. Successful implementation will be reliant on business case and investment being developed across MSE.

- Primary Care Networks (supporting Virtual Surgeries): SEECHS is working alongside emerging PCNs to integrate our services into their population-health focused 'virtual surgeries'. Two PCNs are fully operational – Benfleet PCN and SS9 PCN. SEECHS will continue to work with all PCNs in South East Essex to support these developments.

- Community Nursing: SEECHS is fully engaged in this Community Collaborative priority work stream with overall aim to deliver equitable standardised offer across Mid and South Essex. Comprehensive audit and benchmarking exercises are underway to inform work stream.

- Aligned to this work stream is the development of exciting innovations, in both catheter care and wound care, which have been piloted and tested, by community nursing and wound care teams in South East Essex.

- Palliative Care Services: The SEECHS Community and Palliative Care service offer is unique in its coverage and outcomes. We have developed a team of nurse specialists aligned to PCNs with strong integration with acute palliative care consultants. The service also host an End of Life register for South East Essex, which sees comprehensive reporting on patient outcomes in the provision of end of life care. The model is being adopted across the Mid and South Essex Integrated Care Services.

- Respiratory Care: Given the significant focus on respiratory care linked to pandemic and subsequent impact on acute our dedicated respiratory team SEECHS is undergoing comprehensive transformation. This sees the creation of dedicated respiratory team that provides a range of elements including Respiratory Virtual Wards (supporting admission avoidance and rapid discharge). In 2022/23 it is anticipated that SEECHS will be commissioned to deliver 'Community Diagnostic Hubs' for respiratory services.

5.0 WEST ESSEX COMMUNITY HEALTH SERVICES (WECHS) TRANSFORMATION

There are a number of major transformation work streams related the Out of Hospital Strategy in west Essex community services. These include:

- Urgent Community Response (UCR) – A clinical model and care pathways is established and working well. A new 2 hour waiting times guidance is being reviewed and the team is working with the Clinical Commissioning Group to identify how to manage increased referrals from Urgent Emergency Care (UEC) including 999/111.

  A Snapshot of service evaluation shows positive outcomes for adults in West Essex, including right care at the right time by the right clinical service, a large number of hospital admissions were avoided this year due to this service.

- Care Coordination Centre (CCC). Phase 1 – Discharge to Assess model developed. The project team with clinical colleagues at Princess Alexandra Hospital working to support with discharges. Feedback will be used to shape initial pilot. Digital project

manager and Business Analyst have commenced in roles to progress digital solutions for the care co-ordination centre.

- Virtual wards for respiratory and heart failure in place. Expansion of Virtual Hospital (to include Frailty pathway) ongoing work to prepare and plan in 2022/23.

- PCN Aligned Core Teams (PACTS) development. PACT leadership teams established and Health and social care resources aligned to PACTs. Initial PACT priorities agreed. In 2022/2023 they will continue to monitor impact with PACTs using Out of Hospital Dashboard dataset.

5.0 RISKS

The main risk to all the transformational work is recruitment and having the right workforce remains the biggest challenge. There is a national shortage of all clinical professional groups. This is mitigated by national and International recruitment campaigns, working alongside VCSE organisations as colleagues, apprenticeships and staff development and support for peer support workers and unqualified staff.

A transformation governance structure is in place that links the transformation workforce challenges to the People's Board that oversees a whole systems approach to local workforce challenges.

7.0 SUMMARY

The Board of Directors is asked to note the contents of this report and that

- All EPUT clinical services are engaged in a significant amount of continuous large scale and whole systems transformational change with EPUT holding much of the local system clinical leadership for this.

- Clinical and support staff are busy delivering business as usual clinical activities while at the same time reviewing and redesigning their services. EPUT care pathways are evolving into multi provider integrated offers, taking advantage of the skills and knowledge of the entire local system to improve quality and clinical safety.

- EPUT with its partners is delivering many innovative and exemplar service improvements and is engaged in a number of regional and national activities to share learning.

- The next Clinical Senate planned for early summer will celebrate the achievements of the last year and obtain clinical approval for the plans for the year ahead.

Report prepared by:
Mark Travella
Associate Director Business Development & Service Improvement

On behalf of;
Alex Green
Executive Chief Operating Officer

		Agenda Item No: 11a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 March 2022

Report Title:	**Trust Constitution**					
Executive/Non-Executive Lead:	Professor Sheila Salmon, Chair of the Trust					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Trust Constitution Task and Finish Group Council of Governors Governance Committee Council of Governors					
Level of Assurance:	**Level 1**		**Level 2**	✓	**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		
The report confirms that a review of the Essex Partnership University NHS Foundation Trust Constitution has been undertaken and proposes amendments for ratification by the Board of Directors.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the review process and the proposed amendments to the Constitution following routine annual review as approved by the Council of Governors at the meeting held on Monday 21 March 2022. And the Councils agreement to amend reference to Monitor following the enactment of the Health and Social Care Bill without the requirement to represent for approval.

2 Approve the Constitution as proposed.

- Approve prospectively to amend references to Monitor in the Constitution following the enactment of the Health and Social Care Bill without the requirement to represent for approval.

Summary of Key Issues

It is recognised good governance to undertake a review of the Trust's constitution on an annual basis. The previous review took place in February 2021. It is a responsibility of the Council of Governors to approve recommended amendments to the constitution prior to approval by the Board of Directors.

The Trust Constitution was reviewed by a Task and Finish Group held on the 21 January 2022 attended by Governors, a Non-Executive Director and the Assistant Trust Secretary to check for, discuss and agree any required amendments to the Constitution. The Council of Governors Governance Committee considered the amended Trust Constitution on the 3 February 2022 recommended these for approval. The Council of Governors approved the amendments to the Constitution on the 21 March 2022.

The following minor amendments were approved by the Council of Governors:

- ***Throughout the document***: the removal of the pronoun 'he' throughout the document. Noting that there are no alterations to the content as a result of this action.

- ***Annex 4: Composition of the Council of Governors*****:** The current composition of the Council Governors includes an appointed Governor for Council for Voluntary Services (CVS) Essex. However, the position has been vacant from July 2019, including a significant delay in identification of a new Appointed Governor by CVS and the subsequent nominee unable to engage as a consequence of personal capacity. The Council of Governors Governance Committee proposes an amendment to constitution to state 'Third Sector / Voluntary Sector Appointed Governor', achieving a positive engagement with the voluntary sector through widening the criteria to include other large organisations.
- ***Termination of Office and Removal of Governors (Annex 6, Section 5):*** The Governance Committee agreed to add a clause which would allow the removal of a Governor if they failed to submit documentation relating to conflict of interests or knowingly providing false or misleading information in this regard.
- ***Annex 5: The Model Election Rules:*** The Governance Committee suggested removing this section and making reference to the publically available document, in the same manner as the Standing Orders. This would help reduce the size of the Constitution.

The following areas were discussed, but did not result in a change to the Constitution:

- The Governance Committee discussed references to 'Monitor' and whether these should be removed as there was legislation formally dissolving Monitor as a regulatory body. The legislation had not yet been enacted and therefore the references to Monitor in the Constitution were correct, but likely to be removed once the Health & Social Care Bill is enacted.

The Council of Governors agreed for the Constitution to be amended following the enactment of the Health and Social Care Bill to remove references to Monitor.

The amended Constitution is attached to this report as Appendix 1 for approval by 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			

Supporting Documents and/or Further Reading
Appendix 1: Trust Constitution

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

20220330

Essex Partnership University NHS Foundation Trust

Constitution

Approved by Council of Governors 21 March 2022 and Board of Directors 30 March 2022

TABLE OF CONTENTS

Paragraph

1. Interpretation and Definitions

1.1 Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the 2006 Act as amended by the 2012 Act

1.2 Words importing the plural shall import the singular and vice-versa.

1.3 The **2006 Act** is the National Health Service Act 2006

1.4 The **2012 Act** is the Health and Social Care Act 2012

1.5 **Annual Members' Meeting** is defined in paragraph 13 of the Constitution

1.6 **Board of Directors** or **Board** means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body in accordance with this Constitution

1.7 **Board of Directors Nominations Committee** means a committee of the Board described in paragraph 30.4 of the Constitution

1.8 **Constitution** means this constitution which has effect in accordance with Section 37(1) of the 2006 Act

1.9 **Council of Governors or Council** means the Council of Governors of the Trust as described in paragraph 14 of this Constitution

1.10 **Chair** is the person appointed as Chair of the Board of Directors (and Chair of the Council of Governors) under paragraph 28 of this Constitution

1.11 **Chief Executive** is the person appointed as the Chief Executive Officer of the Trust under paragraph 31 of this Constitution

1.12 **Directors** means the Executive and Non-Executive members of the Board of Directors

1.13 **Executive Director** means a member of the Board of Directors appointed under paragraph 25 of the Constitution

1.14 **Member** means a person registered as a member of one of the constituencies set out in paragraph 5 of this Constitution

1.15 **Model Election Rules** means the Model Election Rules published by Department of Health and/or NHS Providers

1.16 **Monitor** is the body corporate known as Monitor, as part of NHS Improvement, as provided by Section 61 of the 2012 Act

1.17 **NHS England / Improvement (NHSE/I)** the operational name for the organisation which consists of (inter alia) NHS Improvement, NHS England,

Monitor and the NHSTDA;

1.18 **NHSTDA** means the Special Health Authority known as the National Health Service Trust Development Authority established under the NHS Trust Development Authority (Establishment and Constitution) Order 2012 SI 901/2012

1.19 **Non-Executive Director** means a member of the Board of Directors, including the Chair, appointed by the Council of Governors under paragraph 28 of the Constitution

1.20 **Officer** means an employee of the Trust or any person holding a paid appointment or office with the Trust

1.21 **Regulated Activities Regulations** means the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as amended

1.22 The **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act

1.23 The **Trust Secretary** is the person appointed by the Chair and Chief Executive as the Trust Secretary

1.24 **Vice-Chair** means the Non-Executive Director appointed under paragraph 30.1 and 30.3 of this Constitution

1.25 **Acting Chair** means the Non Executive Director appointed under paragraph 30.2 and 30.3 of this Constitution.

1.26 **Voluntary Organisation** is a body, other than a public or local authority, the activities of which are not carried out for profit

1.27 **Working Day** means a day of the week which is not a Saturday, Sunday or public holiday in England.

2. Name

2.1 The name of the foundation trust is Essex Partnership University NHS Foundation Trust (the Trust).

3. Principal Purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the Trust are set out in the 2006 Act

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust

4.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

5. Membership and Constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the constituencies in paragraph 5.2

5.2 The constituencies of the Trust shall be:

5.2.1 a Public Constituency

5.2.2 a Staff Constituency.

6. Application for Membership

6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust subject to paragraphs 8 and 12 below

6.2 An applicant will become a member when the Trust has received and accepted the application, and the name of the applicant has been entered in the Trust's Register of Members (see Annex 9: Further Provisions paragraph 2).

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a Public Constituency may become or continue as a member of the Trust

7.2 Those individuals who live in an area specified for a Public Constituency are referred to collectively as a Public Constituency

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 Individuals who are employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 they have been continuously employed by the Trust under a contract of employment for at least 12 months

8.1.3 For the avoidance of doubt permanent staff are eligible to be members of the staff constituency. Temporary Staff can be a member of a Public Constituency if the criteria is met.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the Staff Constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For the avoidance of doubt, this does not include those who assist or provide services to the Trust on a voluntary basis

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency

8.4 The Staff Constituency shall be divided into two descriptions of individuals who are eligible for membership of the Staff Constituency; each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

9. Automatic Membership by Default – Staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

10. NOT USED

11. NOT USED

12. Restriction on Membership

12.1 An individual who is a member of a constituency, or of a class within a constituency, may not, while membership of that constituency or class continues, be a member of any other constituency or class

12.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency

12.3 An individual must be at least 12 years old to become a member of the Trust

12.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 9: Further Provisions paragraph 2.

13. Annual Members' Meeting

13.1 The Trust shall hold an annual meeting of its members (Annual Members' Meeting). The Annual Members' Meeting shall be open to members of the public

13.2 Annual Members' Meetings shall be conducted in accordance with paragraph 27A of Schedule 7 of the 2006 Act (and as set out in paragraph 46 of this constitution) and the standing orders for the practice and procedure of Annual Members' Meetings as set out in Annex 10: Annual Members' Meeting.

14. Council of Governors – Composition

14.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed Governors

14.2 The composition of the Council of Governors is specified in Annex 4

14.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

15. Council of Governors – Election of Governors

15.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules adopting Single Transferable Vote (STV)

15.2 The Model Election Rules are attached at Annex 5 but they do not form part of this constitution

15.3 A variation of the Model Election Rules by the Department of Health or NHS Providers shall not constitute a variation of the terms of this constitution for the purposes of paragraph 48 of the constitution (amendment of the constitution)

15.4 An election, if contested, shall be by secret ballot

15.5 Where a vacancy arises from amongst the elected Governors within the first 24-months of their term of office, the Trust Secretary shall offer the next highest polling candidate in the election for that post the opportunity to assume the vacancy for the unexpired balance of the former member's term of office. If that candidate does not wish to fill the vacancy, it will then be offered to the next highest polling candidate and so on until the vacancy is filled.

15.6 Governors must be at least 16 years of age at the date they are nominated for election or appointment

16. Council of Governors – Tenure

16.1 An elected Governor may hold office for a period of up to three Years. The period of office shall be known as the 'term'

16.2 Elected Governors shall cease to hold office if they cease to be a member of the constituency or class by which they were elected

16.3 Elected Governors shall be eligible for re-election at the end of their term

16.4 Appointed Governors may hold office for a period of up to three Years

16.5 Appointed Governors shall cease to hold office if the appointing organisation withdraws its sponsorship of them or if the appointing organisation ceases to exist and there is no successor in title to its business

16.6 Appointed Governors shall be eligible for re-appointment at the end of their term

16.7 A Governor may serve a maximum of three terms of each up to three years in office and shall be eligible to stand for election or appointment as a

Governor again following a break of at least a Year

16.8 ‘‘Year’ in this clause 16 means the period commencing on the date of election or appointment (as the case may be) and ending 12 months after such election or appointment.

17. Council of Governors – Disqualification and Removal

17.1 The following may not become or continue as a member of the Council of Governors:

17.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged

17.1.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986)

17.1.3 people who have made a composition or arrangement with, or granted a Trust deed for their creditors and have not been discharged in respect of it

17.1.4 people who within the preceding five years have been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them

17.2 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors and for the removal of Governors are set out in Annex 6 paragraphs 4 and 5.

18. Council of Governors – Duties of Governors

18.1 The general duties of the Council of Governors are:

18.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

18.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public

18.2 Further provision as to the roles and responsibilities of the Council of Governors is set out in Annex 6

18.3 The Trust must take steps to ensure that Governors are equipped with the skills and knowledge they require in their capacity as such.

19. Council of Governors – Meetings of Governors

19.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in

accordance with the provisions of paragraph 28 of this constitution) or, in their absence the Vice-Chair or Acting Chair (appointed in accordance with the provisions of paragraph 30 of this constitution), shall preside at meetings of the Council of Governors except as otherwise provided pursuant to the standing orders for the Council of Governors as at Annex 7

19.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Chair may exclude any person from a meeting of the Council of Governors if that person is interfering with or preventing the proper conduct of the meeting

19.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

20. Council of Governors – Standing Orders

20.1 The standing orders for the practice and procedure of the Council of Governors are referenced at Annex 7

20.2 The standing orders do not form part of this constitution. Any amendment of the standing orders shall not constitute an amendment of the terms of this constitution for the purposes of paragraph 48 of this constitution.

21. NOT USED

22. Council of Governors – Conflicts of Interest of Governors

22.1 If Governors have a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, Governors shall disclose that interest to the members of the Council of Governors as soon as they become aware of it. The standing orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

23. Council of Governors – Travel Expenses

23.1 The Trust may pay travelling and other expenses to Governors that are incurred in carrying out their duties at rates determined by the Trust. These expenses are to be disclosed in the Trust's annual report

23.2 Governors do not receive remuneration when undertaking their duties and role as a Governor.

24. Council of Governors – Further Provisions

24.1 Further provisions with respect to the Council of Governors are set out in Annex 6.

25. Board of Directors – Composition

25.1 The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors

25.2 The Board of Directors is to comprise:

25.2.1 a Non-Executive Chair

25.2.2 not less than five and not more than eight other Non-Executive Directors; and

25.2.3 not less than four and not more than eight Executive Directors,

so that the number of Non-Executive Directors including the Chair shall always exceed the number of Executive Directors including the Chief Executive in a voting capacity.

25.3 One of the Executive Directors shall be the Chief Executive

25.4 The Chief Executive shall be the Accounting Officer

25.5 One of the Executive Directors shall be the Finance Director

25.6 One of the Executive Directors is to be a registered Medical Practitioner or a registered Dentist (within the meaning of the Dentists Act 1984)

25.7 One of the Executive Directors is to be a registered Nurse or a registered Midwife.

26. Board of Directors – General Duty

26.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

27. Board of Directors – Qualification for Appointment as a Non-Executive Director

A person may be appointed as a Non-Executive Director only if:

27.1 they are a member of a Public Constituency, or

27.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, they exercise functions for the purposes of that university, and

27.3 they are not disqualified by virtue of paragraph 33 of this constitution.

28. Board of Directors – Appointment and Removal of Chair and Other Non-Executive Directors

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other Non-Executive Directors

28.2 Appointment of the Chair or another Non-Executive Director shall require the approval of a majority of the Council of Governors present at a meeting of the Council of Governors

28.3 Removal of the Chair or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors

28.4 The Council of Governors shall adopt a procedure for appointing/removing the Chair and/or other Non-Executive Directors in accordance with any guidance issued by Monitor.

29. NOT USED

30. Board of Directors – Appointment of Vice-Chair, Acting Chair, Senior Independent Director and Deputy Chief Executive

30.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as the Vice-Chair

30.2 When the absence of the Chair has or will exceed a period of 3 months the Council of Governors at a meeting shall appoint one of the Non-Executive Directors as the Acting Chair.

30.3 Before a resolution for such appointments is passed, the Chair shall be entitled to advise the Council of Governors of the Non-Executive Director who is recommended by the Board of Directors for that appointment. This recommendation will not, however, be binding upon the Council of Governors; it will be presented to the Council of Governors at its meeting before it comes to its decision.

30.4 The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors as the Senior Independent Director to act in accordance with Monitor's *NHS Foundation Trust Code of Governance* (as may be amended and replaced from time to time) and the Trust's standing orders.

30.5 The Board of Directors Remuneration and Nominations Committee, which comprises of all the Non-Executive Directors, shall appoint an Executive Director as the Deputy Chief Executive in line with agreed procedure.

31. Board of Directors – Appointment and Removal of the Chief Executive and Other Executive Directors

31.1 The Non-Executive Directors shall appoint or remove the Chief Executive

31.2 A committee consisting of the Chair and Non-Executive Directors shall appoint the Chief Executive.

31.3 The appointment of the Chief Executive shall require the approval of a majority of the Council of Governors present at a meeting of the Council of Governors in accordance with the procedure agreed by the Council of Governors from time to time

31.4 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors

31.5 An Executive Director's post may be held by two individuals on a job share basis (save that the Executive positions of registered Medical Practitioner or registered Dentist and registered Nurse or registered Midwife cannot be shared between the two professions). Where such an arrangement is in force, the two individuals may only exercise one vote between them at any meeting of the Board of Directors as in the standing orders.

32. NOT USED

33. Board of Directors – Disqualification

The following may not become or continue as a member of the Board of Directors:

33.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged

33.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986)

33.3 people who have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it

33.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them

33.5 a person who is subject of a disqualification order made under the Company Directors Disqualification Act 1986 and/or who is disqualified from being a trustee of a charity under the Charities Act 2011

33.6 people where disclosures revealed by a Disclosure & Barring Service check against such people are such that it would be inappropriate for them to become or continue as a Director or would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute

33.7 people whose tenure of office as Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service for reasons including non-attendance at meetings, or for non-disclosure of a pecuniary interest

33.8 a person who has within the preceding two years been dismissed: otherwise than by reason of redundancy or for ill health, from any paid employment with;

33.8.1 a health service body or a local authority;
33.8.2 any other public body; or
33.8.3 a private provider or health or social care services;

unless approved by the Board of Directors for Executive Directors or the Council of Governors for Non-Executive Directors

33.9 a person who is the subject of a Sexual Offenders Order under the Sexual Offences Act 2003

33.10 a person who is included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list maintained under the laws of Scotland or Northern Ireland

33.11 a person who is a Director or Governor or Governing Body member or equivalent of another NHS body, including Clinical Commissioning Groups unless approved by the Board of Directors for Executive Directors or the Council of Governors for Non-Executive Directors

33.12 a person who is a member of the Council of Governors

33.13 in the case of Non-Executive Directors, a person who is no longer a member of one of the public constituencies

33.14 in the case of Non-Executive Directors, a person who has refused without any reasonable cause to fulfil any training requirement established by the Board of Directors

33.15 a person who is a member of a Local Authority's Overview & Scrutiny Committee covering health matters or of a Local Healthwatch Board or of a Health & Wellbeing Board

33.16 a person who is the spouse, partner, parent or child of a member of the

Trust's Board of Directors

33.17 a person who has displayed aggressive or violent behaviour at any NHS establishment or against any of the Trust's staff or persons exercising functions for the Trust

33.18 a person who fails to satisfy the requirements of the Regulated Activities Regulations

33.19 a person who has failed to sign and return to the Trust Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for the Board of Directors

33.20 a person who has acted in a manner inconsistent with or who has failed to comply with the Trust's terms of authorisation, standing orders, standing financial instructions and/ or the code of conduct for the Board of Directors.

34. Board of Directors – Meetings

34.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Chair may exclude any person from a meeting of the Board of Directors if that person is interfering with or preventing the proper conduct of the meeting

34.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the Part 1 minutes of the meeting to the Council of Governors. A summary of Part 2 minutes will be provided to the Council of Governors.

35. Board of Directors – Standing Orders

35.1 The Board of Directors has adopted the standing orders for the practice and procedure of the Board of Directors referred to at Annex 8.

35.2 The standing orders do not form part of this constitution. Any amendment of the standing orders shall not constitute an amendment of the terms of this constitution for the purposes of paragraph 48 of the constitution.

36. Board of Directors – Conflicts of Interest of Directors

36.1 The duties that a Director of the Trust has by virtue of being a Director include in particular:

36.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust

36.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity

36.2 The duty referred to in sub-paragraph 36.1.1 is not infringed if:

36.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

36.2.2 the matter has been authorised in accordance with the constitution if it has been considered and approved by the Board of Directors

36.3 The duty referred to in sub-paragraph 36.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest

36.4 In sub-paragraph 36.1.2, "third party" means a person other than:

36.4.1 the Trust, or

36.4.2 a person acting on its behalf

36.5 If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors

36.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made

36.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement

36.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question

36.9 A Director need not declare an interest:

36.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest

36.9.2 if, or to the extent that, the Directors are already aware of it

36.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

36.9.3.1 by a meeting of the Board of Directors, or

36.9.3.2 by a committee of the Directors appointed for the purpose under the constitution

36.10 The standing orders for the Board of Directors make further provision for the disclosure of interests.

37. Board of Directors – Remuneration and Terms of Office

37.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors

37.2 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

38. Registers

The Trust shall have:

38.1 a register of members showing, in respect of each member, the constituency to which they belong and, where there are classes within it, the class to which they belong

38.2 a register of members of the Council of Governors

38.3 a register of interests of Governors

38.4 a register of Directors, and

38.5 a register of interests of the Directors.

39. Admission to and Removal from the Registers

39.1 The Trust Secretary shall be responsible for fulfilling the obligations of the Trust in relation to the maintenance of, admission to and removal from the registers under the provisions of this constitution and as set out in paragraph 38.

39.2 Directors and Governors shall advise the Trust Secretary as soon as practicable of anything which comes to their attention or of which they are aware and which might affect the accuracy of the matters recorded in any of the registers referred to in paragraph 38.

40. Registers – Inspection and Copies

40.1 The Trust shall make the registers specified in paragraph 38 above available for inspection by members of the public, except in the circumstances prescribed below or as otherwise prescribed

40.2 The Trust may withhold all or part of the registers from inspection where disclosure of information could give rise to a real risk of harm or is prohibited by law.

40.3 So far as the registers are required to be made available:

40.3.1 they are to be available for inspection free of charge at all reasonable times, and

40.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract

40.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

41. Documents Available for Public Inspection

41.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

41.1.1 a copy of the current constitution,

41.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

41.1.3 a copy of the latest annual report

41.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

41.2.1 a copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act

41.2.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act

41.2.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act

41.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act

41.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act

41.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act

41.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act

41.2.8 a copy of any final report published under section 65I (administrator's final report) of the 2006 Act

41.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act

41.2.10 a copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act

41.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy

41.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

42. Auditor

42.1 The Trust shall have an auditor

42.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors

42.3 The auditor shall comply with Schedule 10 of the 2006 Act in auditing the accounts of the Trust.

43. Audit Committee

43.1 The Board of Directors shall establish a committee comprising Non-Executive Directors (at least one of whom has competence in accounting and/or auditing and recent and relevant financial experience) as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate

43.2 The Audit Committee as a whole shall have competence relevant to the NHS sector.

44. Accounts

44.1 The Trust must keep proper accounts and proper records in relation to the accounts

44.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts

44.3 The accounts are to be audited by the Trust's auditor

44.4 The Trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct

44.5 The functions of the Trust with respect to the preparation of the annual accounts, as set out in paragraph 25 of Schedule 7 of the 2006 Act, shall be delegated to the Accounting Officer.

45. Annual Report, Forward Plans and Non-NHS Work

45.1 The Trust shall prepare an annual report and send it to Monitor

45.2 The Trust shall give information as to its forward planning in respect of each financial year to Monitor

45.3 The forward plan shall be prepared by the Directors

45.4 In preparing the forward plan, the Directors shall have regard to the views of the Council of Governors

45.5 Each forward plan must include information about:

45.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

45.5.2 the income it expects to receive from doing so

45.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 45.5.1 the Council of Governors must:

45.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

45.6.2 notify the Directors of the Trust of its determination

45.7 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council

of Governors of the Trust voting approve its implementation.

46. Presentation of the Annual Accounts and Reports to the Governors and Members

46.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

46.1.1 the annual accounts

46.1.2 any report of the auditor on them

46.1.3 the annual report

46.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one Board Director in attendance

46.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 46.1 with the Annual Members' Meeting.

47. Instruments

47.1 The Trust shall have a seal

47.2 The seal shall not be affixed except under the authority of the Board of Directors.

48. Amendment of the Constitution

48.1 The Trust may make amendments of its constitution only if:

48.1.1 more than half of the members of the Council of Governors of the Trust voting approve the amendments, and

48.1.2 more than half of the members of the Board of Directors of the Trust voting approve the amendments

48.2 Amendments made under sub-paragraph 48.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act

48.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

48.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

48.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment

If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result. Actions taken by the Trust under the amended constitution, prior to the amendment ceasing to have effect, remain valid

48.4 Amendments by the Trust of its constitution are to be notified to Monitor.

49. Mergers, etc, and Significant Transactions

49.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors

49.2 The Trust may enter into a significant transaction unless it is a merger, acquisition, separation or dissolution only if more than half of the members of the Council of Governors of the Trust voting, approve entering into the transaction

49.3 The definition of "significant transaction" for the purposes of paragraph 49.2 and section 51A of the 2006 Act is set out in Annex 9 paragraph 1.

50. Indemnities

50.1 Members of the Board of Directors, members of the Council of Governors and the Trust Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust

50.2 The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of the Board of Directors, the Council of Governors and the Trust Secretary.

ANNEX 1: THE PUBLIC CONSTITUENCIES

(Paragraphs 7.1 and 7.3)

THE PUBLIC CONSTITUENCIES			
Constituency Name	**Area of the Constituency**	**No of Governors to be Elected**	**Minimum No of Members**
Essex Mid & South	The electoral wards covered by: • Basildon Borough Council • Braintree District Council • Brentwood Borough Council • Castle Point Borough Council • Chelmsford Borough Council • Maldon District Council • Rochford District Council • Southend on Sea Borough Council • Thurrock Borough Council	9	60
North East Essex & Suffolk	• Colchester Borough Council • Suffolk County Council • Tendring District Council	3	60
West Essex & Herts	• Borough of Broxbourne Council • East Herts District Council • Epping Forrest District Council • Harlow Council • North Herts District Council • Stevenage Borough Council • Uttlesford District Council • Welwyn Hatfield Borough Council	5	60
Milton Keynes, Bedfordshire & Luton, and Rest of England	• Bedford Borough Council • Central Bedfordshire Council • Luton Borough Council • Milton Keynes Council • Any other Council in England unless named in Annex 1 to the Trust's Constitution	2	60

ANNEX 2: THE STAFF CONSTITUENCY

(Paragraph 8.4 and 8.5)

THE STAFF CONSTITUENCIES			
Constituency Name	**Area of the Constituency**	**No of Governors to be Elected**	**Minimum No of Members**
Clinical	• Registered medical practitioners and registered dentists • Registered nurses and registered midwives	4	60
Non-Clinical	• Healthcare professionals (not included above) • Social workers • Support staff	2	60

ANNEX 3: NOT USED

ANNEX 4: COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 14.2 and 14.3)

Public Governors		**19**
Essex Mid & South	9	
North East Essex & Suffolk	3	
West Essex & Herts	5	
Milton Keynes, Bedfordshire & Luton, and Rest of England	2	
Staff Governors		**6**
Clinical	4	
Non-Clinical	2	
Appointed and Partnership Governors		**5**
Essex County Council	1	
Southend Borough Council	1	
Thurrock Council	1	
Anglian Ruskin and Essex Universities (joint appointment)	1	
Third Sector / Voluntary Sector	1	
Total Council of Governors		**30**

ANNEX 4.1: NOT USED

ANNEX 5: THE MODEL ELECTION RULES

(Paragraph 15.2)

The Model Election Rules 2014 are included as a separate document to this constitution. (https://nhsproviders.org/resource-library/briefings/model-election-rules)

ANNEX 6: ADDITIONAL PROVISION – COUNCIL OF GOVERNORS

(Paragraphs 17.3, 18.2 and 24.1)

1. Roles and Responsibilities of the Council of Governors

The roles and responsibilities of the Council of Governors which are to be carried out in accordance with the constitution, the Trust's license and Monitor's *NHS Foundation Trust Code of Governance* include

1.1 General Duties

1.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, including ensuring that the Board of Directors acts so that the Trust does not breach the terms of its license. "Holding the Non-Executive Directors to account" includes scrutinising how well the Board is working, challenging the Board in respect of its effectiveness, and asking the Board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the Trust, questioning Non-Executive Directors about the performance of the Board and of the Trust and making sure to represent the interests of the Trust's members and of the public in doing so

1.1.2 to represent the interests of the members of the Trust and the interests of the public

2.1 Non-Executive Directors, Chief Executive and Auditor

2.1.1 to approve the policies and procedures for the appointment and removal of the Chair and Non-Executive Directors on the recommendation of the Nomination Committee of the Council of Governors

2.1.2 to appoint the Chair and Non-Executive Directors

2.1.3 to remove the Chair and the Non-Executive Directors. However, the Council should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all means of

engagement with the Board

2.1.4 to approve the policies and procedures for the appraisal of the Chair, and Non-Executive Directors on the recommendation of the remuneration committee of the Council of Governors. All Non-Executive Directors should be submitted for re-appointment at regular intervals.. The Council of Governors should ensure planned and progressive refreshing of the Non-Executive Directors

2.1.5 to decide the remuneration of Non-Executive Directors and the Chair and to approve changes to the remuneration, allowances and other terms of office for the Chair and the Non-Executive Directors having regard to the recommendations of the Remuneration Committee of the Council of Governors

2.1.6 to approve the appointment of the Chief Executive of the Trust

2.1.7 to approve the criteria for the appointment, removal and reappointment of the auditor

2.1.8 to appoint, remove and reappoint the auditor, having regards to the recommendation of the Audit Committee

3.1 Strategy Planning

3.1.1 to provide feedback to the Board of Directors on the development of the strategic direction of the Trust, as appropriate

3.1.2 to collaborate with the Board of Directors in the development of the forward plan

3.1.3 where the forward plan contains a proposal that the Trust will carry out activities other than the provision of goods and services for the purposes of the NHS in England, to determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions and notify its determination to the Board of Directors

3.1.4 where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the NHS in England, approve such a proposal

3.1.5 to approve the entering into of any significant transaction (as

defined in this constitution) in accordance with the 2006 Act and the constitution

3.1.6 to approve proposals from the Board of Directors for merger, acquisition, dissolution or separation in accordance with 2006 Act and the constitution

3.1.7 when appropriate, to make recommendations for the revision of the constitution and approve any amendments to the constitution in accordance with the 2006 Act and the constitution

3.1.8 to receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council of Governors

4.1 Representing Members and the Public

4.1.1 to prepare and from time to time review the Trust's membership engagement strategy and policy

4.1.2 to notify Monitor, via the Lead Governor, if the Council is concerned that the Trust is at risk of breaching the terms of its license, and if these concerns cannot be resolved at local level

4.1.3 to report to the members annually on the performance of the Council of Governors

4.1.4 to promote membership of the Trust and contribute to opportunities to recruit members in accordance the membership strategy

4.1.5 to seek the views of stakeholders and feed back to the Board of Directors.

(Paragraphs 17.3 and 24.1)

4. Eligibility to be a Governor

4.1 A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so, if:

4.1.1 they are a Director of the Trust, or a director of another health service body

4.1.2 they are the spouse, partner, parent or child of a member of the Board of Directors for the Trust

4.1.3 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986

4.1.4 they are subject to a Sexual Offenders Order under the Sexual Offences Act 2003

4.1.5 they are included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list maintained under the laws of Scotland or Northern Ireland

4.1.6 they are undergoing a period of disqualification from a statutory health or social care register

4.1.7 they have been disqualified from being a member of a relevant authority under the provisions of the Local Government Act 2000

4.1.8 they have been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a health service body

4.1.9 they are a vexatious complainant as determined in accordance with the Trust's complaints procedure

4.1.10 within 5 years prior to his nomination for election or appointment to the Council of Governors, they have had their office of Governor terminated for the reasons set out in paragraphs 5.1.4 – 5.1.9 of this Annex 6.

(Paragraph 17)

5. Termination of Office and Removal of Governors

5.1 People holding office as a Governor shall cease to do so if:

5.1.1. they resign by notice in writing to the Trust Secretary

5.1.2 in the case of elected Governors, they cease to be member of the area of the constituency or class of the constituency by which they were elected

5.1.3. in the case of an appointed or partnership Governor, the appointing organisation terminates the appointment of the individual

5.1.4. they consistently and unjustifiably fail to attend the meetings of the Council of Governors in line with the Governor attendance policy as agreed by the Council of Governors

5.1.5. they have refused without reasonable cause to undertake any training which the Trust requires all Governors to undertake

5.1.6. they have failed to sign and deliver to the Trust Secretary a statement in the form required confirming acceptance of the code of conduct for Governors

5.1.7. they have failed to complete a submission identifying any conflict of interest or they have knowingly provided false or misleading information in this regard.

5.1.8. they have committed a serious breach of the code of conduct for Governors or fails to abide by the Council of Governors standing orders

5.1.9. they have acted in a manner detrimental to the interests of the Trust

5.1.10. they have expressed opinions which are incompatible with the values of the Trust

5.1.11. they are incapable by reason of mental disorder, illness or injury of managing and administering his property and affairs

5.2 Governors who are to be removed under any of the grounds set out in paragraph 5.1 above (with the exception of sub-paragraph 5.1.1 – 5.1.3) above shall be removed from the Council of Governors by a resolution approved by the majority of the remaining Governors present and voting

5.3 There shall be a working group/committee of the Council of Governors whose function shall be to:

5.3.1 receive and consider concerns about the conduct of any governor and/or

5.3.2 consider whether there are grounds to remove a Governor from office and to make recommendations to the Council of Governors. Membership of the working group/committee shall be determined from time to time

5.4 If the Council of Governors receives a complaint in writing about any Governor or is asked to consider whether an individual is eligible to become or remain a Governor, the working group shall investigate the matter and make a recommendation to the Council of Governors, which may include a recommendation that a Governor is removed from office pursuant to paragraph 5.2 above

5.5 The Council of Governors may decide that whilst the working group is carrying out its investigation, the Governor concerned shall be suspended from office. Suspension is a neutral act and any decision to suspend the Governor concerned shall not be seen as an indicator of, or have any bearing on, the eventual recommendation of the working group

5.6 If the Council of Governors decides to terminate a Governor's tenure of office pursuant to paragraph 5.2 above, the Governor may apply in writing to the Council of Governors within seven (7) days of the date of the decision, for the decision to be referred to an independent assessor

5.7 The decision of the Council of Governors to terminate the tenure of office of the Governor concerned shall not take effect until the later of:

5.7.1 seven (7) days after the date of decision; or

5.7.2 where the Governor applies for the decision to be referred to an independent assessor in accordance with paragraph 5.6 above, the date on which the independent assessor determines the matter

5.8 The Governor shall be suspended from office (if they have not already been suspended from office pursuant to paragraph 5.5 above) with effect from the date of the Council of Governors' decision until the later of the two dates set out in paragraph 5.7 above

5.9 On receipt of an application under paragraph 5.6 above the Council of Governors and the applicant Governor will co-operate in good faith to agree on the appointment of the independent assessor. If the parties fail to agree on the identity of the independent assessor within twenty-one (21) days of the date upon which the application is received by the Council of Governors, then the Council of Governors shall request the Chartered Institute of Arbitrators to nominate an independent assessor

5.10 The independent assessor will consider the evidence and conclude whether the decision to remove the Governor was reasonable or otherwise

5.11 The independent assessor's decision will be binding on the parties. If the independent assessor finds that the decision of the Council of Governors to remove the governor was not reasonable, the decision of the Council of Governors will be rescinded

5.12 The Trust shall bear the independent assessor's costs unless the

independent assessor determines that such costs shall be shared between the Trust and the Governor.

ANNEX 7: STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 19.1 and 20)

Standing Orders For The Practice And Procedure Of The Council Of Governors are included as a separate document to this constitution.

ANNEX 8: STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 35)
Standing Orders For The Practice And Procedure Of The Board Of Directors are included as a separate document to this constitution.

ANNEX 9 – FURTHER PROVISIONS

(Paragraph 49)

1. SIGNIFICANT TRANSACTIONS

1.1 In accordance with section 51A of the National Health Service Act 2006, the Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction

1.2 For the purpose of this paragraph 1 and subject to paragraph 1.4 below, "Significant Transaction" means a "transaction" as defined in paragraph 1.3 below which meets any one of the following tests:

1.2.1 the assets which are the subject of the transaction exceed 25% of the total fixed assets of the Trust (Asset Test); or

1.2.2 the income of the Trust will increase or decrease by more than 25% following the completion of the relevant transaction (Income Test); or

1.2.3 the gross capital of the company or business being acquired or divested represents more than 25% of the total capital of the trust following completion (where "gross capital" is the market value of the relevant company or business's shares and debt securities plus the excess of current liabilities over current assets, and the Trust's capital is determined by reference to its balance sheet) (Gross Capital Test); or

1.2.4 the Asset Test, the Income Test and the Gross Capital Test are not satisfied but the transaction, in the reasonable opinion of the Board of Directors:

(a) would impact on the manner in which health services are delivered by the Trust and/or the range of health services the Trust delivers; or

(b) exceeds a total value of £10,000,000 (£10 million) and has an overall risk rating which in the reasonable opinion of the Board of Directors is considered to be significant. The Board of Directors will assess the significance of the overall risk of the transaction against the applicable Trust's own risk management framework in force at the time the risk assessment is conducted by the Board of Directors

1.3 "Transaction" means any agreement (including an amendment to an agreement) entered into by the Trust in respect of a merger, demerger, joint venture, divestment, or any other arrangement for the acquisition, disposal or delivery of health services, but, for the avoidance of doubt, it does not include:

1.3.1 an agreement entered into or changes to the health services carried out by the Trust following a reconfiguration of the health services led by the commissioners of such health services; or

1.3.2 a grant of public dividend capital or the entering into a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the trust

1.3.3 For the purpose of this paragraph 1.3 the following definitions apply:

(a) "merger" means a transaction that involves one organisation acquiring / transferring the assets and liabilities of another, either wholly or in part;

(b) "demerger" means a transaction that involves the disaggregation of a single corporate body into two or more new corporate bodies;

(c) "joint venture" means a transaction involving an agreement between two or more parties to undertake economic activity together which establishes a separate legal entity.; and

(d) "divestment" means a transaction that involves the disposal, in whole or in part, of an organisation's business, services or assets and liabilities where the Board of Directors has made a decision to do so.

1.4 A transaction is not a Significant Transaction if it is:

1.4.1 a transaction which is a statutory merger, acquisition, separation or dissolution under sections 56, 56A, 56B or 57A of the National Health Service Act 2006; or

1.4.2 a transaction in the ordinary course of current business from time to time (including the expiry, termination, renewal, extension of, or the entering into an agreement in respect of the health services carried out by the Trust).

1.4.3 a transaction that involves the disposal, in whole or in part, of an organisation's business services or assets and liabilities where the Board of Directors has not made a decision and therefore is outside Trust control.

(Paragraphs 6.2 and 12.4)

2. TERMINATION OF MEMBERSHIP

2.1 A member shall not become or continue to be a member if:

2.1.1 it is reasonably suspected by the Board that in the five years prior to the individual's application for membership of the Trust or during the

period of their membership of the Trust, they have been involved as a perpetrator in what the Board reasonably considers to be a sufficiently serious incident of intimidation, threat, harassment, assault or violence against:

a) any of the Trust's employees or other persons who exercise functions for the purpose of the Trust, or against any volunteers; or
b) any employee of another health service body or any person who exercises functions for the purposes of another health service body or against any person who volunteers with another health service body; or
c) any service user or carer or visitor to the Trust or any service user, carer or visitor to any other health service body

2.1.2 they have been excluded from the Trust's premises within the previous five years

2.1.3 they are expelled from membership by resolution of the Council of Governors

2.1.4 they cease to be eligible under this Constitution to be a member

2.1.5 they die

2.2 It is the responsibility of members to ensure their eligibility at all times and not the responsibility of the Trust to do so on their behalf. Members who become aware of their ineligibility shall inform the Trust as soon as practicable and their names shall be removed from the Register of Members

2.3 Where the Trust has reason to believe that members cease to be eligible for membership or their membership can be terminated under this constitution, the Trust Secretary shall carry out reasonable enquiries to establish if this is the case.

ANNEX 10: ANNUAL MEMBERS' MEETING

(Paragraphs 13 and 46)

1. Interpretation

1.1. Save as permitted by law, the Chair shall be the final authority on the interpretation of these standing orders (on which the Chair shall be advised by the Chief Executive and the Trust Secretary)

2. General Information

2.1. The purpose of the standing orders for Annual Members' Meetings is to ensure that the highest standards of corporate governance and conduct are applied to all Annual Members' Meetings

2.2. All business shall be conducted in the name of the Trust

3. Attendance

3.1. Each member shall be entitled to attend an Annual Members' Meeting

4. Meetings in Public

4.1. Meetings of the Annual Members' Meetings must be open to the public subject to the provisions of paragraph 4.2 below

4.2. The Chair may exclude members of the public from an Annual Members' Meeting if they are interfering with or preventing the reasonable conduct of the meeting

4.3. Annual Members' Meetings shall be held annually at such times and places as the Chair may determine

5. Notice of Meetings

5.1. Before each Annual Members' Meeting, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair, or by an officer of the Trust authorised by the Chair to sign on their behalf, shall be served upon every member at least 10 clear days before the meeting and posted on the Trust's website and displayed at its headquarters

5.2. The Annual Report and Accounts shall be circulated to Governors and published on the website at the earliest and appropriate opportunity. Copies of the Annual Report and Accounts shall be sent to any member upon written request to the Trust Secretary and shall be available for inspection by a member free of charge at the place of the meeting

6. Setting the Agenda

6.1. The Chair shall determine the agenda for Annual Members' Meetings which must include the business required by the Act

7. Chair of Annual Members' Meetings

7.1. The Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair or Acting Chair shall preside. If neither the Chair, Vice-Chair nor Acting Chair is present the Directors and Governors shall elect one of their number to act as Chair

8. Chair's Ruling

8.1. Statements of members made at Annual Members' Meetings shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final

9. Voting

9.1. Decisions at meetings shall be determined by a majority of the votes of the members present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote subject to the Act

9.2. All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands

9.3. In no circumstances may an absent member vote by proxy

10. Suspension of Standing Orders

10.1. Except where this would contravene any statutory provision, any one or more of these standing orders may be suspended at an Annual Members' Meeting, provided that a majority of members present vote in favour of suspension

10.2. A decision to suspend the standing orders shall be recorded in the minutes of the meeting

10.3. A separate record of matters discussed during the suspension of the standing orders shall be made and shall be available to the members

10.4. No formal business may be transacted while the standing orders are suspended

10.5. The Trust's Audit Committee shall review every decision to suspend the standing orders

11. Variation and Amendment of Standing Orders

11.1. These standing orders may be amended in accordance with paragraph 48 of the constitution

12. Record of Attendance

12.1. The Trust Secretary shall keep a record of the names of the members present at an Annual Members' Meeting

13. Minutes

13.1. The minutes of the proceedings of an Annual Members' Meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next Annual Members' Meeting where they will be signed by the person presiding at it

13.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting

13.3. The minutes of an Annual Members' Meeting shall be made available to the public on the Trust's website

14. Quorum

14.1. No business shall be transacted at an Annual Members' Meeting unless at least 20 members are present.

		Agenda Item No: 11b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 March 2022

Report Title:	**Safe Working of Junior Doctors Quarterly Report**					
Executive/Non-Executive Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr Sethi, Consultant Psychiatrist and Guardian of Safe Working Hours					
Report discussed previously at:	Not previously discussed.					
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)?	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	N/A	

Purpose of the Report		
This report provides the Board of Directors with assurance to that doctors in training are safely rostered and that their working hours are compliance with the Terms and Conditions of the Service.	**Approval**	
	Discussion	
	Information	√

Recommendations/Action Required

The Board of Directors is asked to note the report and that no major concerns raised by doctors at the Junior Doctors Forum apart from points raised within the report.

Summary of Key Issues

1. Refurbishment work at Doctor's room at Linden and Derwent centre is complete, work at Basildon and Rochford Doctor's room is still pending.
2. Trainees are awaiting clarity on Stepping down policy and the pay rate when they have to step down. Human resources are working on this.

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			
HEE	Health Education England	MTI	Medical Training Initiative
FY	Foundation Year		
LAS	Locum Appointment for Service		

Supporting Documents and/or Further Reading
Main Report

Lead
Dr Milind Karale **Executive Medical Director**

Agenda Item: 11b
Board of Directors Part 1
30 March 2022

Quarterly Report on Safe Working of Junior Doctors

1 Purpose of Report

The purpose of this report is to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.

2 Executive Summary

This is the eighteenth quarterly report submitted to the Board on safe working of junior doctors for the period 1 October to the 31 December 2021. The Trust has established robust processes to monitor safe working of junior doctors and report any exceptions to their terms and conditions.

Exception Reporting: (2 Exception reports in this quarter)

18/01/2022: Trainee worked for an extra one and half hours to complete ward duties as other doctors were off due to COVID. Time off in lieu was offered.

20/01/2022: Trainee worked extra 1 hour to complete ward duties as other doctors were off due to COVID. Time off in lieu was offered.

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on the 1 December 2021.

Doctors in Training Data

Number of doctors in training posts (total inclusive of GP and Foundation)	133
Number of doctors in psychiatry training on 2016 Terms and Conditions	71
Total number of vacancies	15
Total vacancies covered LAS/ MTI/Agency	10
Total gaps	5

Agency

The Trust did not use any agency locums during this reporting period but relies on the medical workforce to cover at internal locum rates as follows.

Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy/Maternity/sick/COVID	143	143	0	1481.5	1481.5
Total	143	143	0	1481.5	1481.5

Actions taken to resolve issues:

The Trust has taken the following steps to resolve the gaps in the rota:

1. Rolling adverts on NHS jobs. Few International doctors who were appointed have started their posts.

2. Emails are sent to former GP and FY trainees if they would like to join the bank to do on-calls, this is now part of the termination process for GP's and FY's so they can express an interest in covering extra shifts when they leave EPUT.

Fines: None

Issues Arising:

1. Refurbishment work at Doctor's room in Linden Centre and Derwent centre are complete.

2. Refurbishment work at Basildon and Rochford Doctor's room is still pending. Estates are aware.

3. Trainees still have money left to spend from the funding from Health Education England (HEE). Finance department have agreed for trainees to carry forward this money to this financial year.

4. Trainees are stepping down during their on-calls (although not frequently), trainees are querying on their pay rate, Human Resources are aware and we are awaiting clarity on stepping down policy.

3 Action Required

Board is asked to note the report and that no major concerns raised by doctors at the Junior Doctors Forum apart from points raised above.

Report prepared by
Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours
January 2022

		Agenda Item No: 12a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 March 2022

Report Title:	**Corporate Seal**					
Executive/ Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Horley, PA to Chief Executive Officer, Chair and Non-Executive Directors					
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)?	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 information of when the Trust Corporate Seal has been used.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Receive and note the contents of the report
2 Request any further information or action.

Summary of Key Issues

The Standing Orders for the Practice and Procedure of the Board of Directors (12.3) requires a report of all uses of the corporate seal to be made to the Board, providing a description of the document, the date of the sealing and the name of the person who attested the fixing of the seal or who executed the Deed on behalf of the Trust.

The EPUT Corporate Seal has been used on the following occasions since the last Board of Directors meeting:

- 01 March 2022 Lease renewal Jackson Road (Signed by Trevor Smith, Chief Finance and Resources Officer and Paul Scott, Chief Executive Officer)

- 07 February 2022 Transfer of Chelmsford and Essex Centre (Signed by Trevor Smith, Chief Finance and Resources Officer and Paul Scott, Chief Executive Officer)

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Paul Scott **Chief Executive Officer**