Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public via Teams Live Event
Wednesday 31 March 2021 at 10:00

Vision: Working to Improve Lives

PART ONE: MEETING HELD IN PUBLIC via Teams Live Event
AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
	PRESENTATION: **Staff Survey Results** **Charlie Bosher - Quality Health**			
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 27 January 2021	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	CEO Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	PS	Attached	Noting
(b)	NHS People Plan Update	SL	Attached	Noting
(c)	NHS Workforce Disability Equality Standard Mid Year Progress Report	SL	Attached	Noting
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework 2020/21	PS	Attached	Approval
(b)	Standing Committees:			
	(i) Audit Committee	JW	Attached	Noting
	(ii) Finance & Performance Committee	ML	Attached	Noting
	(iii) Quality Committee	AS	Attached	Noting
	(iv) People, Innovation & Transformation Committee	ARQ	Attached	Noting
9	**RISK ASSURANCE REPORTS**			
	(i) COVID-19 Assurance Report	PS	Attached	Noting

	(ii) EU Exit	NL	Attached	Noting
10	**STRATEGIC INITIATIVES**			
(a)	Mental Health & Community Health Services Transformation	AG	Attached	Noting
(b)	Constitution Review	SS	Attached	Approval
(c)	Engagement Strategy 2017-2022	SL	Verbal	Approval
11	**REGULATION AND COMPLIANCE**			
(a)	CQC Compliance Update	PS	Attached	Noting
12	**OTHER**			
(a)	Use of Corporate Seal	PS	Not used	Noting
(b)	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
(c)	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
(d)	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
(e)	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
13	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
14	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
15	**DATE AND TIME OF NEXT MEETING** **Wednesday 26 May 2021 - Virtual at 10:00**			
16	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** Wednesday 28 July 2021 at 10.00 Wednesday 29 September 2021 at 10.00 Wednesday 24 November 2021 at 10.00			

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 27 January 2021
Held Virtually via MS Teams Video Conferencing

Attendees:

Prof Sheila Salmon (SS)	Chair
Paul Scott (PS)	Chief Executive
Prof Natalie Hammond (NH)	Executive Nurse
Trevor Smith (TS)	Executive Chief Finance Officer
Alex Green (AG)	Executive Chief Operating Officer (Interim)
Sean Leahy (SL)	Executive Director of People and Culture
Nigel Leonard (NL)	Executive Director of Strategy and Transformation
Dr Milind Karale (MK)	Executive Medical Director
Janet Wood (JW)	Non-Executive Director
Alison Davis (AD)	Non-Executive Director
Alison Rose-Quirie (ARQ)	Non-Executive Director
Amanda Sherlock (AS)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director
Rufus Helm (RH)	Non-Executive Director
Mateen Jiwani (MJ)	Non-Executive Director

In Attendance:

Angela Horley	PA to Chief Executive, Chair and NEDs (minutes)
James Day	Interim Trust Secretary
Tina Bixby	Assistant Trust Secretary
Chris Jennings	Assistant Trust Secretary
Greg Wood	Clinical Director of Psychology Services (Observing)
Caroline Thomsett	Interim Director of Communications and Marketing
Paula Grayson	Governor
Dianne Collins	Governor
Mark Dale	Governor
Paul Walker	Governor
Pam Madison	Observer
Matt Gall	Strategy Lead

SS welcomed Board members, Governors, members of the public and members of staff that were viewing the live broadcast. SS was delighted to welcome Greg Wood, who was observing the Board of Directors meeting as part of a leadership programme. SS formally acknowledged and welcomed Dr Mateen Jiwani, Non-Executive Director and Alex Green in her now substantive role as Chief Operating Officer.

001/21 APOLOGIES FOR ABSENCE

There were no apologies for absence. It was noted that NL would join the meeting at 10:55.

002/21 DECLARATIONS OF INTEREST

MJ declared that he was a member of the Royal College of General Practitioners, a lecturer at Imperial and a GP in Essex; these declarations have been formally noted as part of the recruitment processes. There were no other declarations of interest.

003/21 MINUTES OF PREVIOUS MEETINGS

Signed: …… Date: ……

In the Chair

The minutes of the meeting held 25 November 2020 were agreed as an accurate record of discussions held subject to the following amendments:

- Page 6, paragraph four to read: NH added a caveat that the number of training courses has been reduced due to the Covid 19 pandemic, including refresher training; however full training has been undertaken previously which has allowed a thorough focus on training for new starters.
- Page 13 should read as PS not SM presented Corporate Seal paper.

004/21 ACTION LOGS AND MATTERS ARISING

The action log was reviewed and it was noted that there were no actions due.

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

The Board discussed and approved the Action Log.

005/21 CHAIRS REPORT INCLUDING GOVERNANCE UPDATE

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

SS reflected on recent months and the difficult and challenging situation that continues to affect the nation. SS was pleased to report that EPUT had successfully set up and opened large vaccination centres with more to come on line. To date there had been good uptake from staff and public priority groups. SS thanked all who had been involved in implementing this crucial exercise.

SS welcomed Dr Mateen Jiwani, who took up post as Non-Executive Director on 18 January. SS stated that MJ would be a great addition to the Board of Directors, bringing energy and vision as well as key skills in digital and strategic transformation.

SS congratulated AD on her recent appointment as Chair of Milton Keynes University Hospital Foundation Trust and wished her success in her new role. SS thanked AD for her contribution to the EPUT Board.

SS also congratulated AG who following a competitive process had been appointed as substantive Chief Operating Officer.

The Board received and noted the Chair's Report.

006/21 CEO REPORT

PS acknowledged the impact that the pandemic had had across the nation following the recent news that there had now been over one hundred thousand Covid related deaths nationally. This had impacted patients, families and staff and it was now more important than ever to lead with kindness and compassion; PS added that the Trust was holding a remembrance service for colleagues led by the Chaplaincy team. PS reflected on the endeavours colleagues to make sure service remained open during the pandemic as well as responding to the changing needs of the system and extended his and the Executive Team's thanks to all during this very difficult time.

EPUT have had the privilege of playing a key role in the roll out of mass vaccination centres across Mid and South Essex and Suffolk and North East Essex; with two centres now open at the Lodge in Wickford and Gainsborough Sports Centre in Ipswich, with further sites to open in the coming weeks.

PS was pleased that the Safety Strategy was due to be presented to the Board at today's meeting, reiterating that safety is our number one priority.

PS also echoed the warm welcome and congratulations to MJ and AG.

The Board received and noted the CEO's Report.

007/21 QUALITY AND PERFORMANCE SCORECARD

AG presented the Quality and Performance Scorecard which highlighted a high level summary of performance against quality priorities, safer staffing levels, financial targets and NHSI key operational performance metrics. It is important to note that despite additional pressures as a result of the pandemic, performance had remained stable with the November position of 23 key targets on track being sustained. Inpatient capacity had impacted the number of Out of Area Placements, which had increased as a direct result of outbreaks on wards.

Continued focus was being directed towards mandatory training, in respect of which performance had improved this month. Essex STaRS and IAPT services had seen a lower referral rate and affected recovery rates due to the national lockdown. Bank and agency usage was also an area of focus, however with the ongoing pandemic bank and agency staff have contributed to the staffing of wards. CAMHS level four services had seen a high level of activity both nationally and regionally.

NH advised that risk mitigation was in place to ensure quality and safety is the focus, with Gold, Silver and Bronze command meetings focussing on safety. In terms of mitigation, NH confirmed that senior nursing staff based within corporate services have been deployed into clinical services to provide support. Staff wellbeing remains a focus to enable delivery of services, and a number of support services and initiatives are available to staff as well as psychological support.

MK added that in terms of Out of Area placements and bed pressures, Clinical Directors support consultants on rounds as well as supporting the inpatient teams with discharge etc. During the first wave of the pandemic the Trust was able to create inpatient capacity, however this has not been possible during this wave and it has been important to balance inpatient capacity without compromising on safety. Waiting lists are also being reviewed. ARQ noted that waiting lists stood out as an issue, especially if the patient had not been seen for a period of time and queried what processes were in place to mitigate risk to patient safety. MK responded that there were two categories of patient, those that were under the Care Coordination of a CPA and a second cohort that have a psychosocial or low grade mental health issue that are seen in outpatient clinics. A data cleansing exercise was taking place for those that had been discharged from the service. MK continued that there a number of transformation projects taking place looking at different ways of looking at how the second cohort can be supported and managed through primary care services. ARQ suggested that a review of the wording of the report may be beneficial to make this clear.

SL congratulated all staff for their continued efforts throughout this incredibly difficult time, and thanked the HR team for their tremendous effort in processing a large number of new recruits during this time. SL also advised that an online event had also taken place encouraging BAME colleagues to receive their Covid vaccine and dispel myths.

TS advised that we continue to work with system partners within an adapted financial regime to remain within the national financial allocation at month 9 and continue to maintain the stewardship of public funds. Capital investment remains a focus and the Trust are committed to maximising investment in infrastructure. This had been a challenge due to the pandemic but would collectively endeavour to maximise investment for this year.

PS summarised that we continue to see tremendous pressure. However we have managed to maintain performance standards and augment services to manage risks in these unique circumstances.

AG advised that to limit the number of Out of Area placements, the Trust had secured a contract with the Priory Group for 18 beds within their facility. There is a strong contract in place which is aligned with our quality and safety focus.

MK referred to the earlier discussion regarding waiting lists and confirmed that patients seen in outpatient clinics are graded in order of priority and as such a safety system is built in to this process but agreed and reiterated that the lists do require review.

AS shared a reflection querying whether further assurance regarding underpinning processes and procedures should be considered, also querying whether the Trust continues to document ethics lessons learned. NH confirmed that the Trust does have an Ethics Committee and log which is updated within the command structure. AG recognised that there is scope to agree a way of reporting in future which gives more detail and narrative behind performance. ARQ clarified that it is important that the wording is able to demonstrate assurance or provide narrative to explain without becoming involved in specific operational issues.

ARQ congratulated the Executive Team on the way in which they have handled the pandemic stating that the engagement of executives had been superb. The attitude of staff and the number of staff welfare events had been phenomenal and ARQ wished to recognise the excellent work going on despite the enormous challenges we are under.

ML suggested that should the system financial regime continue to the next year there may be an opportunity to look systematically at how control targets are set and at efficiency targets. TS advised that national guidance had been deferred with the current regime extended to Quarter 1 next year. We are committed to continue and progress our plan for next year and beyond. This is a large piece of work which is still progressing but not at the pace expected in light of the current circumstances. As a point of assurance, TS advised that despite the continued pandemic, the Trust continues to ensure good practice and governance within the organisation. JW welcomed the development of the accountability framework and the ability to distinguish what is within our gift to improve.

AD acknowledged the focus on reset and recovery, noting that there are a number of strained targets due to the Covid pandemic and the unique time; however there is recognition these will be in a separate performance area of their own.

PS stated that it was early days, but conversations were beginning to be held regarding what the future looks like; for mental health there is clear direction and expectation that recovery is about adapting to the needs post-Covid and continued investment to the Mental Health Investment Standard (MHIS). There is a large piece of work regarding staffing recovery, acknowledging the impact of this past year both professionally and personally and allowing staff the space to reflect and recover. Consideration is to be given as to how we re-energise staff for a new future post-Covid. SS added that she had recently been able to join a Chair's call with the regional director, at which the importance of Trust Boards deliberating together across the region from a leadership point of view to reflect on how we can reboot and reenergise to give leadership and support to our staff was discussed.

The Board of Directors received and noted the report.

008/21 FINAL CHARITY ACCOUNTS 2019/20

TS presented the Final Charity Accounts for 2019/20 advising that this had been subject to independent examination through an external audit process; and subject to approval would be submitted to the Charity Commission by the deadline of 31 January.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Approved the final Charity Annual Reports and Accounts for 2019/20**
3. **Approved the signing of the associated certificates and Letter of Representation on behalf of the Trust**
4. **Did not request any further information**

009/21 LEARNING FROM DEATHS – MORTALITY REVIEW SUMMARY OF QUARTER 2 2020/21 REPORT

NH presented the summary of Quarter 2 Mortality Review Summary advising that the within the time period (01 July 2020 – 30 September 2020), 35 deaths fell within scope for mortality review in line with the Trust's Mortality Review Policy. This is significantly lower than the previous quarter which was impacted by Covid 19. NH advised that the report included details of the grade of review to which deaths are being subjected and the timeliness of these reviews – this indicated that the improvement in the timeliness of consideration via the Deceased Patient Review Group has continued. It also indicated 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; this is being kept under review and will be taken into account in determining new arrangements to implement the national Patient Safety Incident Response Framework (PSIRF).

JW was pleased to hear how learning was aligned to the PSIRF stating that it was important to share how we learn across the Trust. NH confirmed that EPUT are an early adopter of the PSIRF which was aligned to the mortality review process, as we fully implement the PSIRF we will see thematic analysis and look at a QI methodology to change practice and review if service models and policies are correct and will be able to monitor ourselves more rigorously.

NH felt it appropriate to caution Board members that the data for the next quarter would be significantly impacted by the pandemic, advising that services have been repurposed to provide wider support to the system in response to the Covid pandemic.

SS thanked NH for the comprehensive report acknowledging that every death is a serious event and extended condolences to the families of those that had died.

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

010/21 UPDATE ON NHS CHARITIES TOGETHER GRANTS

TS presented an update on the NHS Charities Together Grants and was pleased to report that the Trust had been given the opportunity access further charitable funds for staff health and wellbeing. Following requests at the CEO brief and via the Executive Team, a number of ideas were put forward for funding from this source, including the provision of Christmas hampers for inpatient services, food and drinks for clinical areas during the pandemic and an extension of the IT lending library to incorporate the buddy scheme and dementia services.

The Trust is also eligible to bid for Stage 3 grants to support the longer term recovery plans up to the value of £110k. The process for accessing Stage 3 funds is more extensive than Stage 1 and therefore we may not hear the outcome of our bids for several months, however if successful the funds have to be spent within two years.

AD suggested that the environment now was one of collaboration and queried whether funding could be pooled; TS confirmed that this was an option and guidance had been shared within system colleagues to consider the deployment of funds. Discussions were also being held with partner organisations regarding joint initiatives.

The Board of Directors:

1. **Received and noted the contents of the report**
2. **Approved the Stage 1 Second Wave bids**
3. **Approved the proposed Stage 3 bids for submission to NHS Charities Together**
4. **Did not request any further information or action**

011/21 BOARD ASSURANCE FRAMEWORK

PS highlighted that over time the BAF had become cluttered and required consolidation and reflection to maintain focus. A focussed ET subgroup has been established to work with the Board to develop the BAF and bring together with the strategy review in late spring, creating a robust interface with strategic objectives and planning processes.

AS agreed that it would be helpful to review the BAF, stating that in her opinion the BAF did not reflect risks but incidents. Better alignment between risk and mitigation would be welcomed, stating there is an opportunity to be clearer regarding the overall risk management framework.

RH stated that as part of the strategic review would be to look at the BAF and understand where we stand and queried whether part of which would be assessing our risk appetite to identify and focus on priorities. PS confirmed that this was the case and sessions would be scheduled with the Board to discuss.

ML advised that he had been party to discussions within the housing sector regarding risk and recent experience as part of the pandemic. A point had been made that despite the extent of the risk management industry, no one could have predicted the impact of the global pandemic and the catastrophic death rate; despite this, organisations have responded magnificently. ML continued that the addressing BAF risks for any organisation relies on skills and capacity to respond to all issue. Therefore providing leadership and capacity to be deployed effectively should enable the Trust to respond to any situation. The BAF also demonstrates the scale of the challenge an organisation has to work through, including looking at items that are significant on their own and interconnected; it was therefore important not to lose substance as this gives the Board exposure to what the organisation is facing.

PS thanked all for their comments which will be taken on board as well as continuing engagement with the Board of Directors.

The Board of Directors:

1. **Reviewed the risks identified in the BAF 2020/21 January summary and approved the risk scores, including recommended changes taking account of actions taken by EOSC at its December meeting.**
2. **Approved the merger of BAF45 and BAF56 and reduction of scores to BAF55 and BAF23.**
3. **Noted the Q3 Key Performance Indicators.**

4. **Noted the CRR January summary table including actions taken by EOSC at its December meeting.**
5. **Approved recommendations for CRR48 and CRR58.**
6. **Noted the new risks added to the Covid19 Risk Register.**
7. **Did not identify any further risks for escalation to the BAF, CRR or Directorate Risk Registers.**

012/21 STANDING COMMITTEES

(i) Finance and Performance Committee

ML advised that the Committee had moved to a lighter touch review of Performance and Finance. JW and ML had gone through key provisions of the report and had held good conversations with AG and TS regarding how to build on the accountability framework and drive through the capacity plan on focus on transformation and trust wide efficiencies; ML added that it is clear that the departmental allocation of CIP is not sustainable.

The Board received and noted the report and confirmed acceptance of assurance provided.

(ii) Quality Committee

AS advised that the December meeting received a presentation on the progress of implementing the new learning disability standards in line with national timeframes. It was recognised that the learning disability services remained behind the curve in relation to high standards of healthcare but building blocks are being put into place. It was agreed that where the constitution allowed, individuals with learning disabilities or their families / carers would be invited to contribute to the Quality Committee agenda.

The Board received and noted the report and confirmed acceptance of assurance provided.

(iii) People, Innovation and Transformation Committee (PIT)

ARQ advised that the meeting scheduled to be held in January had been cancelled as the focus of the committee is around taking the organisation forward and at present due to the pandemic the focus is on the heer and now. ARQ gave assurance that despite the meeting not taking place, papers were circulated to members for review.

The Board received and noted the report and confirmed acceptance of assurance provided.

(iv) Audit Committee

JW advised that the meeting scheduled to be held in January had also been cancelled due to the ongoing pandemic, however papers had been circulated to members for review. For the coming year, the internal audit would link into the safety strategy and therefore capacity is being built into the internal audit programme to support the safety agenda.

The Board received and noted the report and confirmed acceptance of assurance provided.

013/21 EU EXIT

NL provided an update on the current position to the Board of Directors as follows:

- The Trust has had a number of plans in place for some time and is therefore in a strong position.

- The EU Exit group continues to meet to take issues forward.
- There has been discussion regarding the anticipated risk in regards to the supply of medicines and equipment.
- The NHS is keen to ensure that organisations do not stockpile medicines or equipment.
- There is a focus on contingency planning should there be an issue in terms of supply.
- The Trust is in a good position regarding contingency planning.
- EU Settlement – the HR department have been working on this issue for some months and are keen to provide maximum support to staff from the EU with their settlement status. The deadline for completion is June and we have identified 158 members of staff that this will affect.

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

014/21 RISK ASSURANCE REPORTS

i) Covid 19 Assurance Report

PS advised that a number of aspects regarding the impact of the Covid 19 pandemic had been discussed during the course of this meeting, however NL would provide a further update on the Mass Covid Vaccination programme.

NL advised that EPUT were the lead provider for the roll out of the Mass Vaccination Centres across Mid and South Essex and Suffolk and North East Essex, with the programme continuing at pace. Two large vaccination centres are now operational at The Lodge in Wickford and the Gainsborough Centre in Ipswich. These centres are now able to provide a wide range of vaccinations for Health and Social Care Staff as well as members of the public in cohorts 1-4. Further vaccination centres are planned to open in the coming weeks and months. NL acknowledged the tremendous work that had gone into setting up these centres and thanked all involved for their contribution, including NHS staff, statutory and voluntary partners.

ML commented on the excellent response in setting up the centres and queried whether staffing had been an issue and also queried the balance of volunteers, new staff and redeployment of staff. ML also sought assurance that any redeployment of existing staff had not created a risk. ML also commended Hilary Scott, Chief Pharmacist for her contribution to the recent live staff briefing and her comprehensive and clear clinical answers to a myriad of questions set by staff. NL responded that we had been very lucky that a number of people within the organisation had responded to the pandemic and taken on additional tasks as well as recruiting a number of new members of staff, including retired clinical staff and volunteers. NL agreed that Hilary Scott had been a shining star as the Chief Pharmacist and was thankful to all involved for their contribution in reaching the current position. The community response had also been significant with offers of assistance from local authorities and fire services to assist in the setting up of centres.

PS acknowledged the issues around staffing, advising that the establishment of centres was set out over three phases; 1) mobilise centres, 2) scale vaccination centres and 3) recognise that centres will be in place for some time and sustaining the workforce will be a key challenge. PS extended thanks to NL and all involved.

SS advised that she and MJ had recently been shown around the Lodge vaccination centre and had been impressed by the whole operation. SS echoed thanks and congratulations to all involved and to NL for his continued leadership.

The Board of Directors:

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

ii) Ligature Risk Management

PS presented the Ligature Risk Management report providing an overview of the action that is underway currently 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. PS reiterated that ligature is a very important part of the Trust's Safety Strategy for Inpatient Wards and anticipated that this report would feature as part of the safety strategy report to Board.

The Board of Directors:

1. **Noted the contents of the report**
2. **Did not request any further action/information**

015/21 TRUST STRATEGY AND CORPORATE OBJECTIVES 2021/22

NL presented the report which provided an update on the progress of EPUT's new five year strategy and the development of the Trust's annual corporate objectives for 2021/22. NL advised that it is proposed that the current corporate objectives are extended into quarter 2 of 2021/22. The same process is also proposed for the directorate objectives.

The Board of Directors:

1. **Approved the proposal to extend the 2021/21 corporate objectives into quarter 2 of 2021/22.**

016/21 CQC UPDATE

PS presented an update following the recent CQC risk focussed inspection and the internal compliance activity to support the Trust in maintaining the CQC rating of 'Good'. PS advised that the Trust had responded to all recommendations / actions within the agreed timescales and were now focussed on oversight and embedding; the Executive Team would continue to oversee and monitor this.

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

017/21 INPATIENT SAFETY STRATEGY

NH was proud to share the draft Inpatient Safety Strategy: Safety First, Safety Always. This strategy has been pulled together during challenging times and has been presented to the Executive Team, Executive Safety Oversight Group and the Quality Committee where strategic themes were accepted. Since early December there has been widespread engagement with internal and external stakeholders from across the system, including Governors, and a roadmap for implementation and outcomes has been developed. NH continued that if agreed by the Board of Directors, this strategy will be worked across all inpatient areas within the Trust and will be a key aspect of how care is delivered to our patients. The Executive Team are committed to the delivery of the strategy which has been welcomed by stakeholders and senior leaders alike.

RH welcomed the strategy however queried why the strategy was aimed solely at the inpatient areas within the Trust; NH responded that a decision had been made to arrowhead inpatient areas but as we engage we will determine specific outcomes and measures for each area; with the safety strategy being the driver to connect services across the Trust. NH continued as part of the implementation of the strategy there is a clear communications and engagement plan to create a culture of "speak up, speak out". ARQ recognised the challenges noting that we are on a journey of improvement and have made some progress, but there is a way to go. ARQ believed the document was clear and applied to the wider community we serve and was not specific to inpatient services. ARQ continued that engagement is key to ensure the strategy is embedded and all work in the same direction.

ML suggested that the pictures at the beginning of the document may be changed to include pictures that are more relevant to our clinical environments. ML also commented on the strategy being inpatient focussed, however recognised that this is a phased approach to implementation with principles that will apply trust wide. PS agreed that this was the first phase of a broader safety strategy.

TS advised that discussions had taken place among the Executive Team regarding the principles that underpin the strategy applying to broader objectives. TS continued that the emphasis is that this is a joint production piece which all members of EPUT would 'own'. TS was pleased that this document was a clear and accessible documents that sets out our direction of travel in putting patient safety at the forefront.

AD acknowledged that this was a live document and suggested there may be potential to include a glossary to ensure all are on the same page in terms of language. AG agreed with TS that the document is 'owned' by all and stated that it had been well received by clinicians. SS confirmed that a focus group had also taken place with Governors at which the strategy had been well received.

NH confirmed that a glossary and index was currently being developed. NH commented that to ensure the strategy was a success it has to be held by all, the Executive Team are fully committed and have set expectations across the organisation for everyone to be a part of this strategy and ensure safety is a priority.

The Board of Directors:

1. **Approved the strategy and associated themes.**
2. **Approved and agreed the approach to measuring outcomes and high level measures.**

018/21	**CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING**

There were no items of correspondence circulated to the Board.

019/21	**NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING**

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

020/21	**REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS**

AG noted that the conversations held and update from AS regarding learning disabilities were especially well received particularly given the current focus and inequalities we know exist.

Signed: …… Date: ……

021/21 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

It was noted that NL joined the meeting at 10:55, all other Board members remained present and heard all discussion. It was noted that RH and SS had experienced temporary connection issues during the meeting however confirmed they did not lose the train of discussions and debate held.

022/21 ANY OTHER BUSINESS

There was no other business.

023/21 DATE AND TIME OF NEXT MEETING

SS thanked all for joining the live broadcast.

The next meeting of the Board of Directors is to be held on Wednesday 31 March 2021, 10:30am, at the Lodge, Lodge Approach, Wickford, Essex, SS11 7XX.

It was noted that it is currently unclear as to the duration of time social distancing measures will be in place, and therefore, should these measures continue to be enforced, the meeting will again be held virtually via the MS Teams video conferencing facility.

024/21 QUESTION THE DIRECTORS SESSION

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

Appendix 1: Governors / Public / Members Query Tracker (Item 024/21)

Governor / Member / Public	Query	Response provided by the Trust
Paula Grayson	What are the risk mitigations for the necessary increase in out of area placements please?	This is carefully managed through our existing bed management structure and has senior leadership oversight. Our home first treatment teams are linked in to support timely discharge and we aim if the patient continues to require inpatient care to repatriate at the earliest opportunity.
Dianne Collins	Regarding the lower level outpatients who are missing out on appointments. Is it possible for the present where there is extra pressure on the service for those lower level patients to be sent a letter maybe three times a year if they do not get appointments to let them know they are not forgotten and to ask them to contact the service if their symptoms are causing them problems. That way they would at least get a telephone call from the service.	
Anonymous	Are the extra costs of OOA being met by us or the CCG?	
Paula Grayson	In the appropriate re-setting of the BAF to future risks rather than past events, please can we keep the risk of failing to make clinical activity records (58). We have made them but need to follow our target to improve immediately and not fall back.	SS commented that during discussion PS had made it clear that the BAF process was to be reviewed, PS confirmed that Governors would be included in discussions before finalising this process and welcomed the opportunity for Governors contribution.
Paula Grayson	Please can we understand why the "light touch" sub-committee was felt appropriate for good governance and effective assurance?	ML advised that this approach had been taken to release managers from long meetings to continue to focus on the response to the Covid pandemic. ML provided assurance that all papers were circulated to members and received appropriate scrutiny and the opportunity for comment.

Anonymous	The overwhelming internal understanding is that this is a tremendous achievement and required the hard work of many individuals. Is enough being done to make this more publicly known outside of our sector?	
John Jones	On page 51, under Employment, the target of 7% has consistently been exceeded but recently is falling (currently 31.5%). The therapeutic effects of employment are well documented and I ask what is the reason for this continually falling?	AG advised that there are two elements to the target, 1) to assist in to work and 2) employee retention. The first target has been affected by the Covid pandemic. Staffing issues had been seen but staff have remained committed. Service users access to technology has been challenging an we have to acknowledge that there are more limited opportunities in the workforce market currently and so there are things that have impacted on this service; however it remains one of the highest performing in the country.
John Jones	On page 58, concerning Night Unqualified Staff, there is a consistently high fill rate (December 2020 at 186%, target = 90%). Why is this necessary?	AG advised that the fill rate is based on a needs assessment basis. It is acknowledged that some areas have been impacted and therefore had a higher fill rate. CAMHS and MH inpatient areas in particular have been affected as a direct result of managing Covid and enhanced levels of observation.
John Jones	On page 100 of the Mortality Review. The Table 6.1 for 2019/20 shows 36 (16%) of such deaths still awaiting determination, and 7 still outstanding from 2018/19 and 4 from 2017/18. What is being done to resolve these outstanding determinations and to inform the families concerned as to why progress is apparently so slow?	NH advised there can be delays in the system as all of the investigation process must be completed before identifying a score. NH provided assurance that families are engaged and supported throughout. Delays can be multi-faceted – they may be affected by awaiting a cause of death, awaiting inquest or delays due to responding to the Covid pandemic. However the next quarterly report should show an improvement.
Pippa Ecclestone	**Legal & Policy Update Page 4/4** Will EPUT be responding to the MHA Consultation Document Jan 2021? If so, please can this response be circulated to the Associate Hospital managers?	NH confirmed that EPUT are part of the London Mental Health Network collaborative which had provided a formal response to the consultation.

Signed: …… Date: ……

In the Chair

Pippa Ecclestone	**Ref. Chairman's Report. ...** EPUT have the vaccination contract for NE Essex & Suffolk.....please could you explain the reported '"slow roll out" of the vaccination program in Suffolk compared to Essex?	NL advised that the national programme is still in the 'roll out' phase which was progressing at differing pace in different systems. A number of Vaccination Centres were now on line with more to come in both Mid and South Essex and Suffolk and North East Essex. PS added that there are three clear pillars to the vaccination programme, Primary Care Networks, Acute Sector and Vaccination Centres. EPUT are the lead provider for the Vaccination Centres in these two localities, which are now becoming to come online.

Signed: …… Date: ……

In the Chair

ESSEX PARTNERSHIP UNIVERSITY NHS FT

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

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

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
September 117/20 (1)	Workforce Disability Equality Standard (WDES) Update on Action Plan to be presented to BOD in January 2021	SL	~~January 2021~~ March 2021	Report being presented at Board	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
May 064/20 (1)	Freedom to Speak Up Report NHS England and NHS Improvement Self Review: review two actions agreed to bring the Trust into compliance with the self-review tool at a future Board Seminar Session.	SL	September	Due to time constraints (Covid-19) the report received from the National Guardian Office along with accompanying slides was circulated to the Board outside of the Seminar session . SL also discussed the report at the August People, Innovation and Transformation Committee.	Completed	
July 092/20 (1)	Review of BAF41 wording and mitigation in light of recent conversations held at F&P Committee, where challenges in delivering recurrent CIPs were discussed.	TS	September	Wording updated.	Completed	
July 094/20 (1)	Phase 3 Reset and Recovery Planning to be included on agenda for Board Development Session for discussion.	TS	September 2020	Added to the Board Seminar Agenda for November 2020	Completed	
May 068/20 (1)	Board Assurance Framework – Review BAF9 risk in light of review of data for Q1	NH	July 2020	Risk reviewed. Satisfied that progress is being made to mitigate. No Force First Assurance report provided to Board on the 29th July..	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
March 026/20 (1)	Quality Health to explore lack of correlation in questions relating to staff being pleased with the quality of care they are able to provide and the Friends and Family Test responses in relation to recommending the Trust as a place to work or a place for family or friends to receive treatment.	Quality Health SL	May 20	Quality Health have provided a response which has been shared with ARQ. A further Board Seminar Session Plan on 2019 staff survey results will be scheduled as part of the Covid Recovery Plan in future months. Workforce Transformation will also assess results and set local improvement plans.	Completed	
March 026/2020 (2)	SL, ARQ and Quality Health to discuss results in further detail.	SL/ARQ	May 20	On-going discussions in July at the People, Innovation and Transformation Committee	Completed	
March 040/20	AD to check with NL whether the Covid outbreak will impact the ongoing HSE/ PHSO Investigation.	AD/NL	May 20	Our lawyers have confirmed that the Covid19 outbreak has impacted on the HSE progress with responding to the points of clarity requested by EPUT. As soon as an update is received we will reconvene the Task and Finish group and update the Board accordingly.	Completed	
January 023/20 (ii)	Provide the outcome of the deep dive referred to in performance report in respect of older people's readmissions to P. Ecclestone	MK	~~Feb20~~ ~~Mar 20~~ May 20	A higher rate of readmission in the north and west of the Trust is likely due to patients being discharged to acute hospitals and readmitted. In the South East patients are marked on leave whilst transferred to acute. MK to explore why there is not a consistent approach across the Trust. ET discussed and requested operations to agree consistent approach. SW/LW agreed practice should be standardised based on current approach in north Essex.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
September 174/19	Update on progress with implementing the QI framework to be provided to the Board.	NH	~~Mar 20~~ May 20	Governance arrangements to support implementation of the QI Framework are in place. A sub-committee has been formed with agreed terms of reference. Driving the agenda at Directorate level are QI Hubs. Specialist services and mental health are working with clear terms of reference and identified projects and are supporting the development of QI Hubs across community and corporate services. The sub-committee has reviewed the Framework and action plan in light of current challenges and have tightened arrangements to embed QI across the organisation; the changes will be considered by the Quality Committee in June 2020. This is supported by a comprehensive action plan. A training strategy has been drafted providing a framework to build capacity and competency in relation to QI at a range of levels. A tiered approach has been proposed building competency at a range of levels with an aim to train 500 staff during 2020/21. The intranet has a section on QI, and this is under development to make it a platform for staff to access information in relation to training, QI tools and methodology, opportunities and QI projects. The actions relating to the QI ambitions of the frameworks are caveated in relation to the current pandemic and ensuing impact on resource and capacity and innovative ways to deliver are being designed.		
March 034/2020	Weekly WebEx video conference to be scheduled for NEDs and members of the Executive Team, to ensure NEDs are kept up to date of the current situation and actions taken.	SM	May 20	Weekly WebEx call scheduled and invitations sent to NEDs and members of the Executive Team.	Completed	

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 March 2021**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The report attached provides information in respect of:

- Coronavirus / Covid-19
- Covid-19 Vaccination Programme
- Board Changes
- Staff Survey Results
- Staff Recognition Awards
- Equality and Inclusion

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Professor Sheila Salmon **Chair**

Agenda Item: 5
Board of Directors
31 March 2021

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Coronavirus / Covid-19

The situation regarding the Covid-19 pandemic continues to change rapidly, with infection rates peaking on a national scale during February. Tightened control measures have been necessary to curb the scale of the second, more problematic, second surge, with the new variants that further complicated matters. . The Trust has continued to put in place the necessary provisions to protect patients and staff in this regard. Nationally, the guidance for healthcare staff is continually updated as the situation develops further. The Trust is fully engaged with system, regional and national planning to stay firmly aligned to this situation. The Non-Executive Directors and I have been kept fully briefed during this extraordinary time by the Chief Executive and Executive Team. I and the Board continue to extend our thanks to our dedicated staff who have continued tirelessly and with exemplary resolve to provide services to our patients and service users in light of tremendous challenges and uncertainty.

2.2 Covid-19 Vaccination Programme

As indicated in my last Chair's report, EPUT was appointed as one of the three lead providers in the East of England region for the Covid-19 mass vaccination programme and is working with system partners in two integrated system areas (Mid and South Essex Health and Care Partnership and Suffolk and North East Essex ICS) to ensure on target delivery of the vaccine. Health and care staff are pulling out all the stops to open as many centres as possible as supplies become available. At the time of writing, there are now 16 large scale vaccination centres across the two system wide footprints which are able to give hundreds of vaccines a day (scaling up and down according to vaccine supplies).. This is a tremendous achievement and on behalf of the Board I would like to thank all involved for their contribution to this very important programme.

2.3 Board changes

This month we bid a sad and fond farewell to Alison Davis who has been a Non-Executive Director with the former SEPT and with EPUT continuously since 2012. Since 2017 she has also fulfilled the role of Senior Independent Director. We thank her sincerely for her dedicated service and wish her well in her new role as she moves into the position of Chair for Milton Keynes University Hospitals Foundation NHS Trust.

I am delighted to inform you that we welcome Mr Loy Lobo as the incoming NED and he takes up his role with immediate effect. Loy is an experienced strategist and innovator in Healthcare and Life Sciences, with over two decades of technology and consulting experience in over 10 different industries. Loy was previously the Director of Strategy and Innovation at BT Global Health and has undertaken high profile public roles including being the UK co-chair of the Joint Economic Trade Committee (JETCO) between the UK and India. Loy was also on the Expert Panel for Economics, Education and Research at the London Health Commission set up by the

London Mayor, has been a Fellow of the Royal Society of Medicine since 2014 and is the current president of its Digital Health Section. Loy brings a wealth of experience and an extensive network in multiple sectors.

2.4 Staff Survey Results

More than 2300 EPUT employees took the opportunity to share their experiences via the NHS Staff Survey this year, which equates to 47% of our staff members. EPUT scored on or above average for 7 out of the 10 themes in the survey when compared to other NHS Trusts of a similar type. We will be paying particular attention to those three themes where we scored slightly lower than the average and will be seeking staff input to ensure we make significant improvements in these areas.

There have been significant improvements to EPUT's scores since 2019's results with 9 out of the 10 themes showing progress, 1 remaining the same and none getting worse since last year. EPUT have seen positive increases in both the Quality of Care and Health & Wellbeing Themes with significantly higher scores for each individual question when compared to last year.

We are also proud to say that EPUT is one of the top ten HSJ most improved Trusts for the 2020 NHS Staff Survey.

We have been doing lots of work this year to help further improve our staff experience, paying particular attention to staff recognition and wellbeing.

2.5 Staff Recognition Awards

This year we have introduced the newly designed Staff Recognition Awards where all staff, patients and public can nominate staff members for their hard work and dedication. Since the launch of the new Staff Recognition Awards, we have received an incredible 165 nominations across five categories. I was delighted to join the Executive Team at the live All Staff Briefing to announce the very worthy winners. Winners from each category will also be put forward for our new 'Staff Recognition of the Year Award' at our annual Quality Awards celebration.

We are also setting up some dedicated Staff Survey focus groups, called Big Conversations, which will be a place for staff to discuss and make suggestions to the ways in which we can improve on each of the key staff survey themes. Further details of these groups will be announced soon.

2.6 Equality and Inclusion

To promote Equality and Inclusion in EPUT, we have provided multiple resources in for our staff. We updated our Equality Impact Assessment for the COVID-19 Lockdown in January and have been working closely with ICS and CCG partners to provide targeted actions aimed at encouraging staff members from minority and marginalised groups to take part in COVID-19 vaccination as well as internal efforts supported by our Staff Networks aimed at dispelling myths / concerns regarding COVID-19 vaccination.

Alongside this, we have also worked on the following during this period:

- LGBTQ+ Awareness training for staff,
- Training for staff to assist those with sensory impairments (provided by Essex Cares in collaboration with our D&MH Network)
- Celebrated LGBT History Month with regular online articles and updates
- Created new toolkits and online resources in collaboration with lived experience volunteers, distributing approximately 2000 copies of "Identifying and Supporting Protected Characteristics" to frontline services.
- Development of new Autism Spectrum and White Allyship resources on staff Intranet.

- Facilitating the WRES / WDES and Equality Delivery system, with the goal of updating / promoting these in early April.
- Created the Reasonable Adjustments Passport for working carers and those with long-term conditions in the Trust.
- Bi-Monthly Equality Update encourages good practice and updates / opportunities, printable version allows this to be easily shared with frontline staff

We are starting to develop a policy aimed at supporting transgender / non-binary staff and patients in collaboration with LGBTQ+ Network volunteers"

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

- **Primary Care – The Impact of The White Paper:** Please see the link below for a copy Integration and Innovation: "working together to improve health and social care for all" published on 11 February 2021, which is a proposal for Department of Health and Social Care's legislative proposals for a Health and Care Bill. For Information: Link

- **New PPN Published; Requirements for Contracts covered by the WTO Government Procurement Agreement & The UK-EU Trade & Co-operation Agreement:** Please see the link below for a copy of Procurement Policy Note that was published on 19 February 2021. **For Information: Link**

- **CQC Key Lines of Enquiry, Prompts and Ratings Characteristics for Healthcare Services:** Please see the link below for a copy of key lines of enquiry and prompts which takes you through the key questions and actions the CQC are looking for. For Information: Link

- **Procurement: PPN 02/21 - Requirements For Contracts Covered By The WTO GPA And The UK-EU TCA:** Please see the link below for a copy of the Procurement Policy Note PPN 02/21 requirements for contracts covered by the WTO Government Procurement Agreement and the UK-EU Trade and Co-operation Agreement, which applies to the NHS. 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**	**31 March 2021**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

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

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

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

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

CEO Report – March 2021

1.0 Introduction

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

As we reflect on the last 12 months, it is clear how much of a toll the pandemic has taken on society, our patients and our staff. It is also right to recognise the strengths that have been seen through this pandemic. The heroic efforts of staff to maintain, and enhance services during this period, the adaptability of our patients and the collective response of public services has been something to behold. Whilst it has been the worst of times, we have seen the best of people.

For the last few months we have had restrictions on visitors to our inpatient facilities to reduce the risk of Covid infection to patients, staff and the public. We know that these restrictions on visiting have been very difficult for patients and families and we will be looking to safely restore visiting as soon as possible.

I was delighted to see improvements in key measures of our staff survey. We were in the top 10 most improved Mental Health Trusts in the country. This is great for colleagues in EPUT and will mean that the improvements in our services that we are targeting will have more of an impact on patients. We will continue to invest in, and focus on, improving our support to colleagues as the health and care system looks to restore maximum services over the summer.

The roll out of the vaccination programme continues to be a national success story. At the time of writing well over 1/3 of the population had received their first vaccination. We are seeing the impact of this on hospital admissions and deaths – this gives great hope for the future. I am very proud of the teams who have stood up our vaccination hubs that have played such an important role in the success of the vaccination role out. From the 15th March we have a much higher supply of vaccine and our vaccination hubs will be offering significantly more capacity – further accelerating the role out of the vaccine. Thank you to everyone involved.

2.0 Key Issues

Independent Inquiry
As noted in my report in January 2021 historical events relating to services in North Essex were debated in parliament resulting in the commissioning of an Independent Inquiry. The Trust is awaiting further details on the Independent Inquiry, which we will be fully co-operating fully with, ensuring learning is built into our safety practice.

HSE Prosecution
The Trust has received notification that a court date of 16 June 2021 has been set for the HSE prosecution. The Trust extends it sincere condolences to the families of those involved. As with the Independent Inquiry, the Trust is committed to learning from these tragic events and building them into our safety practice.

Partnerships
We continue to build relationships with all our health and care partners.

I am particularly pleased to update on the partnership working that has been taking place across Essex Partnership University NHS Foundation Trust (EPUT), North East London NHS Foundation Trust (NELFT) and Provide Community Interest Company CIC (Provide).

EPUT, NELFT and Provide have signed an agreement to solidify the closer working relationship between our three organisations. The contractual joint venture provides the foundation for developing an integrated community health service for Mid and South Essex that combines the strengths of all three organisations.
The benefits we are seeking from working in partnership include:

- Reduced variation for patients across community services
- Improved patient outcomes and experience
- Increased collaboration, partnership working and innovation for the clinical workforce
- Increased opportunities for agreeing best practice across the three organisations
- Ensuring community services are fit for the future and delivered closer to home

Patient and staff involvement in the development of what an integrated community health service will look and feel like is a key priority for the next phase.
I was also delighted that EPUT has been included as a partner in the award of the integrated care contract in North East Essex. The next phase will be to work with partners to ensure that there is an improved service offer for the particular needs of the population in North East Essex.

Staff Survey
Our staff survey results for 2020 have been returned to us. We have seen an improvement in over 60% of the questions asked. Of particular note were the improvements in how staff felt they were supported to look after their health and wellbeing. We were also pleased to see that we were in the top 10 Mental Health Trusts for positive responses to the question "would you recommend your organisation as a place to work".
We have placed a lot of emphasis in listening to, and supporting, colleagues. We believe that a supported, well-motivated workforce is critical to delivering the improvements in care we want to make. We will continue to seek to improve the experience of all staff working in EPUT.

COVID-19 vaccination programme
The unprecedented effort across the NHS to deliver the COVID-19 vaccine has continued at pace since my last report in January. The national intention to deliver the vaccine to the first four priority groups by mid-February was achieved and the programme has continued to be rolled out progressively across the nationally identified priority groups. Nationally, and locally, the vaccination programme has now reached the point of offering vaccinations to the first nine priority groups (ie residents and staff in care homes for older adults, health and social care workers, the clinically extremely vulnerable, those in an at risk group and all those aged 50 years and over not included in one of the other priority groups listed).

Across Essex and Suffolk, colleagues in primary care, the hospital sector and EPUT have been working together to deliver this challenging programme - with GP-led vaccination services, hospital hubs, community pharmacy vaccination services and large scale vaccination centres now in place across the two counties.

Since mid-January, EPUT has opened 14 large-scale vaccination centres across Essex and Suffolk with the capability to deliver thousands of vaccines each week. It has taken a tremendous amount of work in a short period of time to launch these sites and I would like to express my thanks to all who have been involved in the set up as well as the staff and volunteers who are now working tirelessly to enable the delivery of vaccinations from these centres. This achievement has only been possible as a result of the positive involvement of numerous organisations and individuals for which I am extremely grateful – including from across the Trust, NHS partners, local authorities, third sector and private sector. We are continuing to expand these sites and explore new ways of delivering the vaccine to our community.

Over the last couple weeks, we have extended our vaccination programme with pop up clinics for the homeless in Suffolk and North East Essex who have been placed in priority

group six. We also ran a dedicated clinic in partnership with charity Project 21 for almost 170 people within the Down's Syndrome Community to receive their second dose on World Down's Syndrome Day. This was welcomed by the Minister for Disabled People, Health and Work Justin Tomlinson who sent a video message.

Over the next few weeks, we will be focussing on continuing to vaccinate those in priority groups one to nine who are most vulnerable to COVID-19 and delivering second doses. However, following a recent letter (link to letter) from NHS England and Improvement advising of a significant reduction in weekly supply available from manufacturers from 29 March, our programme will unfortunately slow down because of the supply constraints. We will be ready to step up the programme again when supply resumes.

3.0 Performance and Operational Updates

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

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

- Appointment of a patient safety specialist. This is a key senior role that will advocate safety and highlight areas for improvement.
- The appointment of an improvement partner. At the time of writing this report we were preparing to sign an agreement with a partner who will work with colleagues to ensure our teams have the tools to implement safety improvements.
- Undertaken the first pilot a new incident investigation process that includes families from the start.
- Extended the role out of remote vital signs monitoring to more wards.
- Improved our estate
- Worked with post graduate students from Cambridge University to take a fresh look at how we manage ligature risk
- Prioritised resource to support implementation

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

Our ambition of our patients, families and cares feeling confident and safe in EPUT’s care is in establishing a strong safety and learning culture and increasing patient involvement and co-design in our services. The final permissions from the national team and our commissioners have been achieved for us so we will be an early adopter Trust working with the new Patient Safety Incident Response Framework. Early indications from this pilot are that we are more responsive to the family’s needs and supportive in their involvement in our learning from incidents. We aim to have clearer learning identified to support safety in care and stringent approaches to involving our clinicians with learning ‘collaboratives’ embedding the system changes identified too improve safety.

There are seven themes we are focussing on: leadership, culture, continuous learning, wellbeing, innovation, enhancing environments and governance and information. We continue to regularly update the Board on the progress we have made.

Operational Performance
Our operational performance remained stable throughout February. The number of areas within target improved from 23 to 25. 5 areas continue to be inadequate with significant work being undertaken to support recovery. The number of patients not seen for 12 months improved significantly as a result and we continue to pay attention to this to ensure a position of sustained improvement. We have also secured additional commissioner funding to address our psychology waiting times in South Essex and 7 areas requiring improvement.

Adult mental health inpatient capacity remains challenged although our position improved in month, with one day at OPEL 4, compared to 6 in January. We continue to have a number of closed beds to enable social distancing requirements. We have been working internally and within in our local systems to improve patient flow, including some intensive work on purposeful admission and we look forward to the opening of 17 beds on Topaz Ward at the end of March which will enable further repatriation of our patients placed out of area. IAPT and Essex STaRS remain impacted by lockdown restrictions.

The pressures in our Tier 4 CAHMS service remains and reflects the regional and national picture. Our focus continues to be the management of safety on our inpatient areas while we continue to work with system colleagues and the regional team on improving the overall position.

Medical Directorate Update
EPUT had a successful international recruitment drive under the International Fellowship Scheme and has recruited six Doctors. These are Senior International Doctors with significant experience in Psychiatry who will be working within the organisation.

EPUT will be providing training to medical students from Antigua and is in the process of formalising the medical student placements.

Following successful AAC panel interviews, Dr Shereen Ali has been appointed as Consultant Psychiatrist for Southend CMHT and Dr Karen Stanley has been appointed as Liaison Consultant Psychiatrist for Princess Alexandra Hospital.

The first batch of medical students from Anglia Ruskin Medical School will start their placement in EPUT from 28 April 2021. EPUT will be providing clinical placements to 100 students per year from Anglia Ruskin Medical School. The University of East Anglia has requested EPUT increase the number of medical student placements from 75 per year to 100 per year. Thus, EPUT will be providing clinical placements to 200 medical students each year.

As part of a safety strategy the Executive Team has approved the implementation of I Want Great Care (iWGC), a technology based solution to collect, monitor, analyse and report systematic qualitative and quantative patient experience and outcome data in real time. This will provide direct patient feedback to Inpatient units, Mental Health teams and Medical staff .

Dr Karale has accepted the responsibility of providing the Medical and clinical Leadership in the Contractual Joint Venture for Community Services Partnership Working in Mid & South Essex and will be working closely with James Wilson, Transformation Director.

Finance

The Trusts M11 YTD surplus is £2.2m against the planned YTD deficit of £6.8m. This favourable position is due to the payment received from NHS England in respect of lost income.

Capital resources for the year total £16.7m with expenditure of £9.4m incurred year to date. The Trust continues to forecast and target the full use of its available resources however, this remains a significant risk due to the backend loading of the programme and the impact of the pandemic on the Trust and its suppliers.

Cash balances remain positive and better than planned due to accelerated payments at the start of the financial year which are still to unwind.

People

Recruitment Highlights

- The Trust has been successful in obtaining funding to recruit an additional 50 international nurses for this financial year. The Trust will be working closely with Herts and West Essex and Mid and South Essex ICS on the delivery of this programme. We are also submitting a bid as part of the Herts and West Essex ICS to be involved in a pilot for recruiting International Nurses to work in community services.
- Currently delivering a programme to reduce Healthcare Support Worker Vacancies to 0%. The Trust is aiming to recruit to 200 HCSW posts over the next 2 months. Work is underway and first cohort of recruitment has resulted in excess of 50 employment offers being made.
- Kickstart programme is underway and recruitment in this programme as well as close working on other initiatives e.g. Princes Trust will support in building the apprenticeship pipeline
- Time to hire has further increased as at March 21 (104 days) compared to last reported position in December 2020 (89 Days). The delays are primarily due to the transfer of staff in team to support mass vaccination project and the impact this has had on timescales to undertake pre-employment checks (25 days). Time between unconditional offer stage to start date (43 days) has increased and review is being undertaken on reasons for this. The recruitment team is now back to full establishment and work is being undertaken to streamline processes and reduce time to hire.
- Starters headcount for month February 2021 – Substantive Staff 44, Bank staff 52 and mass vaccination programme 480
- Vacancy and turnover figures remain under Trust's 12% target
- The vaccination project has assisted in the hire of over 3800 bank staff of both mixed qualified and unqualified. In addition to this they have engaged 2800 volunteers to support the vaccination sites.

Sickness

- Absence relating covid peaked week commencing 22nd January 2021 (235 staff) and has started to see significant decline with only 26 staff reporting sickness absence due to covid week commencing 12th March 2021
- Sickness absence remains below target of 5%

Learning and Development

- The Clinical Associate in Psychology programme was validated by Essex University and we are now starting recruitment of the students. The programme will begin delivery in May and will be the first apprenticeship programme we have delivered as a main provider, taking on apprentices from other organisations.

- We have delivered a number of 'virtual placements' as part of the clinical placement expansion project. These placements take place via Microsoft Teams and involve training staff supported by service colleagues, service users and carers.
- The project to fill all Health Care Support Worker vacancies is underway. We are hoping to recruit over 100 new support workers and place them on apprenticeship or other training programmes as appropriate and as capacity allows. This will be our first large scale recruitment of apprentices.
- The Kickstart programme is making great progress and we have found placements within EPUT for 4 – 5 young people to start as support workers for 25 hours a week with postings mostly across North Essex Mental Health. We are also looking at offering administrative posts.
- The team have now trained over 1000 vaccinators for the SNEE and MSE systems.
- The Schwartz Round Steering Group has met for the first time with a view to starting the selection and training of facilitators within the next few weeks.
- We shall be welcoming a Graduate Management Trainee for a flexi-placement in May and June. They will be helping us set up the programme of Team Support Days that will be part of the Reset and Recovery work.

Overseas Clinical Fellowship positions appointed

- Recruitment strategy for medical positions, BMJ supported advertisement and task and finish group set up to look at recruitment and retention, development of skill mix and introducing Physician Associate roles with supported funding from EoE
- Women in Leadership Events have been held for all staff
- Compassionate Leadership Sessions and Compassionate Culture sessions (Compassionate Leadership has now been accredited by CPD)
- Focused sessions for managers of managing effective teams virtually
- Developed and implemented career lounges for staff identifying talent pathways
- Coaching career conversations forming part of appraisal
- Health and wellbeing conversations taking the forefront in 1:1's /supervisions, wellness plan developed , EPUT represented in a regional working group for development

Staff Engagement & Equality

- Planned Promotion of the 2020 Staff Survey Results including dedicated focus groups for staff to suggest improvements
- Staff Recognition Awards first winners announced in March, lots of nominations received
- Continued promotion of Fast Track physio service for staff
- Wellbeing Toolkit Developed for Managers, promotion planned
- Promotion of the Wellbeing Hub (Here for You) including Facebook live video with service lead
- Thank you letter and badge sent to all staff
- Menopause Support Group
- Staff Engagement Champions Network Meetings and Grills.
- Investment in 2 Wellbeing Leads for the Trust (starting April 2021)
- Continued range of Wellbeing Webinars for staff and their families
- Increase in staff Rest Spaces (aka wobble rooms)
- Increased Flexible working and home working
- Staff "Reasonable Adjustments Passport" confirmed as part of Trust Policy and Procedure, and promoted to both staff with long term health conditions and carers in the Trust.
- Close working with the ICS on Equality and Inclusion Projects, including interventions aimed at ethnic minority staff uptake of COVID-19 vaccination. Multiple seminars / events from NHS England and local community groups promoted to all staff.

- Development of online stakeholder session to grade Equality Delivery System and propose new actions for 2021-22 EDS
- Encouraging staff members from minority or marginalised groups to role-model good practice and share photos of them receiving COVID-19 vaccination, used by communications on social media channels / intranet.
- Celebration of LGBT History Month with intranet articles taking place across LGBTQ+ Network meeting, awareness training and intranet messaging to staff.
- “Identifying and Supporting Protected Characteristics” toolkit available online, created collaboratively with Staff Networks to better support staff members when creating care plans for patients and carers from marginalised or minority groups.
- Finalising an updated E&I Induction / Staff OLM Training with new learning and covering important key points in E&I.
- Supporting the creation of a National Disability and Long Term Conditions Network for disabled staff, with initial meetings taking place in regional groups.
- Development of a policy aimed at supporting transgender / non-binary staff and patients in collaboration with LGBTQ+ Network volunteer.
- Development of an updated Autism resource page on E&I Hub with lived experience feedback from staff volunteer.
- Targeted COVID-19 vaccination sessions for staff Networks to discuss impact on marginalised or minority groups and encourage uptake of marginalised and minority groups
- Equality Representation and Equality Discussions at all Silver Command meetings
- Continuation of LGBTQ+ Awareness Training for staff with positive reception in the Trust.
- Sensory Loss Awareness Sessions available to all staff.
- Sunflower Lanyards Scheme for Patients and Staff with hidden conditions in place and promoted throughout Trust
- Reverse Mentoring cohort continue to meet as part of reverse mentoring programme.

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 March 2021**

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

Risk Assessment of Report	
Summary of Risks highlighted in this report	All inadequate and requiring improvement indicators.
State which BAF risk(s) this report relates to	BAF32 Quality Improvement BAF35 Culture that is Morally Right and Fair BAF41 CIP's BAF42 Financial Plan BAF44 Learning from C19 BAF45 CQC Inspections and Learning BAF53 Safety Strategy BAF56 CQC Fundamental Standards
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	Continued monitoring of Trust performance through integrated quality and performance reports.

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

Performance Reporting

This report presents the Board of Directors with a summary of performance for month 11 (February 2021).

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

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

- Timeliness of Data Entry
- CPA 12 Month Reviews
- Inpatient MH Capacity
- Out of Area Placements
- Waiting Lists, inc Patients Not Seen for 12+ Months

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

- Out of Area Placements

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

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

In February 2021 there continues to be two inadequate indicators identified within the Finance scorecard;

- Capital Expenditure (CDEL)
- Efficiency Programmes

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

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

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

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

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

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

Supporting Documents and/or Further Reading
Quality & Performance Scorecards

Lead
Paul Scott **Chief Executive**

NHS
Essex Partnership University
NHS Foundation Trust

EPUT Integrated Quality and Performance Score Cards
February 20

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

Report Guide

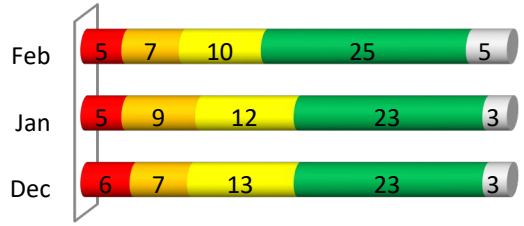
Use of Hyperlinks
Hyperlinks have been added to this report to enable electronic navigation. Hyperlinks are highlighted with an underscore (usually blue or purple colour text), when a hyperlink is clicked on, the report moves to the detailed section. The back button can also be used to return to the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

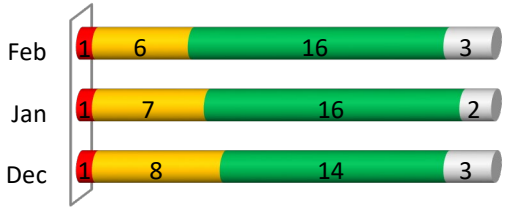


February Inadequate Performance

- Timeliness of Data Entry
- CPA 12 Month Reviews
- Inpatient MH Capacity Adult & PICU
- Out of Area Placements
- Waiting Lists, inc Patients Not Seen for 12+ Months

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

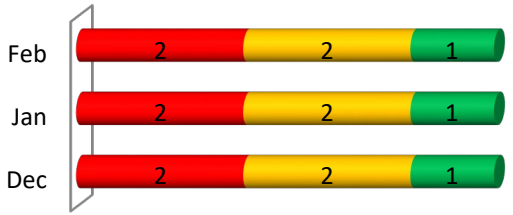
Summary of Safer Staffing Indicators

No risks identified within the Safer Staffing section.

Summary of CQC Indicators

Following the CQCs inspection on Finchingfield in October 2020 a Warning Notice was given. The Trust has now completed the actions for this and the CQC have advised that this is all the evidence they need. As a result the CQC Action Plan has been closed.
The Trust is now taking forward an internal action plan using the CQC information, and developing it across the wider service, therefore there is no longer a CQC Action Plan to report against.

Finance Summary



February Inadequate Performance

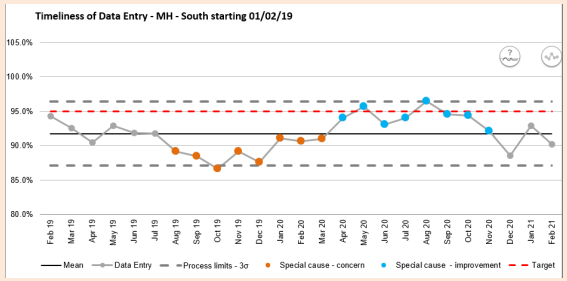
- Capital Expenditure (CDEL)
- Efficiency Programmes

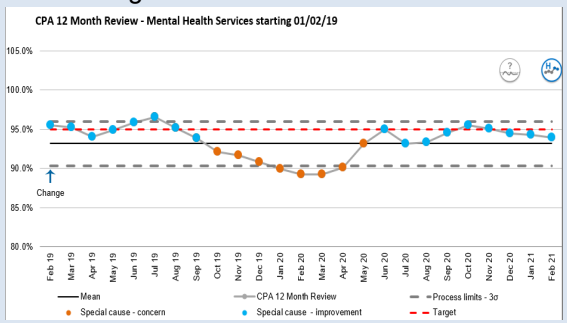
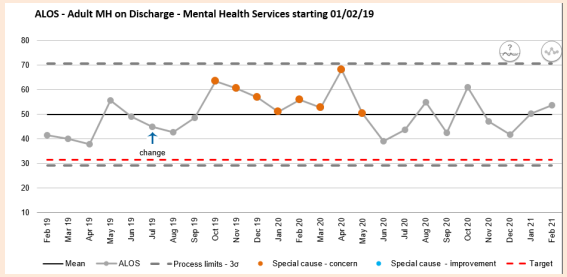
SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

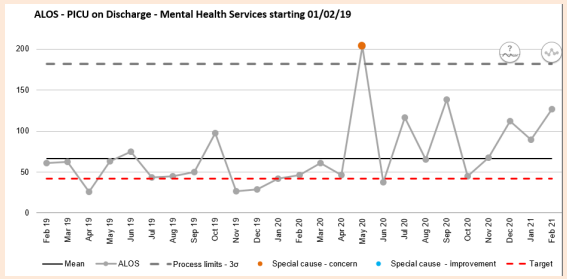
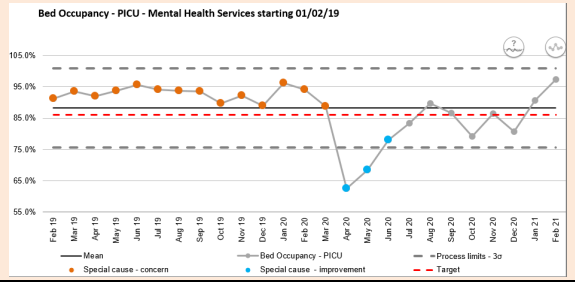
<table>
<tr><th colspan="7">Effective Indicators</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position M11
Perf</th><th>RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td rowspan="2">2.1 Timeliness of Data Entry

Committee: FPC
Indicator: Local
Data Quality RAG: TBC</td><td colspan="7">Inadequate
Timeliness of Data Entry continues to require improvement as Mobius MH data is below target at 89.9% in February, following refresh, January remains below target at 92.4%.

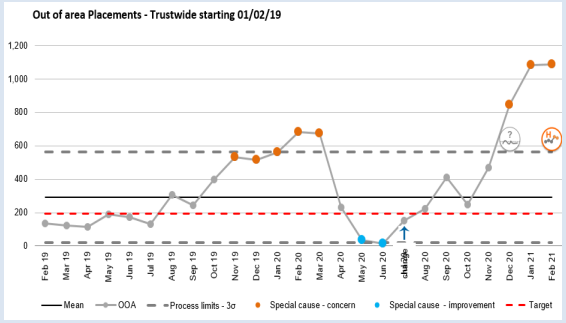
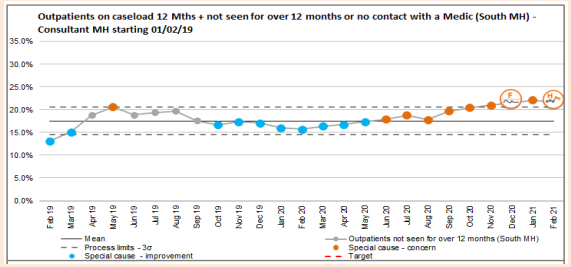
<u>Data Entry MH services (on Mobius)</u> achieved 89.9% in February against a target of 95%. There were nine (out of ten) MH and one (out of two) Specialist MH Services below target, note that the Rehab Recovery team has now been merged with Assertive Outreach (Intensive Outreach Team). The following services were below 90%:
• Crisis Home Treatment
• Psychotherapy
• Other Teams (This includes but is not limited to services relating to Speech Therapy, Psychology, Psychotherapy, OT, and Day Care)
• Forensic Community

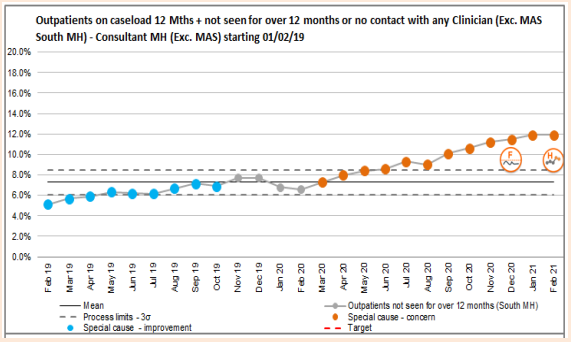
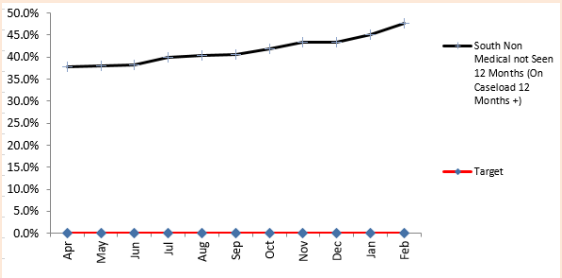
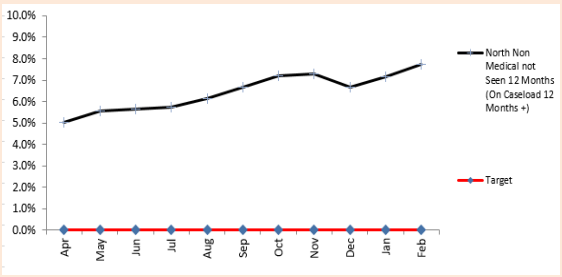
Late data entry has a significant impact on Trust reported performance and internal figures being at variance with national figures.</td></tr>
<tr><td>2.1.2 Timeliness of data entry - Continuation Sheets Completed (Mobius)
Target 95%</td><td>89.9%</td><td></td><td>Above Target = Good
 
</td><td>N/A</td><td>February performance :
Mobius MH & Specialist Total : 89.9%
MH Total : 90.2%
Specialist Total : 86.6%</td><td>N/A</td></tr>
<tr><td>2.3 CPA Review</td><td colspan="7">Inadequate
Performance remains below target in February at 94%, this is a further reduction on the position reported in January (94.3%) and performance remains inconsistent. Performance is required to meet target for three months until this indicator can be downgraded. Since April 2020 this indicator has seen a marked recovery following the decline in performance from July 2019. Significant efforts are being made to maintain this recovery. This performance has been noted by all Commissioners.</td></tr>
</table>

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Indicator: National Data Quality RAG: **Amber**	People on CPA will have a formal CPA review within 12 months **Target 95%**	94%	●	Above Target = Good 	●	There were five Teams in the South, one Team in Specialist Services, three Teams in Mid, Five Teams in NE and three Teams in West below target.	
2.9 Inpatient Capacity Adult & PICU MH ●	**Inadequate** Adult & PICU Inpatient Capacity MH has been highlighted as inadequate due to parts of the indicator being at variance with EPUT ambition. 2.9.1 Opel Status: There was one day at Opel 4 in February (one x North, 08/02/21 am) 2.9.2 ALOS Adults: has increased further in February to 53.8 days and remains outside National Benchmark of <31.6. This is due to 87 discharges in February, 22 of which were long stays (60+ days). 2.9.5 ALOS PICU: remains outside target in February at 126.8 days against benchmark of <42 days, this is due to four discharged in February, two of whom were long stay (60+ days). 2.9.7 Occupancy PICU: remains outside target in February at 97.4% against benchmark of 86%.						
Committee: Quality Indicator: Local Data Quality RAG: TBC	2.9.1 OPEL Status	1	●	One day at OPEL Four in February 2021	N/A		N/A
	2.9.2 Adult Mental Health ALOS on discharge less than NHS benchmark **Target: 31.6**	53.8 days	●	Below Target = Good 	●	Consistently failing target 87 discharges in February (22 of whom were long stays (60+ days))	TBC

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.9.5 PICU Mental Health ALOS on discharge less than NHS benchmark **Target: 42**	126.8 days	●	Below Target = Good 	●	Four discharged in February (two of whom were long stays (60+ days))	
	2.9.7 % PICU Mental Health Bed Occupancy below national benchmark (excluding leave) **Target: 86%**	97.4%	●	Below Target = Good 	●		N/A

Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.5 Out of Area Placements ● Committee: FPC	**Inadequate** OOA placement Occupied Bed Days has seen a significant increase since July 20, this is in part due to the requirement for social distancing on wards limiting occupancy levels and the start of the anticipated surge in MH inpatient activity. The increase is also more recently driven by wards being closed to admission as a result of COVID outbreaks. OOA placements are a key focus in the Phase 3 planning, with increased occupancy of Trust beds agreed to reduce the OOA impact and planned reinstatement of Topaz in Q4 to further offset any COVID surge demand. In February EPUT placed 27 new clients out of Area (24 Adult and three PICU), 28 patients were repatriated in February (22 Adult & six PICU) and 41 remain (32 Adult, one Older Adult and eight PICU) OOA at the end of February. The total Occupied bed days for all out of area placements in February was 1,086. OAP's for locked Rehab patients have been excluded (2 patients) as EPUT do not provide these bed types, therefore these would need to be placed out of area, this was discussed and agreed at ET in July 2020.						

Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: Oversight Framework Data Quality RAG: **Amber**	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by 2021**	1,086 Days	●	Below Target = Good 	●	Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Forecast for 48% increase at year end.	TBC
4.9 Waiting Lists ● Committee: Quality Indicator: Local Data Quality RAG: **Blue**	**Inadequate** Patients not seen / no contact for over 12 months is brought forward as inadequate as all parts are at variance with internal thresholds. 4.9.1 patients on medical caseload for 12 months + who have not been seen and / or had no contact with a medic is above threshold of 0.0% in February at 21.6% this is a reduction on the position reported in January (22.1%).There are currently 5,222 clients who have been on a medical caseload for 12 months +. Data now includes telephone contacts & has been refreshed back to April 2019. 4.9.2 patients on medical caseload (excluding MAS) for 12 months + who have not been seen and / or had no contact with a medic or other HCP is above threshold of 0.0% in February at 11.9% and remains the same as the position reported in January (11.9%). Data now includes telephone contacts & has been refreshed back to April 2019. 4.9.3 patients on non-medical caseload (South Teams) for 12 months + who have not been seen and / or had no contact is above threshold of 0.0% in February at 47.8% this is an increase on the position reported in January (45.1%), this is a new indicator introduced in April 20. 4.9.4 patients on non-medical caseload (North Teams) for 12 months + who have not been seen and / or had no contact is above threshold of 0.0% in February at 7.7% this is an increase on the position reported in January (7.1%), this is a new indicator introduced in April 20.						
	4.9.1 Patients on Medical Caseload South Essex (Inc. Memory Service) not seen / no contact by a Medic for over 12 months **Target 0%**	21.6%	●	On Target = Good 	N/A	The construct of this indicator has been reviewed and now counts the number of clients who have been on a medic caseload for 12 months + and have not been seen or had contact with a medic for 12 months + as at the end of the reporting period. (inc. telephone contacts and contacts with any consultant)	

Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	4.9.2 Patients on Medical Caseload South Essex (Exc Memory Service) not seen / no contact by any clinician for over 12 months **Target 0%**	11.9%	●	On Target = Good 	N/A	As above but excludes MAS Medic Caseload and includes any contact with another HCP.	
	4.9.3 Patients on non-medical South Essex caseload not seen / no contact by any clinician for over 12 months **Target 0%**	47.8%	●	On Target = Good 	N/A	Work has begun to validate and improve these indicators with breach and monitoring reports being supplied to the Operational Productivity team. These indicators will also continue to be monitored as part of the Data Quality & Performance meeting group. *SPC charts to be produced upon accrual of sufficient data.*	
	4.9.4 Patients on any North East, West or Mid caseload not seen / no contact by any clinician for over 12 months **Target 0%**	7.7%	●	On Target = Good 	N/A		

Additional Indicators	Narrative
Waiting Lists	**ADHD -** Approximately half of the 20 remaining West Essex CCG patients under the separate contract have been contacted to arrange appointments, 3 of which have attended an assessment. **Psychology** - Through Commissioner arrangements funding has been sourced with approval to recruit additional staff in South West Essex and South East Essex, as well as the new PD&CN and trauma funding. The combination of a higher criteria threshold for the service, and additional resources, should also make a substantial difference. There are waiting list clearance action plans in place across all areas. Wait times are as follows (as at March 2021): • Rayleigh: there are currently 35 clients waiting and the longest wait is 27 months. • Southend: there are currently 44 clients waiting and the longest wait is 28 months. • Castle Point: there are currently 35 clients waiting and the longest wait is 28 months. • Thurrock: there are currently 74 clients waiting and the longest wait is 35 months. • Basildon: there are currently 112 clients waiting and the longest wait is 38 months. • Brentwood: there are currently 46 clients waiting and the longest wait is 24 months. *Basildon has the longest waits due to being the largest area with the highest demand and density of need.

SECTION 3 – Oversight Framework

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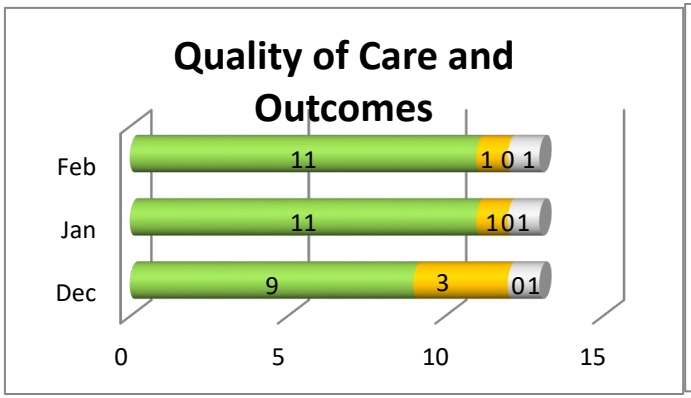
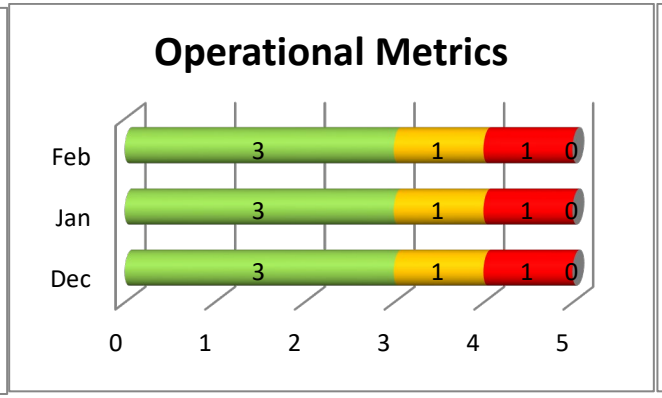
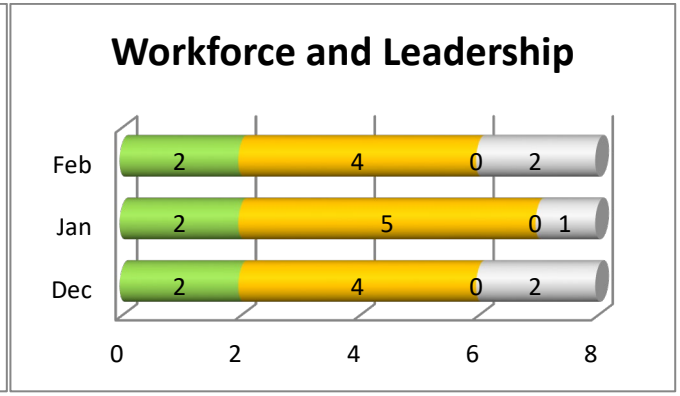
Please note the national Oversight Framework was revised in August 2019. Not all indicators have been issued with a target. Where there is a national target or benchmark this has been used to assess if there is inadequate performance (colour coded Amber) or if it requires improvement (colour coded red).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





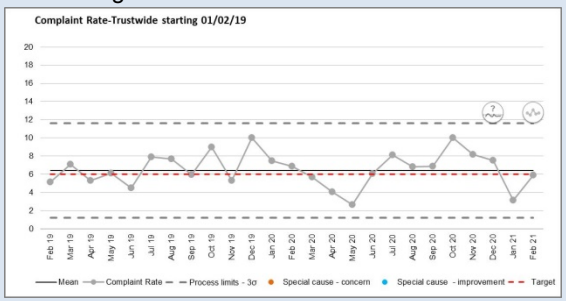


Inadequate

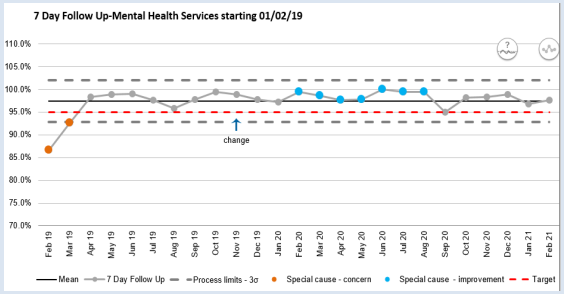
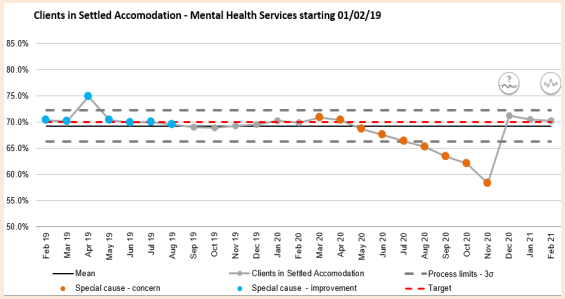
- Out of area placements

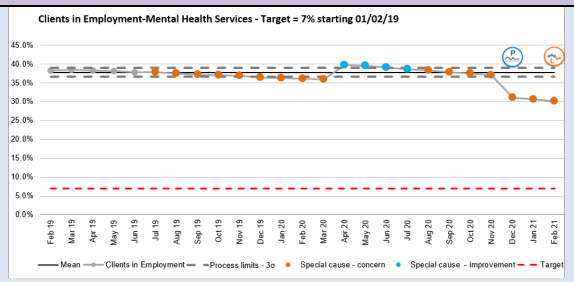
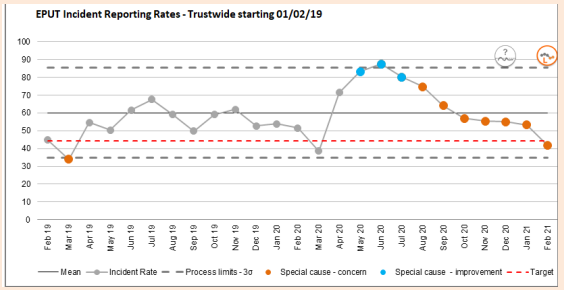
Requires Improvement

- Patient Safety Incidents Reporting
- IAPT Recovery Rates
- Staff Survey indicators (4 indicators)

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1 CQC Rating Committee: FPC Data Quality RAG: **Green**	CQC rating of Good or above (no target set)	Good	●	The Trust is fully registered with the CQC.			
4.1 Complaints Committee: FPC Data Quality RAG: **Green**	4.1.1 Complaint Rate **OF Target TBC** Locally defined target rate of 6 each month	5.9	●	Below Target = Good 	●	Performance remains inconsistent and variation indicates inconsistently hitting and failing target.	N/A
5.6 Staff FFT Committee: FPC Data Quality RAG: **Green**	Staff Friends and Family Test % recommended – care (extremely likely or likely to recommend) **Target 74%**		●		●	Indicator suspended nationally over Covid period	N/A
1.1 Never Event Committee: Quality	0 Never Events 2019/20 Outturn 0	0	●	Year to Date 0	●	Monitored over six-month rolling period	N/A

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: Oversight Framework Data Quality RAG: **Blue**							
1.6 Safety Alerts Committee: Quality Indicator: OF Data Quality RAG: **Green**	There will be 0 Safety Alert breaches **2019/20 Outturn 0**	0	●	Year to date there have been no CAS safety alerts incomplete by deadline.	●		N/A
3.1 Patient MH Survey Committee: Quality Data Quality RAG: **Green**	Positive Results from CQC MH Patient Survey	●		EPUT achieved "about the same" in all 11 domains in the 2020 survey when compared with other Trusts.	●	Responses were received from people at Essex Partnership University NHS Foundation Trust.	N/A
3.3.1 Patient FFT MH Committee: Quality Data Quality RAG: **Green**	Patient FFT MH response in line with benchmark **Target = 88.3%**	91%	●	Since April 2020 all forms were updated to ask a new mandatory standard question "Overall, how was your experience of our service". As from January 1st 2021, any old forms submitted are disregarded. New forms can be obtained from the Patient Experience Team.	●	44 total responses for MH	N/A

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
3.3.2 Patient FFT CHS Committee: Quality Data Quality RAG: **Green**	Patient FFT CHS response in line with benchmark **Target = 96%**	91%	●		●	34 total responses for CHS 31 Very Good/Good 3 Neither Good or Poor/ /Don't Know	N/A
2.8.1 7 Day Follow Up Committee: Quality Data Quality RAG: **Blue**	95% of people on Care programme approach (CPA) are followed up within 7 days of discharge from hospital **Target 95%**	97.6%	●	Below Target = Good 	●	Discharge follow ups form part of EPUT's "10 ways to improve safety" initiative.	N/A
2.4 Settled Accomodation Committee: Quality Data Quality RAG: **Green**	We will support patients to live in settled accommodation **Target 70% (locally set)**	70.2%	●	Trend above Target = Good 	●	Paris 67.2% in February Mobius 78.3% in February	N/A
2.5 Employment	We will support patients into employment	30.2%	●	Trend above Target = Good	●	Assurance indicates consistently Passing target. Decline in performance noted since April.	N/A

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Data Quality RAG: **Green**	**Target 7% (locally set)**						
1.8 Patient Safety Incidents Reporting Committee: Quality Data Quality RAG: **Amber**	Potential under-reporting of patient safety incidents **Target >44.33**	41.6		Trend above Target = Good 		Incident reporting rates continue to decline in February with performance at 42, this is just outside the target of >44.3. A trend of decline has been noted and recent perofrmance has been affected by earlier reporting and therefore more incidents awaiting sign off. Potential concern with eight months of reducing rate. **Fewer incidents have been signed off by managers in time to be included in this report. This is due to the earlier production of performance reporting since November. This data will be refreshed the following month which will improve performance.**	N/A
1.15 Under 16 Admissions Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	0 admissions to adult facilities of patients under 16	0		Zero admissions in February and One YTD.			N/A

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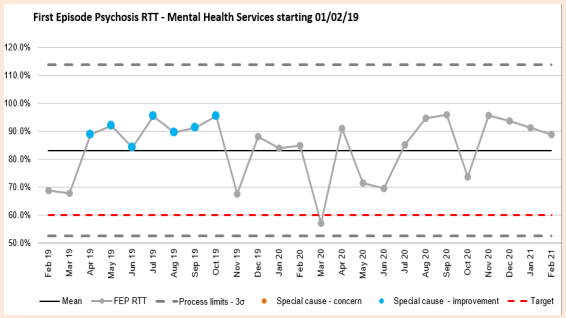
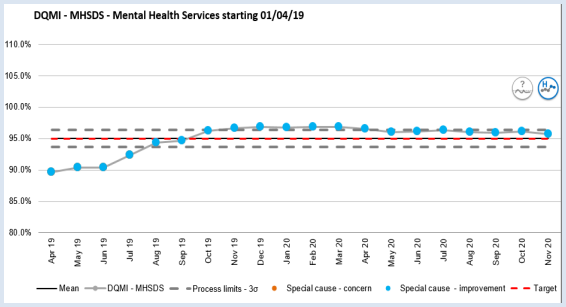
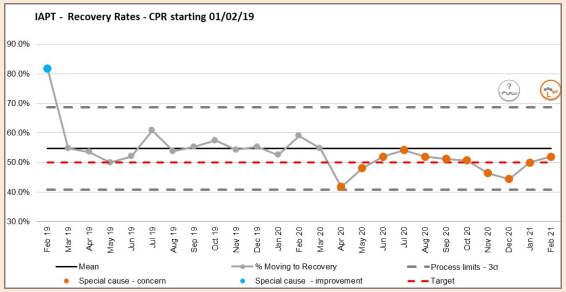
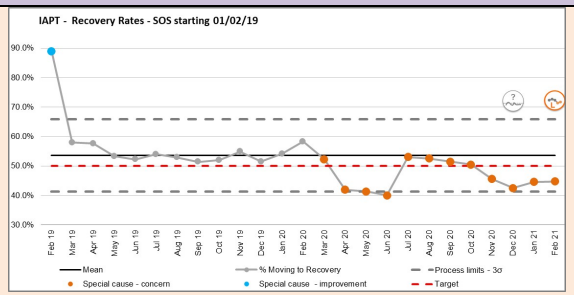
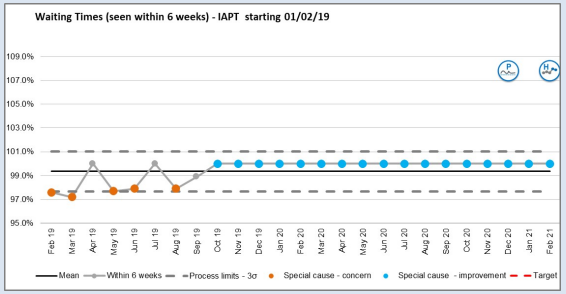
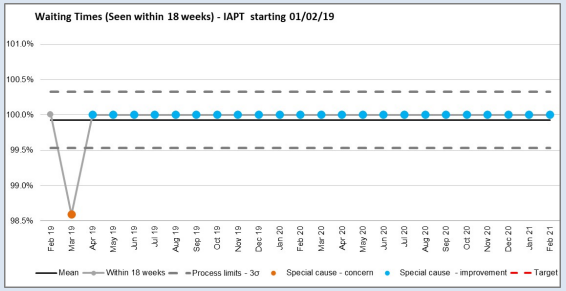
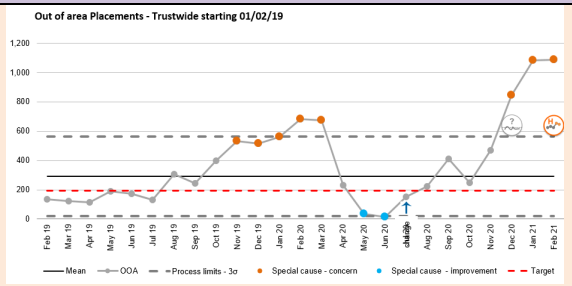
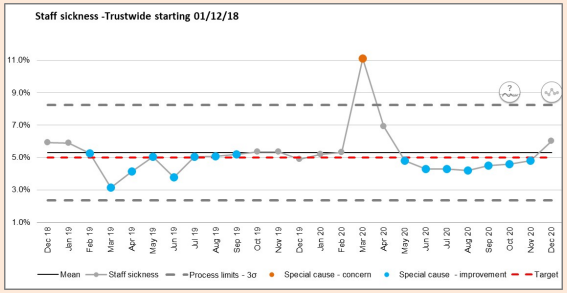
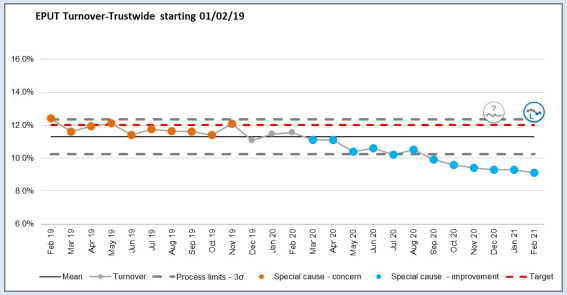
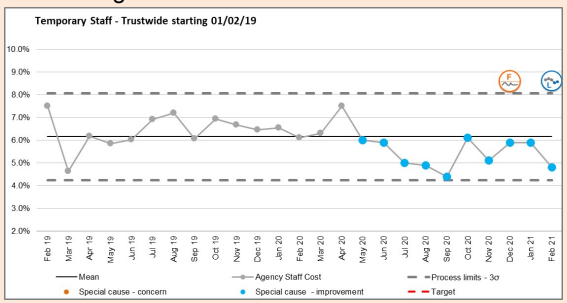
Operational Metrics							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.6 First Episode Psychosis Committee: Quality Data Quality RAG: **Green**	All Patients with F.E.P begin treatment with a NICE recommended package of care within 2 weeks of referral **Target 60%**	88.9%	●	Trend above Target = Good 	●	Target change effective April 20 (from 56% to 60%) February performance represents: 16 / 18 patients.	N/A
2.2 DQMI Committee: FPC Data Quality RAG: TBC **Green**	Data Quality Maturity Index (DQMI) – MHSDS dataset score above 95% **Target 95%**	95.7%	●	Trend above target = good 	●	Latest published figures are for November 20	Dec 20 achieved
2.16.3/4 IAPT Recovery Rates Committee: FPC Data Quality RAG: **Green**	Improving Access to Psychological Therapies (IAPT) /talking therapies 50% of people completing treatment who move to recovery **Target 50%**	CPR 52%	●	Trend above target = Good 	●	Target achieved in February. Recovery rates have slowed in the last few months as service have seen an increase in numbers of patients dropping out of treatment, and worsening clinical presentations.	N/A
		SOS 44%	●	Trend above target = Good	●	Consistent with last month. Decline has slowed but remains below target.	N/A

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
						Recovery rates have slowed in the last few months as service have seen an increase in numbers of patients dropping out of treatment, and worsening clinical presentations.	
2.16.5/6 IAPT Waiting Times Committee: FPC Data Quality RAG: **Green**	Improving Access to Psychological Therapies (IAPT)/talking therapies b. waiting time to begin treatment: i) 75% within 6 weeks ii) 95% within 18 weeks	i) 100%	●	Trend above target = Good 	●	Consistently achieving target	N/A
		ii) 100%	●	Trend above target = Good 	●		
4.5 Out of Area Placements Committee: FPC	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by 2021**	1,086 Days	●	Below Target = Good	●	In February EPUT placed 27 new clients out of Area (24 Adult and three PICU), 28 patients were repatriated in February (22 Adult & six PICU) and 41 remain (32 Adult, one Older Adult and eight PICU) OOA at the end of February. The total Occupied bed days for all out of area placements in February was 1,086. OAP's for locked Rehab patients have	N/A

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Amber**						been excluded (2 patients) as EPUT do not provide these bed types, therefore these would need to be placed out of area, this was discussed and agreed at ET in July 2020.	

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3.1 Staff Sickness Committee: FPC Data Quality RAG: TBC	Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**			Below Target = Good 		At time of reporting sickness data is currently unavailable due to ESR upload timescales.	N/A
5.2.2 Turnover Committee: FPC Data Quality RAG: TBC	Staff Turnover (Benchmark 2017/18 MH 12% / CHS 12.1%) **OF Target TBC** **Target <12%**	9.1%		Below Target = Good 		Special Cause of improving nature of lower pressure due to (L)ower values. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.	N/A

5.7.3 Temporary Staff Committee: FPC Data Quality RAG: TBC	Proportion of temporary Staff (Provider Return) OF Target TBC	4.8%	●	Below Target = Good 	N/A	Special Cause of improving nature of lower pressure due to (L)ower values	N/A
5.5 Staff Survey Committee: FPC Data Quality RAG: **Green**	5.5.1 Outcome of CQC NHS staff survey	The 2020 Staff Survey Results are under embargo and will be available in next months report.					
	5.5.2 Support & Compassion, Team Work and Inclusion						

SECTION 4 – Safer Staffing Summary

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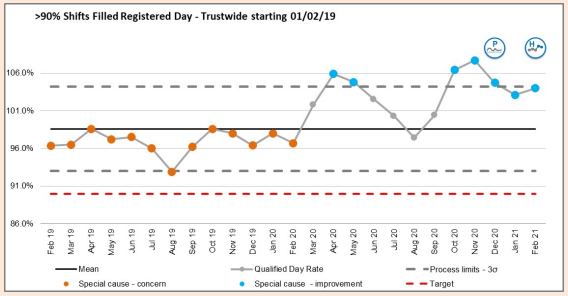
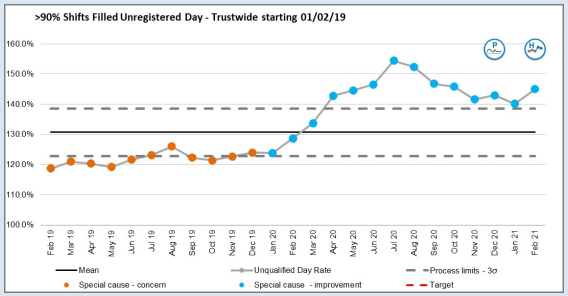
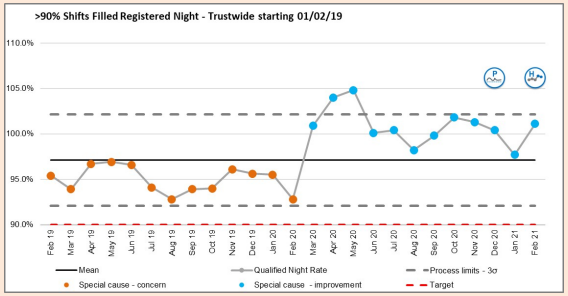
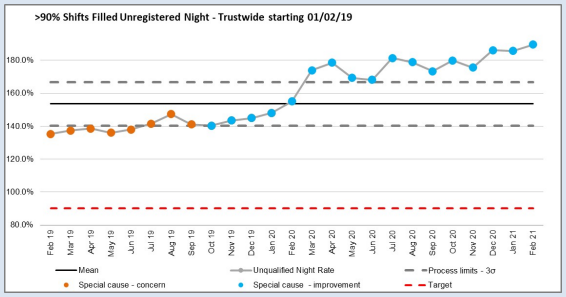
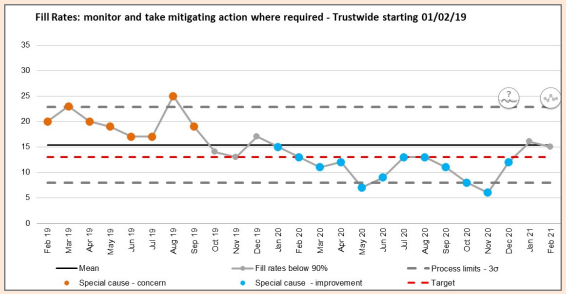
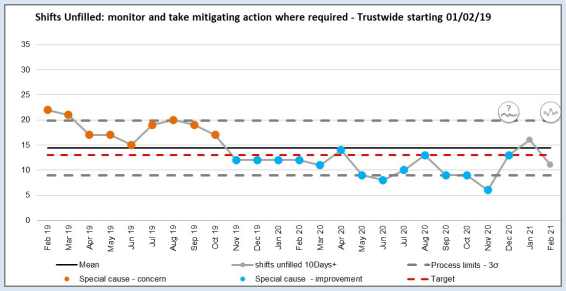
Safer Staffing							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards.							
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	104%	●	Trend above target = good 	●	The following wards were below target in February: CHS: Beech & Poplar Nursing Home: Clifton Lodge Specialist: Poplar & Longview Adult: Ardleigh, Gosfield & Peter Bruff	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	145%	●	Trend above target = good 	●	The following wards were below target in February: CHS: Avocet Specialist: Fuji	N/A
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	101.1%	●	Trend above target = good 	●	The following wards were below target in February: Older Adult: Kitwood, Henneage, Meadowview, & Beech - Rochford Nursing Homes: Clifton Lodge & Rawreth Court Adult: Gosfield & Peter Bruff	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts	189.5%	●	Trend above target = good 	●	There were no wards below target in February.	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required	15	●	Below Target = Good 	●	The following wards had fill rates of <90% in February: Adult: Ardleigh, Gosfield & Peter Bruff Older Adult: Beech – Rochford, Henneage, Kitwood, & Medowview Nursing Homes: Clifton Lodge & Rawreth Court Specialist: Fuji, Longview, Poplar CHS: Avocet, Poplar & Beech	N/A
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	11	●	Below Target = Good 	●	The following wards had more than 10 days without shifts filled in February: Adult: Gosfield, & Peter Bruff Older Adult: Beech – Rochford, Henneage, & Kitwood Nursing Homes: Clifton Lodge & Rawreth Court Specialist: Edward House & Fuji CHS: Avocet & Beech	

SECTION 5 – CQC

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The CQC completed an unannounced inspection on the 29th October focusing on Finchingfield Ward following a series of incidents that took place on the 23rd October. Following this inspection the CQC issued EPUT with a Warning Notice served under Section 29A of the Health and Social Care Act 2008 (issued on 27th November 2020). An action plan was developed to meet the Warning Notice areas of concern and all areas have been compliance checked to ensure all actions have been addressed and implemented prior to reporting back to the CQC. The Warning Notice Action Plan has now been closed and submitted to the CQC as required.

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

SECTION 6 - Finance

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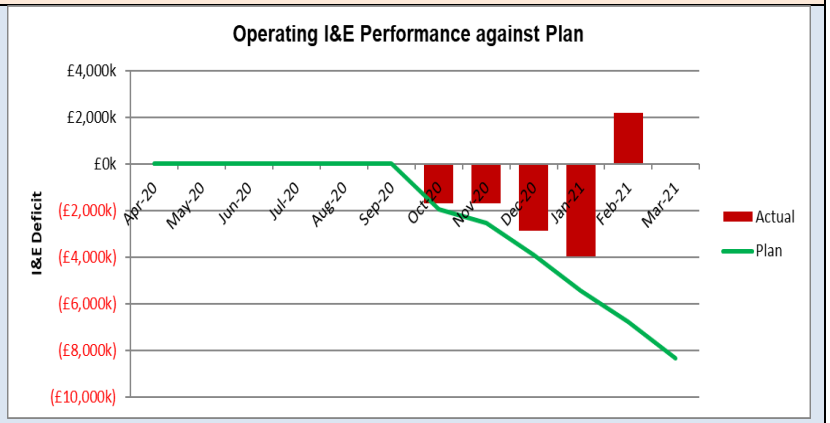
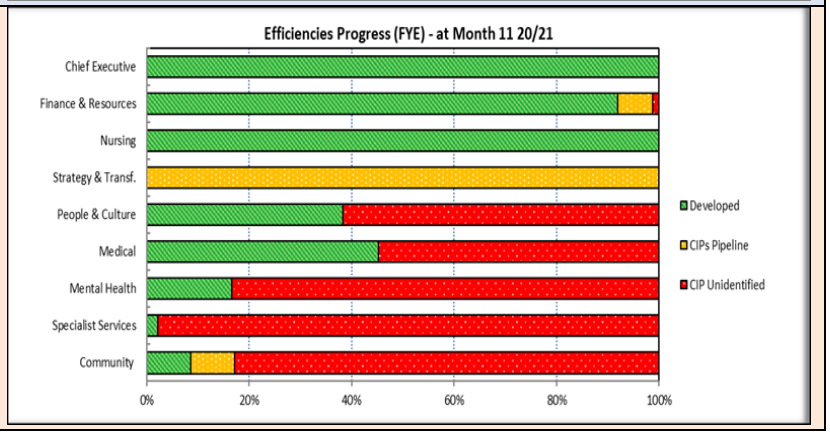
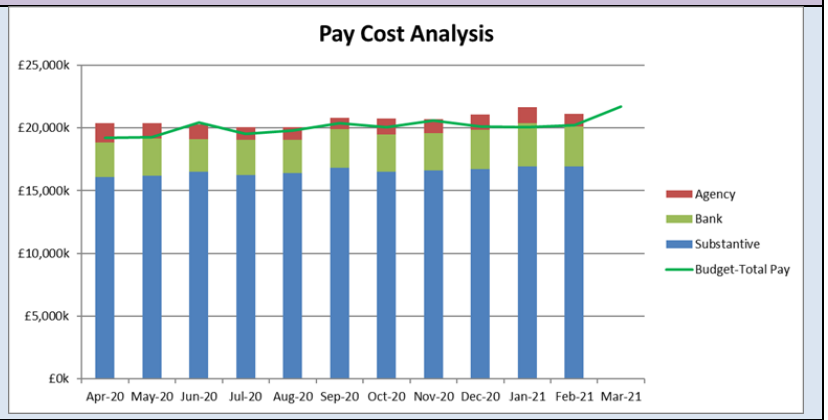
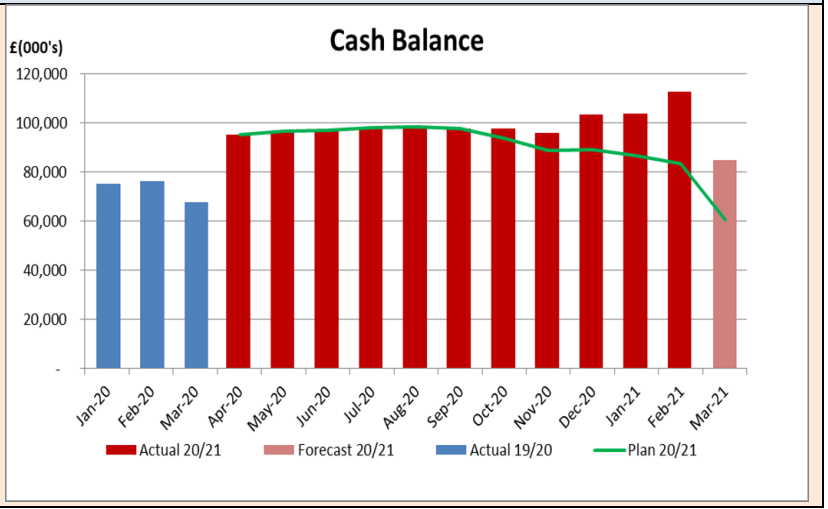
RAG	Ambition / Indicator	Position	Trend
Capital Expenditure (CDEL)	Maximising Capital Resources	The Trust's Capital programme has significantly increased this year to £16.7m due to additional funds to eliminate mental health dormitories. Despite the ongoing impact of COVID, the Trust continues mobilising a significant number of schemes to make sure the resources are fully utilised; this represents a significant investment and spend in the latter part of this financial year.	The Capital Programme has been attached as an appendix to the Finance Report.
Trust I&E 2020/21	Operating Income and Expenditure	The Trust continues to operate within the adapted financial regime, this includes national income allocations for months 7 to 12. The year-to-date £2.2m surplus is ahead of the submitted plan due to the receipt from NHSE in M11 for lost income. During the first 6 months of the year income and expenditure have been matched under the adapted regime.	
Efficiency Programmes	Planned improvement in productivity and efficiency	The Trust's Efficiency target for 20/21 is £11.7m, including the 19/20 recurrent Efficiency shortfall brought forward of £5.1m. In Year savings of £8.5m have been agreed with £0.4m identified as in pipeline. Recurrent savings at Month 11 of £3.4m have been agreed.	

RAG	Ambition / Indicator	Position	Trend
Temporary Staffing	Level of Temporary Staffing Costs	The Trust has made good progress in reducing its historic reliance on agency staffing. Overall temporary staffing costs for the month of £4.2m including Bank usage (£3.2m) remain significant (20% of total pay spend M11).	
Cash Balance	Positive Cash Balance	The cash balance at the end of February £112.9m is better than plan. The variance is mainly due to: capital spend less than anticipated due to unplanned additional income received from NHSE in the interim, to fund their estimate of the Trust's lost income over the current financial year; unplanned Public Dividend Capital income to fund additional central capital programmes such as the St Aubyn's Centre, Larkwood Ward refurbishment; variance in profiled spend on the dormitory project; less trade creditor payments than anticipated and less Pay expenditure than anticipated.	

END

		Agenda Item No: 7b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 March 2021**

Report Title:	**NHS People Plan Update**					
Executive/Non-Executive Lead:	Sean Leahy, Executive Director, People & Culture					
Report Author(s):	Kelly Gibbs, Associate Director of HR					
Report discussed previously at:	N/a					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report

This report provides:

- An update on the progress in delivery of the NHS People Plan

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

Positive progress has been made on the Trust's delivery of the plan.

- 25 of 55 actions have been completed. All remaining actions are in progress and on target

In delivering the plan there will be a particular focus in the following areas:-

- Development of recruitment and retention plan for 2021/2022
- Reintroduction of virtual carer lounges from May 2021
- Focus on reducing the ethnicity gap in BAME staff entering the disciplinary procedure

Relationship to Trust Strategic Objectives

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

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

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

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

Acronyms/Terms Used in the Report			
NHS	National Health Service	BAME	Black Asian and Minority Ethnic
EPUT	Essex Partnership University NHS Foundation Trust		

Supporting Documents and/or Further Reading
NHS People Plan – Update APPENDIX 1 – NHS PEOPLE PLAN UPDATE

Lead

Sean Leahy
Executive Director People and Culture

Agenda Item 7b
Board of Directors
31 March 2021

NHS People Plan – Update

1 Purpose of Report

The purpose of this report is to provide the Board of Directors with an update of the progress the Trust has made to tackle the range of workforce challenges in the NHS as set out in the People Plan.

This report and its appendix highlight actions that will be taken by EPUT and the progress achieved to date.

2 Executive Summary

2.1 Background

The NHS People Plan published on 30th July 2020, along with Our People Promise, sets out what our NHS people can expect from their leaders and from each other. It builds on the creativity and drive NHS people gave in their response, to the COVID-19 pandemic and the interim NHS People Plan. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as take action to grow our workforce, train our people and work together differently to deliver patient care.

This plan sets out practical actions for employers and systems, as well as the actions that NHS England and NHS Improvement and Health Education England will take, over the remainder of 2020/21. It includes specific commitments around:

- Looking after our people – with quality health and wellbeing support for everyone
- Belonging in the NHS – with a particular focus on tackling the discrimination that some staff face
- New ways of working and delivering care – making effective use of the full range of our people's skills and experience
- Growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return

2.2 Themes and Key Progress

Positive progress has been made on the Trust's delivery of the plan detailed in appendix 1 and highlighted below:-

Looking after our people

- 24 Actions of which 9 are completed
- Key areas of progress
    - 99% completion of Covid 19 risk assessments for BAME and Vulnerable Staff
    - Implementation of staff psychological service "here for you" – cross system working
    - Implementation of Schwartz Rounds
    - Introduction of Health & Wellbeing conversations forms part of supervision
    - Programme of creating "rest nest" and take a break culture
    - 60% and increasing up take of staff covid 19 vaccination
    - All roles advertised as flexible working and right to request flexible working extended to day one of appointment

Belonging in the NHS

- 9 Actions of which 6 completed
- Key areas of progress
    - Implementation and delivery of compassionate leadership/culture workshops both within EPUT and across system
    - Just and learning culture training forms part of management development programme
    - Programme of cultural intelligence launched

New ways of working and delivering care

- 5 Actions of which 3 completed
- Key areas of progress
    - Over 400 staff engagement champions and monthly grill introduced

Growing for the Future

- 17 actions of which 7 completed
- Key areas of progress
    - Highest Student intake in September 2020 due to engagement with student during covid pandemic
    - Commencement of health care support worker 0% vacancy recruitment programme, system wide international recruitment programme and kickstart programme
    - System working to engage young people in careers in the NHS

In delivering the plan there will be a focus in the following areas:-

- Development of recruitment and retention plan for 2021/2022
- Reintroduction of virtual carer lounges from May 2021
- Focus on reducing the ethnicity gap in BAME staff entering the disciplinary procedure

3 Action Required

The Board of Directors is asked to:

1 Note the contents of the report

Report prepared by
Kelly Gibbs
Associate Director of HR

On behalf of

Sean Leahy
Executive Director People and Culture
24th March 2021

NHS
Essex Partnership University
NHS Foundation Trust

EPUT PEOPLE & CULTURE ACTION PLAN

HEALTH AND WELLBEING

	Action Detail	Lead	Timescale	Progress	RAG
1	Put in place effective infection prevention and control procedures.	IPC Team	Ongoing	Guidelines developed and available on Intranet for all staff to access. Regularly updated in line with Government guidance and changes to COVID-19. Policies and procedures updated to reflect change	
2	Ensure all staff have access to appropriate personal protective equipment (PPE) and are trained to use it.	IPC Team/Operational Managers	Ongoing	PPE monitored through daily/weekly sitreps and available across all Trust sites for staff to access. Updates provided through regular staff comms.	
3	All frontline healthcare workers should have a vaccine provided by their employer.	IPC Team/Operational Managers	Ongoing	Vaccine delivery is underway and the Trust are currently reporting a completion rate of 60%+ Supportive conversations to ensure staff have correct information to encourage uptake of vaccine	
4	Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.	HR/Operational Managers	Complete	99% Trust return. 98% BAME, 98% other vulnerable staff. Ongoing review process in place being managed at management level	
5	Ensure people working from home can do safely and have support to do so, including having the equipment they need.	HR/Operational Managers/IT/Finance/ Risk	Ongoing	Temporary home working guidance developed, home working questionnaire developed and completed for all staff working from home. Equipment requirements assessed and provided where necessary.. Further work needed on reviewing the long term plan for home-working	

6	Ensure people have sufficient rests and breaks from work and encourage staff to take their annual leave allowance in a managed way.	HR/Operational Managers	Ongoing	Take a break campaign – re-design and re-circulate the message and encourage staff to book annual leave. Programme of 'Rest Nests' Set up for staff to attend virtual rest spaces and take time out. Increase in Rest Spaces made available to staff equipped with facilities to support wellbeing. Annual leave carry over procedure agreed.	
7	Prevent and tackle bullying, harassment and abuse against staff, and a create a culture of civility and respect.	Debbie Prentice/ Freya Whiting/Senior HR Mgmt Team/Ops Mgrs	ongoing	- Focus on Violence and Aggression from Patients and Public through Violence & Aggression Task and Finish Group - Work with the Staff Equality Networks - Network of Anti-Bullying Ambassadors - Promotion of B&H toolkit; - Update the D&R and grievance policy and procedure to encompass and promote better learning for management in progress - HRBP's providing lessons learning at local management meetings - Updating MDP	
8	Prevent and control violence in the workplace – in line with existing legislation and awaited Violence and Aggression Toolkit from NHSI.	Head of Staff Engagement/Ops Mgrs/Risk Team	ongoing	- Focus on Violence and Aggression from Patients and Public through Health Safety and Security Committee - Relevant issues reflected in WRES and WDES action plans. - Staff Survey Focus Groups taking place April/May 21 - Local areas planning based on their staff survey results Spring 21	
10	Appoint a wellbeing guardian.	Executive Team	Complete	Sean Leahy	
11	Continue to give staff free car parking at their place of work.	Executive Team	Ongoing	Basildon Car Parking has been free for staff during pandemic and continues.	

12	Support staff to use other modes of transport and identify a cycle-to-work lead.	Staff Engagement Team	Ongoing	Jo Debenham – Cycle to Work Lead	
13	Ensure staff have safe rest spaces to manage and process the physical and psychological demands of the work.	ET/Estates/Staff Engagement	Ongoing	Rest Nests and Take A Break Culture promoted. Charitable Funds used to support conversion of unused office spaces into rest spaces for staff.	
14	Ensure that all staff have access to psychological support.	ET/Staff Engagement/Psychology	Completed	Here for You Service in place and operational with activity monitoring taking place at OD Group. Schwartz Round steering group is now in place- advert for Schwartz round facilitators & clinical lead EOI will be sent to comms -week commencing 22nd March 2021. Schwartz Rounds commencing April 2021 Wellbeing Leads appointed and in place Fixed Term one Year. Cross refer to OD and Wellbeing Plans	
16	Identify and proactively support staff when they go off sick and support their return to work.	HR	Ongoing	Implemented wellbeing service for all staff sickness absences - Updated sickness and ill-health procedure with additional support tools; - Removal of BF scoring and formal absence written warnings - Increased promotion of support staff with disabilities and impairments - Updated sickness and mental health toolkits - Implemented a reasonable adjustment procedure - Regular monitoring in place of reasons why staff are absent and actions taken to support and bring them back to work	

				- Absence wellbeing calls in place - MSK fast track physio in place	
17	Ensure that workplaces offer opportunities to be physically active and that staff are able to access physical activity throughout their working day.	Staff Engagement	ongoing	Range of access to virtual Fitness Classes available to all staff and promoted regularly Rest Nests in place to encourage staff breaks. Programme of health and wellbeing competitions and challenges to start April 21 Take a break culture promoted and range of activities available on intranet to support physical movement	
18	Make sure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout.	Staff Engagement/Ops Mgrs/OD	Ongoing	Supervision template includes wellbeing conversation: wellness and stress/fatigue/burnout. Wellbeing will be a focus of Senior Leadership development sessions Stress management policy and procedure in place	
19	Every member of NHS staff should have a health and wellbeing conversation.	HR/Ops Mgrs	Complete	Supervision template includes wellbeing conversation. Training updated to reflect new requirement. Wellbeing procedure updated Additional supportive tools and appendices have been added to identify stress in others and in self	
20	All new starters should have a health and wellbeing induction.	Anthea Hockly/Staff Engagement/Mgrs	Complete	Staff Induction includes section on staff health and wellbeing and how/where to access support. A review of the supervision template with the reviewed appraisal documents just awaiting for documents to attend the next policy sub-group meeting. Within the new documents a wellness	

				plan will now be offered to staff in supervision if they choose. 'compassionate health and wellbeing conversations' will be rolled out to the organisation in April	
21	Staff Benefit Programme. Marketing at various stages of employment – System approach to agree benefit package and promotion	System/JD	ongoing	Staff benefit page available intranet and regularly promoted through staff briefings "Why work at EPUT" document part of recruitment marketing	

FLEXIBLE WORKING

	Action Detail	Lead	Timescale	Progress	RAG
1	Be open to all clinical and non-clinical permanent roles being flexible.	HR/Ops Directors	Completed	All roles advertised as potential flexible working available	
2	Cover flexible working in standard induction conversations for new starters and in annual appraisals.	Induction/Staff Engagement/ Managers/ OD/HR	completed	Flexible Working Toolkit up-to-date and published	
3	Requesting flexibility – whether in hours or location, should (as far as possible) be offered regardless of role, team, organisation or grade.	Employers	Complete	All flexible working requests considered through the flexible working policy and procedure Introducing day one flexible working request Procedure	

4	Board members must give flexible working their focus and support - .	ET/HR	November 2020/March 2021	Need to draft paper for Board consideration for all posts to be considered for flexible working	
5	Roll out the new working Carers passport to support people with caring responsibilities.	KG/GB/JD	Completed	Working Carers added to EPUT Reasonable Adjustment's Passport as part of HR26, guidance created to support working carers in completing this in collaboration with their senior lead. Intranet resource available here and promoted via Internal Comms, Equality Champions, Staff Induction and Staff Carers Equality Network.	

EQUALITY AND DIVERSITY

	Action Detail	Lead	Timescale	Progress	RAG
1	Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.	JR/KG/KK	Completed	Implemented internal transfer scheme. written to all Band 5 staff making them aware of promotional opportunities across the Trust BAME Rep on interview panels for Band 8a and above	
2	Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table.	OD/HR/Ops Mgrs	Complete	Incorporated in to the Supervision template and training	
3	Publish progress against the Model Employer goals to ensure that the workforce leadership is	ET/JD	Completed	Published 2020.	

	representative of the overall BAME workforce.			The projections for EPUT from the 'model employer' document are included in the annual WRES report which is next Due September 2021.	
4	51 per cent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes.	HR	By the end of 2020	- Increased analytical monitoring of all disciplinary cases - Implemented new best practices inc decision tree - Involvement of BAME network when launching a case - Applying in depth lessons learnt on all cases especially NFA outcome that may involve BAME - Reviewing disciplinary policy to introduce learning culture	

CULTURE AND LEADERSHIP

	Action Detail	Lead	Timescale	Progress	RAG
	Develop the EPUT People pledge, ties in with the NHS People Promise, branded and promoted – highlighting good practice	KG/Comms			
1	Promoting the inclusive and Compassionate Leadership Programme – threaded through all OD activity	FW/AH/NR	Completed	Compassionate leadership Workshops have been delivered throughout the Trust from February 2021 which are for managers only, from April 2021 compassionate culture workshops will be delivered to non managers. Also in conjunction with the 'here for you' support service the compassionate leadership workshop has been delivered to external partners.	

				Compassionate leadership workshop is now part of the Leadership Development pathway in workshop 3.	
2	Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.	SL/JD	Completed	All networks report directly into the Equality and Inclusion Committee – Sub-Committee of Board. Protected Time Paper being presented to Board Autumn 2020 to ensure network chairs have time to dedicate to the role.	
3	Just & Learning culture training and embedding. Identify trainers to attend national training	KK/FW/KG	completed	Programme on the MDP and away days/one off events Disciplinary and dignity, respect and grievance policy and procedures under review	
4	Talent Management	FW/MC	Ongoing	Virtual career lounges scheduling and running- completed. Appraisal updated to reflect career conversations. Further work to be undertaken re: 'talent spotting'. Work has been supported to highlight pipelines and opportunities. A virtual talent hub is on the intranet which supports development and communicates information re: education and development pathways. Virtual career lounges had been put on hold but will be reinstated in May	
5	Programme of Cultural Intelligence	SL/JD/FW	Ongoing	Cultural Intelligence Coaching Programme launched for Senior Leaders – Part 1 complete and Part 2 about to reconvene (delayed due to Covid)	

NEW WAYS OF DELIVERING CARE

	Action Detail	Lead	Timescale	Progress	RAG
1	Use guidance on safely redeploying existing staff and deploying returning staff, developed in response to COVID-19 by NHSEI and key partners, alongside the existing tool to support a structured approach to ongoing workforce transformation.	HR/Ops Directors	Complete	In place across the workforce. Services transferred temporarily to other providers to support the emergency. MOU agreed and in place	
2	Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression.	AH/FW	ongoing	New development pathways being established in Therapies, Psychology and Administration. Working with the STP, in particular MSE, to look at how system opportunities can be developed with rotational roles, placements and flexible working.	
3	Use HEE's e-Learning for Healthcare programme and a new online Learning Hub, which was launched to support learning during COVID-19.	AH	Complete	The HEE framework has been used as a guide for staff to understand which programmes are relevant for their role. Reports are published weekly on uptake and managers are asked to encourage staff to complete.	
4	Continuous upskilling which is technology focussed	AH		We are currently working with NHS Digital at a regional and national level to look at how we can use technology to deliver training differently using VR, AT and simulation.	
5	Work with Staff Engagement Champions to get real time feedback and use co-production to develop plans	Execs/JD	completed	Scheme is live and operational. Currently Staff Over 400 Engagement Champions in Place. Schedule of events and meetings currently being set with a focus on Staff Survey Results March/April 2021. Grills continue on a monthly	

				basis. Plans to increase numbers of Staff Engagement Champions in place.	

GROWING THE WORKFORCE

	Action Detail	Lead	Timescale	Progress	RAG
1	Employers should fully integrate education and training into their plans to rebuild and restart clinical services, releasing the time of educators and supervisors; supporting expansion of clinical placement capacity during the remainder of 2020/21; and providing an increased focus on support for students and trainees, particularly those deployed during the pandemic response.	AH	2020/21	We are working on an expansion and support plan for student placement capacity. This involves some use of virtual placements but also detailed work with teams on how they can work with students differently. High intake of students in September 2020 intake due to engagement with students during covid pandemic As a training team we have piloted virtual placements for Adult insights and paramedics in relation to an introduction to mental health. These have been positively responded to and have also identified ways we can develop these programs. We have also implemented a new process with the support of I/T where students are able to access Trust systems via a secure AP and this is being used currently. This process does not require the Trust to provide a laptop to students.	
2	For medical trainees, employers should ensure that training in procedure-based competencies is restored as services resume and are redesigned to sustain the pipeline of new consultants in hospital specialties.	Dr Raoof	2020/21		

3	Ensure people have access to continuing professional development, supportive supervision and protected time for training.	AH/HR/ Mgrs	2020/21	We are implementing the allocation of £1k per registrant over 3 years across the Trust. Training both internal and external courses is advertised and staff are supported in enrolling on the courses that are right for them. This is also included as part of the appraisal process	

RECRUITMENT

	Action Detail	Lead	Timescale	Progress	RAG
1	Increase recruitment to roles such as clinical support workers, highlighting the importance of these roles for patients and other healthcare workers as well as potential career pathways to other registered roles.	JR/FW		Currently working on moving Temporary workers in to support worker roles, making them aware of the career pathway opportunities available. All support worker roles to be engaged as apprenticeship with the potential career pathway to registered roles. HCSW project underway to support career pathways for those entering the Healthcare with the aim to reduce HCSW vacancies to 0%	
2	Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles.	AH/Ops Directors	Ongoing	Mandatory all HCA roles are apprenticeships. Apprenticeship routes are being expanded and more will be offered in-house. Kick start recruitment is underway with 8 Healthcare Assistant applicants currently going through DBS checks. 4 placements are planned with EPUT For Cohort 2, the advert was extended to include Admin and Healthcare Assistant roles and all key areas are now covered – Mid, South and North	

				Essex. 31 CVs have been received and initial interviews have already taken place for 24 of these. The majority of applicants are looking for Admin Assistant roles. The standard of applicant is generally very good and potential teams to accept a placement have been engaged meaning c.70 placement opportunities have been identified. Given the high demand for Kickstarters across EPUT and its partners, an application has been put forward to DWP to extend our Kickstart numbers from 30 to 100 in total during 2021. Further extensions can be submitted depending on the ongoing demand and quality of Kickstart candidates coming through.	
3	Develop lead-recruiter and system-level models of international recruitment, which will improve support to new starters as well as being more efficient and better value for money.	JR/KG/Medical Staffing		Kick off meetings held during w/c 5th October with Mid and South and West and Herts STP to discuss potential funding bids. MSE System recruitment model for HCSW programme in place MSE and Herts and West Essex System recruitment model in place for international recruitment	
4	Encourage our former people to return to			Continue to write to retiree's and offer them the Covid Pandemic response through both our	

				internal communication process and the national Bring Back Staff Scheme	

RETAINING STAFF

	Action Detail	Lead	Timescale	Progress	RAG
1	Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences.	HR/ Recruitment/ Ops Mgrs		- Current review of recruitment retention procedure applying process for assisting those with hidden impairment	
2	Ensure that staff who are mid-career have a career conversation with their line manager, HR and occupational health.	HR/Ops Mgrs	Complete	- Supervision template updated to incorporate - Appraisal documentation and Talent Management tool implemented - Talent mapping process underway	
3	Ensure staff are aware of the increase in the annual allowance pensions tax threshold.	KK/KG/JR	Completed	Regular communications including in our weekly newsletters for staff to access	
4	Make sure future potential returners, or those who plan to retire and return this financial year, are aware of the ongoing pension flexibilities.	JR	Completed	Retire and Return guidance document implemented and provided to staff looking to retire and available on intranet for staff to access	
5	Develop and implement an annual staff retention/recognition plan – reviewed after 12 months.	JR/JD/FW		Staff Recognition Scheme Live and implemented. Currently running on a quarterly basis with a paper pending to move to monthly Retention plan being developed	

6	Use Staff Surveys/pulse Surveys to support workstreams and identify Priorities.	JD/ALL	March 2021	Staff Survey 2020 results released March 21. Communication Plan in place to consult on the results and set plans in place for next 12 months. Focus will be on Anti-Bullying, Staff Engagement and Equality & Diversity.	

RECRUITMENT AND DEPLOYMENT ACROSS SYSTEMS

	Action Detail	Lead	Timescale	Progress	RAG
1	Actively work alongside schools, colleges, universities and local communities to attract a more diverse range of people into health and care careers.	AH/JR	ongoing	Have set up and participated in the Health and Care Academy in North Essex and we are now working on one with MSE STP> This engages with schools/colleges to introduce young people to the breadth of careers in health and care and to give them the opportunity to find out more.	
2	Make better use of routes into NHS careers (including volunteering, apprenticeships and direct-entry clinical roles) as well as supporting recruitment into non-clinical roles.	AH/JR	Completed	This is using the routes outlined above in terms of apprenticeships and the Health and Care Academy. We are also looking at Kickstart to see if we can use this to offer young people some short term work and increase the pipeline into Trust roles. Have started working with Prices Trusts	
3	Develop workforce sharing agreements locally, to enable rapid deployment of our people across localities.	HR/Systems	completed	MOU's in place across all system partners for deployment of staff	
4	When recruiting temporary staff, prioritise the use of bank staff before more expensive agency and locum options and reducing the use of 'off	JR/Ops Mgrs/HRBP	completed	Bank workforce has been increased by over 700 in the last 6 months to support a reduction in agency use. Agency use has decreased significantly in areas. Will continue to monitor monthly	

	framework’ agency shifts during 2020/21.				

		Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 March 2021**

Report Title:	**NHS WORKFORCE DISABILITY EQUALITY STANDARD (WDES) MID-YEAR PROGRESS REPORT MARCH 2021**					
Executive/Non-Executive Lead:	Sean Leahy Executive Director of People & Culture					
Report Author(s):	Gary Brisco Equality Adviser					
Report discussed previously at:	n/a					
Level of Assurance:	**Level 1**	√	**Level 2**		**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors with an update on progress on the Workforce Race Equality Standard (WDES) for the first 6 months of the reporting year. In this case, October 20 to March 21.	**Approval**	
	Discussion	√
	Information	√

Recommendations/Action Required
The Board of Directors is asked to note and discuss the progress made so far.

Summary of Key Issues
Mid-Year review of progress made on workforce disability equality and experience at EPUT.

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

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

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

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

Acronyms/Terms Used in the Report			
WDES	Workforce Disability Equality Standard		

Supporting Documents and/or Further Reading
None.

Lead
 **Sean Leahy** **Executive Director of People and Culture**

TRUST BOARD
Agenda Item 7c
31 March 2021

NHS WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

MID-YEAR PROGRESS REPORT MARCH 2021

1 Purpose of Report

The purpose of this report is to share progress on the Workforce Race Equality Standard (WDES) for the first 6 months of the reporting year. In this case, October 20 to March 21.

The WDES analyses the experience of our disabled staff in comparison to non-disabled staff in our workforce across 10 specific metrics.

2 EPUT WDES Position.

This table illustrates the current experience of our disabled v non-disabled staff across each of the metrics. We report annually in the summer however, the staff survey metrics are available as they were published March 21.

2021 Workforce Disability Equality Standard Data EPUT Progress

WDES No	Description	EPUT 2019 score Baseline	EPUT 2020 score	EPUT 2021 score	EPUT Direction 2021	National Report 2019	EPUT Comp to National
1	% Disabled staff in the workforce *Higher = Better*	3%	3% —	Due Aug 21	Due Aug 21	Not included	Not included
2	Likelihood of Disabled staff being appointed from shortlisting compared to non-disabled staff across all posts *Lower = Better*	1.24	0.95 ▼	Due Aug 21	Due Aug 21	1.23	▼
3	Likelihood of Disabled staff entering formal capability process compared to non-disabled staff *Lower = Better*	0	1.41 ▲	Due Aug 21	Due Aug 21	1.1	▲
4ai	% Disabled staff experiencing harassment bullying abuse from **patients relatives and public** in last 12 months *Lower = Better*	41%	39% ▼	39% —	—	34%	▲
4aii	% DISABLED staff experiencing harassment bullying abuse from **managers** in last 12 months *Lower = Better*	23%	20% ▼	18% ▼	▼	20%	▼
4aiii	% DISABLED staff experiencing harassment bullying abuse from **colleagues** in last 12 months *Lower = Better*	28%	26% ▼	22% ▼	▼	27%	▼
4b	% DISABLED staff **reporting** harassment bullying abuse from colleagues in last 12 months *Higher = Better*	49%	52% ▲	52% —	—	Not included	Not included
5	% Disabled staff believing the Trust provides equal opportunities for career progression & promotion *Higher = Better*	75%	75% —	79% ▲	▲	75%	▲
6	Disabled staff feeling pressure to come to work despite not feeling well enough to perform their duties. *Lower = Better*	31%	30% ▼	32% ▲	▲	32%	—
7	Disabled staff feeling satisfied with the extent to which the organisation values their work. *Higher = Better*	36%	38% ▲	43% ▲	▲	37%	▲
8	% disabled staff saying their employer made adequate adjustments to enable them to carry out their work *Higher = Better*	70%	72% ▲	78% ▲	▲	72%	▲
9	Disabled Staff Engagement Score *Higher = Better*	6.5	6.5 —	6.8 ▲	▲	6.6	▲
10	Difference between DISABLED Board membership & overall workforce *Lower = Better*	-3%	-3% —	Due Aug 21	Due Aug 21	2.1	▲

3 Progress in the last 6 months.

The WDES Action plan is reviewed quarterly with a review due early April 2021. Key highlights are as follows:-

- Implementation of “Sensory Champions” training implemented by D&MH Network and Equality Advisor (with funding by NHS Charities, provided by Essex Cares Ltd.)
- D&MH Vice-Chair acting as a representative for Board / Exec Team recruitment processes to ensure representation.
- Board requested to update ESR information as part of Gold / Silver command representation review.
- WDES Infographic developed to raise awareness and clearly communicating disparities faced.
- OD Team have developed “Talent Conversation Hub”, with a virtual career lounge and access to training and education opportunities, featured as part of annual appraisal with training for managers and staff to understand the process.
- Positive cultures training provided across the Trust; promoting understanding of protected characteristics as well as a positive, healthy and supportive work environment.
- Reasonable Adjustments Passports implemented into Trust with guidance for staff and their managers. Staff FAQ for reasonable adjustments process / accessing equipment and assessment. Part of Wellbeing, Sickness and Ill Health Policy.
- Regular promotion via Trust Announcements to raise awareness of the WDES and support for D&MH, including the Staff D&MH Equality Network.
- Promotion and participation in relevant events, including Disability History Month and, World Mental Health day, with staff sharing lived experience accounts on Trust intranet
- Equality Questions Guidance Sheet for staff on interview panels. Including D&MH
- Big Conversations Session “Supporting Disability and Mental Health” and “Tea at three, supporting disability and mental health during COVID-19” sessions held, with recordings available on Trust Intranet.
- Staff members with lived experience of long-term conditions now part of Reverse Mentoring Programme.
- “Feeling Pressured to come into work?” page added to E&I Hub.
- Promoting awareness of micro-aggressions across the Trust, with a poster and intranet page as well as a dedicated resource for D&MH.
- We have also created bespoke staff profiles and videos for Dyslexia and Dyspraxia awareness week and Disability History Month, and these were shared throughout the Trust via our Communications Team.

4 Still to come

- Equality and Inclusion training to be updated and provided through OLM as well as Staff inductions: Providing improved information on D&MH support to all staff.
- More Positive Cultures Sessions being delivered in teams.
- Developing a “Post-COVID” Equality Impact Assessment, to ascertain the impact on D&MH staff.
- Invitation of Senior Leaders / Board Representatives to D&MH Network
- Continued promotion of encouraging all staff to update ESR to better reflect staff data and reduce “not known” field.
- Further sensory awareness training sessions (provided by Essex Cares Ltd)
- Review process for Job Interview Guarantee Programme and ensure that this is being used appropriately (delayed by COVID-19 pressures)
- Review of D&MH staff entering formal processes to ensure equity and fairness, as well as identifying key themes (delayed by COVID-19 pressures)
- Carry out six-monthly review of grievances related to reasonable adjustments to ensure that these were processed fairly and to identify any areas of misunderstanding
- Highlighting good practice stories of reasonable adjustments
- Staff Survey Focus Groups on Equality, Wellbeing and Engagement (April 2021)
- Focus on ‘feeling pressure to come to work’ Staff Survey finding.

5 Conclusion

The Progress chart in section 2 shows some initial pleasing results from staff survey. Whilst many of the metrics are not due to be reported until the summer the staff survey metrics have performed well with all showing improved experience except on Metric 6 – ‘*Disabled staff feeling pressure to come to work* ‘ which is currently being investigated.

The full report to Board in September 2021 will give a more accurate position on how we have applied HR processes, how that has impacted the WDES standards but we are pleased with the progress so far.

6 Action Required

Trust Board are asked to note and discuss the progress made so far.

Report prepared by

Name **Gary Brisco**
Job Title **Equality Advisor**
Date **March 2021**

On Behalf of:

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

		Agenda Item No: 8a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 March 2021**

Report Title:	Board Assurance Framework 2020/21 March 2021 Q4					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Susan Barry, Head of Assurance					
Report discussed previously at:	EOSC BAF Sub-Group February and March 2021 (single reports)					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report presents the EPUT Board of Directors with an overview of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) 2020/21 as at 31 March 2021 covering the two month period February 21 and March 21 (Q4)	**Approval**	✓
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the rollover of BAF and risk registers to align with proposal to agree new strategic objectives at future Board meeting
2 Review the risks identified in the BAF 2020/21 March summary and approve the risk scores including recommended changes (Appendix 1) taking account of actions taken by EOSC at its February meeting
3 Approve the BAF risk escalations, closures and amendments iterated in key issues below
4 Note the Q4 Key Performance Indicators (Appendix 2)
5 Note the CRR March summary table (Appendix 3) including actions taken by EOSC at its February meeting;
6 Approve the CRR risk escalations, closures and amendments iterated in key issues below
7 Identify any further risks for escalation to the BAF, CRR or Directorate risk registers

Summary of Key Issues

Introduction

- This report covers two months of reporting to EOSC BAF Sub-Group and the March summary includes reference to any changes made by Executive BAF Sub-Group February 2021
- The EOSC BAF Sub-Group was established in January, with agreed Terms of Reference in place, and is a dedicated forum for detailed review of the BAF and CRR. Further information is included in the main report.
- In view of the work progressing at Board/Executive level around governance, structure and accountability, the BAF, CRR and Directorate Risk Registers (DRR) will roll over until the Board approves Strategic Objectives for 2021/22

Board Assurance Framework (Appendix 1)

- There are **24 risks** on the Board Assurance Framework. Recommendations in the report take this to **20** on approval.
- The **summary sheet (Appendix 1)** iterates the current mitigating actions/ controls in place for risks on the BAF and any further actions that needed. Work continues on the review of individual risks ahead of a refresh of the BAF.
- **BAF action plans** are under regular review with Executives and their direct reports. All action plans are seen by the Executive Team and by the relevant Board Standing Committees on a quarterly basis

- **The following risks are recommended for escalation to the BAF:**

ID	Risk	Rationale and discussion points
BAF61	If EPUT fails to embed, recognise and celebrate equality and diversity as part of its culture and conversation then the Trust may struggle to address inequalities resulting in poor staff and patient experience and a challenge to the CQC rating for well-led, and exposure to legal challenge for discrimination Score: C5 x L4 = 20 Executive Leads: SL/all Executives	Escalation from CRR due to recommended increase in score by Executive Director for People & Culture and a proposal to undertake an Equality and Diversity root and branch review
BAF62	If EPUT does not have adequate systems and processes in place to deploy staffing then it will not support staff wellbeing and patient safety resulting in a failure to deliver our Safety First, Safety Always Strategy Score: C5 x L4 = 20 Executive Leads NH/SL/AG	Proposal put to ET regarding staffing establishment issues and the larger piece of work that needs to take place in reviewing staffing numbers and skills mix to mitigate this risk. Newton will undertake diagnostics around Health Roster, reliance on temporary staff and establishment budgets. This will feed into an action plan.

- **The following risks are recommended for a reduction in score and closure:**

ID	Risk	Rationale and discussion points

BAF9	If EPUT does not embed a No Force First strategy through comprehensive and sustainable structures to monitor, deliver and integrate the approach in clinical practice then a reduction in conflict and restraint may not be achieved resulting in work related staff sickness and poor patient experience	Action plan and work completed. Risks will be considered following Safety First, Safety Always Strategy implementation plan Board approval in May
BAF35	If EPUT does not develop a culture based on what is morally right and fair in response to incidents and errors, and is unable to demonstrate that lessons are learnt, then protection of both staff and patients is reduced which may result in poor quality services and patient experience together with lack of actions consistent with prevention impacting on CQC rating	A meeting has been set up between Head of Assurance and Executive Directors for People and Culture, Nursing and Operations to discuss an alternative risk associated with implementing the Safety First, Safety Always Strategy for 2021/22
BAF55	If EPUT does not act at pace on the CQC S29A Warning Notice then it may not meet the deadlines set resulting in further action being taken against EPUT	Action plan and work completed. Learning from the warning notice is covered in BAF45 CQC risk
BAF46	If EPUT is unable to secure low secure and other placements for young people with complex care needs then an increase in restraints and assaults may be seen resulting in potential harm to patients and staff	This risk reflected at a national and regional level. A formal business case for CAMHS is part of the provider collaborative work. A new risk is under consideration around acuity and service provision for children and young people.
BAF44	If EPUT does not embed learning from C19 then changing, evolving and delivering new pathways is compromised resulting in a challenge to retention/ recruitment, establishment and skills mix as well as recovery of services	BAF62 will replace (see new risk section).
BAF47	If EPUT limits bed occupancy to the 85% ambition on mental health inpatient wards to facilitate social distancing requirements then there may be a shortfall in beds resulting in delays to admissions or an increase in out of area placements	EOSC requests the closure of this risk. There is some fluctuation is bed occupancy, mainly on dormitory wards. Outbreaks of C19 now negligible.

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

ID	Risk	Rationale and discussion points
BAF23	If EPUT does not monitor EU Exit trade deal areas without agreements or with further discussions pending then there may be unforeseen circumstances resulting in an impact on service delivery	Reflects that we are post trade deal and the national requirement for this risk to remain on the BAF for the time being. There are areas without agreements.

BAF57	If EPUT receives a substantial fine from the HSE court case then there may be a significant impact on resources and recovery from past failings, resulting in lower public confidence in our vision of 'safety first, safety always'	Reflects financial implications.
BAF54	If EPUT is not open, transparent or demonstrate learning from the Independent Inquiry then it may not deal with the consequences of past failings resulting in undermining our Safety First, Safety Always Strategy	Reflects our wish to have an open, honest and learning approach to the inquiry and this will be our mitigation.

- **There are currently eight risks sitting at a score of 20 (extreme) following closures and escalations above**:

ID	Risk	Comments/Action
BAF43	If EPUT does not plan for an expected **surge** in demand for Mental Health services or physical CHS and rehabilitation during or post C19 then skills and capacity may not be in place resulting in long waiting lists and self-harm in the community	Long term risk and all current resources are targeted at management of the pandemic
BAF45	If EPUT does not prepare for future **CQC** inspections by learning from focused inspections, patient safety incidents, and meeting CQC fundamental standards then it will be held to account for failure to provide high quality care resulting in further regulatory action	Intelligence affirms that unannounced inspection may be expected from April 2021
BAF50	If EPUT does not have the **skills, resource and capacity** to deliver high quality business as usual care and services, manage the C19 pandemic, mass C19 vaccination programme, EU Exit Transition, regulatory responses, independent inquiry and increased variation of demands on corporate services then it may not achieve the deliverables on this wide range of priorities and pressures resulting in not achieving organisational objectives, unsustainability in corporate services, stagnation of risks and failure to maintain our position within the wider health economy	Need to ensure we implement new strategies in an integrated way. A new action plan will be developed for 2021/22
BAF53	If EPUT does not complete required **safety actions** or effectively shape its safety plans for the future then patients may be harmed resulting in a failure to deliver a safe, high quality service as well as our new Safety First, Safety Always Strategy	For discussion at ESOG 30 March
BAF54	If EPUT is not open, transparent or demonstrate learning from the **Independent Inquiry** then it may not deal with the consequences of past failings resulting in undermining our Safety First,	

	Safety Always Strategy	
BAF57	If EPUT receives a substantial fine from the HSE court case then there may be a significant impact on resources and recovery from past failings, resulting in lower public confidence in our Safety First, Safety Always Strategy	
BAF58	If EPUT does not record **clinical activity** in real time, accurately and on the patient information system(s) then patient and staff safety is compromised resulting in failure to deliver its Safety First, Safety Always Strategy	Task and Finish Group set up with Chairs of Quality and Safety Groups, Clinical Governance, Performance and Assurance Teams with specific aims outlined in summary table
BAF61	If EPUT fails to embed, recognise and celebrate **equality and diversity** as part of its culture and conversation then the Trust may struggle to address inequalities resulting in poor staff and patient experience and a challenge to the CQC rating for well-led, and exposure to legal challenge for discrimination	

Key Performance Indicators (Appendix 2)

- This is the second set of indicators produced for the BAF. The Trust Board will receive these bi-monthly from April 2021
- KPI 1 % risks with action plans completed by target completion date – RAG *Green*
- KPI 2 % stagnant risks 2a % increased scores – RAG *Green* (improvement on Q3) and 2b % decreased scores – RAG *Red*
- KPI 3 % current risks on BAF over 12 months – RAG *Green* 3a % current risks on BAF over 24 months – RAG *Green* 3b % current risks on BAF over 12 months (excluding known ongoing risks) – RAG *Green (improvement on Q3)*

Corporate Risk Register (Appendix 3)

- There are **14 risks** on the Corporate Risk Register. Recommendations in the report take this to **13** if approved.

- **The following risks are recommended for escalation to the CRR:**

ID	Risk	Rationale and discussion points
CRR75	If EPUT does not achieve ECTAS accreditation then there may be adverse media coverage resulting in a lack of public confidence in the services offered to our patients Proposed score 4 x 3 = 12 Lead: Dr Milind Karale	Delay in accreditation process due to Covid19
CRR76	If EPUT continues to receive inferior quality towels and bedding from its contractor then ligature incidents may increase resulting in possible serious patient harm C5 x L4 = 20 Executive Leads: PS/TS/AG	This new risk reflects increased use of these products as ligatures and is a real cause for concern since new contractor appointed.

- **The following risks are recommended for closure:**

ID	Risk	Rationale and discussion points
CRR56	If EPUT continues to operate global restrictions in in-patient mental health services, then patient experience is compromised resulting in further regulatory scrutiny	New risks will be developed alongside implementation of the Safety First, Safety Always Strategy
CRR49	If urgent care pathway services receive high levels of referrals which do not meet the threshold for secondary services then the ability to respond is reduced resulting in poor patient experience	From April EPUT will have more control over referrals from IAPT into core services
CRR57	If EPUT fails to embed, recognise and celebrate equality and diversity as part of its culture and conversation then the Trust may struggle to address inequalities resulting in poor staff and patient experience and a challenge to the CQC rating for well-led, and exposure to legal challenge for discrimination	Escalated to BAF

- **The following risks are recommended for amendment:**

ID	Risk	Rationale and discussion points
CRR34	If EPUT does not train and support staff effectively in suicide prevention then staff may not have the necessary skills or confidence to support suicidal patients resulting in self-harm and death.	The risk is more about effective training and support rather than having sufficient trainers in place
CRR64	If EPUT experiences further serious inpatient safety incidents then high quality patient care is compromised resulting in additional regulatory scrutiny	Focus on scrutiny. Mitigated by Safety First, Safety Always Strategy implementation

Covid19 Risk Register Summary

The Covid19 Risk Register is up to date and is part of the Covid19 report to EOSC 23 March and report to Board 31 March.

Mass Vaccinations Risk Register

The EPUT Mass Vaccination risks are agreed and currently being put into EPUT risk register format.

EU Exit Trade Deal Risk Register

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

Directorate Risk Registers

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

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

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

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

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

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

Supporting Documents and/or Further Reading
Appendix 1 Summary of BAF as at 31 March 2021 (Q4) Appendix 2 Key Performance Indicators (Q4)

Appendix 3 Summary of CRR as at 31 March 2021 (Q4)

Lead
Paul Scott **Chief Executive Officer**

Agenda item 8a
Board of Directors Part 1
31 March 2021

EPUT

BOARD ASSURANCE FRAMEWORK 2020/21 MARCH 2021

PURPOSE OF THE REPORT

This report presents the Board of Directors with an overview of the Board Assurance Framework and Corporate Risk Register 2020/21 as at 31 March 2021.

UPDATE AS AT MARCH 2021

1. Board Assurance Framework 2020/21

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

There are 24 risks on the BAF. Recommendations in the report take this to 20 on approval. **Appendix 1** provides a summary of BAF risks as at March 2021 (and notes of any changes made in February 2021), including mapping of risks against the 5 x 5 scoring matrix and movement on scoring from April 2019 to March 2021.

The EOSC BAF Sub-Group now meets monthly to discuss the BAF and CRR and a Task and Finish Group meets in between to undertake further work. A new Board meeting cover sheet is in place for March reports with a focus on risks.

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

2. Recommendations for BAF escalation, closures and amendments

The key issues above iterates:

- Recommendations for two escalations to the BAF, namely BAF61 Equality and Diversity, and BAF62 Effective Staffing.
- Recommendations for six closures, namely BAF9 No Force First; BAF35 Culture of Fairness and Learning; BAF55 CQC Warning Notice; BAF46 Young People with Complex Needs; BAF44 Learning from C19; and BAF47 Bed Occupancy. Some new risks will replace these associated with implementation of the Safety First, Safety Always Strategy.
- Recommendations for three amended risks, namely BAF23 EU Exit Trade Deal; BAF57 HSE; and BAF54 Independent Inquiry.

EOSC BAF Sub Group made the following changes in February 2021:

- BAF52 skills resource and capacity for mass vaccinations – covered by BAF50; BAF56 CQC fundamental standards – consolidated into BAF45; and BAF59 recent deaths – as recommended at January Board all closed
- BAF51 oversight and scrutiny of mass vaccination programme reduced in score

3. BAF Action Plans

Potential risks on the BAF should have (in most cases) a detailed action plan to mitigate risks. EOSC reviewed BAF Action Plans in March 2021. Standing Committees reviewed their allocated risks in March 2021. BAF action plans are available on request.

4. Key Performance Indicators

Appendix 2 highlights Key Performance Indicators and progress against these for March Q4. The Board will receive monthly from April 2021.

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

5. Corporate Risk Register

There are 14 risks on the Corporate Risk Register. Recommendations in the report take this to 13 on approval. **Appendix 3** provides a summary of CRR risks as at March 2021 (and notes of any changes made in February 2021), including mapping of risks against the 5 x 5 scoring matrix.

The key issues above iterates:

- Recommendation for two escalations to the CRR, namely CRR75 ECTAS accreditation and CRR76 Towels and Bedding
- Recommendation for three closures, namely CRR56 global restrictions; CRR49 urgent care pathways; and CRR57 equality and diversity
- Recommendation for two amendments, namely CRR34 effective training in suicide prevention; and CRR64 serious inpatient safety incidents

6. Covid19 Risk Register

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

7. Mass Vaccinations Risk Register

The EPUT Mass Vaccination risks are agreed and currently being put into EPUT risk register format.

8. EU Exit Trade Deal Risk Register

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

9. Directorate Risk Registers

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

9. Recommendations

The Board of Directors is asked to:

1 Note the rollover of BAF and risk registers to align with proposal to agree new strategic objectives at future Board meeting
2 Review the risks identified in the BAF 2020/21 March summary and approve the risk scores including recommended changes (Appendix 1) taking account of actions taken by EOSC at its February meeting
3 Approve the BAF risk escalations, closures and amendments iterated in key issues below
4 Note the Q4 Key Performance Indicators (Appendix 2)
5 Note the CRR March summary table (Appendix 3) including actions taken by EOSC at its February meeting;
6 Approve the CRR risk escalations, closures and amendments iterated in key issues below
7 Identify any further risks for escalation to the BAF, CRR or Directorate risk registers

Report prepared by**:**

Susan Barry
Head of Assurance

On behalf of:

Paul Scott
Chief Executive

Appendix 1 - Table 1 – BAF 2020/21 Summary of Risks as at March 2021

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

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
Strategic Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe and innovative services - Lead Director: Natalie Hammond - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score							
BAF23	If EPUT does not monitor EU Exit trade deal areas without agreements or with further discussions pending then there may be unforeseen circumstances resulting in an impact on service delivery	PS and all Executives	Finance and Performance	Monitoring	• EU Exit (transition) deal in place • Task and Finish Group in place and meeting monthly • Risk Register in place • Action log in place, monitored and updated monthly • EU Admin meeting monthly • Daily sitrep through Silver Command • Assessment of financial risks in supply chain is that there is negligible impact	Risk score unchanged Feb/Mar 4 x 3 = 12 Target date moved from March to June 21 – 4 x 2 = 8 will be carried forward to 2021/22 reworded	• Maintain watching brief on gaps during first six months of deal ○ Data adequacy ○ Mutual recognition of professional qualifications ○ EU staff ○ Medicinal products approval process ○ Pharmacovigilance co-operation • Retain on BAF whilst there is a national expectation to do so
BAF32	If EPUT does not drive quality improvement through innovation then maintaining 'Good' rating and moving towards an 'Outstanding' rating may be difficult resulting in potential stagnation of services and falling behind in whole system transformation	NH	People Innovation and Transformation	Action Plan	• BAF action plan in place with five actions, four completed and one delayed due to C19 • Task and finish group in place (NED led) • Quality Academy • Quality Improvement Hubs • Local dashboards and case studies • Intranet pages • Quality awards • Quality Improvement Framework • Patient Safety Incident Management System • Remains a focus in Quality Priorities • Learning Oversight Group	Score has remained at threshold Feb/Mar 4 x 3 = 12 Target date changed to May 21 due to report going to May Board Will be carried forward until end of May when consideration will be given to all risks associated with the Safety First Safety Always Strategy implementation plan	• Integration of QI, research and innovation arrangements with governance arrangements. Task and Finish Group led by Dr Rufus Helm (NED) has made significant progress by setting key principles and is working on the following (presented to its January meeting) and supporting a paper to Board (advised May Board meeting as delayed by C19): ○ Process map, documentation to support the process and identified needs for investment/ funding ○ High-level communications strategy including launch and website ○ Representation from QI Hubs to contribute to planning and support for the programme • Ensure link to Safety First Safety Always Strategy

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
Corporate Objective 1: To provide safe and high quality services during Covid19 pandemic – Lead: Paul Scott supported by all Executive Directors - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score							
BAF4	If EPUT fire safety systems and processes are not suitable and sufficient there is a potential risk of injury or death to patients, staff and visitors, and that enforcement action could be taken by the Fire Authority in the form or restrictions, forced closure of premises, fines, and prosecution / custodial sentencing for 'Responsible' persons	TS	Finance and Performance	Action Plan	• Trust follows all relevant statutory fire safety legislation and adheres to articles of RRO, HTM Fire Code and Government standards/ guidance as best practice • Trust Fire Safety Officer in post • Fire Policy and Procedures in place • Fire Safety Group (Executive led) • Rolling Fire Strategy programme in place • Fire Risk Assessments in place with spot checks undertaken • Remedial action trackers in place and monitored • Directorate Risk Registers have this risk mirrored particularly in relation to fire wardens and fire drills • BAF action plan in place with 11 actions, six completed, three in progress to timescale, two overdue in relation to fire wardens and fire drills	Risk unchanged Feb/Mar 5 x 3 = 15 Target date March 2021 Threshold 4 x 3 = 12 Inherent risk that will be carried forward to 2021/22	• Fire drills remain an issue although there is some improvement in form completion for fire evacuation drills. Training to include a reminder that form should be in site folders. • Fire wardens remain a significant issue monitored through FSG – as at end of January 70 sites out of 94 have no known compliant fire wardens. • Fire risk assessment remedial works is an ongoing rolling action for the year monitored through FSG • Vaccination hub FRA programme continues to impact • Category 1 and 2 fire training compliance below target end January • Action plans to be presented to FSG in April • 2021/22 action plan will evolve to include new actions required to mitigate the risk • This will link to the accountability framework to ensure clear responsibility for key issues such as fire wardens and fire drills

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
BAF10	If EPUT fails to provide high quality services from premises that are safe, then the risk related to ligatures is not minimised resulting in potential harm to patients in inpatient services.	TS/PS/All Executives	Quality	Action Plan	• Ligature Risk Policy and Procedures • Ligature Risk Assessment Process • Ligature Risk Training and Awareness Programme in place and monitored • Ligature Risk Stratification Process • Ligature Risk Reduction Group • Interim Ligature Risk Co-ordinator in post • Executive Lead in place • Ligature risk assessments cross-referenced with Risk Stratification reports • LRRG monitors follow up of actions • Floor plan heat maps in place • Checking process in place for actions • Medical staff involved in ligature risk assessments • Quarterly reporting to HSSC, Quality Committee and four monthly to Board • 'Tidal Training' bespoke course in place • Suicide prevention and general ligature e-learning training linked • Human factors training included in OLM programmes following up with reflection sessions • Retrospective review of serious incident action plans carried out and now followed up monthly through LRRG with assurance to LOG • Annual programme of curtain rail testing • Garden audit completed • Technical innovations task and finish group in place in conjunction with Oxehealth • Dementia Friendly Standards Group • Ligature inspectors undertake e-learning, compliance process training and practical testing • Ligature dashboards on Datix • Recommendations from BDO audit implemented • Ligature story developed through timeline of works to feed the four monthly assurance report to Board • Standards developed and agreed for Dementia wards • BAF action plan in place with 37 actions now completed out of a total of 46	Risk score unchanged Feb/Mar 5 x 3 = 15 Target date March 2021 Threshold 4 x 3 = 12 This risk will be carried forward to 2021/22	• Ongoing comparative audit of ligature inspections carried out in 2018 against 2020 to identify any commonalities among non-compliance – two wards remaining will be complete by end Mar • Outcome of recent meeting with Estates is risk stratification will be available for March meeting and monthly presentation of the Gantt chart (covering hinges and garden works) • Ligature Co-ordinator post at shortlisting/interview stage • Develop project plan on open actions and non-compliance, looking at actions more than three years old. ESOG to monitor governance process. Still cross-referencing 3i system with Datix to identify gaps • Four actions overdue to be completed on BAF action plan • Three actions to be completed on BAF action plan by end March 2021 • Mitigation statement work added to Ligature Co-ordinator work plan for further action when new post holder in place • New corporate risk identified for all inpatient areas from increased ligature incidents involving towels and bedding supplied by new contractor – risk shared by operations, estates/ facilities, and compliance/assurance

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
BAF9	If EPUT does not embed a No Force First strategy through comprehensive and sustainable structures to monitor, deliver and integrate the approach in clinical practice then a reduction in conflict and restraint may not be achieved resulting in work related staff sickness and poor patient experience	NH	Quality	Action Plan	• Restrictive Practice Steering Group in place • BAF action plan in place with 19 actions completed out of 21 • System across all wards to comply with the requirements of the new national data set • Restrictive practice collaborative across all inpatient areas with toolkit and action plans in place • Quality Improvement facilitator works with all inpatient areas introducing tools and techniques • Safety crosses and safety pods implemented and evaluated • Care plans reviewed to ensure learning from C19 • One page strategy developed and circulated • Core strategies from Reducing Restrictive Practice Guide implemented across all inpatient areas • Significant reduction in prone restraint • Prone restraints managed as critical incidents • 10 Ways to Improve Safety rolled out • Online learning package and communication for restrictive practices completed • National Training Standards for Restrictive Practice implemented • Pilot system to identify lessons learned because of seclusion or long-term segregation prior to full roll out complete • Accreditation with National Training Standards for Restrictive Training now due to take place April 2021 (delayed externally due to C19) – EPUT is fully prepared	Risk score remains at threshold Feb/Mar 4 x 2 = 8 Target date March 2021 Recommend closure of this risk. Risks will be considered following Safety First Safety Always Strategy implementation plan Board approval in May	• Advanced statements are included in TASI training but may be light touch in practice. Implement corporate messaging and enhance clinical supervision. Look at processes to streamline basic operational working practices – to be considered for 2021/22

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
BAF38	If EPUT does not implement effective emergency planning arrangements for managing the Covid19 outbreak in line with national and local requirements then the ability to deliver services reduces resulting in a lack of containment of the pandemic.	PS	Finance and Performance	Monitoring	• Executive lead in place for EPRR • Business Continuity Plans in place and undergoing constant review • Gold, Silver and Bronze Command well established • Sit rep daily monitoring • Covid intranet page and range of staff training in place	Risk score remains at threshold Feb/Mar 5 x 2 = 10 Target date – ongoing throughout pandemic Risk will carry over into 2021/22 for duration of pandemic	• None identified
BAF53	If EPUT does not complete required safety actions or effectively shape its safety plans for the future then patients may be harmed resulting in a failure to deliver a safe, high quality service as well as our Safety First Safety Always Strategy *patient safety actions – refer to any internal actions arising from assessments/ inspections or external inspections/ investigations	NH/AG/MK all Executives	Quality	Monitoring	• Executive lead in place for Patient Safety • Executive Safety Oversight Group in place with Terms of Reference and chaired by Chief Executive • 'Safety First Safety Always' Strategy approved at January Board • Agreed SFSA implementation plan be used to monitor the risk	Risk score unchanged Feb/Mar 5 x 4 = 20 Target date to be aligned with implementation plan Threshold 5 x 2 = 10 Inherent risk to be considered in depth as part of the review of the BAF and implementation of Safety First Safety Always Strategy	• Improvement journey includes urgent actions such as improvements in record keeping and urgent estate/security issues • Workstreams that will underpin the strategy – engagement, leadership, culture, wellbeing, innovation, enhancing environments, governance and information • Key outcomes (high level) – no preventable deaths, a reduction in serious incidents, a reduction in self-harm, patients and families feel safe in EPUT's care, and stakeholders have confidence that EPUT is a safe organisation • Report to be discussed at ESOG 30 March • This will be a step change risk, evolving throughout 2021/22

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
BAF36	If EPUT continues to experience high numbers of female patients with personality disorders admitted to inpatient services then there is a risk that the ward environment may become more volatile and difficult to manage, impacting patient safety and length of stay Risk wording will remain the same for 2021/22 with new action plan	AG/MK supported by NH/PS	Quality	Action Plan	• Increased staffing levels in place since April 2020 following establishment review • Implementation of Crisis 24/7 service since April 2020 • Restrictive practice, restraint and attempted ligature reduced through 'My Safety Plan' and Sensory Room • Increased provision of activities and therapeutic offer including out of hours • Psychology Assistant posts introduced on all wards with high level of PD/ trauma • PD/Trauma pathway to support inpatient services • Four papers presented to EOSC on Clinical Associate in Psychology Apprenticeships • Roll out of Oxehealth and body worn cameras • Work has been undertaken on meaningful principles for admission and psychology services to be part of the MDT to link with community services • A task and finish group has been set up with terms of reference and an action log. First meeting discussion purposeful admission, therapeutic offer/model, EUPD Management principles, BAF risk, safety first safety always strategy, implementation and mobilisation plan	Risk scoring unchanged Feb/Mar 5 x 3 = 15 Target date not met due to delays caused by C19 – change to March 21 Threshold 5 x 2 = 10 Risk will be carried forward to 2021/22 with a new action plan aligned with the Task and Finish Group action log	• Place 9 CAPs into inpatient wards and appoint a 1 WTE Band 8a Clinical Psychologist to manage/supervise them, and provide input into Ipswich Road – approved to pump-prime with underspend and employ permanently. MSE to pick up funding from 21/22 from baseline. Approaching NEE and WE to do the same • Employ a CAP training team using underspend until levy kicks in and covers costs. Finalising contract with UoE to confer Master's Degree and working towards a degree approval board meeting in February 2021 with first CAP training intake in April/May 21. EPUT have 14 funded post of 24 that will commence then • Two CAP posts will support the PD pathway in west and NEE and nine are in the inpatient out of hours and weekend cover for enhanced access to psychological interventions and activity on inpatient wards • All staff to have Mentalisation/ stabilisation training and SCM training • Standard operating protocols • Develop new action plan for 2021/22

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
BAF45	If EPUT does not prepare for future CQC inspections by learning from focused inspections, patient safety incidents, and meeting CQC fundamental standards then it will be held to account for failure to provide high quality care resulting in further regulatory action	PS/AG/MK and all Executives	Quality	Action Plan	• CQC Executive Steering Group in place • Compliance Team • Monitored through audit processes, internal audit and compliance inspections, complaints, safeguarding and serious incidents • Action plan testing • Compliance Team inspection plan scheduled • Monthly reporting to Executive Safety Oversight Group • Up to date with all CQC guidance and new developments • Focussed reviews on patient safety incidents • Inspection plan schedule in place	Risk score unchanged Feb/Mar 5 x 4 = 20 Target date March 2021 Threshold 4 x 2 = 8 This risk will carry forward to 2021/22	• Demonstrate adherence through internal processes to CQC action plans • Address sustainability, culture change and long-term embedding of changes • PHSO/HSE Action plan testing • Develop communications strategy • Intelligence affirms that unannounced inspection may be expected in April • Themes are being developed for internal compliance inspections • Further actions to be developed relating to fundamental standards
BAF54	If EPUT is not open, transparent or demonstrate learning from the Independent Inquiry then it may not deal with the consequences of past failings resulting in undermining our Safety First, Safety Always Strategy	NL/All Executives	Quality	Monitoring	• Executive Lead identified • Establishing governance arrangements • Updated stakeholders including NHSE/I • Principles developed on EPUT approach	Risk score unchanged Feb/Mar 5 x 4 = 20 Target date March 21 Threshold 5 x 2 = 10 This risk will carry forward to 2021/22	• Awaiting Terms of Reference – likely to be April 2021 • Pulling together a core team with appropriate skills, and resources required to support EPUT internally • Job matching and posts to be advertised on a secondment or fixed term basis

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
BAF55	If EPUT does not act at pace on the CQC S29A Warning Notice then it may not meet the deadlines set resulting in further action being taken against EPUT	PS	Quality	Action Plan	• CQC Executive Steering Group • Factual accuracy completed • Press release completed • Clinical Intensive Support Process and Group (CISG) set up for Finchingfield Ward • Identified wider learning for other acute wards and across EPUT • CQC warning notice action plan in place and monitored by CISG • Compliance testing undertaken at Galleywood Ward • Weekly testing undertaken on Finchingfield action plan – December actions closed • Identified risks and filled gaps on current risk registers related to the CQC actions • Full response submitted to CQC by the deadlines of 27 December and 27 January	Risk score recommended reduction to 5 x 2 = 10 Target date March 21 Threshold 5 x 2 = 10 Recommend take to threshold and close this risk as action plan completed and BAF45 risk in place	• Develop and implement an action plan for wider learning and areas of systemic failings – will link with BAF45
BAF57	If EPUT receives a substantial fine from the HSE court case then there may be a significant impact on resources and recovery from past failings, resulting in lower public confidence in our vision of 'safety first, safety always'	NL/TS	Finance & Performance	Monitoring	• Executive Lead in place • All actions taken in relation to HSE investigation • Guilty plea submitted • 'Safety First Safety Always' Strategy approved at January Board	Risk score unchanged Feb/Mar 5 x 4 = 20 Target March 2021 Threshold 5 x 2 = 10 Risk will carry forward to 2021/22	• Implementation of Safety First Safety Always Strategy • Communications plan • Sentencing date has been re-scheduled for June 2021

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
BAF58	If EPUT does not record clinical activity in real time, accurately and on the patient information system(s) then patient and staff safety is compromised resulting in failure to deliver its Safety First Safety Always Strategy	AG/MK	Quality	Monitoring	• Recognised that this is a fundamental shift in philosophy with 5% gap being identified as patient safety risk, rather than the tolerated variance • 'Safety First Safety Always' Strategy approved at January Board • Task and finish group set up with Chairs of Quality and Safety Groups, Clinical Governance, Performance and Assurance Teams – Meeting 1 April	Risk score unchanged Feb/Mar 5 x 4 = 20 Target March 2021 Threshold 5 x 2 = 10 Risk will carry forward to 2021/22	• Task and Finish Group will consider this risk and look at: o The need for a very small percentage tolerance to accommodate system downtime and how we reflect delays resulting from this o Understanding real risk and root cause o Exploring new ways of thinking in conjunction with key individuals/ teams o Developing mitigating actions that address the 5% non-adherence rather than an adherence to 95% accuracy of record keeping o Adapting clinical audit tools for record keeping o Developing an action plan for 2021/22 • Specialist Services identified a problem with the Medical Secretariat. Whilst records are now contemporaneous there is a backlog going back to October 2020 that needs addressing. This may be more widespread than Specialist Services.

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
BAF46	If EPUT is unable to secure low secure and other placements for young people with complex care needs then an increase in restraints and assaults may be seen resulting in potential harm to patients and staff	AG	Quality	Monitoring	• Actions logs and feedback from the system wide clinical reference group and associated workstreams as well as clinical design group for clinical care models are used to monitor this risk in conjunction with Specialist Services • Work streams continue as part of the New Care Models work. At this stage, there is no proposed increase in LSU capacity in the system. However, a focus on preventative work across the system is suggested to mitigate escalation • Draft business case for CAMHS submitted to the Consortia (provider collaborative) and other forums including EPUT Board. This will return to EPUT Board in January for final agreement. • Reflected at national and regional level • Risk reduced to threshold on Specialist Services DRR	Risk score recommended to reduce to threshold and close 4 x 2 = 8 Target March 2021 4 x 2 = 8 Above threshold	• Formal business case • Trial temporary leave to facilitate discharge, transfer currently impacted, and curtailed by Covid restrictions • A new risk is under consideration around acuity and service provision for children and young people

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
BAF50	If EPUT does not have the skills, resource and capacity to deliver high quality business as usual care and services, manage the C19 pandemic, C19 mass vaccination programme, EU Exit Transition, regulatory responses, independent inquiry and increased variation of demands on corporate services then it may not achieve the deliverables on this wide range of priorities and pressures resulting in not achieving organisational objectives, unsustainability in corporate services, stagnation of risks and failure to maintain our position within the wider health economy	PS and all Executives	People Innovation and Transformation	Action Plan	• BAF action plan in place from previous consolidated risks with 14 actions, with nine completed and five in progress to timescale • Participation by EPUT on system calls • Staffing risk assessment in progress through Command structure • Some reduced Committee process throughout December and January except for patient safety relates Committees • Staff redeployment from Corporate Services and wider use of agency staff • EU exit (transition) element of risk has diminished since deal reached • Identifying top senior talent and succession planning for key leadership posts • High performing leaders becoming Quality Champions to drive Trust priorities • Quality improvement hubs driving continuous improvement • Root cause analysis on staff absence • Staff support and wellbeing initiatives • Recruitment and retention strategies • Establishment model aligned to patient acuity • Ward leadership handbook	Risk score unchanged Feb/Mar 5 x 4 = 20 Ongoing for duration of pandemic Threshold 5 x 2 = 10 This risk will carry forward to 2021/22	• Community Leader's handbook • Embed competency framework to support succession planning • Link mortality work to PSIRF as part of nursing Directorate • Ensure mortality reporting (data analysis) building into work of information team • Developing Datix IQ Cloud • Address issues of potential burnout among all groups of staff • Address pace of change as part of safety initiatives • Ensure new strategies (safety first safety always, operational strategy and financial plan) are implemented in an integrated way • Develop new action plan for 2021/22

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
Strategic Objective 2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts - Lead Director: Paul Scott supported by all other Executive Directors - Impact of not achieving the Strategic Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score							
Corporate Objective 3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response – Lead Director: Sean Leahy supported by all other Executive Directors – Impact of not achieving the Corporate Objective 4 x 3 = 12							
BAF35	If EPUT does not develop a culture based on what is morally right and fair in response to incidents and errors, and is unable to demonstrate that lessons are learnt, then protection of both staff and patients is reduced which may result in poor quality services and patient experience together with lack of actions consistent with prevention impacting on CQC rating	SL/NH	People Innovation and Transformation	Monitoring	• Monitored through People Plan, WRES, WDES, Communications and PSIRF implementation • 'Safety First Safety Always' Patient Safety Strategy approved at January Board • Disciplinary/grievance policies under review • HR team is retrospectively reviewing disciplinary hearings with a cultural focus • HR team meeting with BAME colleagues to listen to disciplinary and grievance experiences • WRES action plan updated • Live events on lunchtime learning promote the people plan and culture • Cultural intelligence training for Board and Senior Leadership complete with roll out • Culture of patient safety/QI built into induction programme effective from January 2021 with 90 minute session • Service user and carer experience framework approved promoting co-production • Patient safety/QI programme offered to service users and carers from Feb 2021	Risk score recommend reduction to threshold 4 x 2 = 8 Recommend closure of this risk	• Board Development Session on EPUT People Plan • Implementation Plan for Safety First Safety Always Strategy • Head of Assurance has set up meeting with Executive Directors of Nursing, People and Culture and Operations to discuss an alternative risk

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
BAF61	If EPUT fails to embed, recognise and celebrate equality and diversity as part of its culture and conversation then the Trust may struggle to address inequalities resulting in poor staff and patient experience and a challenge to the CQC rating for well-led, and exposure to legal challenge for discrimination	SL supported by all Executives	PIT	TBA	• Equality and Diversity events • Be You programme • This risk was reworded in Dec 20 to consolidate a similar risk within the People and Culture Directorate • Equality and Diversity networks in place • Recommend escalation to BAF	Risk score recommended to escalate from CRR and increase score to 5 x 4 = 20 from 3 x 4 = 12 Target March 2021 3 x 2 = 6	• People and Culture Team will be undertaking an Equality and Diversity root and branch review
BAF62	If EPUT does not have adequate systems and processes in place to deploy staffing then it will not support staff wellbeing and patient safety resulting in a failure to deliver our Safety First, Safety Always Strategy	TS/SL/NH/AG/all Executives	PIT	Action Plan to be developed	• Diagnostic work being undertaken by Newton around Health Rosters, reliance on temporary staff and establishment budgets • Proposal presented to EOSC regarding staffing establishment issues and the larger piece of work that needs to take place in reviewing staffing numbers and skills mix to mitigate this risk	New risk Mar Score 5 x 4 = 20 Target Nov 21 5 x 2 = 10	• Develop action plan from diagnostic work
BAF41	If recurrent CIPs for 2020/21 are not identified then delivery of the programme is compromised resulting in a challenge to the sustainability of EPUT going forward	TS (financial)	F&P	Monitoring	• The Trust's internal Cost Improvement target for 20/21 is now £8.6m from the initial £11.7m because of the suspension of 2020/21 national efficiency requirement • A total of £7.1m remains to be identified recurrently from historic shortfalls	Risk score unchanged Feb/Mar 3 x 4 = 12 Target March 2021 Threshold 4 x 2 = 8 This is a constant risk on the BAF and will carry over to 2021/22	• The focus remains on delivery of the full recurrent efficiency • Executive sign-off meetings need to take place to ensure full approval of agreed schemes

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
BAF42	If the Covid19 crisis continues then EPUT may experience an adverse impact on its financial plan as a knock on from system wide financial planning resulting in additional risk for EPUT to its sustainability	TS	Finance & Performance	Monitoring	• The revised planned deficit is £8.3m • The Trust has received an additional £8.3m income from NHSE/I in recognition of national planning process income error assumptions • In February 2021 M11 as a consequence of the above the Trust recorded a surplus of £6.2m against the planned deficit of £1.3m (year to date surplus £2.2m against the planned deficit £6.8m) • The forecast outturn is £2.7m deficit • M11 year to date Covid19 costs of £13.3m with M7-M12 recovery anticipated from M&SE and H&CP • M11 cash was £112.9m, which remains better than planned • Continuous monitoring through reporting to F&PC, EOSC, and the Board	Risk score unchanged Feb/Mar 4 x 3 = 12 Target March 2021 Threshold 4 x 2 = 8 This risk will carry forward during the C19 pandemic as financial regime in place will continue into Q1/2	• Continue to monitor financial situation and Covid19 costs to ensure recovery
BAF43	If EPUT does not plan for an expected surge in demand for Mental Health services or physical CHS and rehabilitation during or post C19 then skills and capacity may not be in place resulting in long waiting lists and self-harm in the community	AG	People Innovation and Transformation	Monitoring	• A phased plan is in place to manage the surge demand alongside winter planning • From October – April 2021 existing capacity, flow and escalation initiatives are in place • From Nov to Mar 21 winter funding schemes to be signed off, implemented/ monitored, underpinned by MH Winter KLOE's • Topaz Ward planned to provide additional mental health surge capacity • 18 spot purchase beds available at The Priory • Allocation of additional funding confirmed on STP/ICS footprints to support capacity and flow; schemes in development which address both process and capacity • This may be a longer term risk but all current resources are targeted at management of the pandemic incident	Risk score unchanged Feb/Mar 5 x 4 = 20 Target date March 2021 Threshold 5 x 2 = 10 This risk will carry forward into 2021/22	• Contingency plans include exploring use of other estate options for additional beds (Kelvedon) or a COVID19 ward for unwell patients who are not a ligature risk • Issues with Topaz Ward refurbishment resolved and ESOG will be asked to sign off by end of March prior to opening – now likely to be early April

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
Corporate Objective 4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance – Lead: Paul Scott supported by all Executive Directors - Impact of not achieving the Corporate Objective 5 x 3 = 15 risk score							
BAF44	If EPUT does not embed learning from C19 then changing, evolving and delivering new pathways is compromised resulting in a challenge to retention/ recruitment, establishment and skills mix as well as recovery of services	AG	People Innovation and Transformation	Action Plan	• A full action plan is in place with 10 actions (two completed and eight in progress) • C19 is now in phase 4 (Phase 1, 2 and 3 completed) • Executive Lead is Executive Chief Operating Officer • Reset and recovery group suspended • EPUT has taken part in system learning across all systems • Service leads continue to adjust local arrangements to ensure the safety of services and to maintain new operational practices introduced as part of C19 locally • This risk currently has a watching brief • Policy changes recorded • Covid secure buildings	Risk score unchanged Feb/Mar 4 x 3 = 12 Target March 2021 Threshold 4 x 2 = 8 Recommend take to threshold for closure and replace with BAF62	• Reconvene Reset and Recovery Group at appropriate point in time • Review all system changes and new national digital software introduced as part of C19 to make recommendations to Board on future adoption of software in line with national arrangements longer term • Incentivise new ways of working and explore opportunities to support more flexible working • Consider patient journey by individual need using the right tools to deliver future care
BAF47	If EPUT limits bed occupancy to the 85% ambition on mental health inpatient wards to facilitate social distancing requirements then there may be a shortfall in beds resulting in delays to admissions or an increase in out of area placements	AG	Finance & Performance	Action Plan	• AG and TS are Executive sponsors for operational plan, which will include capacity management • 18 beds commissioned from Priory • 17 beds will open on Topaz Ward in March 21	Risk score unchanged Feb/Mar 4 x 4 = 16 Recommend take to threshold and close Target date March 2021 4 x 2 = 8	• Ambition may be 85% as RCP – not about social distancing but safe level of occupancy and certain level of acuity

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Completion Date / Assurance Proposed 2021/22 status	Actions outstanding / further mitigating actions required
Strategic Objective 3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve - Lead Director: Nigel Leonard supported by all other Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score							
BAF51	If EPUT does not have sufficient oversight and scrutiny to effectively direct and implement the mass C19 vaccination programme across MSE and SUNEE systems then it may not meet the deliverables and timescales requested by NHSE/I resulting in potential programme delays	NL	Quality	Monitoring	• A risk register set up specifically related to the Mass Vaccination programme to strengthen governance around the project • Urgent work underway to develop new BCPs ready for testing as part of a table-top exercise to look at emergency planning for each centre as it comes on line • Programme Board in place to manage this • Allocating some sites to be operated by acute partners • Working with Local Resilience Forums, Local Authorities and other providers to deliver the programme • Certainty of vaccination supply will be confirmed by Mid-March	Risk score unchanged 5 x 3 = 15 Target date is ongoing for the duration of the mass vaccination programme This risk will carry forward to 2021/22	• No contracts have been issued to us and at this stage we are unable to sub-contract any elements of the service to other organisations

Table 2 – Mapping of risks against 5 x 5 scoring matrix

	RISK RATING					
	Consequence					
Likelihood	1	2	3	4	5	
1						
2				~~BAF9~~ ~~BAF46~~	BAF38 ~~BAF55~~	
3				BAF23 ~~BAF35~~ BAF42 ~~BAF44~~ BAF32	BAF4 BAF10 BAF36 BAF51	
4			BAF41	~~BAF47~~	BAF43 BAF45 BAF50 BAF53 BAF54 BAF57 BAF58 BAF61 BAF62	
5						

Table 3: Movement on scoring – period from April 2019 to March 2021 *Notes: Risks closed for over two years removed from table*

Risk ID	Initial Score	Apr 19	May 19	Jun 19	July 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Risk ID
BAF4	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF4
BAF6	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔																BAF6
BAF9	16	12↔	12↔	12↔	12↔	12↔	16↑	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	8↓	8↔	8↔	8↔	close	BAF9
BAF10	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF10
BAF13	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	6↓											BAF13
BAF14	12	12↔	12↔	12↔	12↔	12↔																				BAF14
BAF15	15	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	Close					BAF15
BAF16	12	12↔	12↔	12↔	12↔	12↔																				BAF16
BAF18	15	20↔	16↓	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔											BAF18
BAF20	12	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	Close				BAF20
BAF21	15	8↔	8↔	8↔	8↔	8↔	8↔																			BAF21
BAF22	16	9↔	9↔	9↔	9↔	9↔	9↔																			BAF22
BAF23	15	8↓					20↑	20↔										Esc	20	20↔	16↓	16↔	12↓	12↔	12↔	BAF23
BAF28	16	12↔	12↔	12↔	12↔	12↔																				BAF28
BAF30	12	12	12↔	12↔	12↔	12↔	12↔																			BAF30
BAF31	16	16	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	Close					BAF31
BAF32	16	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	BAF32
BAF33	12					New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	6↓											BAF33
BAF34	16						New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	8↓					BAF34
BAF35	16						New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	close	BAF35
BAF36	15								New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF36
BAF37	15										New	15	15↔													BAF37
BAF38	15											New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	10↓	10↔	10↔	10↔	10↔	BAF38
BAF39	20											New	16													BAF39
BAF40	12													New	12	16↑	16↔	16↔	12↓	12↔	Close					BAF40
BAF41	16													New	16	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	BAF41
BAF42	12													New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	BAF42
BAF43	20													New	15	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	BAF43
BAF44	12														New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	close	BAF44
BAF45	12														New	12	12↔	12↔	12↔	12↔	12↔	16↑	20↑	20↔	20↔	BAF45
BAF46	16															New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	close	BAF46
BAF47	16																New	16	16↔	16↔	16↔	16↔	16↔	16↔	close	BAF47
BAF48	16																New	16	16↔	16↔	Close					BAF48
BAF49	15																New	15	15↔	15↔	8↓					BAF49
BAF50	20																			New	20	20↔	20↔	20↔	20↔	BAF50
BAF51	20																			New	20	20↔	20↔	15↓	15↔	BAF51
BAF52	20																			New	20	20↔	20↔	Close		BAF52
BAF53	20																			New	20	20↔	20↔	20↔	20↔	BAF53
BAF54	20																				New	20	20↔	20↔	20↔	BAF54
BAF55	20																				New	20	15↓	15↔	close	BAF55
BAF56	20																				New	20	Merge	Close		BAF56
BAF57	20																				New	20	20↔	20↔	20↔	BAF57
BAF58	20																				New	20	20↔	20↔	20↔	BAF58
BAF59	20																			Esc	from	CRR	20	Close		BAF59
BAF61	20																								20	BAF61
BAF62	20																								20	BAF62

Table 4: Milestones – under development (*intermittent)

Risk ID	Initial Score	Length of time on BAF	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Risk ID
BAF4	15	> 2 years																									BAF4
BAF9	16	> 2 years						16↑								12↓						8↓				Closed	BAF9
BAF10	12	> 2 years	15↔								20↑					15↓											BAF10
BAF20	12	> 2 years	15↓																				Closed				BAF20
BAF23*	15	> 2 years	8↓					20↑													20↔	16↓		12↓			*BAF23
BAF32	16	> 2 years	16																			12					BAF32
BAF35	16	> 1 year						New	16																	Closed	BAF35
BAF36	15	> 1 year								New	15																BAF36
BAF38	15	> 1 year											New	15													BAF38
BAF41	16	> 6 months													New	16					20↑	12↓					BAF41
BAF42	12	> 6 months													New	12					16↑	12↓					BAF42
BAF43	20	> 6 months													New	15	20↑										BAF43
BAF44	12	> 6 months														New	12									Closed	BAF44
BAF45	12	> 6 months														New	12						16	20↑			BAF45
BAF46	16	> 6 months															New	16								Closed	BAF46
BAF47	16	>6 months																	16							Closed	BAF47
BAF48	16	>6 months																	16			Closed					BAF48
BAF49	15	>6 months																	15			Closed					BAF49
BAF50	20	<6 months																			New	20					BAF50
BAF51	20	<6 months																			New	20			15↓		BAF51
BAF52	20	<6 months																			New	20			Closed		BAF52
BAF53	20	<6 months																			New	20					BAF53
BAF54	20	<6 months																				New	20				BAF54
BAF55	20	<6 months																				New	20	15↓		Closed	BAF55
BAF56	20	<6 months																				New	20	Merge	Closed		BAF56
BAF57	20	<6 months																				New	20				BAF57
BAF58	20	<6 months																				New	20				BAF58
BAF59	20	<6 months																						20	Closed		BAF59
BAF61	20	New																								20	BAF61
BAF62	20	New																								20	BAF62

Appendix 2

Key Performance Indicators for Board Assurance Framework March 21 Q4

KPI reference	Key performance indicator (KPI)	Target	Oct 20	Nov 20	Dec 20 * recommended risks included	Q3 YTD * recommended risks included	Jan 21	Feb 21	Mar 21 * recommended risks included	Q4 YTD * recommended risks included
Total number of risks on BAF			**22**	**20**	**24* (19)**	**24* (19)**	**25**	**22**	**24* (20)**	**24* (20)**
KPI 1	% risks with action plans completed by target completion date	90%	100% (1)	0	0	Q3 100% (1)	0	0	100% (2)	100% (2)
KPI 1a	Number of risks open with action plans fully completed	Information only	0	0	0	0	0	0	2* (0)	2* (0)
KPI 1b	Number of risks with open action plans	Information only	11	10	12*(11)	12*(11)	9	10	10* (8)	10* (8)
KPI 1c	Number of risks with no action plan	Information only	10	10	14*(13)	14*(13)	15	12	14* (12)	14* (12)
KPI 1d	Number of risks closed/de-escalated in month (YTD)	Information only	0	6	1*	Q3 7*(6) YTD 11*(10)	0	3	4* (0)	7* YTD 18*(14)
KPI 1e	Number of new/ escalated risks in month (YTD)	Information only	0	4	5*	Q3 9*(4) YTD 19*(14)	0	0	2* (0)	2* (0) YTD 21*(19)
KPI 2	% stagnant risks (no movement)	Less than 30%	68% (15)	40% (8)	57.8% (11 of 19)	57.8%	56%	45%	55%	55%
KPI 2a	% of increased risks	Less than 10%	18% (4)	20% (4)	26% (5 of 19)	26%	0%	9%	10%	10%
KPI 2b	% of decreased risks	60%	13% (3)	25% (5)	26% (5 of 19)	26%	8%	4.5%	10%	10%
KPI 3	% of current risks on BAF over 12 months	Less than 40%	45% (10)	35% (7)	21% (4 of 19)	21%	8%	9%	15%	15%
KPI 3a	% of current risks on BAF over 24 months	Less than 30%	22.7% (5)	15% (3)	15.7% (3)	15.7%	20%	22.7%	25%	25%
KPI 3b	% of current risks on BAF over 12 months (excluding known ongoing risks)#	0%	36.8% (7 of 19)	23.5% (4 of 17)	6% (1 of 16)	6%	0%	0%	0%	0%

Notes:

* recommended risks (March) included – figure in parenthesis does not include these risks and % calculations do not include recommended risks

#known ongoing risks – BAF4 Fire Safety BAF10 Ligature Reduction BAF41 CIPs

BAF23 not included in KPI3/3a/3b – intermittent on BAF over two-year period

Any action plans of risks carried forward into a new financial year are reviewed and updated

- KPI 1 % risks with action plans completed by target completion date – RAG *Green*
- KPI 2 % stagnant risks – RAG *Red;* 2a % increased scores – RAG *Green* and 2b % decreased scores – RAG *Red*
- KPI 3 % current risks on BAF over 12 months – RAG *Green* 3a % current risks on BAF over 24 months – RAG *Green* 3b % current risks on BAF over 12 months (excluding known ongoing risks) – RAG *Green*

Appendix 3 - Table 1 – CRR 20/21 Summary of Risks as at March 21

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

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
Strategic Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe and innovative services – Lead Director: Natalie Hammond – impact of not achieving the strategic objective C5 x L3 = 15 risk score						
Corporate Objective 1: To provide safe and high quality services during Covid19 pandemic – Lead: Paul Scott supported by all Executive Directors – impact on not achieving the strategic objective C5 x L3 = 15 risk score						
CRR11	If EPUT fails to implement and embed its Suicide Prevention Strategy into Trust services then it may not track and monitor progress against the ten key parameters for safer mental health services resulting in not taking the correct action to minimise unexpected deaths and an increase in numbers	NH/MK	Quality Committee and Sub-Committees	• A campaign of awareness took place between 10 September and 10 October with a number of live events that were well supported • Robust implementation plan in place • System wide learning and teaching • Working with CCGs • Sets with NHSE/ I • Locally reflective sessions • Schwartz Rounds (funded project with structure and governance)	Risk score unchanged Feb/Mar 4 x 3 = 12 Target March 2021 4 x 2 = 8	• A plan in place for review of the 2018-20 Suicide Prevention Strategy
CRR56	If EPUT continues to operate global restrictions in in-patient mental health services, then patient experience is compromised resulting in further regulatory scrutiny	AG/NH	Restrictive Practice Group	• Risk assessments continue on wards • 5 steps to managing global restrictions in inpatient wards was introduced • Work ongoing within Older People's wards • Managing higher occupancy levels because of C19 pandemic and winter pressures • Recommend for closure	Risk score recommended to reduce and be closed 3 x 2 = 6 Target March 2021 3 x 2 = 6	• Monitor through RPG the potential interpretation of 'global restrictions' in the context of enforcing social distancing and staggered mealtimes due to C19 but deemed important for staff and patients at the current time • Risks will be reviewed in line with the Patient Safety Strategy

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR64	If EPUT experiences further serious inpatient safety incidents then high quality patient care is compromised resulting in additional regulatory scrutiny	AG/PS	LRRG	• Risk closely aligned to BAF10 Ligature reduction • Information requests to CQC responded to in a timely manner • Joint meetings across operations to encompass learning from serious incidents	Risk score unchanged Feb/Mar 4 x 3 = 12 Target March 2021 4 x 2 = 8	• Serious incident resulting in death related to an abscond from Finchingfield saw this risk materialise with an unannounced visit from CQC • Serious incident resulting in death related to ligature on Henneage also saw this risk materialise
CRR75	If EPUT does not achieve ECTAS accreditation then there may be adverse media coverage resulting in a lack of public confidence in the services offered to our patients	MK	ESOG	• EPUT is working to ECTAS standards • EPUT is prepared for the accreditation inspection	New risk 4 x 3 = 12 Target date June 21 4 x 2 = 8	• Awareness of media/social media activism related to ECT • Delay in accreditation is due to Covid19
CRR48	If EPUT is unable to suitably fill consultant vacancies across clinical services on a substantive or locum basis then the Trust may not be able to deliver safe and effective services, resulting in poor patient flow and possible patient harm	MK	Medical Staffing Committee	• Cover maintained by locum and agency staff • GMC approval to allow overseas doctors to work in the UK • National Fellowship Scheme in place	Risk score unchanged Feb/Mar 4 x 4 = 16 Target March 2021 4 x 2 = 8	• Continue to recruit to vacancies - there are 20 Consultant vacancies, of which Locum posts cover 16. Locums remain hard to source.
CRR68	If EPUT does not complete annual General Workplace Risk Assessments or they are of poor quality then its statutory requirement is not met resulting in non-compliance with CQC well led standards	PS supported by all Execs	HSSC	• A Task and Finish Group within the Risk, Compliance and Assurance Directorate reviewed and simplified risk assessment paperwork, looking at other Trusts' paperwork as well as HSE guidance • Taking legal advice on proposed documentation • Discussion through HSSC	Risk score unchanged Feb/Mar 4 x 4 = 16 Target March 2021 4 x 2 = 8	• Formal launch of new GWPRA documentation

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR74	If EPUT inpatient areas do have robust airlocks in place for access/egress then patients detained under the MHA may abscond resulting in potential serious harm to patients, staff or the public	TS/AG	Executive Safety Oversight Group	• Recent incident on Finchingfield resulted in the death of a patient, injury to a member of staff and a focused inspection by the CQC – all action taken as required by the CQC inspection report	Risk score unchanged Feb/Mar 5 x 3 = 15 Target March 21 5 x 2 = 10	• Linden Centre door set scheduled for delivery w/c 22 March with completion by 31 March • Rochford due to completion w/c 15 March with air lock fully operational on 19 March
CRR76	If EPUT continues to receive inferior quality towels and bedding from its contractor then ligature incidents are increased resulting in possible serious patient harm	PS/TS/AG	ESOG/LRRG	• Head of Estates and Facilities in communication with new contractor • Observation and engagement • Datix analysis being undertaken	New Risk Score C5 x L4 = 20	• Ensure patient privacy and dignity is not compromised • Enhanced observation and engagement • Further discussion with contractor
Strategic Objective 2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts - Lead Director: Paul Scott supported by all other Executive Directors - Impact of not achieving the Strategic Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score						
CRR40	If the Trust is not adequately prepared, or there is a lack of funding for the cyber team, it could be subject to a cyber-attack that compromises clinical or corporate IT systems, and the consequent cost pressure may result in a financial risk to EPUT	TS	ESOG PST	• Windows 10 upgrade licences now purchased • Cyber Essentials Accreditation • Cyber Team in place • Robust updates and patching	Risk score unchanged and at threshold Feb/Mar 4 x 2 = 8	• None

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR53	If the dormitory elimination project plan is not implemented in line with agreed timescales then there could be a delay to providing single bedroom accommodation by 2021 which could potentially impact on CQC ratings and patient experiences.	TS	Capital Group	• Phases 1 and 2 completed • Tender specification document issued to contractors end Jan 21 • Phase 3: Cherrydown and Kelvedon – redundant pipe work complete. Infrastructure on Cherrydown installed – cabling, new heating pipework, potable water and domestic water services. Walls, ceiling constructed, and being plastered. • Phase 4 moving Cherrydown Ward to Langdon Unit and Sankey House and relocate Kelvedon Ward to Willow Ward completed • Phase 8 alterations to the Assessment Unit to reduce bed numbers to 18 and create better male and female segregation	Risk score unchanged Feb/Mar 4 x 3 = 12 Target date December 2021 – will carry forward	• Phase 3: Cherrydown and Kelvedon Ward – Kelvedon slippage due to additional works to remove old pipes and access issues. Late request for assisted bathrooms and these will be in the Assessment Unit. Some access issues due to Covid. Additional work taking place to BMHU in order to remove ligature points, improving ventilation and heat loss as well as aesthetic appearance. • Phase 4 Grangewater Ward/ Thorpe Ward – works include refurbishing the ward to 16 single en-suite bedrooms. Work planned 21/22. Thorpe Ward will become a staff rest and change area with some offices, touchdown, meeting, conference and training rooms

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR34	If EPUT does not train and support staff effectively in suicide prevention then staff may not have the necessary skills or confidence to support suicidal patients resulting in self-harm and death.	NH/MK	Suicide Prevention Group	• Training is now virtual • Suicide prevention month provided a range of events and opportunities for learning for all staff • Access and assessment services no longer exist in West and North East are moving away from this service to new community assessment model. The new Crisis 24 team are also taking referrals • Community transformation paper signed off in NEE, redesign of CMH pathways and provision of IAPT through EPUT • Transparent monitoring through contracting • MH/LD network members discussion on Suicide Prevention Training	Risk score unchanged Feb/Mar 3 x 3 = 9 Target March 2021 3 x 2 = 6	• Exploring Connecting for People training virtual delivery • Improvement trajectory and reporting on suicide prevention training. • Raise frequency of training and adherence to targets with workforce as budget/resource holder – continue dialogue • Cover required for appointed suicide prevention trainer for 12 months commencing late 2021 • Explore whether role can be moved to Nursing Directorate to provide closer support/management and oversight
CRR49	If urgent care pathway services receive high levels of referrals which do not meet the threshold for secondary services then the ability to respond is reduced resulting in poor patient experience	AG	CCG QCPM	• Access and assessment services no longer exist in West and North East are moving away from this service to new community assessment model. The new Crisis 24 team are also taking referrals • Operations leads have reviewed the wording of this risk and cross referenced with surge planning • Community transformation paper signed off in NEE, redesign of CMH pathways and provision of IAPT through EPUT • Transparent contract monitoring	Risk score at threshold 3 x 2 = 6 March 21 3 x 2 = 6 Recommend closure of risk	• By April 21 EPUT will have more control over referrals from IAPT into core services • Community transformation is a phased model • Meet 28 day target

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR72	If EPUT does not have a suitable IT/communication systems in place for its STaRS and dual diagnosis services then patients may not receive appropriate care, treatment or medication, partners may not be able to access clinical records in a timely manner, and data integrity may be compromised, resulting in potential serious harm to patients, staff vulnerability and poor system working	AG/TS	SSMG	• Auditing and monthly data cleansing exercises in place • Dual Diagnosis working group restarted and reviewing Policy and Procedure • Pilot in West using Pando for Consultants at Derwent Centre to ping each other drug and alcohol cases to check with STaRS	Risk score unchanged Feb/Mar 4 x 3 = 12 Target March 2021 4 x 2 = 8	• Reinforce importance of Datix recording to map incidents and build evidence of problems • Theseus does not constitute an official medical record as content may be deleted – numerous difficulties experienced with Theseus including non-connection to HIE and no access to prescribing activity -ECC advise Theseus 2.0 in development • Open Road not checking if patient known to MH and vice versa – poor system working and communication • Plan to move to SystmOne for prescribing • EPUT ITT working towards a resolution
Corporate Objective 3: Deliver our people agenda for 20/21 with adjustments in line with the Covid19 response – Lead Director: Sean Leahy supported by all other Executive Directors – Impact of not achieving the Corporate Objective 4 x 3 = 12						
CRR14	If EPUT does not continue to work on staff morale then it may not be able to deliver high quality services resulting in a challenge to transformational change, patient experience and outcomes	SL	WTG	• Thank you vouchers sent to staff • Staff are saying they are tired and fatigued as opposed to having low morale • EPUT hero badges sent to all staff	Risk score unchanged Feb/Mar 4 x 3 = 12 Target March 2021 4 x 2 = 8	• Reviewing and refreshing communication strategies

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR57	If EPUT fails to embed, recognise and celebrate equality and diversity as part of its culture and conversation then the Trust may struggle to address inequalities resulting in poor staff and patient experience and a challenge to the CQC rating for well-led, and exposure to legal challenge for discrimination	SL supported by all Executives	Equality and Inclusion Sub-Committee	• Equality and Diversity events • Be You programme • This risk was reworded in Dec 20 to consolidate a similar risk within the People and Culture Directorate • Equality and Diversity networks in place • Recommend escalation to BAF	Risk score recommended to increase to 5 x 4 = 20 from 3 x 4 = 12 and escalate to BAF Target March 2021 3 x 2 = 6	• People and Culture Team will be undertaking an Equality and Diversity root and branch review
Strategic Priority 3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve - Lead Director: Nigel Leonard supported by all other Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						
Corporate Objective 2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans - Lead Director: Nigel Leonard supported by all other Executive Directors - impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						
CRR45	If EPUT does not achieve mandatory training policy requirements then patient and staff safety may be compromised resulting in additional scrutiny by regulators and not meeting the IG Toolkit requirements	SL supported by all Executives	Training and Development Group	• Local trajectory in place for safety focused and IG mandatory training as a priority	Risk score unchanged Feb/Mar 4 x 4 = 16 Target March 2021 4 x 2 = 8	• Plan to return to recommended update training intervals • All staff to ensure that mandatory training is up-to-date as soon as possible, including Information Governance and fire training for all staff and Grab Bag and TASI training for frontline colleagues • Managers are reminded to check training trackers and prompt staff whose training is overdue
Corporate Objective 4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance – Lead: Paul Scott supported by all Executive Directors - Impact of not achieving the Corporate Objective 5 x 3 = 15 risk score						

Table 2 – Mapping of risks against 5 x 5 scoring matrix

	RISK RATING				
	Consequence				
	1	2	3	4	5
Likelihood 1					
Likelihood 2			~~CRR56~~ ~~CRR49~~	CRR40 ~~CRR57~~	
Likelihood 3			CRR34 CRR75	CRR11 CRR14 CRR53 CRR64 CRR72	CRR74
Likelihood 4				CRR45 CRR48 CRR68	
Likelihood 5					CRR76

		Agenda Item No: 8b (i)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 March 2021**

Report Title:	**Board of Directors Audit Committee Assurance Report**					
Executive/Non-Executive Lead:	Janet Wood, Chair					
Report Author(s):	Carol Riley, Audit Committee Secretary					
Report discussed previously at:	Assurance Reports provided to the Board following Audit Committee Meetings.					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors: • Assurance to the Board that the duties of the Audit Committee, which include Governance, Risk Management and Internal Control, have been appropriately complied with.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

- Internal Audit Progress Report 2020/21
- Internal Audit Annual Plan
- LCFS Progress Report
- External Audit
- Waiver of Standing Orders
- Asset Verification and Statement of Financial Position Write Offs
- Impaired Debt Write Offs
- Losses and Special Payments
- Non Consolidation of Charity Accounts 2020/21
- Self Assessment Checklist

- Annual review of Terms of Reference
- Annual Workplan

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
Appendix 1 – Terms of Reference

Lead
 Janet Wood **Chair of Audit Committee**

Agenda Item: 8b (i)
Board of Directors
Meeting: 31 March 2021

EPUT

ASSURANCE REPORT FROM THE AUDIT COMMITTEE CHAIR

1.0 PURPOSE OF REPORT

This report is provided by the Chair of the Audit Committee, a sub-committee of the Board of Directors to provide assurance to Board members that the duties of the Audit Committee, which include Governance, Risk Management and Internal Control have been appropriately complied with.

2.0 EXECUTIVE SUMMARY

Audit Committee Meeting 16 March 2021

The Audit Committee met on the 16 March 2021. The meeting previously arranged for the 15 January 2021 was cancelled due to the Covid pandemic. However, papers were circulated to members for comments and the Chair of the Audit Committee, Chief Finance Officer and the Head of Financial Accounts had a brief meeting on the 15 January 2021 whereby minutes of the 19 November 2020 were approved under Chairs Action. A file note was issued to members.

At the meeting held on 16 March 2021 the following matters were discussed:

The Audit Committee

1. **Internal Audit**

Internal Audit Progress Report 2020/21
The following reports have been finalised and issued with the following assurance:

- Patient Experience (moderate assurance)
- Safeguarding (design substantial assurance and effectiveness moderate)

The following reports are due to be presented to the Audit Committee in May 2021.

- Inpatient Deaths
- Data Security & Protection

Internal Audit 2021/22 Annual Plan
The Committee approved the above annual plan.

LCFS Progress Report

NHSCFA
The NHSCFA are in the process of issuing new standards. The new standards will be presented to the May 2021 Audit Committee.

Procurement Exercise
The recent procurement exercise carried by the NHSCFA showed no discrepancies for the Trust.

LCFS 2021/22 Annual Workplan
The above workplan is due to be presented to the Audit Committee in May 2021.

2. **External Audit**

External Audit Plan 2021/22
The Committee approved the Provisional Audit Plan for 2020/21

3. **Waiver of Standing Orders**
During the period from 1 January 2021 to 28 February 2021, standing orders for competitive quotations were waived on ten occasions to the value of £513,148 (including VAT). It was noted that one of these related to the mass vaccination programme which totalled £297,585.

4. **Asset Verification and Statement of Financial Position Write Offs**
The Trust's annual verification of fixed assets has now been completed. The list of assets unable to be verified or have become obsolete totals £3,080.

The Committee approved the write down of Oxehealth totalling £206,420.06. The Committee had previously approved the write down of £188,454.83 prior to accounting treatment finalisation.

5. **Impaired Debt Write Offs**
The total write offs as at the 28 February 2021 totals £17,346.25.

6. **Losses and Special Payments**
The report highlighted that as at the end of Month 10 the Trust is reporting losses and special payments of £5,047.

7. **Non Consolidation of Charity Accounts 2020/21**
The Committee approved the above.

8. **Self Assessment Checklist**
The Committee approved the above.

9. **Annual Review of Terms of Reference**
The terms of reference were approved subject to minor amendments and attached at Appendix 1 for approval by Board.

10. **Annual Workplan – 2021/22**
The Committee approved the above.

3.0 MANAGEMENT OF RISK

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

4.0 NEW RISKS

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

5.0 ACTION REQUIRED

The Board of Directors are asked to:

1. Note the summary of the meeting held on 16 March 2021
2. Confirm acceptance of assurance given in respect of risk
3. Request further action/information as required.

Janet Wood
Non Executive Director
Chair of Audit Committee

Appendix 1

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

AUDIT COMMITTEE
TERMS OF REFERENCE

1. AUTHORITY

1.1 The Audit Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future board of directors meetings

1.2 The Audit Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by this Committee

1.3 The Audit Committee is authorised by the Board of Directors to instruct the in-house legal advisors and other professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions

1.4 The Audit Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions

1.5 These terms of reference shall be read in conjunction with the Trust's Scheme of Delegation, Standing Orders, Constitution and Standing Financial Instructions, as appropriate.

2. ROLE

2.1 The Committee is authorised by the Board of Directors to investigate any activity within the Trust. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee

2.2 The remit of this committee and delegated limits is contained within the Scheme of Delegations.

3. FUNCTIONS

3.1 The duties of the Committee shall include the following:

Governance, Risk Management and Internal Control

3.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives

3.3 In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and Care Quality Commission essential standards of quality and care), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board

- arrangements by which staff of the Trust may raise, in confidence concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Counter Fraud Authority
- proposals for tendering for both Internal or External Audit services and the Local Counter Fraud Specialist services or for purchase of non-audit services from contractors who provide audit services

3.4 In carrying out this work the Committee will primarily utilize the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness

3.5 The Committee will create an Annual Working Plan setting out proposed actions, priorities and objectives and against which its performance is to be evaluated on an annual basis in accordance with paragraph 12 below

3.6 To receive assurance that the Board Assurance Framework, Corporate Risk Register and the Directorate Risk Registers are properly utilised by the standing committees of the Board of Directors and by the Executive Directors to identify and adequately manage risk and identify mitigating actions.

Internal Audit

3.7 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the Internal Audit strategy, operational plan and more detailed program of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimize audit resources
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- annually reviewing of the effectiveness of internal audit.

External Audit

3.8 The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment of the External Auditor leading to an annual recommendation by the Audit Committee to the Council of Governors regarding the appointment/re-appointment of the External Auditor. This report will include reference to the performance of the external auditor including details such as the quality and value of the work and the timeliness of reporting and fees
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact of the audit fee
- review all External Audit reports before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses
- ensuring that there is a current policy on the engagement of the external auditor to supply non-audit services which has been approved by the Council of Governors
- ensuring that there is a process in place so as to be able to report to the Council of Governors on any matters of significance

- ensuring that there is a process in place which delegates responsibility to the Audit Committee to review and monitor the independence and objectivity of the external auditor.

3.9 The Audit Committee have a responsibility to ensure that the Trust's appointed External Auditors are not compromised in

terms of maintaining their integrity, objectivity and independence (as per section 1.8 of the Code of Audit Practice produced by the National Audit Office) or prohibited from undertaking such work. The Chair of the Audit Committee is required to be consulted with, and approve the use of the Trust External Auditors for any non-audit work prior to their appointment. This does not delegate the approval of expenditure to the Chair of the Committee.

Counter Fraud

3.10 The Committee will:

- review and approve the annual Local Counter Fraud Specialist work plan
- review the effectiveness of the counter fraud strategy
- monitor the implementation of Counter Fraud reports
- consider the annual report of the Local Counter Fraud Specialist.

~~**Local Security Management Specialist**~~

~~3.11 Consider the annual report of the Local Security Management Specialist.~~

Standing Orders, Standing Financial Instructions and Scheme of Delegation (SOs, SFIs and SoD)

3.12 The Committee will:

- review annually the SOs, SFIs and the Scheme of Delegation
- review changes to the SOs, SFIs and the Scheme of Delegation
- examine the circumstances associated with each occasion when SOs are waived and comment as necessary.

Other Assurance Functions

3.13 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation

3.14 These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc).

3.15 Where necessary, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee

Management

3.16 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control, including but not limited to:

- Annual Counter Fraud Report
- Annual Local Security Management Specialist Report
- Annual Report
- Financial Statements
- Annual Internal Audit Plan
- External Audit Report
- Other reports as required (Clinical Audit Annual Report, LSMS Annual Report, Freedom to Speak Up Annual Report, Cyber Security)

3.17 They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to overall arrangements.

3.18 **Annual Accounts Review**
To review the annual statutory accounts for exchequer funds and the Charitable Funds accounts (which subject to an annual materiality test, are not consolidated), before they are presented to the Board of Directors, in order to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- the meaning and significance of the figures, notes and significant changes
- areas where judgement has been exercised
- adherence to accounting policies and practices
- explanation of estimates or provisions having material effect
- the schedule of losses and special payments
- any unadjusted statements
- any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved

3.19 To review the annual report and annual governance statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy

3.20 To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

3.21 **Value for Money (VFM)**
The Committee will consider the appropriateness of value for money projects undertaken by the Trust and receive regular reviews of VFM progress

3.22 The Committee will also consider other topics as defined by the Board of Directors or Council of Governors arising from any sources that are considered by the Committee to be significant to the Trust.

4 SUB COMMITTEES AND SUB-GROUPS	None
5 MEMBERSHIP	Three (3) ~~Four (4)~~ Non-Executive Directors, one of whom must have relevant and recent financial experience
6 IN ATTENDANCE (as required)	• Where limited assurance reports are received from the internal auditors, the Director responsible will be invited to attend the meeting to discuss the report and actions taken • Deputy Chief Finance Officer / Head of Financial Accounts • Executive Chief Finance Officer • Internal Audit Representative • External Audit Representative • Local Counter Fraud Specialist • Chief Executive to present the Annual Governance Statement • Other Directors and officers as requested by the members • At each meeting the Internal or External Auditors will have the opportunity to meet with the Committee without an Executive Director of the Board being present. • Associate Director of IT Business Operations • Chair of the Quality Committee
7 SUPPORT TO COMMITTEE	PA to the Executive Chief Finance Officer, or as agreed by the members
8 ATTENDANCE AT MEETINGS	It is expected that members will attend a minimum of 75% of meetings per year.
9 QUORUM	Two (2) Non-Executive Directors
10 FREQUENCY OF MEETINGS	Meetings shall be held not less than four times a year or more often as the members may deem necessary.
11 REPORTING AND MINUTES	11.1 Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval 11.2 The Committee will report in writing to the Board of Directors after each meeting advising the Committee has met and the decisions it has made. If requested to do so it will provide further information to the Board of Directors including the terms

of any advice it has received and considered

11.3 The Audit Committee will provide to the Board an annual self-assessment report including highlighting areas for improvement.

12. MONITORING OF EFFECTIVENESS

12.1 These terms of reference shall be reviewed by the Board of Directors at least annually.

12.2 The Audit Committee shall undertake an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors and in achieving the Trust's objectives. The Audit Committee shall report to the Board of Directors on the results of this review and consult with the Council of Governors.

13 DATE ORIGINALLY APPROVED

03 April 2017

14 REVIEW DATES

March 2018, March 2019, Final amendments approved on 1 May 2019, March 2020, March 2021

15 NEXT REVIEW DATE

March 2022

		Agenda Item No:8(b)ii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 March 2021**

Report Title:	**Finance & Performance Committee Assurance Report**					
Executive/Non-Executive Lead:	Manny Lewis Chair of the Finance and Performance Committee Paul Scott Chief Executive Officer					
Report Author(s):	Janette Leonard Director of ITT, Business Analysis and Reporting					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors •	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance provided
3 Request any further information or action.

Summary of Key Issues

Performance Report

This month's report has been aligned to the CQC scoring metrics in order to align the monitoring of key performance indicators, using inadequate, Requires improvement and Good as the principles for the prioritisation of focus. This report covers the position for month 11.

In February 2021, there were 25 indicators within target, of which 5 have been identified as **inadequate performance**

- Timeliness of Data Entry
- CPA 12 Month Reviews
- Inpatient MH Capacity (Adults & PICU)
- Out of Area Placements
- Waiting Lists

Executive Chief Operating Officer (ECOO) updated the Committee on the work currently being undertaken to address the 5 areas of inadequate performance.

The ECOO also updated the Committee on the work currently taking place on Inpatient wards and out of area placements both internally and externally alongside NHSE who are working with organisations across Essex to understand the bed demand and the impact on our bed occupancy due to COVID19.

The ECOO also highlighted the continued difficulties with accessing Children's inpatient beds and shared some early discussions that had taken place with Essex County Council on reviewing Tier's 3 and 4 models of care and agreed to keep the Committee updated on progress.

Contract Exception Reporting

Two Contract Performance Notices issued by Mid & South Essex CCG's continue to be on hold for MH RTT, Patient Referred to the MH First Response Team seen within 28 days, and Community MH service users on CPA with a care plan. CCG's have agreed to remove this following several months of target attainment this was formally removed at the beginning of March 2021.

The Committee were assured that these areas of inadequate performance were being managed and were keen to continue monitoring these areas against agreed trajectories at the next meeting.

Financial Position:

The Trusts M11 YTD surplus is £2.2m against the planned YTD deficit of £6.8m. This favourable position is due to the payment received from NHS England in respect of lost income.

Capital resources for the year total £16.7m with expenditure of £9.4m incurred year to date. The Trust continues to forecast and target the full use of its available resources however, this remains a significant risk due to the backend loading of the programme and the impact of the pandemic on the Trust and its suppliers.

Cash balances remain positive and better than planned due to accelerated payments at the start of the financial year which are still to unwind.

Sub-Committee Reports

The committee received 8 sets of Executive Operational Sub-Committee Part one minutes for noting:

- 5th January 2021
- 12th January 2021
- 26th January 2021
- 2nd February 2021
- 9th February 2021
- 16th February 2021

- 23rd February 2021
- 2nd March 2021

Quarter 4 – Board Assurance Framework (BAF) Action Plan Update

The Deputy Director of Compliance and Assurance updated the committee on the current position with the progress against the BAF.

The Committee reviewed and scrutinised the BAF summary of F&PC risks as at March 2021 and reviewed and scrutinised the BAF action plans.

The Committee agreed that the Action plans mitigated the identified risks.

Any risks or Issues

There were no Risks or issues identified.

Any Other Business

There was no other business

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

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

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

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

		Non Recurrent £	
Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	YES/NO	If YES, EIA Score	

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Name; Manny Lewis **Job Title: Non Executive Director**

Agenda Item 8(b)ii
Board of Directors Meeting Part 1
31 March 2021

FINANCE AND PERFORMANCE COMMITTEE ASSURANCE REPORT

1.0 Purpose of Report

This report is provided by the Chair of the Finance and Performance Committee, Manny Lewis to provide assurance to Board members that the performance operational, financial and governance as at Month 11 February 2021.

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

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

2.0 Quality and Performance Report

This month's report has been aligned to the CQC scoring metrics in order to align the monitoring of key performance indicators, using Inadequate; Needs Improvement and Good as the principles for prioritisation of focus. This report covers the position of both month 6 and month 7 in line with the agreed bi-monthly Trust Board.

The Committee considered the following key issues:

In February 2021, there were 25 Indicators within target, of which 5 have been identified as **Inadequate performance.**

- Timeliness of Data Entry
- CPA 12 Month Reviews
- Inpatient MH Capacity (Adults & PICU)
- Out of Area Placements
- Waiting Lists

Executive Chief Operating Officer (ECOO) updated the Committee on the work currently being undertaken to address the 5 areas of inadequate performance. Additional work for both CPA 12 month reviews and Psychology Waiting lists having taken place through a deep dive approach with a view to addressing this under-performance. There is also additional work currently taking place by Meridian on behalf of the Medical Director looking at the outpatient waiting times. These pieces of work will identify trajectories for achieving compliance.

The ECOO also updated the Committee on the work currently taking place on Inpatient wards and out of area placements both internally and externally alongside NHSE who are working with organisations across Essex to understand the bed demand and the impact on our bed occupancy due to COVID19. The ECOO also highlighted the continued difficulties with accessing Children's inpatient beds and shared some early discussions that had taken place with Essex County

Council on reviewing Tier's 3 and 4 models of care and agreed to keep the Committee updated on progress.

The Committee were assured that these areas of inadequate performance were being managed and were keen to continue monitoring these areas against agreed trajectories at the next meeting.

Contract Exception Reporting

Two Contract Performance Notice issues by Mid & South Essex CCG's continue to be on hold for MH RTT, Patient Referred to the MH First Response Team seen within 28 days, and Community MH service users on CPA with a care plan. CCG's have agreed to remove this following several months of on target attainment, and was formally removed at the beginning of March 2021.

3.0 Financial Performance Report

The Trusts M11 YTD surplus is £2.2m against the planned YTD deficit of £6.8m. This favourable position is due to the payment received from NHS England in respect of lost income.

Capital resources for the year total £16.7m with expenditure of £9.4m incurred year to date. The Trust continues to forecast and target the full use of its available resources however, this remains a significant risk due to the backend loading of the programme and the impact of the pandemic on the Trust and its suppliers.

Cash balances remain positive and better than planned due to accelerated payments at the start of the financial year which are still to unwind.

Month 11 financial position:

Financial Position: Year-to-date (YTD) surplus £2.2m, against the planned YTD deficit of £6.8m. This favourable position is due to the payment received from NHS England in respect of lost income.

COVID Spend: The Trust incurred further expenditure of £1.7m in February 2021 (year to date £13.4m). Financial recovery of month 7 to month 12 spend is anticipated from Mid & South Essex Health and Care Partnership allocation (with month 1 to month 6 through national reimbursement).

Mass Vaccination Spend: The Trust has incurred expenditure of £1.4m in February 2021 (year to date £2.4m) with full recovery expected.

CIP Position: 2020/21 target £11.7m including the 19/20 recurrent shortfall of £5.1m. In Year savings of £8.5m have been agreed with £0.4m identified as in pipeline. Recurrent savings at Month 11 are £3.8m.

Temporary Staffing Spend: Total spend M11 £4.2m, with Bank spend £3.2m (YTD £32.5m) and Agency spend £1.0m (YTD £12.8m). Total temporary staff spend YTD £45.3m with total YTD COVID temporary staff spend £9.2m and YTD Mass Vaccination temporary staff spend £0.9m.

CAPEX: At M11 the Trust has incurred expenditure of £9.4m against capital resources £16.7m.

Cash: The cash balance at the end of February was £112.9m which is better than planned with the supplementary national payment still to unwind.

UoRR: Due to COVID-19 and the Adapted Financial Regime, NHSI is not monitoring against this metric.

Sub Committee Reports

The Committee received 8 sets of Executive Operational Sub-Committee part one minutes for noting:

- 5th January 2021
- 12th January 2021
- 26th January 2021
- 2nd February 2021
- 9th February 2021
- 16th February 2021
- 23rd February 2021
- 2nd March 2021

Policies for Approval

The following Policies and Procedures were approved by the Committee:

- Retirement Policy
- Job Evaluation Policy
- Adverse Weather Policy
- Policy for Policy Approval
- Study Leave

Quarter 4 - Board Assurance Framework (BAF)Action Plan Update

The Board Assurance Framework (BAF) provides a comprehensive method for the effective management of the potential risks that may prevent achievement of the key aims agreed by the Board of Directors. EPUT's risk Management and Assurance Framework requires that Standing Committees of the Board have a scrutiny and oversight role in ensuring that Action Plans developed to mitigate risks on the BAF are robust.

The Deputy Director of Compliance and Assurance updated the committee on the current position with the progress against the BAF.

The Committee reviewed and scrutinised the BAF summary of F&PC risks as at March 2021 and reviewed and scrutinised the BAF action plans.

The committee agreed that the Action plans mitigated the identified risks.

Any Risks or Issues

There are no risks and Issues identified.

Any other Business

There was no other business

Report prepared by:

Janette Leonard
Director of ITT, Business Analysis and Reporting
On behalf of:

Manny Lewis
Chair of the Finance and Performance Committee

		Agenda Item No: 8biii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 March 2021**

Report Title:	**Quality Committee Assurance Report**					
Executive/Non-Executive Lead:	**Amanda Sherlock, NED and Chair of Quality Committee**					
Report Author(s):	**Natalie Hammond, Executive Nurse**					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	Individual risks are identified for each sub-committee, COVID has had an impact on resources but all sub-committees remain on track.
State which BAF risk(s) this report relates to	BAF53 Safety Actions BAF45 CQC Inspections and Learning BAF55 Warning Notice BAF32 Quality Improvement BAF4 Fire Safety BAF10 Ligature Reduction
Does this report mitigate the BAF risk(s)?	Yes, it mitigates risk in relation to substantive staffing.
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	On-going review is scheduled through meeting structures.

Purpose of the Report		
This report provides assurance to the Board that the Quality Committee is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objectives and impact on quality, are being managed effectively.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance given in respect of risks and actions identified
3 Request further action/information as required.

Summary of Key Issues

At the meetings held on 11 February 2021 and 11 March 2021, the Quality Committee:

Received the following reports:

- Quality Performance Report
- CQC Exception Report
- Combined Assurance Report
- Performance Hotspot Report
- COVID BAF Assurance Framework

- BAF Action Plan

Reviewed the following policies:

- CLP74 – AMHP Approval and Re-approval Policy subject to a check that changes were administrative
- Overarching Clinical Guidelines (Marsden Manual) Policy
- CP75 Ligature Risk Assessment & Management Policy
- CPG59 Data Protection & Confidentiality Policy
- Corporate Health & Safety Policy & Procedure

Risks/Hotspots:

The Committee identified:

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

The Committee identified good progress against governance agenda particular medical and profession education, equality and seclusion and MHA and safeguarding.

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

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Healthwatch	

Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **TO BE SUBMITTED ONCE COSTINGS HAVE BEEN DEVELOPED** **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Amanda Sherlock **Non Executive Director and Chair of the Quality Committee**

Agenda Item 8(b)iii
Board of Directors Meeting
31 March 2021

ESSEX PARTNERSHIP UNIVERSITY NHS TRUST

QUALITY COMMITTEE ASSURANCE REPORT

1 Purpose of Report

This report is provided to the Board of Directors by the Chair of the Board of Directors Quality Committee. As an integral part of the Trust's agreed assurance system, the report is designed to provide assurance to the Board that:

- Risks that may affect the achievement of the Trust's objectives and impact on quality are being managed effectively. This is an integral part of the Trust's agreed assurance system;
- The Committee is discharging its terms of reference and delegated responsibilities effectively.

2 Executive Summary

2.1 Minutes of previous meetings

The minutes of the Quality Committee meeting held on 11 February 2021 and 11 March 2021 were approved.

2.2 Summary of discussions and issues identified as well as assurances provided at the February and March meetings:

February 2021

2.2.1 Quality Performance Report: The Committee received the report that gave an updated position as at December 2020. Four hotspots areas were showing inadequate performance:

- CPA 12 Month Reviews – Performance in December was below the national 95% target at 94.4%. Performance remains inconsistent with monthly fluctuations below and above target. Performance is required to meet target for three months until this indicator can be downgraded. The Committee was advised that this indicator remained under review with Commissioners.
- 2 Inpatient indicators, Inpatient MH Capacity (Adults, PICU and Older Adults) – Increases in staff and patient COVID outbreaks are resulting in ward closures, which are driving need for out of area placements. The Committee was advised that EPUT is not alone with the pandemic causing a major incident across Essex. Contractual arrangements had been made with The Priory in recognition that it was not good patient experience to be located out of the vicinity. Assurance was sought that processes had been put in place to maintain robust communication with out of area placements and it was confirmed that quality and safety reviews had been built into contractual arrangements. It was agreed that Service Directors would be contacted to give assurance that robust communication was taking place.
- Waiting lists: There has been an increase in the number of patients not seen 12+ months. And whilst there has been a reduction in the ADHD there remains a lack of engagement with the expectation that a further 90 will be discharged to General Practice as a consequence. The Committee sought assurance that a range of options were being considered to improve this

indicator and were advised that there has been an increase in virtual and telephone consultations. The issue was associated with demand and capacity due to increases in case loads particularly in relation to psychological services.

In December 2 areas were identified requiring improvement:

- Bullying and Harassment – These incidents currently represent a concern for the Trust with 21 cases raised to HR year to date. The Trust has been working to increase the number of staff who report bullying and harassment incidents by introducing anti-bullying ambassadors. The Committee was advised that staff survey results are expected and initial indications are showing some improvement in this area.
- Cardio Metabolic Assessments/SMI indicators continue to be at variance with local targets however improvement is being seen across all indicators that EPUT is responsible for. It was noted that compliance is based on full assessment being completed however during the COVID pandemic community teams have encountered difficulties in completing the parts of this assessment where face to face contact can be essential, e.g. blood tests and blood pressure.

The Committee was advised that safer staffing had been achieved with many areas being over on staffing linked to increased patient safety requirements as a result of the pandemic. It was noted that a risk assessment tool linked to OPEL requirements had been introduced to give assurance that staffing levels are appropriate. It was noted that due to increased need to use temporary staffing there was an inherent risk that systems and processes may be compromised due to lack of knowledge. It was questioned if overfill costs were refunded and it was confirmed that during the first wave a COVID fund had been established which was being managed by the Director of Finance.

It was noted that within the report there were a number of areas of improvement and assurance was sought that frontline team were commended for their work. It was agreed that an action would be taken to provide feedback.

The Committee concluded that that was insufficient assurance that progress was being made in some areas and requested details of ownership and the plan to drive improvement. It was agreed that a deep dive report would be requested in relation to CPA and waiting lists.

The Committee discussed Committee ownership of the report that is currently reviewed at three meetings. It was agreed that clarity would be sought within the development of the accountability framework and the review of governance arrangements.

2.2.2 CQC Exception Report: The Committee received an update report outlining assurance on the key CQC related activities that are being undertaken within the Trust. The report also gave details of CQC guidance/updates that have been received since the last report.

- Meeting Registration Requirements – The Committee was advised that the CQC had been notified of the appointment of a new NED. In addition a submission was made on 3 February listing 14 sites from which the mass vaccination programme will be delivered with overarching registration being held by the Trust Head Office.

- Unannounced CQC Inspection – The Committee was given an update of

actions that had been taken following receipt of a warning notice after an unannounced inspection on the 29 October 2020 focusing on Finchingfield Ward following a series of incidents that took place on 23 October. All actions have been addressed and the warning notice action plan has now been closed and submitted to the CQC as required. The Trust is expecting to receive a formal report from CQC but are continuing to work to a draft copy. The clinical intensive support group remains in place and continues to address all actions including those received from the 6 "Must Do" requirement notice actions. Incorporated into the action plan is a review of other areas to address any inconsistencies in service provision.

- CQC Action Plan Testing – The Compliance Team have completed a final test of the actions, which utilized a mix of table top evidence reviews, virtual interviews and focused site visits to confirm of the actions put in place have been embedded and sustained in practice.

- Ligature Briefing - 17 virtual ligature inspections have been undertaken which overall were positive with a few minor concerns pick up. LRRG have been made aware of the non-compliance and will be managing the actions. It was noted that Cambridge University students are looking into ligature management and the Trust is in discussion with them and across the Nursing Director network a provider group is working with the CQC to develop guidance in relation to ligature management. The Committee sought assurance that the guidance would be seen as a minimum requirement and therapeutic interventions would be considered in addition to environmental. It was agreed that this should include early warning signs.

March 2021

2.2.3 Combined Assurance Report

- Information Governance: The sub-committee last met on 10 February with no new risks being identified. Progress had been noted against two previous hotspots. Due to changes to the Records Management Code of Practice the adequacy agreement being extended to 30 June 2021. IG training is currently at 91%. It was confirmed that the achievement of 95% remains a priority for the Trust and individual Directorates were taking action. There continues to be ongoing changes to legislation and these were being monitored and implemented.
- Mortality: The last two meetings have been postponed due to the transfer of resources to the vaccination programme. It was confirmed that meetings will commence in March and whilst capacity had been reduced focus had been maintained in relation to ensuring nationally mandated reporting requirements were met. The quarter 3 report would be considered by the sub-committee this month and would be brought to the Quality Committee last month.
- Equality and Inclusion: The Committee noted that there were no risks to note and commended the significant areas of work that were being delivered.
- MHA and Safeguarding: Due to changes to the legislation it was noted that the pressure on teams remained high. There was an improved position in relation to the electronic medical scrutiny process and issues had been resolved in relation to the input of information onto PARIS. MHA mandatory training is up to 94% across the Trust. It was noted that agreement had been given for tribunal meetings to be held virtually for another year. Discussion took place in relation to the impact of the Devonshire Judgment. The MHA office are in the process of completing the remedial work required e.g. a review of all detentions. It was acknowledged that this was a huge piece of

work impacting over 2,500 records. Assurance was sought in relation to risk and it was confirmed that legal advice had been sought and the risk was expected to be small.

- Restrictive Practices: It was confirmed that meetings had continued to take place. All training standards had been reviewed and the Trust was ready to commence delivery in line with the national accreditation standards that are scheduled to commence in April. A detailed review has been undertaken of seclusion and segregation incidents and as a result it had been agreed to commence a pilot QI programme on Poplar Ward. The Seclusion Policy has been agreed and final amendments are being made to the TASID Policy.
- Clinical Governance: The sub-committee had continued to meet with progress made against the action plan. One hotspot had been identified in relation to medical representation at resuscitation and deteriorating patient sub group. Discussions have taken place and it is anticipated this hotspot will be rectified.
- Quality Improvement: Work is ongoing to outline a proposal to more closely integrate quality improvement, innovation and research. The proposal will be brought to the May Quality Committee prior to consideration by the Trust Board. All training has recommenced although it was noted that operational pressures were impacting on trainer availability. A proposal has been circulated across service and user and carer forums for increased involvement in quality improvements and training.
- Physical Health: The last meeting had been cancelled however, a new Physical Health Framework has been drafted and has been circulated for consultation and the physical health collaborative has reconvened. Assurance was sought that work was taking place with system partners to improve the overall health of local populations and compliance with health checks. The Committee received assurance that discussions were taking place with commissioners and some funding has already been received, Transformation programmes already in place with Trust employees working with primary care. It was noted that the collaborative was supporting joint working with each area taking the most appropriate approach for their local populations.
- Health, Safety and Security: The sub-committee last met on the 22 February where a number of decisions were made. Whilst mitigation is being introduced there continues to be delays in the sign off of incident and safety alert. Two ligature fixed points had been identified and blind spots noted on Topaz ward. There is also a drop on eLearning training compliance at 68% that has been escalated. Action plans are in place covering all risks.
- Patient Experience: Assurance was given that patient and carers have responded positively to the range of technological communications that had been introduced. Work was underway to relaunch family and friends feedback and the action plan for Community Mental Health Survey was approved. The next sub-committee is due to meet on 18 March where the drafts recompense policy and procedure will be presented for approval. The committee noted that this was a significant step forward increasing the potential for joint working in relation to patient safety and quality of care.
- Research and Innovation: The Committee noted that research had recommenced and confirmation had been given that funding streams will be maintained. There remained a potential that staff may be asked to support acute Trusts in relation to the pandemic but this was deemed unlikely if the reduction in pressure continues.
- Medical, Professional Education and Training: The Committee were assured that a great deal of positive work was ongoing though this sub-committee.
    - Preceptors: Action-learning sets have been initiated to support preceptees
    - Student placements: It was reported that the Trust is working creatively with local universities to accommodate the 37% increase in students.

Virtual placements are in place and are involving the community and third sector. It was noted that this was critical in assuring a workforce for the future.
- CPD: Update has improved with many courses going on line.
- MHA Training: EPUT consultants are contributing to national RCPsych Induction and Refresher courses.
- Links with medical schools – The Trust has received positive feedback for placements provided during COVID restrictions. A new cohort has started their placement and is on schedule.
- A proposal has been submitted to increase GP trainee placements within EPUT is under consideration in line with national programme to change structure and increase GP training capacity.

2.2.4 Performance Hotspot Report

- CPA: A great deal of work is currently underway to establish the level of performance in each locality. There has been sustained improvement since April 2020 and there is confidence that this will be on track moving forward. A review of the causes of the breaches found that the majority of issues lay with service users remaining on CPA on the electronic system when they should have been discharged off the system. The Committee was challenged to ensure all cased were being reviewed and that support was being given through medical caseloads to remove cases where CPA is not relevant. It was noted that sickness relating to the pandemic and turnover has had an impact during the recent period. It was noted that the Trust is reviewing procurement of an app that would support caseload management building in an accountability framework against a dashboard. The Committee were assured that appropriate actions were being taken.
- Waiting Lists: A hotspot had been included in relation to patients not seen for 12 months plus. Work undertaken has highlighted concern in relation to the live dashboard. A full data cleansing is taking place and is showing that the majority should be removed from the system or that the individuals involved in services across other areas of the Trust. Assurance was given that tighter management arrangements will be in place moving forward. Work is being undertaken with Meridian to understand the issues in more detail, following a review of the outcomes changes would be made to job plans.
- It was reported that psychology waiting times had been reviewed in detail. A psychological awareness programme had been introduced and was resulting in a marked reduction in DNA rates. Work was being undertaken with commissioners to look at delivery models with some areas wishing to focus on capacity and others on need. It was noted that resourcing within the Trust was lower than the national average but investment was being brought forward particularly through NHSE. It was expected that within 8-12 months the backlog would be completely erased. Assurance was given to the committee that the work programme was covering three main areas: exposure to identify the problem, mitigation within the current contract and dialogue with commissioners in relation to thresholds.

2.2.5 CQC Assurance Report

Confirmation was given that the Trust is meeting all registration requirements and there are no open action plans with the CQC. Commissioners have recently undertaken a check of Finchingfield and confirmed that action plans had been embedded and made one suggestion to add additional CCTV to the ward. This is currently being initiated. The Inpatient Clinical Support Group has been expanded

and good progress is being made against the action plan that covers all inpatient services.

An update was requested in relation to Rawreth and Clifton and it was confirmed that they remained with a 'Requires Improvement' status as there had been no subsequent inspections for two years as a result of the pandemic. It was confirmed that a CQC inspection was planned to learning disability services within the next week. Virtual desktop reviews continued to be undertaken and assurance was given that an issues raised were being addressed.

2.2.6 COVID BAF Assurance Framework

The Committee was informed that this was a regular update. Work was ongoing and continued to be adapted as new guidance was received. It was noted that this was expected to continue for some time.

2.2.7 BAF Action Plan

The Committee received a reported of all items covered by the Quality Committee. The Committee was assured that considerable actions had been taken to mitigate risks. It was noted that a review of BAF and Risk Registers was being undertaken and it was likely that the format would be different within the next financial year. Any changes were to be embedded within an accountability framework that was being developed. It was confirmed that a further meeting had been arranged that week to go through all items outstanding and ensure that actions were being taken.

2.2.8 The Committee approved the following policies and procedures:

- CLP74 – AMHP Approval and Re-approval Policy subject to a check that changes were administrative
- Overarching Clinical Guidelines (Marsden Manual) Policy
- CP75 Ligature Risk Assessment & Management Policy NH Attached Approval
- CPG59 Data Protection & Confidentiality Policy TS Attached Approval
- Corporate Health & Safety Policy & Procedure

2.2.9 Risks/Hotspots:

The Committee identified:

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

The Committee identified good progress against governance agenda particular medical and profession education, equality and seclusion and MHA and safeguarding.

The Compliance Team were commended for on-going work managing the agenda.

Report prepared by:
Natalie Hammond
Executive Nurse

On behalf of:
Amanda Sherlock
Non-Executive Director Chair of the Quality Committee

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Agenda Item No: 8b (iv)

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31 March 2021

Report Title:	**People, Innovation & Transformation Committee Assurance Report**					
Executive/Non-Executive Lead:	Dr Alison Rose-Quirie Non-Executive Director and Chair of Committee					
Report Author:	Nigel Leonard Executive Director Strategy & Transformation					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	None.
State which BAF risk(s) this report relates to	BAF18.
Does this report mitigate the BAF risk(s)?	No.
Are you recommending a new risk for the EPUT BAF?	No.
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	n/a.
Describe what measures will you use to monitor mitigation of the risk	n/a.

Purpose of the Report		
This report is provided to the Board of Directors by the Chair of the People, Innovation & Transformation Committee. It is designed to provide assurance to the Board of Directors that risks that may affect the identification and/or achievement of the organisation's objectives are being managed effectively.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report.
2 Confirm acceptance of assurance given in respect of risks and actions identified.
3 Request further action/information as required.

Summary of Key Issues

The People, Innovation & Transformation Committee met on 1 March 2021 and discussed the following key issues:

- Patient Safety Strategy
- Planning Process
- Mental Health Transformation
- Digital Innovation
- Board Assurance Framework Action Plan

A summary of these discussions are outlined in the attached report.

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

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

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

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

Acronyms/Terms Used in the Report			
BAF	Board Assurance Framework	SMART	Surge Management & Resilience Toolset

Supporting Documents and/or Further Reading
None

Lead

Dr Alison Rose-Quirie
Chair of the People, Innovation & Transformation Committee

Part 1 Agenda Item: 8b (iv)
Board of Directors
31 March 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PEOPLE, INNOVATION & TRANSFORMATION COMMITTEE

PURPOSE OF REPORT

This report is provided to the Board of Directors by the Chair of the People, Innovation & Transformation Committee. It is designed to provide assurance to the Board of Directors that risks that may affect the achievement of the organisation's objectives are being managed effectively.

EXECUTIVE SUMMARY

People, Innovation & Transformation Committee 1 March 2021

The People, Innovation & Transformation Committee met on 1 March 2021, where Committee members had a successful and positive debate on a number of key areas.

The following matters were considered:

1. Patient Safety Strategy

People, Innovation & Transformation Committee members received a report on the Patient Safety Strategy for information and discussion.

The report included the draft Inpatient Safety Strategy, 'Safety First, Safety Always', outlined the outcomes of widespread engagement with internal and external stakeholders from across the system, and provided a roadmap for implementation.

The governance processes would now be set up. Committee members agreed that oversight should be the responsibility of the Quality Committee and the Finance & Performance Committee.

2. Planning Process

People, Innovation & Transformation Committee members received a report on the Planning Process for the Period 2021/22 and beyond, for information and discussion.

Publication of the National Planning Guidance had been delayed due to the Covid-19 pandemic. However, the team had commenced planning and budget setting, and it was expected that the initial budget would be shared with Board members by the end of March 2021.

Committee members were supportive of the proposal to move to a 5-year planning process, agreeing that this would put the Trust in a stronger position overall, and able to manage resources and services more efficiently. It would also enable more innovative new opportunities to be explored.

3. Mental Health Transformation

People, Innovation & Transformation Committee members received a report on the progress of the Mental Health Transformation programme, for information and discussion.

Some transformational work had been paused to enable resources to be redirected to support the Covid-19 pandemic, and to enable critical business as usual services to continue. Other areas of transformation had progressed with adaptions in response to the new environment.

Committee members agreed that the programme had continued to progress well despite the challenges caused by the pandemic.

4. Digital Innovation

People, Innovation & Transformation Committee members received a report providing an update on digital innovation, for information and discussion.

The report provided highlights of some of the more prominent innovations that had been completed during the Covid-19 pandemic, and identified work currently being carried out using digital technology to improve patient safety and support staff in delivering patient care.

The key achievements during this period included:

- The rollout of Oxihealth Digital Care Assistant across several wards.
- Internal rollout of the Surge Management & Resilience Toolset (SMART).
- Successful adaption to a new way of working during this challenging period.
- Supporting the Trust-wide response to the Covid-19 Pandemic.

Committee members agreed that digital innovation was key to providing quality services for patients, and achieving more using less resource.

5. Board Assurance Framework Action Plan

People, Innovation & Transformation Committee members received a report on the Trust's Board Assurance Framework (BAF) Action Plan, for information and discussion.

There had been some delays to a risk linked to quality improvement through innovation, whilst the new Patient Safety Strategy was being produced.

Committee members agreed that once the new upcoming Corporate Strategy had been rolled out, the BAF Action Plan would need to be revised and refreshed to ensure that it reflects the Trust's strategies going forward.

ACTION REQUIRED

The Board of Directors is asked to:

1. Note the summary of the meeting of the People, Innovation & Transformation Committee held on 1 March 2021.
2. Confirm acceptance of assurance given in respect of risk and the action identified.
3. Request further action/information as required.

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

On behalf of:
Dr Alison Rose-Quirie
Chair of the People, Innovation & Transformation Committee

		Agenda Item No: 9i
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	31 March 2021

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

Risk Assessment of Report	
Summary of Risks highlighted in this report	This report outlines current response to Covid 19 national pandemic
State which BAF risk(s) this report relates to	• BAF38 Emergency Planning • BAF50 Skills Resource and Capacity • BAF42 Financial Plan • BAF43 Surge Planning • BAF44 Learning from C19
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides the Board with assurance in relation to the actions taken in response to the Covid 19 pandemic.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

Background

- The country has now been dealing with the corona virus outbreak for one year.
- The Trust's arrangements continue to be in place and are working effectively.
- On 4th January 2021 a further lockdown was announced and an increased incident response alert level to Level 5 alert status for pandemic. Lockdown has remained in place over this reporting period.
- Following the return into national lockdown, we have started to see a gradual decrease of prevalence across the country and plans of a national road map detailing four steps to cautiously ease the lockdown restrictions over the next 3 months have been published.

Command Structure

- The Gold, Silver and Bronze Command meetings have continued. The frequency of the meetings is continuously being reviewed and adjusted to reflect the current risk. Meetings have been reduced to three times a week and there are further plans in place to now step down to a command structure of 2 meetings a week
- The (virtual) Incident Control room operational times have had a slight decrease at weekends to now run 8am until 6pm however weekdays remain as 8am until 8pm
- The Covid Risk Register is regularly reviewed and updated by Gold and Silver Command.
- National daily / regular sit reps remain in place.

Impact to Date

- At the time of writing this report we no longer have any outbreaks open and the overall learning from all 35 outbreaks experienced within the trust have continued to be shared across teams and made available to all staff via the trust intranet. (this is pending closure of Rawreth Court outbreak on 23rd March 2021)
- We previously reported a total of 32 patients who sadly passed away within our inpatient services as a result of Covid-19 as a direct or indirect cause since the pandemic began. Unfortunately, this has again increased to 44 (2 in Mental Health services and 40 in Community beds). It should be noted that the majority of these additional patient deaths were from within our covid-19 assigned community health service inpatient wards. All cases have been appropriately reported via the Covid-19 Patient Notification System (CPNS).
- At time of writing we have a total of 85 staff off sick due to covid-19 (a significant reduction from 297 at last report) and no Covid-19 confirmed patients.
- Since the commencement of lateral flow testing for asymptomatic patient facing staff in late November 2020. We have recorded a total of 50,244 test results, from a total of approximately 3900 different staff, which has proven to be a reliable indication of Covid-19 with only 14 false positives. The programme to date has successfully identified 215 cases of staff testing positive.
- The Trust Committee and Governance Structure have continued on a reduced basis through the utilisation of Microsoft Teams.

Trustwide Response

- Changes have been made to how EPUT provide both community health services and mental health services. This is in line with national guidance to prioritise particular services while the NHS responds to the COVID-19 pandemic.
- EPUT have opened 5 Covid wards to support the local healthcare system in the West Essex Locality and South Essex Locality. Over this reporting period the majority of these have returned to their usual purpose.

Communication

- The success of the weekly Live events and time hosted by the Chief Executive with the Executive Directors, continues as a means to keep staff updated on the current status and for staff to raise questions directly with the Executives.
- A number of different live events have continued to be held including staff support events

Risks

- There are 3 extreme risks on the Covid 19 Risk Register (Skills, Resource and Capacity, Planning for expected surge in demand for MH Services and Adherence to PPE). Mitigating actions are in place for all three.

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:
  - COVID-19 Deaths Review Working Group, reporting to mortality review sub-committee
  - Incorporation of staff support offering into reflective learning.
  - Learning emerging from all activity being collated for sharing at meetings with acute trusts.

- Daily data analysis at ward level of Staff and Patient Covid sickness/isolation rates
- Outbreak analysis and learning shared at ICP live events

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

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			✓
Service impact/health improvement gains			✓
Financial implications The Government has confirmed any appropriate and reasonable expenditure related to Covid-19 will be supported. All costs identified in year ended 31/3/20 have been agreed and funded.			✓
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed?	**~~YES~~/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
PPE	Personal Protective Equipment	IPC	Infection Prevention and Control
MSE	Mid and South Essex	STP	Sustainably and Transformation Partnership

Supporting Documents and/or Further Reading
Covid Assurance Report Gold Command Covid Risk Register Summary

Lead
Paul Scott **Chief Executive**

Agenda Item 9i
Board of Directors
31 March 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FT

COVID 19 ASSURANCE REPORT

Purpose of Report

The purpose of this report is to provide the Board of Directors with an update on how the Trust continues to respond to the Covid 19 pandemic, and assurance that the actions being taken are mitigating the risks identified.

Background

As previously reported a further national lockdown was announced on 4th January 2021 at which time there was an increase to the incident response alert to level 5 (driven by the new more transmissible variant). Since the last report the country has remained in national lockdown and the incident response alert level remains at level 5. The NHS remains at an incident response level 4.

To support the local system EPUT has continued to have a change in some services, in particular 4 CHS wards and 1 MH dementia ward which were converted to COVID Step down wards.

Following the return into national lockdown we have started to see a gradual decrease of prevalence across the country and plans of a national road map detailing 4 steps to cautiously ease the lockdown restrictions over the next 3 months have been published.

Locally we have seen the fortnightly provider briefing calls being stood down and only reinstated should there be a system or incident need. Along with a decrease in demand for Covid beds resulting in the majority of our wards returning to their original purpose.

This is a reflection of the gradual decrease of prevalence however we remain alert to the fact that as lockdown reduces we may see again see a change in activity for our services. With an awareness that our referrals and activity are continuing to return to pre-covid levels and are now exceeding 2019 averages.

Command Structure

Previously reported was the requirement for us to have a stepped up approach to our command meetings however we have since been able to reduce these back down to one full separate Silver and Gold meeting a week (Wed) and 2 joint Silver and Golds (Mon/Fri). There are plans in place to further review and reduce the meeting frequency taking into account the continued risks as the lockdown is gradually lifted and the requirement to have the oversight of this for at least a few more weeks.

The (virtual) Incident Control room remains operational 7 days a week with extended hours of 8am until 8pm Monday to Friday still in place due to the NHS remaining at an incident response level 4. However there has now been an agreed slight reduction to the hours of cover over the weekends which are now 8am until 6pm in line with the East of England Operational Centre working hours.

There continues to be a number of regular sit reps required by the Centre including the National Covid daily sitrep, Community discharge daily sit rep, regular Lateral Flow Testing numbers and Long Covid activity.

Over the past few weeks there has been a noted decrease in the national and regional information

and guidance into the incident control inbox. However there continues to be information asks with short timeframes for responses which are challenging for the organisation. We continue to cascade all national and regional guidance, information and requests to the appropriate Directors and through discussion at the Command meetings for information and consideration of the actions required.

The Covid Risk Register continues to be regularly reviewed and the mitigation updated by Gold and Silver Command and as such there has been a reduction in our number of open risks. The Chairs from the Trust's equalities networks continue to attend the Silver 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, or recommendations submitted to Gold Command.

We now have the availability of additional Strategic Command training for our new executive team Gold members who work at the strategic level and for those who have overall responsibility for the command, response and recovery of an incident. All staff that have a command role during incident or emergencies must complete this training in line with the National Occupational Standards (NOS) and required competencies for that role as outlined in the NHS England and NHS Improvement Emergency Preparedness, Resilience and Response (EPRR) Minimum Occupational Standards for EPRR 2019.

Impact to Date

Since last reporting in January there has been a significant reduction in our reporting of both Covid-19 positive patients and staff sickness. At time of writing we have zero Covid-19 confirmed patients (previously reported as 123) and 85 staff off sick due to Covid-19 related illness (a reduction from 297 at last report).

Unfortunately we have had further patients pass away due to Covid-19 as either a direct or indirect cause within our hospital wards. It should be noted that the majority of these additional patient deaths were from within our covid-19 assigned community health service inpatient wards. Therefore the previously reported total of 32 patients who sadly passed away since the crisis began now stands at 44 deaths (3 in Mental Health services and 41 in Community beds). All cases have been appropriately reported via the Covid-19 Patient Notification System (CPNS). There is now a further national requirement to check if any of these patients acquired Covid-19 from within hospital settings (nosocomial spread) and for those where this would apply the required incident investigation will take place.

I am pleased to be able to report that all 15 previously reported outbreaks have now passed the 28 day period and all processes were followed as advised through joint meetings with NHSE, CCG's and PHE. As a result all cases have been successfully closed from an outbreak status. The lessons learnt from the total of 35 outbreaks experienced within the trust have continued to be shared across teams and made available to all staff via the trust intranet. The themes to highlight as learning from the outbreaks are the following;

- Ensuring the completion of a robust, thorough and informed Covid Risk Assessment on a patient's admission, return from leave or return from an Acute Trust attendance. This will help staff to identify the required period of isolation safely.
- The importance of maintaining 2 metre social distancing amongst patients in general and common areas, to prevent spread amongst patients, especially if any are unknown asymptomatically positive.
- Ensuring shared equipment – phones, keyboards etc. are cleaned between each use.
- Maintaining strict adherence to room allocation, 2m social distancing, and safe PPE doffing and donning in staff break rooms.
- Maintaining strict adherence to 2 meter social distancing and mask-wearing principles in shared office spaces.
- Prompt recognition and action of symptoms in patients.
- Staff to be aware they should not come on duty if they are symptomatic and rather to self-isolate and get tested as a priority.

Since last reporting the lateral flow testing for asymptomatic patient facing staff is now in the 2nd roll out across the trust with a different approach taken to enhance uptake. A number of staff have been allocated different and far-reaching geographical areas of the trust to lead on the roll out and to enhance staffs understanding and uptake of the testing. Since the commencement of lateral flow testing for asymptomatic patient facing staff in late November 2020. We have recorded a total of 50,244 test results, from a total of approximately 3900 different staff, which has proven to be a reliable indication of Covid-19 with only 14 false positives. The programme to date has successfully identified 215 cases of staff testing positive.

With the support of the Health and Safety team we have been reviewing the Covid secure risk assessments that were undertaken for non-patient facing areas. This is to ensure that these have been updated following the learning from the 2nd wave and our outbreaks and that they remain a suitable and sufficient and that the control measures identified are implemented in line with relevant guidance.

The Trust Committee and Governance Structure was reduced over the height of the second Covid Wave with a focus remaining on patient safety. Committee have continued through the utilisation of Microsoft Teams to undertake corporate meetings on a virtual basis.

Trustwide Response

Since early February 2021 the Trust has been able to gradually return our wards back to their original functionality. This is following the changes that were made as a response to support the system wide pressures of the 2nd wave.

For example;

- 01/02/21 Avocet CHS Ward at Saffron Walden returned to amber pathway
- 08/02/21 Meadowview MH Ward at Thurrock returned to Dementia Ward
- 08/02/21 Plane CHS Ward at St Margaret's returned to amber pathway
- 22/02/21 Poplar CHS Ward at St Margaret's reduced to 5 Covid beds (back to amber pathway)
- 08/03/21 CICC CHS Ward at Rochford began transition back to Stroke Rehabilitation service

- A further Adult Acute ward (Topaz previously an older adult ward) on the Broomfield Hospital Site will be opening shortly for all of Essex and will provide 17 beds. The ward has been transformed with anti-ligature specification to meet the requirements of an adult acute ward.

- Bernard Ward, Clacton Hospital remains temporarily closed with no changes.

- Mountnessing Court remains at Brentwood Community Hospital

We continue to work with our system partners to meet the demands of the pandemic.

Communication

Decisions made by Gold Command continue to be communicated to all staff through the regular production of the Covid Brief in addition to the Wednesday Weekly publication and updates following the Live briefing, which is now held every Thursday.

The success of the weekly Live events and time hosted by the Chief Executive with the Executive Directors, continues as a means to keep staff updated on the current status and for staff to raise questions directly with the Executives. In addition to this there has also been the implementation of numerous virtual events made available to support staff and their wellbeing.

Non-Executive Directors continue to receive a weekly briefing via Microsoft Teams from the Chief Executive, as well as ad hoc briefings when necessary

Risks

The Trust Covid risk register has remained a live document with the risks constantly being updated to reflect the changing environment and are detailed in the summary Covid Gold Risk Register in Appendix 1. There are currently 3 Extreme Risks, 13 High Risks and 3 Medium Risks open.

From this it can be seen that major risks currently facing the Trust are: -

- Skills, Resource and Capacity
  We have consolidated a number of risks on the BAF and one of the highest risks is EPUT having the skills, resource and capacity to deliver the following:
  - High quality business as usual care,
  - Manage the C19 pandemic,
  - Increased variation of demands on corporate services to deliver a wide range of priorities and pressures as well as meet its organisational objectives.

- Planning for expected surge in demand for MH Services
  Planning for MH surge in demand while still working under the Covid 19 pandemic remains a risk for the organisation. Phased plan is in place alongside the winter plan and the Trust is currently working to open an additional adult ward.

- Adherence to PPE
  Failure to robustly adhere to PPE guidance contributed to some of the outbreaks experienced. Ongoing engagement with staff is being undertaken.

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:

- COVID-19 Deaths Review Working Group, reporting to mortality review sub-committee
- Incorporation of staff support offering into reflective learning.
- Learning emerging from all activity being collated for sharing at meetings with acute trusts.
- Daily data analysis at ward level of Staff and Patient Covid sickness/isolation rates
- Outbreak analysis and learning shared at ICP live events

Action Required

The Board of Directors is asked to:

1. Note the content of this report for submission to the Trust Board of Directors,

Report compiled by:

Paul Scott Chief Executive

		Agenda Item No: 9ii
SUMMARY REPORT	**BOARD OF DIRECTORS** **PART 1**	**31 March 2021**

Report Title:	**EU Exit**					
Executive/Non-Executive Lead:	Nigel Leonard, Executive Director of Strategy & Transformation					
Report Author(s):	Lara Brooks, Head of Risk Management and Legal Services					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	EU Settlement scheme
State which BAF risk(s) this report relates to	BAF23
Does this report mitigate the BAF risk(s)?	Yes (part)
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report presents an update on EPUT's position in regards to the EU Exit and highlights any risks.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Trust Board is recommended to:

1. Note the content of this report
2. Request any further information or action as necessary

Summary of Key Issues

This report presents an update on EPUT's monitoring of the Exit trade deal areas without agreements or awaiting further guidance and provides details of any impact on service delivery and assurance on the Trust's continued response to this.

The UK government has agreed a trade agreement with the EU. There will still be changes following the end of the transition period and having left the Single Market and Customs Union. The Trust's preparations for the end of the transition period and post transition have been taking place alongside our response to Covid-19 and winter pressures.

NHSEI has highlighted to Trusts key messages on the exit immediately post the transition period and following the agreement with the EU on the relationship for future, these are in relation to the areas detailed below:

- Medicines

- Workforce
- Data
- Reciprocal Healthcare & Cost Recovery
- Vaccines
- Medical Devices, clinical consumables, non-clinical goods and services
- Research & Clinical networks
- Health Security

The Trusts EU Exit Task & Finish Group continues to meet on a monthly basis alongside monthly admin meetings.

There will still be changes post transition and the Task & Finish Group will continue to meet to discuss and monitor any requirements that are relevant to the Trust and our services.

EU Exit correspondence is included in the daily ICC procedures covering the mailboxes between 8am-8pm Monday to Friday. With effect from the 23 December 2020 the Trust were asked to highlight any areas of concern in our National Daily Sit Rep return to NHSEI positively or negatively. Members of the Task & Finish Group are in attendance at Silver Command and confirmation is obtained on the above requirements for the daily returns. To date no concerns have been raised on these areas.

The risk score on the BAF has been reduced in January from 16 to 12 (4(C) X 3(L)) and the action plan has been revised and completed.

The BAF action plan and risk register is considered by the task and finish group and is available on request to Board Members.

The Task & Finish group are able to confirm that it met the majority of requirements for preparedness that NHSEI has identified. Whilst difficult to predict, the Task & Finish Group believe the following to be the key areas of concern:

EU Settlement Scheme and new immigration system from 1 January 2021

- The Settlement Scheme will allow EU Nationals to continue to live and work in the UK beyond June 2021, meaning they will not need to apply for visas when the new immigration systems takes effect. The scheme will also lock in the rights of EU nationals, meaning they will be able to access healthcare, benefits and other government services in the same way they currently do. They have the right to remain until June 2021.
- The risk identified is if staff needed to apply to the settlement scheme do not do so or are unable to do so they will not be able to remain in the UK. The impact is particularly noticeable for operational staff and estates and facilities staff. To mitigate all staff have been asked to update the Trust before June 2021. HR is continuing to assist staff on a regular basis and encouraging them to apply to the EU Settlement Scheme.
- There are 110 Workers working on EU Passports and still requiring settlement status (45 of which are permanent staff). The table below outlines details of permanent staff by directorate and staff speciality.
- 50 staff have settlement status and 14 staff are in application process.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓

SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

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

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

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

Acronyms/Terms Used in the Report			
EU	European Union	NIHR	National Institute for Health Research
BAF	Board Assurance Framework	MHRA	Medicines and Healthcare products Regulatory Agency
EHIC	European Health Insurance Card	ICC	Incident Control Centre
GHIC	Global Health Insurance Card	HR	Human Resources
BAU	Business as usual	ITT	Information Technology
NHSEI	NHS England/Improvement	CCG	Clinical Commissioning Group
PHE	Public Health England	EEA	European Economic Area

Supporting Documents and/or Further Reading
EU Exit Report

Lead
 Nigel Leonard Executive Director of Strategy & Transformation

Agenda item 9ii
Trust Board of Directors
31 March 2021

EU Exit

1.0 PURPOSE OF THE REPORT

This report presents an update on EPUT's position within the Trust for EU Exit, post transition and assurance on EPUT's continued response to this.

2.0 BACKGROUND

This report presents an update on EPUT's monitoring of the Exit trade deal areas without agreements or awaiting further guidance and provides details of any impact on service delivery and assurance on the Trust's continued response to this. The UK government has agreed a trade agreement with the EU. There will still be changes following the end of the transition period and having left the Single Market and Customs Union. The Trust's continued monitoring for the end of the transition period and post transition have been taking place alongside our response to Covid-19 and winter pressures.

3.0 EU Agreement

3.1 NHSEI highlighted key messages to Trusts on the exit immediately post the transition period and following the agreement with the EU on the relationship for future. The below were the key messages received:

- **Medicines**
  Prescribe and dispense as normal.
  Don't stockpile locally.
  Report shortage through usual routes.

- **Medical Devices, clinical consumables, non-clinical goods and services**
  Measures are in place to help ensure stocks continue to be available even if there are transport delays.
  Don't stockpile products (adjust lead times for ordering process).
  Ensure all staff are aware of changes to delivery lead times.

- **Workforce**
  Government and the NHS support staff from the EU to continue to work in the NHS.
  The EU Settlement Scheme is open to all EU citizens, encourage staff to apply to EU Settlement Scheme.
  Recognition of professional qualifications will apply for at least two years after the end of the transition period.
  Most healthcare roles are exempt from the restrictions imposed by the Immigration Bill.
  The immigration surcharge does not apply to registered professionals and their family members.

- **Data**
  NHS organisations and staff should continue to handle data as they currently do.

The agreement the Government has reached includes a provision to provide for the continued free flow of personal data from the EU and EEA until adequacy decisions are adopted (and for not longer than 6 months).

- **Reciprocal healthcare and cost recovery**
  A new UK Global Health Insurance Card (GHIC) will be available for the new year in recognition of the new agreement with the EU. This will replace the EHIC.
  The agreement the Government has reached with the EU ensures that UK residents will continue to have access to emergency and necessary healthcare cover when they travel to the EU. This will operate like the current EHIC scheme. Current EHIC will still be able to be used when travelling to the EU and remain valid until their expiry date.

- **Vaccines**
  Don't stockpile vaccines beyond BAU levels.
  Pharmacists and emergency planning staff should meet at a local level to discuss and agree local contingency and collaboration agreements.
  Local cross-system medicines supply continuity plans should be developed and agreed at trust/CCG board level.
  There is a Vaccines Shortage Response Group for nationally and locally procured vaccines, co-ordinated by PHE and NHSEI with membership from the Devolved Administrators.
  Any COVID-19 vaccine will be included in the mitigations set out in the Medicines section above.

- **Research and clinical networks**
  Continue participating in and recruiting patients to clinical trials and investigations.
  Principal investigators are encouraged to work with their suppliers to review their existing supply chains for clinical trials.
  Continue to monitor and follow guidance from NIHR and MHRA in relation to how to operate from 1 January 2021.
  Clinical trial sponsors should ensure appropriate supplies of trial drugs and medical products are in place.

- **Health Security**
  The agreement will ensure we can continue to cooperate, exchange information and coordinate on measures to protect public health. This includes a framework for the UK's ad-hoc access to the EU's Early Warning System, which will strengthen cooperation in the event of a cross-border threat to health.

The above areas are monitored by the Task & Finish Group members who provide assurance that there are no risks or concerns from these key messages.

4.0 EU Exit Task and Finish Group

4.1 Frequency

The Trusts EU Exit Task & Finish Group continues to meet on a monthly basis alongside monthly EPRR admin meetings.

There will still be changes post transition and the Task & Finish Group will continue to meet to discuss and monitor any requirements that are relevant to the Trust and our services.

4.2 Review of Guidance

EU Exit correspondence is included in the daily ICC procedures covering the mailboxes between 8am-8pm Monday to Friday. With effect from the 23 December 2020 the Trust have highlighted any areas of concern in our National Daily Sit Rep return to NHSEI positively or negatively to the below:

Are there any EU Exit related issues which are expected to impact business critical services until the next daily sitrep is due, for each of the following areas:

- Supply of Medicines & Pharmacy
- Supply of Medical Devices & Clinical Consumables
- Supply of non-clinical consumables, goods and services
- Supply of blood products, transplant organs and tissues
- Workforce
- Estates & Facilities
- Clinical Trials
- Data sharing, processing & access
- Reciprocal Healthcare
- Cost recovery
- Partner organisations that are essential to delivery of healthcare

Members of the Task & Finish Group are in attendance at Silver Command and confirmation is obtained daily on the above requirements for the daily returns. To date no concerns have been raised on these areas.

4.3 Business Continuity Plans

As part of our preparations, all services are continuing to review and update their business continuity plans to ensure potential risks and impacts of the UK leaving the EU on a 'no deal' basis are mitigated. It is also been requested that services also use the opportunity to take into account learning from COVID19 and winter planning 2020/2021 and include these in their updated plans.

4.4 BAF23 Action Plan

The risk score on the BAF in January was reduced from previous scores to 4(C) X 3(L) = 12 and the action plan has been revised.

The BAF action plan and risk register is considered by the task and finish group and is available on request to Board Members.

The Task & Finish group are able to confirm that it met the majority of requirements for preparedness that NHSEI has identified. Whilst difficult to predict, the Task & Finish Group believe the following to be areas of concern:

EU Settlement Scheme and new immigration system from 1 January 2021.

- The Settlement Scheme will allow EU Nationals to continue to live and work in the UK beyond June 2021, meaning they will not need to apply for visas when the new immigration systems takes effect. The scheme will also lock in the rights of EU nationals, meaning they will be able to access healthcare, benefits and other government services in the same way they currently do. They have the right to remain until June 2021.
- The risk identified is if staff needed to apply to the settlement scheme do not do so or are unable to do so then they will not be able to remain in the UK. The impact is particularly noticeable for operational staff and estates and facilities staff. To mitigate all staff have been asked to update the Trust before June 2021. HR is continuing to assist staff on a regular basis and encouraging them to apply to the EU Settlement Scheme.

- There are 110 Workers working on EU Passports and still requiring settlement status (45 of which are permanent staff). The table below outlines details of permanent staff by directorate and staff speciality.
- 50 staff have settlement status and 14 staff are in application process.

Permanent Staff by Directorate		Permanent Staff by Speciality	
MH – Mid and South	13	Admin / Management	14
MH – NE and West	10	Support workers	12
Estates and Facilities	6	Mental Health Qualified	7
West Essex Community	6	Estates and Facilities	6
Medical	3	Psychologists	4
Specialist Services	3	Medical	3
People & Culture	2	Community Qualified	2
Psychology	2	Occupational Therapists	2
IT	1	Speech & language	1
South east Essex Community	1	Dietician	1
Research & Development	1		

5.0 RECOMMENDATIONS

The Trust Board of Directors are recommended to:

1. Note the content of this report
2. Request any further action or information as necessary

Prepared by:

Lara Brooks
Head of Risk Management & Legal Services

On behalf of:

Nigel Leonard
Executive Director of Strategy & Transformation

		Agenda Item No: 10a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 March 2021**

Report Title:	**Mental Health & Community Health Services Transformation Update**					
Executive/Non-Executive Lead:	Alexandra Green Executive Chief Operating Officer					
Report Author(s):	Mark Travella Associate Director Service Improvement and Business Development Russell Middleton Head of Financial Management					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	Recruitment has been an on-going risk over the last two years due to significant UK wide MH investment and in particular neighbouring systems competing for a similar pool of staff.
State which BAF risk(s) this report relates to	BAF 50 Skills, Resource and Capacity
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	Continuous recruitment taking place. Working with local system members to recruit into development posts, review skill mix, employ people from VCS where possible.

Purpose of the Report		
This report provides the Executive Operational Committee: • Overview of transformation service lines. • Progress on 20/21 spend and forecast. • Issues and risks. • Next steps and points to note for 21/22.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Executive Operational Committee is asked to:

1 Note the contents of the report

2 Request any further information or action.

Summary of Key Issues

Due to the Coronavirus outbreak, NHS England, local CCGs and the Trust operational and support services are carrying out a large number of unplanned activities including regular deep cleaning and taking extra care and time to meet patients emotional, mental and physical health needs. Re-deployment of some staff to support safe, effective and operational resilience has taken place.

Trust and system staff had paused some transformational work to support operational services concentrating on BAU. The Trust, with local commissioners and other stakeholders are now adjusting to the second coronavirus lockdown and resetting clinical services and its transformation activities. Services have attempted to maintain BAU activities during the current second lockdown where possible.

The significant Covid-19 Immunisation programme along with a large number of COVID-19 outbreaks in clinical areas remains an ongoing operational challenge. Transformation has not significantly been impeded during the second lockdown with supported action plans directing continual activity even where some meetings have been cancelled.

Most local systems have planned to adjust to a 'new normal' and the main report updates those positions with a wide range of Mental Health and Community Health Services transformation activities described below.

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

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

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

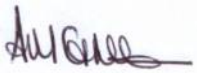
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			
Involvement of Service Users/Healthwatch			✓
Communication and consultation with stakeholders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

Acronyms/Terms Used in the Report			
IPCC	Integrated Primary Community Care	ECC	Essex County Council
PCN	Primary Care Network	SBC	Southend Borough Council
VCS	Voluntary Community Services	MHIS	Mental Health Investment Standard
PLACE	Local services provided at CCG level		

Supporting Documents and/or Further Reading

Main report - Mental Health & Community Services Transformation Update (March 2021).

Lead



Alexandra Green
Executive Chief Operating Officer

Agenda Item 10a
Board of Directors
31st March 2021

MENTAL HEALTH & COMMUNITY SERVICES TRANSFORMATION UPDATE

1 Purpose of Report

This report provides an update on the Trust's Mental Health and Community Health Services Transformation Programme in three sections;

- Mental Health Transformation
- Community Health Services Transformation - South East Essex
- Community Health Services Transformation - West Essex

It also describes how the MH Transformation programme is evolving from four original major programmes to a wider and broader portfolio of projects organised within its constituent programmes. This is linked to the national drive to review and redesign primary and secondary care services as part of an Integrated Primary Community Care (IPCC) structure and review and redesign complex care as part of the national Mental Health Investment Standard.

2 Executive Summary

Due to the Coronavirus outbreak, NHS England, local CCGs and the Trust operational and support services are carrying out a large number of unplanned activities including regular deep cleaning and taking extra care and time to meet patients emotional, mental and physical health needs. Re-deployment of some staff to support safe, effective and operational resilience has taken place.

Trust and system staff had paused some transformational work to support operational services concentrating on BAU. The Trust, with local commissioners and other stakeholders are now adjusting to the second coronavirus lockdown and resetting clinical services and its transformation activities. Services have attempted to maintain BAU activities during the current second lockdown where possible.

The significant Covid-19 Immunisation programme along with a large number of COVID-19 outbreaks in clinical areas remains an ongoing operational challenge. Transformation has not significantly been impeded during the second lockdown with supported action plans directing continual activity even where some meetings have been cancelled.

Most local systems have planned to adjust to a 'new normal' and the main report updates those positions with a wide range of Mental Health and Community Health Services transformation activities described below.

3 MH Transformation Programme – Summary to date and Evolving 20/21 Position

History and Development to 2020/2021

As part of the case for the merger of NEP and SEPT in 2016 the full business case highlighted the opportunity to transform the Essex clinical model delivery by reducing variation, and increasing quality and effectiveness by reviewing and redesigning services fit for the future. It proposed a MH transformation programme portfolio organised by each STP area as;

1. Emergency Response and Crisis Care Service
2. Personality Disorders & Complex Need

3. Older People & Dementia
4. Community (Primary) Care

1. Urgent and Emergency Care

This programme at STP level is made of three separate crisis response service projects for West Essex, MSE and NE Essex. All three projects went live successfully on or around 1 April 2020 in line with our plan and have been operational throughout Covid19. The Trust was commended by commissioners and NHSe for going live during the first lockdown when other providers put similar plans on hold. This service has provided a much needed MH crisis service at a critical time of high need for the people of Essex.

The model for 24 hour crisis assessment and treatment services links with the current Home Treatment Teams. Crisis Cafes provided by the third sector enable an option to support people in crisis and interface with EPUT services. Crisis Cafes are located in MSE, NEE & West. In MSE the Crisis Cafes have extended their hours recently and are heavily used by the MSE crisis assessment and treatment service. MSE are considering extending the service to include a separate team that responds just to ambulance calls as a joint response service and conversations between the Trust and commissioners are planned to scope this. The NE Crisis Café based in Clacton has continued to develop during 2020 as a collaborative between MIND, The haven and EPUIT led by MIND and has opened up to a self- referral model for 2021. West Crisis Café – The Sanctuary, launched in January 2021.

Due to Coronavirus the Crisis Cafes have adapted to support the 111 pathways. Instead of providing drop-ins, they have adapted to provide telephone support. EPUT technologies have been developed to provide for automated real time electronic referrals straight through to the Crisis Cafes. Southend Crisis Cafe is currently planning to start providing an adapted safe drop in model shortly.

In light of the coronavirus outbreak, the resources available to the new U&EC services have been focussed on telephone triage and support initially with home visits increasing as time has progressed where required. The police and ambulance services have been directly interfacing with the crisis services to reduce A/E attendances.

Due to workforce challenges the services will develop across 20/21 as the full workforce is recruited mainly in MSE. Recruitment remains a high priority.

This service is considered BAU however ongoing development with some additional investment is planned for 2021

2. Personality Disorder

This Essex wide model will transform the way staff across entire systems understand and treat people with a personality disorder. The model comprises training and consultation support across local systems, from GPs and the third sector to specialist mental health staff in secondary care. New model of care, delivering DBT and CAT and other psychotherapeutic approaches are being introduced and rolled out across the workforce. This outcome is a range of benefits including better supported patients and carers, improved rates of recovery and independence and fewer admissions to hospital.

The Model is funded separately by the three STPs with three different business cases. West Essex were last to approve very recently and will be funding fully from 20/21. It is therefore the least developed of the four programmes.

An Essex wide implementation plan and governance structure is in place and implementation is being overseen by a steering group.

3. Older People and Dementia

This programme is at CCG level. SE Essex and Mid Essex have developed and are implementing transformed community teams to manage patients and carers at home instead of hospital. SE Essex data shows very significant falls in inpatient use to the point that admission is now an unusual event. SE Essex is now in its second phase of development that seeks to implement the dementia wrap-around model developed in conjunction with the South East Essex CCG, ECC and SBC.

SW Essex comprising Thurrock and BB CCGs are planning to work together to implement a common transformation solution across the patch based on the SE Essex model. Project teams are being set up to oversee this work and may require further investment through Business Cases depending on the detail of the chosen model and use of existing resources.

NEE older people's transformation is going to be a phased complex piece of work that incorporates the revision plans of Clacton Hospital. A local system steering group has been set up to oversee this work and its relationship with other clinical services as part of the North East Essex Health and Wellbeing Alliance. The plan is to implement the same Dementia & Frailty pathway that has been successfully implemented in West with positive outcomes for older adults.

West Essex is advanced in the delivery of dementia services which links closely with community health services. This learning has been shared with other localities to help frame their pathways.

4. Community (Primary Care)

This programme at CCG level comprises six projects (Southend and CPR CCGs are working together) to transform community mental health services. Mental health community services are being transformed to provide Mental Health expertise at GP surgery level, organised against the newly formed PCNs. This will ensure that physical and mental health will be more integrated with local health, social care and VCS colleagues. GPs and their patients will have rapid access to mental health expertise at surgery level, supporting the aspirations of Five Year Forward View and the NHS Long Term Plan.

Southend/CPR CCGs have implemented a clinical manager. MH nurses and physical health care support workers in all seven PCNs have been recruited and are currently planning to roll out the model across all PCNs through the remainder of 2021/2022.

Thurrock has piloted MH support in one PCN and now recruited a clinical manager, MH nurses and physical health care support workers for its four PCNs. It plans to fully recruit other planned staff and fully implement the model in 2021/22. Thurrock has a well developed integrated local system and is planning to support the local system with consultant psychiatrist sessions instead of the current stand alone outpatients model. This will require all members of the local system working together to meet psychological and social need who in turn will be supported by the consultants with released capacity.

The West Essex model is part of a national early implementer pilot. This pilot along with the other national pilots will be evaluated and will inform clinical models for the future across England by 2024. The evaluation is substantial and is supported by the Service Improvement and Development Team.

NEE has developed an IPCC model and good local relationships with stakeholders. It has commenced recruitment and will be recruiting a clinical manager and another 3 band 7 nurses to the 7 it has already recruited.

BB CCG and MID Essex CCGs are planning to commence project work Q1 2021 based on the submitted model as part of the IPCC funding application. Implementation will be more complex in BB and Mid Essex as the mental health nurses working in the PCNs will be provided by other organisations. This will require joint working agreements and a Trusted Assessor model between EPUT as a treatment service and other organisations as assessment/triage services.

The benefits to PCN transformation are far reaching including much improved customer experience for patients e.g. less queuing, faster access along care pathways including testing the new 4 week standard. For local providers system interoperability and shared records are being piloted with EPUT delivering significant innovative solutions that will inform other areas of the UK. It will also have a significant impact on the future configuration of community mental health services as they are re-formed into an IPCC structure.

All PCN work is being overseen by a steering group in MSE and transformation Boards in NE and WE.

2021/22 Planning

MH IPCC
The fourth transformation programme, Community (Primary) Care is now more commonly referred to as Integrated Primary Community Care (IPCC) and is linked with the national drive to move towards a new mental health service configuration that does not recognise primary and secondary care terms or structures. Instead it refers to integrated community MH services set within a Primary Care Network (PCN) organisation. This organisation will increasingly operate with GPs and surgery staff, social care, mental health and voluntary staff working together as colleagues to support prevention, early intervention and timely joined up treatment and care.

This community mental health provision set within a PCN organisation will require significant local health, social care and VCS transformation which includes community mental health resources currently in secondary care. This will require a broader set of projects to realign existing care pathways with integrated place based PCN provision.

IPCC project work is planned for and defined by the 2021/2024 funding applications that have been developed and submitted to NHSe over the last few months.

Detailed programme portfolio plans are being developed to track implementation, recruitment and investment over the next year by operational managers, the Service Improvement and Development Team and local commissioners.

MH Complex Care/Rehabilitation
NHSe has asked local systems to speed up transformation plans and have committed to bring forward 2022/23 funding to support this.
Therefore another set of major transformation programmes of work to review, redesign and transform complex care/MH rehabilitation will take place over the next year. This work with include reform of the Care Programme Approach, a care planning, care co-ordination and risk management framework for those with complex health and social care needs.
Thurrock starts this work in March 2021. Other local systems will plan for this shortly.

Detailed project planning and delivery forecasting with operational, finance, workforce and projects leads will take place end of March/early April.

4 Community Health Services Transformation

EPUT provides Community Health Services in two areas of Essex. South East Essex and West Essex.

A summary of transformation work is shown below, but it should be noted that SEE plans are likely to undergo significant change with the new MSE Joint Venture. EPUT, NELFT and Provide have signed an agreement to solidify the closer working relationship between our three organisations. The contractual joint venture provides the foundation for developing an integrated community health service for Mid and South Essex that combines the strengths of all three sovereign organisations.

The benefits of working in partnership include:
•Reduced variation for patients across community services
•Improved patient outcomes and experience
•Increased collaboration, partnership working and innovation for the clinical workforce
•Increased opportunities for agreeing best practice across the three organisations
•Ensuring community services are fit for the future and delivered closer to home

More detail about the impact on SEE services will be shared later in the year.

SEE Community Health Service Transformation Plans

A range of initiatives have been put in place to support the system by focusing and transforming key priority service areas during the Coronavirus outbreak across both Adult and Children's services.

Discharge to Assess (D2A)
In order to support people being discharged from hospital at pace, community services have developed a model for 'discharge to assess' services in partnership with local authorities, which will support the delivery of care to people in their own homes and reduce the need for individuals to be placed in a community bed. This will achieve better outcomes overall for patients. This included on 7th Dec 2020, opening our new 'Community Coordination Centre (CCC)' which streamlines access to our urgent/crisis services, consolidated under one number that incorporates our UCRT, Nursing and Specialist Nursing and Discharge to Assess services. The CCC will also accommodate our local authority partners to deliver collaborative, integrated working and improved patient outcomes.

Urgent Community Response Teams (UCRT)
Existing UCRT (SWIFT) has been strengthened to enhanced 'admission avoidance' requirement and deliver 2 hour crisis response in patients' homes. This saw the development and implementation on 30th April 2020 of a Single Point of Access for UCRT across the STP hosted by SEE Community Services in EPUT. This was a three month project funded via COVID monies until end of July and has now been approved for on-going funding by the STP. EPUT continue to lead the development and transformation of UCRT across the MSE HCP. The next phase of the project sees improved dashboard reporting, improved pathways with EEAST and 111 services and introduction of new technology.

Community Beds
In first spike of pandemic, Mountnessing Court and Cumberledge Intermediate Care Centre (CICC) were relocated to Brentwood Community Hospital. This was part of the MSE HCP decision to consolidate all community beds on two sites as part of the Covid-19 response. CICC was repatriated to Rochford Hospital early Oct 2020 and has been operating as sub-acute intermediate care facility managing Covid positive patients. Discussions are now

underway to secure agreement for the optimum community bed configuration for post 1st April 2021 including decision on Mountnessing Court..

West Essex Community Health Service Transformation Plans

Out Of Hospital Strategy
West Essex are implementing an out of hospital strategy/model programme which comprises four projects;

1. PCN Alignment of Community Teams (PACTS)
2. Care Coordination Centre (CCC)
3. Intermediate Care
4. Specialist Teams

These are integrated transformation projects working with our system partners, CCG, ECC, Acute Hospitals, St Clare's Hospice and PCNs.

PACTS **(**PCN Alignment of Community Teams)
The aim of this project is to establish an integrated West Essex integrated system partnership approach for Out of Hospital Care for 18+ residents in West Essex, this includes acute, EPUT community & mental health, ECC, hospice, GPs, ambulance, 111 services. Discussions are under way with each of the PCNs to support their agreement for a focussed approach within their PACTS.

CCC Care Coordination Centre
The aim is to implement an integrated (with system partners) Care Coordination Centre to receive, triage and onward refer all system referrals. Currently the referral form is being reviewed with the aim to use this electronically for all parties in order to facilitate this and an expert IT group has been set up to review the many clinical record systems currently used by different organisations.

Intermediate Care
The focus of the Intermediate Care project for the Out of Hospital Programme is to:

- Review rapid response and implement a 24 hour community response
- Re-designated community beds
- Support at home for patients as part of the Reablement agenda
- Develop and better interfacing with the Patient at Home Service and better integration with community teams and expansion of services
- Single system wide therapy team development

Specialist Teams
This is major transformation project involving a large number of specialist team. One of the first phases is the patient remote monitoring pilot The Community Respiratory team will be implementing the use of remote monitoring of vital statistics for Covid and moderate to low respiratory patients. Doccla, a company that specialises in virtual ward technology that support care at home and early discharge will supply and monitor readings into a dashboard which the community team will have access to, this will show if there are missing readings, readings within range or those that have exceed range. The aim is to roll this out w/c 29 March and is a six month pilot. Other phases will be designed and implemented later in the year.

5 Risks and Issues

The significant risk relates to recruitment in all three STPs/ICSs. Due to workforce challenges the Trust is examining options to improve recruitment but is also considering alterative staffing structures with commissioners to enable service initiatives to commence in 2021/22. This includes working with VCS organisations to complement service delivery along-side EPUT services but also providing VCS training opportunities leading to future recruitment of staff. A major recruitment plan is in place and is showing signs of success but this will need to be monitored closely and regular monitoring and adjustment to plans. Preparedness plans are also being developed where required to predict any workforce shortfalls and re look at skill mix and other options for providing a safe and effective service, in the interim and long term.

Recruitment has remained the biggest risk to the transformation portfolio with a number of highlighted factors;

- EPUT borders East London where outer London weighting and fringe allowances are payable.
- Most professional groups have always been difficult to recruit to, with particular challenges with psychology and medical staff. National shortages of nursing staff is a long-term challenge.
- Support worker staff pools have also been heavily recruited to with increasing difficulty in recruiting to new initiatives, e.g. Mental Health Discharge Funding, even when bandings have been increased with no applications.
- Many of the transformational posts have required senior staff e.g. band 7 nurses in integrated primary care networks which are promotion opportunities for band 6 posts. These in turn are hard to recruit to. The local health economy across the three STPs will have drawn off the best of the band 5 nurses, either into band 5 posts or promotions to band 6.
- Neighbouring providers have the same extra funding and transformation plans. EPUT is directing competing with a shrinking pool of staff.

The Trust has continuously tried to mitigate the difficulties in recruitment including;

- Advertising campaigns including local airports, train stations
- Financial incentives, including staff referral incentives
- Support with moving to Essex
- Successful group sponsor licences from the Home Office for employing oversees professionals.
- International journal advertising campaigns.
- Skill mix reviews
- Strong and successful national representation to increase psychologist training places and EPUT successfully applied to be a main provider for psychologist apprentice training, the only one in the UK to be successful.

Despite the significant challenges, with the continuous effort put in, EPUT has overall successfully recruited with nearly 70% of MH positions being permanent with a further approximate 10% of positions filled with temporary staff, mostly bank staff.

Communications plans are also in place to ensure that the public, patients and carers as well as wider system health, social care and third sector staff are aware of the changes and access the new service appropriately.

6 Finance update

There was a big push (by CCGs) on getting this year's MHIS investments developed, agreed and in place for the reporting that was required mid-year. Our (EPUT) difficulty is lack of transparency on the funding stream and the year to which they are being tagged, so whilst we see investment in mental health services, unpicking what the CCGs are counting as MHIS spend for the year is a complex and not easily achievable task. It is therefore proving difficult for us to monitor CCG MHIS plans or actual spend and this is one of the key points that has been flagged in the past by MH providers being asked to confirm/sign off the CCG MHIS plans. The monitoring has improved in the last 12-18 months, there is more transparency and the CCGs seem more willing to be open about where investments are being made.

The Trust transformation finance and service development leads will be organising the 21/22 investments by schemes into a programme management schedule to assist in understanding investment and delivery against that investment.

7 Action Required

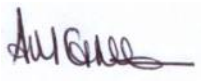
The Executive Operational Committee is asked to note the contents of this report,

Report prepared by:

Mark Travella
Associate Director Business
Development & Service Improvement

Opeyemi Adetokunbo-Aina
Senior Finance Manager for Transformation Projects

On behalf of:



Alexandra Green
Executive Chief Operating Officer

		Agenda Item No: 10(b)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**31 March 2021**

Report Title:	**Constitution Review**					
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 18 February 2021					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report presents the Trust Constitution for approval.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of this report.
2 Approve the Trust Constitution

Summary of Key Issues

The Trust is required to undertake a review of its Constitution on an annual basis. The last review of the Constitution took place in February 2020, with final sign-off completed in March 2020 The review of the Trust Constitution requires approval by the Council of Governors and the Board of Directors.

The Trust Constitution was reviewed by a Task and Finish Group (nine Governors, two NEDs, Assistant Trust Secretary and Interim Trust Secretary) held on the 11 January 2021. The group proposed a number of changes and / or queried existing clauses. John Coutts (NHS Providers) reviewed the proposals and queries identified, providing advice which was discussed by the CoG Governance Committee.

The Council of Governors considered the amended Trust Constitution on the 18 February 2021. The revised Trust Constitution is attached to this report for approval.

Three key changes were agreed as follows:

- **Staff Constituency (Section 8.0):** The elections held in 2020 highlighted an issue when

a temporary member of staff tried to stand in the election for the staff constituency. It was noted that the constitution was vague in this area and therefore a new clause has been added as Section 8.1.3 "*For the avoidance of doubt solely 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."*

- **Deputy Chief Executive Officer (Section 30.5):** The Governance Committee agreed to amend the wording for this section to *"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"* This allows the CEO to implement a more flexible process, rather than appointing a single Executive Director, subject to approval by the BoD Remuneration & Nominations Committee.
- **Mergers etc. and Significant Transactions (Section 49.2):** The words "*unless it is a merger, acquisition, separation or dissolution"* have been added to differentiate between section 49.1 which requires more than half of the Governors to approve, rather than just those voting at the time, due to the higher risk nature of the decision.

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

- **Election of Governors (Section 15.5):** It was agreed that in the event of a vacancy within the first 2-years of a Governors term of office, the Trust Secretary's Office would return to the results of the last election that took place in the constituency, which would better reflect the electorate at the time. There was a risk that there would be an imbalance in the terms of office served by Governors, depending on which Governor they replaced on the Council, however, this was accepted based on the benefits associated with reflecting the more recent electorate.
- **Annex 1: The Public Constituencies:** The Governance Committee reviewed the current composition of the Council with a view to amending the number of Governors representing West Essex & Hertfordshire and North East Essex. However, data and advice from NHS Providers suggested that the Council was fairly represented and therefore it was agreed no change was required at this time.
- **Model Election Rule 2014 Section 11.1(b) Declaration of Interest "*whether the candidate is a member of a political party, and if so, which party"***: The Governance Committee had discussed whether to remove this section as it was not relevant to an individual standing for election. However, it was agreed that it would be useful for the Trust to know if the Council was composed of a large number of individuals from the same political party and therefore the Committee agreed no change would be made to this statement.
- **Strategy Planning (Section 3.1.4):** The Committee considered removing the words "in any financial year" from the clause. However, it was agreed that the clause reflected the law as written in the Health & Social Care Act and therefore should not be changed.

The Board of Directors is asked to approve the revised Trust Constitution.

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

Relationship to Trust Corporate Objectives

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

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

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

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

20210331

Essex Partnership University NHS Foundation Trust

Constitution

Approved by Council of Governors ~~13th February 2020~~18 February 2021 and Board of Directors ~~25th March 2020~~ TBC

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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 masculine gender only shall include the feminine gender; words importing the singular shall import the plural 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 An individual who is 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 he is 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 he has 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 he informs the Trust that he does 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.

Commented [JC(EP2]: The Governance Committee agreed to the principle of going back to the latest election figures, with the acceptance that there is a risk of unfairness in relation to the term of office.

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 An elected Governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected

16.3 An elected Governor shall be eligible for re-election at the end of his term

16.4 An appointed Governor may hold office for a period of up to three Years

16.5 An appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him or if the appointing organisation ceases to exist and there is no successor in title to its business

16.6 An appointed Governor shall be eligible for re-appointment at the end of his term

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

16.7 ‘‘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 a person who has made a composition or arrangement with, or granted a Trust deed for his creditors and has not been discharged in respect of it

17.1.4 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 him

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 his 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 ~~attached~~ 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 a Governor has 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, the Governor shall disclose that interest to the members of the Council of Governors as soon as he becomes 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

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 he is 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, he exercises functions for the purposes of that university, and

27.3 he is 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 general 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 ~~one of the~~an Executive Director~~s~~ 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 a person who has made a composition or arrangement with, or granted a Trust deed for, his creditors and has 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 him

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 a person where disclosures revealed by a Disclosure & Barring Service check against such a person are such that it would be inappropriate for him 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 a person 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 behavior 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 Director 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 attached 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 he belongs and, where there are classes within it, the class to which he belongs

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 Each Director and Governor shall advise the Trust Secretary as soon as practicable of anything which comes to his attention or of which he is 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

Commented [JC(EP3]: Wording added to clarify difference between section 49.1 in relation to a significant 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	
CVS Essex	1	
Total Council of Governors		**30**

ANNEX 4.1: NOT USED

ANNEX 5: THE MODEL ELECTION RULES

(Paragraph 15.2)

MODEL ELECTION RULES 2014

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*Council of Governors*" means the Council of Governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead Governor*" means the Governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic

communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution, and

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand

(b) decides that the nomination form is invalid

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election

(b) that the paper does not contain the candidate's particulars, as required by rule 10

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each

candidate standing, and

(b) the declared interests of each candidate standing

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules, and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules, and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules, and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information

in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address, and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation

(b) the constituency, or class within a constituency, for which the election is being held

(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3

(g) the address for return of the ballot papers

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located

(k) the date and time of the close of the poll

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope

(b) the ID declaration form (if required)

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required)

(b) the voter's voter ID number

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate

(d) contact details of the returning officer

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information, or

(b) only be sent e-voting information, or

(c) be sent both postal voting information and e-voting information

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number, and

(ii) where the election is for a public or ~~patient~~ staff constituency, make a declaration of identity,

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation

(ii) the constituency, or class within a constituency, for which the election is being held

(iii) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency

(iv) the names and other particulars of the candidates standing for

election, with the details and order being the same as in the statement of nominated candidates

(v) instructions on how to vote and how to make a declaration of identity

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of:

(i) the voter's voter ID number

(ii) the voter's declaration of identity (where required)

(iii) the candidate or candidates for whom the voter has voted, and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this, and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote, and

(ii) where the election is for a public or patient constituency, make a declaration of identity

(b) specify:

(i) the name of the corporation

(ii) the constituency, or class within a constituency, for which the election is being held

(iii) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency

(iv) instructions on how to vote and how to make a declaration of identity

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number

(ii) the voter's declaration of identity (where required)

(iii) the candidate or candidates for whom the voter has voted, and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number, and

(ii) where the election is for a public or patient constituency, make a declaration of identity

in order to be able to cast his or her vote:

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number

(ii) the voter's declaration of identity (where required)

(ii) the candidate or candidates for whom the voter has voted, and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity, and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity

(b) has no reason to doubt that the voter did not receive the original voting information

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or

30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter

(b) the unique identifier of any replacement ballot paper issued under this rule

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the

telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper

envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”), and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he

or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified"

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents, and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified"

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number, and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified"

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

(d) place the document or documents in a separate packet, and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it

(b) the ID declaration forms, if required

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,
(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference,

and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:
(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:
(a) the Board of Directors and the Council of Governors of the corporation have approved:
(i) the use of such software for the purpose of counting votes in the relevant election, and
(ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned, and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced

(b) on which votes are given for more candidates than the voter is entitled to vote

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place

(b) otherwise than by means of a clear mark

(c) by more than one mark

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper

(b) voting for more candidates than the voter is entitled to

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text

voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub-parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being

made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate

(b) add that value to the previous total of votes recorded for each candidate and record the new total

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall

treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-

parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate

(b) add that total to the previous total of votes recorded for each candidate and record the new total

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of

votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at

which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the Council of Governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on Essex Partnership University NHS Foundation Trust by section 33(4) of the 2006 Act, to the Chairman of the NHS Trust, or

(ii) in any other case, to the Chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5

(c) the number of rejected text voting records under each of the headings in rule FPP44.10

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on Essex Partnership University NHS Foundation Trust by section 33(4) of the 2006 Act, to the Chairman of the NHS Trust, or

(ii) in any other case, to the Chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not

(b) any transfer of votes

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1

(f) the number of rejected text voting records under each of the headings in rule STV44.3

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is

practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected

(b) give notice of the name of each candidate who he or she has declared elected to the Chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records

(b) the ballot papers and text voting records endorsed with “rejected in part”

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

a) the disqualified documents, with the list of disqualified documents inside it

(b) the list of spoilt ballot papers and the list of spoilt text message votes

(c) the list of lost ballot documents, and

(d) the list of eligible voters

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents

(b) the date of the publication of notice of the election

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the Board of Directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing:

(i) any rejected ballot papers, including ballot papers rejected in part

(ii) any rejected text voting records, including text voting records rejected in part

(iii) any disqualified documents, or the list of disqualified documents

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage

by any person without the consent of the Board of Directors of the corporation.

58.2 A person may apply to the Board of Directors of the corporation to inspect any of the documents listed in rule 58.1, and the Board of Directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The Board of Directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to:

(a) persons

(b) time

(c) place and mode of inspection

(d) production or opening

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the Board of Directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents

(b) the date of the publication of notice of the election

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the Chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that:

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be

questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair

(b) equivalent in size and content for all candidates

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer

(b) the returning officer's staff

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation

(b) an employee of the corporation

(c) a Director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

51. ANNEX 6: ADDITIONAL PROVISIONS – 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 he is a Director of the Trust, or a director of another health service body

4.1.2 he is the spouse, partner, parent or child of a member of the Board of Directors for the Trust

4.1.3 he is the subject of a disqualification order made under the Company Directors Disqualification Act 1986

4.1.4 he is subject to a Sexual Offenders Order under the Sexual Offences Act 2003

4.1.5 he 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

4.1.6 he is undergoing a period of disqualification from a statutory health or social care register

4.1.7 he has been disqualified from being a member of a relevant authority under the provisions of the Local Government Act 2000

4.1.8 he has been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a health service body

4.1.9 he is 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, he has had his 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 A person holding office as a Governor shall cease to do so if:

he resigns by notice in writing to the Trust Secretary

in the case of an elected Governor, he ceases to be member of the area of the constituency or class of the constituency by which he was elected

5.1.1 in the case of an appointed or partnership Governor, the appointing organisation terminates the appointment of the individual

5.1.2 he consistently and unjustifiably fails to attend the meetings of the Council of Governors in line with the Governor attendance policy as agreed by the Council of Governors

5.1.3 he has refused without reasonable cause to undertake any training which the Trust requires all Governors to undertake

5.1.4 he has failed to sign and deliver to the Trust Secretary a statement in the form required confirming acceptance of the code of conduct for Governors

5.1.5 he has committed a serious breach of the code of conduct for Governors or fails to abide by the Council of Governors standing orders

5.1.6 he has acted in a manner detrimental to the interests of the Trust

5.1.7 he has expressed opinions which are incompatible with the values of the Trust

5.1.8 he is 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 he/ she has 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 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 has been involved as a perpetrator in ~~a~~ what the Board reasonably considers to be a sufficiently serious incident of intimidation, threat~~s~~, 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 he has been excluded from the Trust's premises within the previous five years

2.1.3 he is expelled from membership by resolution of the Council of Governors

2.1.4 he ceases to be eligible under this Constitution to be a member

2.1.5 he dies

2.2 It is the responsibility of each member to ensure their eligibility at all times and not the responsibility of the Trust to do so on their behalf. A member who becomes aware of their ineligibility shall inform the Trust as soon as practicable and the name of that person shall be removed from the Register of Members

2.3 Where the Trust has reason to believe that a member ceases 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 he 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 any member of the public from an Annual Members' Meeting if he is 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 his 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: 11a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	31 March 2021

Report Title:	CQC Compliance Update					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive					
Report Author(s):	Amanda Webb, Senior Emergency Planning and Compliance Officer					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	July-August 2019 Action plan testing identified gaps of non-compliance
State which BAF risk(s) this report relates to	BAF45 - CQC Inspections and Learning BAF46 - CQC Fundamental Standards
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and requirements and to support the Trust's ambition of achieving an outstanding rating by 2022.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Identify any further action that is required to be taken.

Summary of Key Issues

Meeting Registration Requirements

EPUT is fully registered with the CQC.

CQC Inspections

There have been no new CQC inspections in this reporting period. EPUT has no action plans open with the CQC following inspection.

As previously reported the CQC undertook an inspection of Finchingfield in 2020 and the action plan following this visit has been completed in full and submitted to the CQC. An assurance visit was undertaken by Trust Commissioners to Finchingfield Ward who checked implementation of the Action Plan and found that the actions had been embedded. Commissioner made one suggestion to have additional CCTV in the garden area of the ward.

Following completion of the Finchingfield Action plan the Inpatient Clinical Support Group agreed to expand membership to include all adult MH inpatient services to ensure

organisational learning from the inspection. An internal action plan has been developed by the Inpatient Clinical Support Group to share and embed changes across adult MH inpatient services

CQC Action Plan Testing - CQC Well Led Inspection (July-August 2019)
As previously reported the Compliance Team CQC action plan testing has found gaps in embedding actions fully from the 2019 inspection. As agreed by the Executive Safety Oversight Group these gaps were allocated to the relevant Trust Committee(s) to review and take forward further action to ensure changes have been embedded.

Testing identified 9 gaps where further embedding was needed and have been presented to the appropriate committees in February and March and actions agreed to further embed.

CQC Guidance / Updates
A range of new publications have been issued by the CQC over this reporting period including:

- Adult Social Care PIR Pilot
- Covid19 Insight V8
- CQC Proposed changes to flexible regulations

The CQC has had two consultations open in this reporting period:

- Strategy Consultation – This outlines the CQC 5 year strategy. The CQC aim is to implement their strategy over the next five years enabling them to be as flexible as possible and adapt to changes in health and care, they will review it when they need to. The Trust provided a response to the strategy welcoming the direction of travel and raising some queries around how it will work in practice.
- Changes to how the CQC will regulate – this outlines changes to the way the CQC propose they will regulate. Key changes are to make regulation more flexible and move away from only using inspections to provide ratings. The Compliance Team are reviewing the proposal in detail and will respond to the Consultation

The CQC have recently confirmed that they will be re-starting their inspection programme from April 2021 with initial focus on organisations in special measures or that have warning notices. Work is being undertaken to assist wards in preparing for potential unannounced visits.

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

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

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

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	LRRG	Ligature Risk Reduction Group

Supporting Documents and/or Further Reading
Accompanying Report – CQC Compliance

Lead
Paul Scott **Chief Executive**

Agenda Item 11a
Board of Directors
31 March 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Compliance Update

1. Introduction

This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and requirements and to support the Trust's ambition of achieving an outstanding rating by 2022.

2. Meeting Registration Requirements

EPUT is fully registered with the CQC.

3. CQC Inspections

3.1. Unannounced CQC Inspection (Finchingfield October 2020)

The CQC completed an unannounced inspection on the 29th October focusing on Finchingfield Ward following a series of incidents that took place on the 23rd October. Following this inspection the CQC issued EPUT with a Warning Notice served under Section 29A of the Health and Social Care Act 2008 (issued on 27th November 2020). An action plan was developed to meet the Warning Notice areas of concern and this has been fully implemented and all areas have been compliance checked to ensure all actions have been addressed. The action plan has been closed and reported back to the CQC.

An assurance visit was undertaken by Trust Commissioners to Finchingfield Ward, on the 12th February, who checked implementation of the Action Plan. Commissioners found that the action plan has been embedded and made one suggestion to have additional CCTV within the garden area of the ward.

The final CQC report of findings was received by the Trust on 11th February 2021 following publication of the report on the CQC website on 14th January 2021. The CQC advised that as the trust was issued with a Section 29a Warning Notice, with dates for compliance set out, and for which the Trust developed and has complete an action plan no further action plans are required following the publication of their report.

Therefore it is acknowledged that there is not a formal requirement to submit a further action plan to the CQC.

Following completion of the Finchingfield Action plan the Inpatient Clinical Support Group agreed to expand membership to include all adult MH inpatient services to ensure organisational learning from the inspection. An internal action plan has been developed by the Inpatient Clinical Support Group to share and embed changes across adult MH inpatient services.

4. CQC Action Plan Testing – 2019

Compliance CQC action plan testing has found gaps in embedded actions. These have been reported to Executive Safety Oversight Group who have agreed that where there are gaps found these should be allocated to the appropriate Trust Committees to agree and take forward appropriate actions to ensure changes have been embedded.

The table below outlined gaps found and assurance on action being taken

Committee	Actions Monitoring	Progress
LRRG	M1.1 / M1.2 S1.1 / S1.2 Ligature	M1.1 /M1.2 – action complete S1.1/S1.2 - underway
HSSC	M6.1 Safety Alerts M12.1 Manager 3i sign off	M6.1 – underway M12.1 - underway
CG&CQ	M7.1 Single Sex Accommodation / Sexual Safety	M7.1 - underway
Inpatient Quality & Safety Group	M9.1 Informing of rights M8.a Observation & Engagement	M9 - underway M8.1 - underway

5. CQC Guidance / Updates

5.1. Adult Social Care PIR Pilot

The CQC have confirmed they will be piloting an updated version of the Adult Social Care (ASC) Provider Information Return (PIR) (Appendix 1) from 10th March 2021. The PIR has been paused for the last 12 months therefore they took the opportunity to improve the PIR. The PIR gathers important information not collected elsewhere which they use to support how they monitor the quality of care within the Service.

Historically the ASC PIR's are sent via email to the Registered Manager on the anniversary of the first site visit date therefore for EPUT this would be January for Clifton Lodge and November for Rawreth Court however within the new pilot additional requests can be sent for services registered for more than 10 months. EPUT last submitted a PIR in November 2019 for Rawreth Court and January 2020 for Clifton Lodge with no subsequent inspection undertaken therefore there is the potential that we could receive a request at any time.

During March, submissions are voluntary as they understand the challenges in social care at the moment and they will not be sent to service that currently have a Covid-19 outbreak.

The Compliance Team will be supporting the Nursing Homes to complete the PIR prior to a request from the CQC.

5.2. Covid19 Insight – Version 8

In February's Covid19 Insight Report, the CQC looked at how urgent and emergency care services were affected by the pandemic in addition to providing updated data in regards to 'provision of '"designated settings" for COVID-19 patients being discharged from hospital into adult social care' and the 'number of deaths of people detained under the Mental Health Act'.

They report on 144 deaths, between 1 March 2020 and 5 February 2021, where the individual was detained of liable to be detained under the MHA and either had confirmed or suspected Covid-19. This is an increase of 7 since the last report in December

The full report can be found at COVID-19 insight report

5.3. CQC Proposed changes to flexible regulations

Following the consultation regarding the new strategy, the CQC are proposing some additional specific changes that will enable them to deal with the ongoing challenges from the pandemic and move towards their ambition to be a more dynamic, proportionate and flexible regulator.

The CQC inspection reports and ratings give a view of quality that is vital for the public, service providers and stakeholders. They want to introduce changes to allow them to assess and rate services more flexibly, so they can update the ratings more often in a more accessible, responsive and proportionate way.

Under the current ways of working, the CQC must always carry out a site visit in order to assess quality and rate the service. The site visits enable them to observe care and the culture in a service (particularly services at risk of developing a closed culture). They also help the CQC check whether the information they have reflects people's experience of care.

The CQC have highlighted the need for their assessment activity to be more targeted and focused, depending less on 'physical' sites inspections and Pre-inspections information requests (PIR's).

The CQC want to move away from using comprehensive on-site inspection and propose the following changes:

- Use wider sources of evidence, tools, and techniques to assess quality.
- Make their on-site inspections more targeted and flexible
- They want to stop describing frequency of assessment in terms of 'inspection', and instead by how often we review quality and update ratings.
- If we need to ask health and care providers for information before an inspection, the requests will be targeted and proportionate.
- Focus on reviewing, confirming and changing ratings in a variety of ways and not just after a physical on-site inspection or a full assessment of quality
- They want a less rigid approach that allows them to update ratings more often when they recognise changes in quality
- Interesting they want to be more responsive with ratings. Update more frequently and responsively.
- Moving away from a fixed schedule, flexible and risk-based approach will be used
- Change in language from inspections to "reviewing quality and updating rating": developing what this means in practice
- More targeted consultation in the future about how they will regulate

In addition to becoming more flexible with the way they regulate they want to change how they publish the ratings. For the NHS, they propose to simplify the ratings by publishing a single rating at the overall Trust level, rather than multiple levels of complex, aggregated ratings. This single rating will be based on our overall assessment of the organisation's performance against the well-led key question, including findings from service-level assessments.

5.4 CQC Re-Starting Inspection Programme

The CQC have recently confirmed that they will be re-starting their inspection programme from April 2021 with initial focus on organisations in special measures or that have warning notices. Work is being undertaken to assist wards in preparing for potential unannounced visits.

6. Recommendations and Action Required

The Board of Directors is asked to:

1. Note the contents of this report
2. Identify any further action that is required to be taken.

Report Prepared by:

Amanda Webb
Senior Emergency Planning and Compliance Officer

On behalf of:

Paul Scott
Chief Executive