Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public via Teams Live Event
Wednesday 27 January 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
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 25 November 2020	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)	Final Charity Accounts 2019/20	TS	Attached	Approval
(c)	Learning from Deaths - Mortality Review Summary of Quarter 2 2020/21 Report	NH	Attached	Noting
(d)	Update on NHS Charities Together Grants	TS	Attached	Approval
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework 2020/21	PS	Attached	Approval
(b)	Standing Committees:			
	(i) Finance & Performance Committee	ML	Attached	Noting
	(ii) Quality Committee	AS	Attached	Noting
	(iii) People, Innovation & Transformation Committee	ARQ	Attached	Noting
	(iv) Audit Committee	JW	Attached	Noting
(c)	EU Exit	NL	Attached	Noting
9	**RISK ASSURANCE REPORTS**			
	(i) COVID-19 Assurance Report	PS	Attached	Noting
	(ii) Ligature Risk Management	PS	Attached	Noting

10	**STRATEGIC INITIATIVES**			
(a)	Trust Strategy and Corporate Objectives 2021/22	NL	Attached	Approval
11	**REGULATION AND COMPLIANCE**			
(a)	CQC Update	PS	Attached	Noting
(b)	Inpatient Safety Strategy	NH	Attached	Approval
12	**OTHER**			
(a)	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
(b)	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
(c)	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
(d)	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 31 March 2021 - Virtual at 10:00			
16	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** Wednesday 26 May 2021 at 10.00 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 25 November 2020
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

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
Charlie Bosher (CB)	Quality Health
Yogeeta Mohur (YM)	Freedom to Speak Up Guardian
Kirsti Walters	Staff Member
John Jones	Lead Governor
Paula Grayson	Governor
Dianne Collins	Governor
Mark Dale	Governor
Keith Bobbin	Governor
Pippa Ecclestone	Governor
Brian Arney	Governor
Jared Davis	Governor
Emmanuel Jessa	Governor
Stuart Scriverner	Governor
Davis Short	Governor

SS welcomed Board members, Governors, members of the public and members of staff that were viewing the live broadcast. SS formally noted and welcomed Paul Scott as Chief Executive, Trevor Smith as Executive Chief Finance and Resource Officer and Alex Green as Interim Executive Chief Operating Officer.

137/20 APOLOGIES FOR ABSENCE

There were no apologies for absence. It was noted that ML would leave the meeting at 11.15 for an essential appointment.

138/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

Signed: …… Date: ……

139/20 PRESENTATION: NHS Community Mental Health Service User Survey 2020

SS welcomed Charlie Bosher from Quality Health to present the results of the NHS Community Mental Health Service User Survey 2020.

CB reminded all that Quality Health was a private independent company that ran the survey on behalf of the CQC, CB added that Quality Health do not set the questions as part of this survey, however can provide feedback regarding questions on behalf of the Trust if desired.

The survey was run between February and June 2020. The comparative data displayed in this report is from the 50 mental health trusts and Community Interest Companies with mental health functions surveyed by Quality Health this year. This differs slightly from the national data however Quality Health work with 91% of the Trusts who are surveyed and as such the difference is minimal.

Lockdown occurred during the fieldwork period of this survey and as such the coordination service responsible for the survey have noted that there are some significant differences in some questions compared to previous years; as a result have made the decision that this year's survey is classed as not directly comparable with previous years. CB confirmed that as a reference point this presentation did include previous year's data but it is important to remember the impact of Covid-19 where there are large fluctuations as some may be explained by the national lockdown imposed.

The response rate has not changed significantly to previous years and is around 27% which is above average. CB advised that 23 of questions (83%) scored in the intermediate 60% of Trusts, this indicates that the Trusts are performing well. 4 questions (14%) scored in the highest 20% of Trusts and 1 question (4%) scored in the lowest 20% of Trusts. This was an improvement compared to previous years.

CB advised that due to the time restrictions, he would not refer to each question within the survey but would highlight particular areas where the scoring had changed / fluctuated. CB advised that there had been a decrease in the scoring of the question 'Have you been told who is in charge of organising your care and services?". However this was not necessarily a cause for concern as it was not a significant decrease, however may become an issue should this trend continue.

Results in regards to 'reviewing your care' CB advised that an important indicator of the quality of services was whether in the last 12 months, has the patient had a specific meeting with someone from MH services to discuss how your care is working. CB confirmed that EPUT had scored above the national average over the past two years which was very positive. An increase in the response rate to the question "did you feel that decisions were made together by you and the person you saw during the discussion?" which was also very positive and demonstrated good communication between health care professionals and patients and that patients were engaged in their care planning.

In terms of Crisis Care, disappointingly the response rate to the question 'would you know who to contact out of office hours within the NHS if you had a crisis?" had decreased significantly, however the response rate to the question "in the last 12 months, did you get the help you needed when you tried contacting this person or team?" had significantly increased. Encouragingly service users are reporting being checked in on regarding use of medication.

In terms of support and wellbeing there had been some good improvements around being supported with physical needs, receiving help or advice with finding support for finding or keeping work and involving family members or someone else close to the service users in their care.

Overall rating of experience and service users feeling that they were treated with respect and dignity by NHS mental health services has improved significantly.

In summary, results should be looked at with caution due to fluctuations surrounding Covid 19 and the associated national lockdown. Whilst there are some lower scores, the majority of scores are improving. The majority of scores are in the intermediate 60% range which was encouraging. Just one score is in the bottom 20% category and on the whole, the scores indicate the Trust is performing well.

As a result of the survey results, Quality Health had identified a number of recommendations including:

- ensuring service users know who is in charge of organising their care
- ensuring service users are involved in planning their care
- continuing to ensure all service users are being offered a formal review meeting
- continuing to seek to involve service users in decision making at this meeting
- investigate why there has been a decline in the number of service users reporting that they know how to access the crisis care services
- ensuing the side effects of medication are clearly explained clearly to the service user

SS thanked CB for an informative presentation showcasing the feedback as a result of this survey which provided real insight to the Board. SS was pleased to note the positive improvements and overall encouraging results, as well as those highlighted as markers to take account of and investigate more.

PS thanked CB for a clear presentation, noting the encouraging improvements. PS suggested this survey provided rich data that will help inform our Safety Strategy and the opportunity to cross reference the findings from this survey against other data points to focus our resources to make significant improvement for our service users, suggesting this could be triangulated through the Quality Committee.

MK reflected that during this time the Crisis Service was being reorganised with the launch of Crisis 24/7 and suggested it would be interesting to see what impact this reorganisation would have on the results for next year.

AG thanked CB for highlighting areas for improvement stating that the Trust will review and explore these areas and also noted the positive improvements. AG added that it was important to note that Covid had impacted people very differently and therefore it is quite difficult to measure, suggesting there may be potential to review system wide work around people's experience of Covid to begin to unpick where this has impacted their experience.

JW welcomed PS' suggestion that the Quality Committee triangulate data. JW also stated that the graphic at the beginning of the slide show was powerful and there may be opportunity use graphics such as these to help demonstrate and for the public to understand where the Trust sits in the global spectrum in respect of these surveys.

AD noted the score around being involved in decision making was good, however the score around being involved in care had decreased slightly, suggesting these two results were at odds and required further exploration to determine why those two similar areas were so different. CB agreed that this was an area for exploration using the breakdown tool provided by Quality Health.

SS again thanked CB for the insightful presentation and noted the work required to continue keeping focus on the journey of improvement as we move through the year.

140/20 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 30 September 2020 were agreed as an accurate record of discussions held.

141/20 ACTION LOGS AND MATTERS ARISING

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

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

The Board discussed and approved the Action Log.

142/20 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.

The Board received and noted the Chair's Report.

143/20 CEO REPORT

SS advised that this was a new approach under PS's leadership to bring a written report highlighting key areas or issues to flag as Chief Executive which was welcomed by the Board.

PS wished to draw out some key pieces from the report, beginning with the warm welcome he had received from staff across the Trust as well as system partners and stakeholders. The structure of the report is to pick up three areas; 1) key issues the Trust is facing, 2) performance and 3) strategic developments.

The key issues currently facing the Trust are Covid and the Health and Safety Executive prosecution, both of which had required a lot of emotional and physical resources and thanked all staff for their continued dedication during the Covid pandemic. PS recognised that this period had been difficult both personally and professionally for all and the Board acknowledged the challenges that our staff are responding to. PS added that whilst responding to the pandemic had been challenging, it was important not only to focus on the here and now, but also look to and plan for the future; stating that the strategy of the organisation would be reviewed with the Board later in the year. In the meantime the Board were focussed on three areas of strategic direction: 1) ensure we are confident that we are progressing and prioritising safety in the organisation, engaging the Safety Strategy during December and January. 2) Ensuring EPUT are a good partner to our health and care stakeholders and partners, especially in the context of system recovery from Covid. Leadership within the three STP and ICS areas the Trust are engaged with has been refreshed and we are supporting our clinicians to take leadership roles within STPs and we are delivering a number of provider collaboratives. 3) We know that Covid has had a devastating impact on the local economy. As the sole NHS MH Provider that straddles Essex, we have a responsibility to use this status to support the recovery of the Essex economy, as such we will be seeking new partnerships with the commercial sector, educational facilities and housing associations to encourage innovation and investment to support our population in the future.

SL began by advising that to date the Trust had recruited 107 newly qualified nurses this year which was an increase of over 60% compared to last year. The Trust had also increased our bank by 700 staff to support the Trust response to Covid since March. The overall vacancy rate is down to 9.3%.

In terms of learning and development, the Trust have expanded student capacity to 320 new students which is significantly higher than previous years. We have also been approved as a training provider of Clinical Associate Psychology apprentices. The Trust has also developed Talent Lounges for administration and clinical staff supporting staff to reach their maximum potential. A new appraisal process will be introduced in December that encourages conversations around the individual's performance, learning needs and commitment to safety objectives. Mandatory training sessions have been expanded to evenings and weekends to support the backlog, and the rostering of training has commenced to support the planning.

In terms of staff engagement, SL advised that the Staff Survey response rate is currently at 44% with another two weeks before close, this is one of the highest response rates in the region. 450 Staff Engagement Champions have also engaged with senior leaders and 'The Grill' has been introduced creating a forum for Engagement Champions to have direct access to Executives and Board members to air challenges and frustration.

ARQ thanked PS for this helpful report updating on various issues across the Trust. ARQ referred to the 'Be You' campaign and queried whether this campaign has resonated with staff; SL confirmed that only this week he had received a video from a staff member stating that they now felt able to be their complete self at work; metrics are currently unavailable but the impact of the campaign is felt across the organisation.

RH echoed and agreed that this was a useful report; RH congratulated SL and teams in terms of recruitment and noted that student numbers have increased and queried what infrastructure and support was in place for these students. NH advised that nationally there was a focus on increasing students across organisations, particularly due to workforce shortages experienced. Regionally we have been part of an innovation of expansion of student placements and capacity. We have been using different means in innovative ways to increase our ability to deliver good training and experience for our students; this has involved establishment of a virtual learning centre and more networking opportunities. Mentoring guidance has recently been amended, and as such students are now able to be mentored by any professional in any context and so we have been able to broaden the experience for our students.

The Board received and noted the CEO's Report.

144/20 QUALITY AND PERFORMANCE SCORECARD

AG advised that operational performance has remained consistent during October. Conversations are taking place with senior managers regarding how performance is reported and how our performance supports patient experience and quality of care. In October, the Trust achieved 23 of its Key Performance Indicators (KPI) within our target with 13 requiring improvement. Focus is directed towards mandatory training, in particular those that relate to patient safety and there are robust plans in place to improve compliance. Unfortunately during October there was a situation where a person under 16 had to be admitted to an adult facility; AG assured colleagues that care and support was in place for that person during their stay and the Trust worked with NHS England to find a suitable alternative for the patient. The Trust is reviewing the history of admissions with regional and national colleagues and AG wished to highlight that this is a national issue. With a focus on patient safety, the Trust are looking at waiting times, in particular for IAPT and psychology services, which in the wake of Covid are expected to see higher numbers of referrals. A review of timeliness of data entry and record keeping is also taking place and it is anticipated that this focussed work will improve a number of KPIs.

With regard to pressures on services, in particular inpatient facilities, we have a robust inpatient flow and capacity plan in place. This is a three point plan which looks at:

1) rigour of internal processes and escalation;
2) use of winter funding (which have now been agreed with each of our local systems) focussing on avoidance of admission to an acute setting wherever possible and working with harder to reach groups.
3) securing additional inpatient capacity, including the use of Topaz Ward, which as a result an additional 17 beds are anticipated to become available during January.

Focussed work is also taking place regarding staffing establishments, particularly within inpatient areas; a significant reduction in the use of agency staff has been seen and a review of bank staff usage is also taking place. AG acknowledged the important role that bank staff play in supporting our patients and the flexibility bank working allows many of our staff, however stressed the importance that our staffing establishments for our substantive staff recruitment are appropriate and vacancies are not filled using bank staff in the long term.

NH wished to highlight that the admission of people under 16 into an adult facility is not a decision that is taken lightly and is a Board Assurance Framework risk, this is scrutinised through our Quality Committee and is escalated through the region. We do know that Children and Young People's services are challenged across our region and we are part of a solution to provide good care to children when needed.

In regards to training, NH confirmed that this is a key priority to ensure staff are capable and competent to undertake their roles. There is weekly executive oversight of training data, and this is a key area that the Executive Team are focussing on. NH added a caveat that a number of the training that has been reduced due to the Covid-19 pandemic is refresher training, therefore full training has been received / undertaken previously which has allowed a focus on training for new starters.

TS wished to highlight two key matters for the Board's attention: The Trust continues to operate within the adapted financial regime due to the Covid-19 pandemic, meaning that for the second half of this year we are operating to national allocations. These allocations are subject to ongoing discussions with regional and national colleagues, which brings with it some uncertainty for our performance currently and our planned position at year end, and potentially our plans going forward. TS advised that the Board would be kept fully appraised of this position. In terms of our Capital Programme, TS was pleased to confirm that the Trust received national allocation for the elimination of dormitories in mental health facilities which gives a tremendous opportunity with our Capital Programme, however also puts pressure on teams to fully utilise capital resources during the remainder of the year. In order to make sure these resources are fully utilised, a restated financial programme has been developed.

AD noted that previously there have been issues accessing the online training which was frustrating for staff, although this is a national system and may not be within our gift to address, AD sought assurance that this was taken into consideration and escalated through the system to request this was addressed if this was one of the key issues.

RH noted metric 2.4 – settled accommodation was showing a consistent reduction since April, reaching 62% which was lower than the local authority target, RH sought further information and potential implications as a result of this reduction. AG advised that the Associate Director for Social Care was working closely with local authority colleagues, AG acknowledged that this was an area of concern and advised that further specific work was being undertaken. MK advised that a multi-agency project called Essex Ambitions was working to support patients with mental illness into accommodation and also addressing delayed discharges from the ward which is a national issue. A number of initiatives have been implemented and was a work in progress.

Following PS's comments regarding the Trust being keen to work closely with housing agencies etc, ARQ declared an interest stating that she currently works with a housing group that operates supported housing for people with mental health issues in multiple locations including Essex; if this was of interest to the Trust ARQ offered to facilitate introductions.

PS highlighted that there is an explicit connection between finance resources, performance report and safety and advised that the Finance and Performance Committee will continue to make these connections more explicit, adding that the scorecard will evolve over time to reflect not only contractual obligations but the ambition we have to improve safety.

The Board of Directors received and noted the report.

145/20 UPDATE ON QUALITY IMPROVEMENT FRAMEWORK

NH presented an overview of the action that is underway currently and that which is planned going forward to embed a culture of quality improvement across all services in a drive to continuously improve patient safety and the quality of care we provide for our patients. NH continued that the Trust are marking ourselves against the criteria set by the CQC, we find this criteria useful and important and are therefore endeavouring to match our delivery of quality improvement alongside this criteria. The Covid-19 pandemic has impacted at points on some of the quality improvement hubs and the ability to gather staff together to focus on quality improvement, with demand and patient safety due to responding to the pandemic taking priority. The Trust have engaged with national collaboratives and have been seen as a successful Trust within them. The Trust has also started to embed quality and improvement within 'business as usual'.

AS noted that there is a lot going on with the development of the quality and safety strategies and it is important to ensure that the Trust focus on outcomes and outputs through these frameworks, to understand and measure the impact these strategies may have. NH agreed and stated that key to the delivery of the safety strategy was the ability to demonstrate the improvement the strategy has had. Key to the safety strategy is continuous improvement but also the Trust is an early adopter of the Patient Safety Incident Response Framework, which enables the Trust to clearly set goals and targets in prevention and improvement through patient safety incidents.

SS thanked NH for the report and looked forward to verbal updates going forward.

The Board of Directors received the contents of the report.

146/20 STAFF FLU VACCINATION PROGRAMME SELF-AUDIT

NH advised that NHS England required organisations to present in public by December 2020 their flu vaccination plan. It is to be noted that EPUT began their flu vaccination planning some months ago, we knew then that we would be challenged this year. Firstly as the expectation was that 95% of all front line staff are expected to receive their flu vaccination, at the same time we are working differently due to the Covid pandemic and we have the challenge in being able to deliver the flu vaccination differently to previous years. There have been restrictions based on open clinics and therefore the Trust approach had to change significantly. Staff have been required to register for their vaccination using the Shift Partner system in order to book an allotted vaccination time. Our communication plan has also had to be flexible and adaptable, informing and reporting our progress. Incentives have also been made available to staff to encourage them to have a vaccination. The Covid-19 vaccination is expected to become available shortly and therefore there has been pressure to deliver flu vaccinations promptly due to the requirement for a break between receiving a flu and Covid-19 vaccination. NH confirmed that the Trust currently reported 52% of front line staff

receiving their flu vaccination, with many further clinics and availability for staff to receive their vaccination.

SS acknowledged the greater challenge compared to previous years in terms of the flu vaccination programme and thanked staff for their continuous efforts.

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

147/20 FREEDOM TO SPEAK UP GUARDIAN SERVICE

SL introduced Principle Freedom to Speak Up Guardian Yogeeta Mohur. YM thanked the Board and Executives for their continued support. YM advised that prior to the pandemic, the number of contacts to the F2SU service had increased dramatically. There were 18 concerns raised to the F2SU service in 2018 and 45 in 2019, with over 120 raised in 2020 so far. YM was pleased that staff felt empowered to approach the F2SU service with concerns to enable them to be escalated, investigated and addressed. YM introduced Kirsti Walters who would speak about her experience of using the F2SU platform. KW advised that she had approached YM in April during the height of the pandemic, advising that she believed that she was in an unsafe situation around Covid, that contradicted rules in place. KW advised that her line manager was supportive but KW felt that she required further support and contacted YM. KW advised that from the first telephone conversation she felt listened to and supported in terms of escalation of her concerns. KW advised that the situation was resolved but having the positive experience of using this resource, she encouraged colleagues to use this service where appropriate.

SS thanked KW for her reflections, honesty and openness of her experience of this valuable resource, stating that this emphasised the importance of this independent service.

YM thanked KW for joining the meeting today to speak about her experience and highlighting the support that this service can provide. YM also thanked SL, PS and ARQ for their continuing support for the service.

PS reinforced the importance of this resource and thanked YM for her tenacity and continued dedication to this difficult role which is increasing in profile. AG echoed PS's thanks and stated that it was important not to underestimate this important resource and its impact on staff experience and patient safety across the Trust.

ARQ expressed her support and thanks to YM during this difficult and challenging year. ARQ noted that the report indicated a rise in staff contacting the F2SU Guardian relating to bullying and harassment, with a number of staff being signposted elsewhere, and thought it may be useful to include data on the number of queries signposted and where to. This would then provide useful data as to the number of concerns dealt with by the guardians and those being dealt elsewhere.

SL gave the Board assurance that the work of the F2SU resource is triangulated with complaints and staff survey data, to pinpoint and deal with issues as they arise and indeed prevent further occurrences.

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

148/20 FINAL EPUT QUALITY ACCOUNT 19/20

SS recalled that the interim EPUT Quality Account was approved in July, with this revised final iteration including feedback from stakeholders. NH advised that this final draft was now ready for publication in line with national time scales. NH was pleased to state that the Trust met all quality

commitments for 2019/20, importantly relating to harm free care and achieving CQC rating as Outstanding in the domain of Caring and End of Life Services. NH shared that stakeholders have stated that they wished to commend and thank EPUT staff and volunteers for their commitment during the Covid-19 pandemic, stating that our staff were seen to have responded with professionalism, energy and adaptability which enabled the care of patients to continue during this challenging time. NH also wished to thank staff for their continued delivery of outstanding services.

SS thanked NH for the update regarding the thorough and comprehensive final Quality Account. AS sought clarity on the status of the 2021 CQUINS, which had been stood down until July, AS queried whether this had been reinstated. NH advised that a detailed report will be provided to the Quality Committee, however confirmed that a number of CQUINs had been stalled and the Flu Vaccination CQUIN was now an expectation and no longer a CQUIN.

JW reminded colleagues that the Quality Account was not subject to scrutiny by Audit due to the Covid pandemic and it was also unclear in terms of the Quality Account for the coming year. JW wished to note her delight in the comments from Director of Nursing colleagues in terms of consistency of data stating that these comments provided the Board with assurance in the absence of external scrutiny.

The Board of Directors approved the EPUT Quality Account 2019/20 for submission to the Secretary of State for Health and Social Care via NHS Choices and publication on the EPUT public website.

149/20 BOARD ASSURANCE FRAMEWORK

PS presented that Board Assurance Framework, noting that this was a comprehensive document and will be reviewing how the BAF is used as a management tool for our strategic risks and it's use as a live document.

AD noted CGV42 referred to the lockdown risks and queried whether the national discussions currently taking place regarding a tier system across the country may also be a risk itself due to the Trust having services across Essex, Bedfordshire and Suffolk. PS agreed to take this away for consideration.

ARQ noted that the score on BAF41 CIP had been reduced and queried the rationale behind this, also queried whether there were any risks associated with the Covid-19 vaccination and our role in delivering these vaccines. TS advised that the CIP risk was connected to both the context and mitigation, advising that as we are working within the adapted financial regime, there is no explicit CIP target established within that. Previously mitigations had been considered around non-recurrent CIPs generated and the overall underspend across delegated budgets mitigated that risk this year. There are still some concerns regarding recurrence but TS confirmed that we have managed to balance the position within the financial resources available. NL advised that there is a vast amount of preparatory work being undertaken in regards to the Covid mass vaccination programme, NL advised that this has not been included within the Board BAF at this time as there are a number of national announcements expected, but this will be updated as further information is received.

JW was drawn to the summary of length of time a risk had been open on the BAF and noted there were a number that had been active for over two years. Although acknowledging the detail behind some of the risks, JW considered whether it was time for a refresh and review of longer standing risks, adding that there was now a fresh perspective from the new members of our new leadership team.

The Board of Directors:

1. **Reviewed the risks identified the BAF 2020/21 November Summary and approved the risk scores taking account of actions taken by EOSC at its early November meeting.**
2. **Noted the CRR November summary table, including actions taken by EOSC at its early November meeting.**
3. **Noted the new risks added to the Covid-19 Risk Register**
4. **Did not identify any further risks for escalation to the BAF, CRR or Directorate Risk Registers.**

150/20 STANDING COMMITTEES

(i) Finance and Performance Committee

JW gave assurance to Board members that the Finance and Performance Committee were taking a scrutiny role in the development of the new integrated performance report and the new language used, working through with TS and AG in some detail. JW noted that in Community Services this year there have been no serious incidents reported and wished to commend the work undertaken regarding pressure ulcers and falls.

The Board were asked to agree the updated capital programme as set out within the assurance report.

SS echoed JW's commendation of community services and the good work being undertaken to reduce pressure ulcers and falls and thanked staff for their continued dedication to providing positive patient outcomes.

The Board of Directors:

1. **Received and noted the report**
2. **Confirmed acceptance of assurance provided**
3. **Agreed the updated capital programme 2020/21**
4. **Did not request any further information or action**

(ii) Quality Committee (October 2020 and November 2020)

AS presented the assurance report following Quality Committee meetings held in October and November 2020. AS advised that the Quality Committee were delighted to hear of the achievement of Cyber Essentials Plus accreditation and congratulated the IM&T Team, the Trust were only one of three in the country to achieve this accreditation.

Demonstrating the use and value of the patient story, a long conversation took place at the November Quality Committee regarding 'doing the right thing' being as important as 'doing things right'; this is in relation to the service user friendliness of some policies and procedures that sometimes may have a negative impact on people using our services. The Quality Committee will continue through the use of the patient story to discuss the patient experience.

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

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

ARQ advised that the advantage of the PIT Committee was to bring together people away from their 'day job' and challenges people are facing to discuss both business as usual and transformation and innovation. The focus of the last committee was to look ahead and discuss system wide issues and the Trust placement within that. Discussion was also held around EU Exit and the associated risks.

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

(iv) Audit Committee

JW advised that there was no written assurance report due to the meeting taking place after the deadline for Board papers, however a written report would be presented at the next meeting. JW shared that three reports were presented by the internal auditors on Covid expenditure, ligature risk and safety alerts. Colleagues will recall that internal audit review the design for those systems within our control and for those three areas substantial assurance was given (this is the highest level of assurance that Trust can be given). They also review the effectiveness of systems with substantial assurance given for Covid expenditure and moderate assurance in terms of systems for ligature risk and safety alerts with some recommendations made, all of which have been accepted and will be implemented. Interestingly the recommendations relate to training and so it is anticipated the work we are undertaking regarding the approach to training will address these issues. Extra dates have been added to the audit programme to focus on ligature risks. Work has begun on finalising next year's audit programme with safety at the heart of the audit programme.

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

151/20 EU EXIT (TRANSITION) OPERATIONAL PREPAREDNESS

NL advised that we are not anticipating any significant problems in terms of the end of the EU Transition Period, with government organisations working hard to minimise any impact, however as an NHS organisation, we have been asked to check our business continuity planning. NL referred to the Board Assurance Framework discussions, noting that that Trust has reduced the risk around EU Exit and are in a strong position as an organisation should some of those risks begin to crystallise. The Trust has identified four areas that may impact on the Trust's ability to deliver services; however business continuity plans are in place and have been tested during the Covid-19 pandemic and we are also now adept at using digital technology. One issue that is closely monitored is the EU settlement scheme, we like a number of public sector employers have a number of staff from the European Union and as such must keep them informed of any changes. Staff are written to regularly and have until June 2021 to apply for the EU settlement scheme. There are circa 150 members of EPUT staff that this relates to and our HR Team are taking this forward. In relation to IT, arrangements are being made to ensure we have appropriate cover should there be a shortage of supply of equipment and resource required to keep our electronic systems operational.

SS thanked NL for this helpful and assuring report and noted the tremendous efforts continuing nationally, regionally, locally and throughout the organisation.

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

152/20 RISK ASSURANCE REPORTS

i) Covid 19

PS noted that the country was now in the second wave of the Covid-19 pandemic and the intensity of the response has increased. EPUT's infrastructure and capacity to respond to this pandemic is substantial, with daily Gold Command meetings taking place, multiple external reporting requirements, monitoring and review of staffing and providing support to our staff and patients. A significant rise of staff absent due to Covid related issues has been seen, as well as a number of outbreaks across services – the Trust is focussing on this to ensure staff are supported in regards to availability of PPE.

Overall the Trust has assurance that both availability of PPE and oxygen supply is sustainable. The roll out of rapid testing for front line staff is now taking place which will give clearer data regarding the prevalence of the virus, and also allow staff to act promptly should a staff member test positive for the virus. We have tried hard to support staff during this unprecedented time and have invested heavily to ensure a robust wellbeing service is available, including live wellbeing, support and mindfulness sessions.

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) Covid 19 Infection and Prevention Control Board Assurance Report

NH advised that the Trust was now in a good position regarding receiving swab results within 5 – 12 hours and this initiates the right level of care, prevention and protection we offer our patients. The Trust is also now participating in Lateral Flow Testing for front line staff members to test themselves twice per week, this is currently being rolled out across the Trust.

SS thanked NH for this report advising that the Board recognised the ever increasing scope of responding to this pandemic and commended staff for their commitment and dedication to provide services for our patients.

The Board of Directors:

1. **Noted the contents of the report**
2. **Confirmed acceptance of assurance given in respect of risks and actions identified**
3. **Did not request any further action/information**

153/20 COVID 19 MASS VACCINATION

NL presented the Covid-19 Mass Vaccination report, advising that the Trust continue to make preparations in line with national preparations and guidance and will continue to keep the Board updated following national announcements.

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

154/20 SAFE WORKING OF JUNIOR DOCTORS QUARTERLY REPORT

MK presented the quarterly report on the Safety Working of Junior Doctors advising that there were eight exception reports raised by the Trainees, including overtime, accommodation and on call which have been addressed. MK took the opportunity to bring to the Board's attention the successful delivery of the first psychiatry lecture series with the Anglia Ruskin University, of which initial feedback is extremely positive. The Trust have also set up a new Psychiatry Society at the ARU medical school, as well as continuing to support the physician associates programme and are fully prepared to receive 100 new students in April 2021, which will bring the total number of students rotating through the Trust to 175 throughout the year. MK was pleased to advise that overall the relationship with ARU medical school was very positive.

SS was pleased to note the impact of the partnership with ARU Medical School and was pleased to see colleagues engaging.

AD noted that existing staff are taking up locum positions which is helping to keep agency usage lower, but sought assurance that working hours were being monitored to ensure staff were not stretched and risk exhaustion. MK noted that out of hours work was coordinated via a rota programme noting that this was for a training requirement and not for a service requirement.

The Board of Directors noted:

1. **There were 8 Exception Reports raised by the trainees**
2. **No fines were issued in this quarter**
3. **There are gaps in the on call rota which are filled by MTI and LAS doctors**
4. **The Board noted the 'Issues Arising' section in the main report**

155/20 CQC UPDATE

PS presented the CQC update following the CQC unannounced inspection that took place in October 2020 focussing on Finchingfield Ward. The CQC provided a high level feedback letter on 03 November which provided positive areas as well as identifying issues for improvement. Immediate actions were taken following the incidents and inspection including the establishment of an Intensive Clinical Support Group.

SS thanked PS for assurance in terms of actions taken as necessary in terms of the CQC feedback, acknowledging that the Trust is awaiting a formal feedback report from the CQC.

NH advised that in terms of the draft CQC strategy, the Trust is at the forefront of this and have been inclusive of its elements within the development of our safety strategy.

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

156/20 USE OF CORPORATE SEAL

SM confirmed that the Corporate Seal had been used once since the previous Board meeting as follows:

- Steppingley Hospital – occupancy agreement and licence for alterations to room at porters lodge to house fridges for vaccination storage.

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

157/20 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

There were no items of correspondence circulated to the Board.

158/20 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.

159/20 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

SS advised that a video was produced by the Mid and South Essex Care Partnership to thank staff and volunteers for their contribution in responding to the Covid-19 pandemic, this video also includes members of EPUT staff and SS wished to share this with the Board and viewers to acknowledge the contribution of all during this unprecedented and challenging time.

160/20 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

It was noted that ML left the meeting at 11.15, all other Board members remained present and heard all discussion.

161/20 ANY OTHER BUSINESS

There was no other business.

162/20 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 27 January 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.

163/20 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 163/20)

Governor / Member / Public	Query	Response provided by the Trust
Pippa Ecclestone	Length of Stay of 16 year old on HBPoS Derwent Centre admitted in October	AG confirmed that this had been addressed during discussions around the performance report.
Pippa Ecclestone	EPUT total bed state pre Covid / total available bed state after March / April 20 due to Covid rules. An update on .....current out of area placement numbers? I was at my local (virtual) PCN update meeting this afternoon and both Adult and Older Adult MH contributions were dire. OA spoke about pressure on EPUT beds and having to go out of area?	In regards to out of area placements, this is a national ambition to achieve zero OOA placements by March 2021. It is acknowledged that this is extremely challenging given the unprecedented times that we are currently in and the surge of MH demand that has been seen. We have had a steady use of OOA placements over the last five months (between 12 – 15 since July – October). Looking ahead, we know that the number of MHA Assessments taking place is increasing and this needs to be taken into account. To mitigate the risk EPUT are part of a regional collaborative looking at OOA placements and standards have been set regarding the use of independent sector placements. Discussions are currently taking place with commissioners to secure 18 additional independent sector beds within the Essex system. Internal processes have been reviewed and we have good in reach to ensure patients are repatriated to our bed stock or the community as appropriate. We will also be opening 17 beds on Topaz wards in January. In terms of the number of beds closed due to Covid, the 85% capacity ambition was reviewed. There are currently 11 beds closed within our dormitory style ward to allow social distancing. For other ward areas, the environment is being managed to allow social distancing measures including rotation of dining and communal areas. We are at 100% occupancy in some areas.

Nosi Murefu	Quite a number of staff who are on 14 days self-isolating due to family members having tested positive to Covid-19, want to know how the Trust is supporting them in monetary terms as staff are not being paid their bank or average bank . The staff want to know how the Furlough system works for NHS staff as they seem to think they are being disadvantaged. Please be aware that this is for permanent staff who have 2 contracts, one for bank and the other as permanent staff. Please advise.	SL advised that this relates to staff that have both bank and substantive contracts with the Trust. SL advised that staff should let the bank staff office know that they are isolating and if staff have booked shifts these will be paid, if staff do not have booked shifts, they will be paid the average for the previous period. The Trust is committed to supporting staff that are isolating. In terms of the furlough system, this system is designed for organisations that are told to close, to support staff that are unable to work. The NHS had remained operational throughout the pandemic and therefore the furlough scheme does not apply to NHS staff.
John Jones	I note the reference in the Chief Exec Report on page 36 of the bundle that "all time low across two months for prone restraints". I see that the BAF9 'No Force First' has been re-scored down to 8. What are the figures to justify this, including the split between prone restraints and seclusion, given that there have been some problems on the safety of the 'pods' installed to administer medication, and long-held policy of this Board to reduce prone restraints to zero?	NH noted that prone restraint is at its lowest point for 24 months. Data around this has been reviewed and Board colleagues will recall that at the start of the pandemic it was predicted that levels of acuity and restrictive practice may increase given some of the new ways we had to operate such as isolation requirements and swabbing requirements. The Trust took proactive steps and operated a rapid reducing restrictive practice collaborative across all wards. We also took every prone restraint as requiring a critical incident investigation and debrief and new ways of working have now started to deliver. Previously circa 40 prone restraints were reported in month which from July has halved, and now for the past 3 months less than 10 prone restraints have been reported per month. A combination of support from pharmacy colleagues regarding different site for injection and the responsiveness of the practice development team working with the units where they are still struggling to manage prone restraints has contributed to this reduction. Also significant is that sometimes the patient places themselves in prone position and we are now receiving further guidance around patient choice. The reduction in the BAF score is due to the number of actions that have successfully been completed. AG was pleased that the reduction in prone restraints reflected the hard work being carried out across the Trust.

Jean Juniper	Not sure this is a question for the Board but having looked at the papers I am struggling a little to understand. 1. It does say on the risk BAF20 that out of area placements remain challenging. It is marked Amber. 2. Due to Covid I believe there was agreement to reduce inpatient numbers to 0. So has a reduction in the stats come about due to Covid policy? If so then this surely should not be counted as 'improvement' 3. On page 50 it talks about 247 number of days in October OOA. BAF 47 mentions the need for 85% occupancy due to Covid. A red rating was also given for an under 16 being placed OOA as no beds available. In short I'm not sure that real improvements have been made (re Covid) and it appears that it is accepted that OOA placements will continue (see risk) in which case should the risk rating for likelihood be 4 not 3. And what exactly is being done to address the need as 2021 is just weeks away and the zero target looks unachievable.	It was noted that these questions had been responded to as part of the performance report and previous questions from Governors. SS advised that should any further clarification be required, contact should be made via the Trust Secretaries office. MK advised that in terms of reducing inpatient capacity due to the pandemic, during the first wave of the pandemic the Trust had been successful in reducing the number of inpatients in our services, however the extent of reduction is unlikely to be achieved again, with an increase in patients seen with higher acuity. As mentioned the Trust is sourcing additional capacity. PS advised that it is important to balance the response to the Covid pandemic but also continuing to develop and maintain services during this period of time. The Trust are attendant to responding to the pandemic, but also to continue to drive safety improvements across the organisation. The 0 out of area placements target is national and the ambition is to achieve the target by the end of March 21. The numbers have been fairly consistent over the last six months. We had originally planned to reduce occupancy to 85% but this is only now in place on our dormitory wards in the south of essex due to social distancing challenges. We are managing the social distancing in our other ward areas, for example using the dining room areas on a rotational basis. The young person under 16 was placed in the health based place of safety in West Essex due to no CAMHS being available. This is a challenge at both regional and national level. To assure, we ensured that the right level of skills and expertise in terms of staffing was available throughout the 72 hour stay The BAF risk will continue to be reviewed. We are planning to open 17 beds on Topaz ward in mid January 2021 and are in negotiation with the CCG's and a private provider to secure an additional 18 beds to manage the surge of demand.
Paula Grayson	In the Chief Executive's report, there is a reference to reducing bank staff numbers. We can provide safer care by reducing agency staff but why do we need to	Our aim is to transfer as many Bank staff into permanent roles as possible and recognise the excellent work our Bank staff deliver.

Signed: …… Date: ……

John Jones	What arrangements are there on site to publicise the F2SU service?	We are working on a refresh of the marketing strategy for F2SU including both intranet and web site to support our virtual working environment. We are also using the engagement network to highlight this useful resource.
Dianne Collins	Regarding the guardian role is the Trust going to look annually at the issues raised and look back to previous years as it goes forward to ensure that issues do not keep on happening. This is a very positive commitment by the Trust.	Yes, 100%, we will also be triangulating this with complaints and the staff survey.
Keith Bobbin	How do we work with non mental health organisations locally – our local hospitals?	We work closely with a range of providers in our local systems across Essex including community hospitals both those delivered by EPUT and other community providers. We have good relationshiops with our acute hospitals. We are also continuing to develop our relationships and closer working with the primary care networks and working locally in neighbourhood models of care.
Mark Dale	With prone restraints are you still looking at working with patient on patient passports to look at triggers etc to again minimise restraint? Some work was moving forward last year to know certain triggers and areas where users are known to services and that new kinds of de-escalation is given.	Of course, our 'my care, my recovery' care plan document specifically asks for triggers and how best to respond and what works best. Also behavioural support plans are now fully embedded in the specialist services.

<table>
<tr>
<td>Pippa Ecclestone</td>
<td>IAPT waiting times – the figures show that for some time now, 99% of patients wait less than 6 weeks to begin treatment. Does an assessment count as begin treatment? (as it has in some IAPT service contracts elsewhere). Time between ‘referral – assessment – treatment’ starting, is EPUT able to give support to service users whilst they wait, even if this is only a weekly phone call?</td>
<td>
We are fully meeting the first appointment national targets (75% of first treatment within 6 weeks and 95% of first treatment within 18 weeks). With regard to second appointment waiting times we have no patients waiting over 90 days. Waiting times (under 28 days and over 28) are outlined below.
<table>
<tr><td>As of 18th November 2020</td><td><u>CPR</u></td><td><u>Southend</u></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td><u>SECOND APPOINTMENT</u></td><td></td><td></td></tr>
<tr><td>No: of patients waiting over 90 days</td><td>0</td><td>0</td></tr>
<tr><td>No: of patients waiting over 28 days</td><td>317</td><td>366</td></tr>
<tr><td>No: of patients waiting under 28 days</td><td>198</td><td>272</td></tr>
<tr><td>Total no: of patients waiting for 2nd appointment:</td><td>515</td><td>639</td></tr>
</table>
In terms of support offered to patients whilst adults are waiting for treatment (2nd appointment) please see below a summary of contact:-

During the process of an assessment patients will be offered a variety of signposting options (if relevant) and these are also summarised in their letter of acceptance which is then sent to the patient and GP at the end of their assessment appointment.
All patients are encouraged to access the service website at any point during their waiting time.
We have a system in place whereby any patients whom have presented with high risk at the point of their assessment (1st appointment) are offered a wellbeing call with our clinical team, for the duration of their wait, to monitor their risk presentation.
We have implemented a wellbeing call back service during COVID to any patients that identify as being at risk or vulnerable whilst waiting.
We contact patients waiting for second appointments routinely at between 60 and 70 days of waiting to ensure they are still requiring our service.

</td>
</tr>
</table>

Signed: …… Date: ……

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 27 November 2020)

Lead	Initials	Lead	Initials	Lead	Initials
Andy Brogan	AB	Nigel Leonard	NL	Amanda Sherlock	AS
Alison Davis	AD	Manny Lewis	ML	Nigel Turner	NT
Natalie Hammond	NH	Mark Madden	MM	Janet Wood	JW
Rufus Helm	RH	Sally Morris	SM	Trust Secretary	TS
Milind Karale	MK	Alison Rose-Quirie	ARQ		
Sean Leahy	SL	Sheila Salmon	SS		

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
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	Deferred to March for a 6 month update.	Deferred	
May 064/20 (1)	Freedom to Speak Up Report NHS England and NHS Improvement Self Review: review two actions agreed to bring the Trust into compliance with the self-review tool at a future Board Seminar Session.	SL	September	Due to time constraints (Covid-19) the report received from the National Guardian Office along with accompanying slides was circulated to the Board outside of the Seminar session . SL also discussed the report at the August People, Innovation and Transformation Committee.	Completed	

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
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**	**27 January 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**	

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 this report
2. Request any further information or action as necessary

Summary of Key Issues

The report attached provides information in respect of:

- Coronavirus / Covid-19
- Covid-19 Vaccination Programme
- New Non-Executive Director

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

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	
Involvement of Service Users/Healthwatch	✓
Communication and consultation with stakeholders required	
Service impact/health improvement gains	✓
Financial implications: **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
27 January 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 rising on a national scale and tightened control measures. The Trust has put in place the necessary provisions to protect patients and staff in this regard. Nationally, the guidance for healthcare staff is being updated frequently as the situation develops further. The Trust is fully engaged with system, regional and national planning to respond 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 has been appointed one of the three lead providers in the East of England region for the Covid-19 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 delivery of the vaccine. EPUT was proud to open one of the first large-scale vaccination centres in the East of England - our large-scale vaccination centre at The Lodge in Wickford offers significant additional vaccination capacity within the system, in addition to the hospital hubs and GP led vaccination services already offering Covid-19 vaccinations to the public and health and care staff across Essex and Suffolk. Further large-scale vaccination centres are due to open across both counties over the coming weeks. This has been and continues to be a tremendous undertaking and I would like to thank our staff and volunteers for their continued dedication and contribution to this vital piece of work.

2.3 Board Changes

Non-Executive Directors

I am delighted to welcome Dr Mateen Jiwani to EPUT as our new Non-Executive Director. Mateen is a practising GP and former NHS Medical Director with a passion for technology and innovation. Mateen offers a strong track record and awareness of the health and care landscape, alongside a deep insight into driving innovation and developing digital solutions. His appointment further anchors the clinical capability of the Board of Directors and will strengthen our resolve to place safety first and always.

Whilst it is with regret I note that Alison Davis our current Senior Independent Director and longstanding NED will be stepping down from her role with EPUT, I am delighted that she has been appointed as the incoming Chair of Milton Keynes Hospital NHS Foundation Trust. We extend our sincerest congratulations to Alison and wish her well as she moves into this exciting new role over the coming weeks.

Executive Directors

I am also delighted to welcome Alex Green as our permanent Executive Chief Operating Officer. Alex was appointed as Interim Executive Chief Operating Officer in October 2020 and following a competitive process has been permanently appointed. Alex brings a wealth of experience to the role having worked in health and social care for more than 25 years, and over the last few months Alex has demonstrated her extensive experience and sound leadership during this unprecedented time.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

- **Mental Health Network Welcomes Proposed Reforms To Mental Health Laws**
  Please see the first link below for a copy of "Responding to the Mental Health Act White Paper" following the review of the Mental Health Act in 2018 which was published on 13 January 2021. The second link is a "Summary", the third link is a "Impact Assessment" and the fourth link is "Reforming the Mental Health Act"
  For Information: Link; Link; Link; Link

- **PCPsych Publishes New Strategic Plan**
  Please see the link below for a copy of the strategic plan which was published on 1 January 2021. The strategic plan focuses on values, delivering training, promoting education, improving standards across psychiatry and wider mental health services.
  For Information: Link

- **Shared Decision Making Is An Integral Part Of Healthcare, Says NICE**
  Please see the first link below which explains the measures being taken to help ensure that patients are involved in decision making around their care. The second link is a consultation on the draft recommendations giving the opportunity to comment until 9 February 2021. **For Information: Link; 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**	**27 January 2020**

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**	

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
- Health and Safety Executive Prosecution and Safety
- Performance
- Strategic Developments

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

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	N/A
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	

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			
HSE	Health and Safety Executive		

Supporting Documents and/or Further Reading

Lead
Paul Scott **Chief Executive**

CEO Report – January 2021

1.0 Introduction

The healthcare environment we are working in has changed substantially since my last Board report in November. The prevalence of COVID-19 has increased dramatically with the emergence of a new variant, our health and care system is under enormous pressure, and, consequently, society is in lockdown. Hope is on the horizon with the roll out of the vaccine at an unprecedented scale – the biggest immunisation programme in the history of the NHS.

My thoughts are with everyone suffering from the effects of the pandemic whether that is because of illness, bereavement, disruption to personal lives or the unrelenting pressure of being a health and care professional during a pandemic.

We also continue to strengthen our executive team and I am delighted that, following a competitive process Alex Green has been appointed as our permanent Chief Operating Officer.

2.0 Key Issues

COVID-19

Everyone will know that the pandemic entered into a new phase during December with rapid increases in the prevalence of infection and subsequent admissions to hospital. Hospitals across Essex are dealing with unprecedented admissions of patients with Covid-19. My heartfelt gratitude goes to all involved in caring for these patients.

Over the last 8 weeks, we have worked around the clock with our health partners in MSE/SNEE/Hertfordshire and West Essex etc to support colleagues in the hospital sector as the numbers of hospital patients with coronavirus has rapidly increased and there has been increased pressure on our mental health services.

Our response has included opening and repurposing five community wards for intermediate care patients, redeploying clinical teams to community hospitals, our community teams supporting faster discharge from hospitals as well as enabling more patients to have rehabilitation and therapy in their own homes. None of this would have been possible without the skill and dedication of colleagues who reacted rapidly to increased pressures locally without complaint, during this time. It would also not have been possible without our partnership working with other organisations across the three health systems we work in. I would like to thank our colleagues across primary care, Provide, NELFT and local government, acute trusts who have shown the same desire to adapt and be able to provide the best possible services for our population.

Our inpatient services reflect the community we serve, and coronavirus cases amongst patients and staff have increased over the last few weeks. This has resulted in high levels of staff absence and a reduced number of available beds on our wards. I am very grateful for colleagues in our Mental Health services who are adapting every day to keep our services safe.

We are well aware of the enormous strain the pandemic has placed on colleagues across the health and care system. We have looked to support colleagues with further measures to support their wellbeing and resilience, as well as support them when caring for patients. . These have included ensuring they have access to support they needed including psychological support, wobble rooms and availability to snacks and drinks.

Whilst our services are under pressure it is from the tremendous efforts of our teams, and partners, that our services remain open to all. From our referrals we know that the pandemic is affecting the mental health of many people and I would like to emphasise that we are open and are here for everyone who needs our services. Please seek help through the usual routes and, if you are in a crisis, please call NHS 111 and select option 2.

COVID-19 Vaccination Programme

As you will have seen in the news, there is an unprecedented effort across the NHS to deliver the COVID-19 vaccine to the first four priority groups by mid-February. Across Essex and Suffolk, colleagues in primary care and the hospital sector have got off to a tremendous start and I am very proud that EPUT is playing a key role in the programme locally.
On Monday 18 January, we opened the first large vaccination centre in Essex at The Lodge in Wickford – it was among the first three in the East of England with the capability of delivering thousands of vaccines each week. Our teams have pulled out all the stops, working around the clock to get the sites ready and train staff.

Over the next few weeks, we will be opening more large vaccination centres, in addition to the hospital hubs and GP-led vaccination services already open, to ensure we can deliver the vaccines as close to people as possible. I would like to thank all the teams who have come together across the NHS, local authorities and third sector to make this happen – it has been an incredible effort.

Improving Safety

Since joining EPUT I have highlighted safety is our number one priority. It is clear that much has been done to improve safety on our wards, especially increased investment to make the environment safer, since EPUT was established. When benchmarking EPUT services against other Trusts it can be seen that this work has meant that EPUT provides relatively safe services. It is clear, however, following further investigation and conversations with patients, families and colleagues that, there is still more to do and our ambition is to provide the best and safest care possible for patients and become one of the safest organisations in the country.

I am delighted that our safety strategy is in front of the Trust Board today. Safety first, safety always sets out our ambition and our plans to continuously improve safety and build confidence in the trust as a safe organisation. We are looking for some elements to have an impact quickly, such as the implementation of innovative technology to support our wards. Other aspects we will look to build on include establishing a strong safety and learning culture and increasing patient involvement and codesign in our services. There are seven themes we are focussing on: leadership, culture, continuous learning, wellbeing, innovation, enhancing environments and governance and information. We will regularly update the Board on the progress we have made.

The strategy is in its first draft and we have more consultation to do. As we learn and get more feedback I expect the strategy will adapt – we will ensure that all adaptations are presented to Trust Board.

Independent Inquiry

Historical events relating to services in North Essex were debated in parliament in November resulting in the commission of an independent inquiry. The inquiry will commence in April and will cover all inpatient deaths from 2000 to 2020 across all Essex services. We welcome the further details announced on the independent inquiry including the appointment of Dr Geraldine Strathdee CBE as chair and are extremely sorry for the ongoing pain and distress to the families involved. We will, of course, co-operate fully with the inquiry and ensure we build the learning into our safety practice. Since starting as CEO I have stated that safety

is my number one priority. I want our community to have confidence that their families are safe in our hands.

Finance

The Trusts M9 YTD deficit is £2.9m against the planned YTD deficit of £3.9m.
All organisations have now been asked to include the impact of additional annual leave carry forward due to the pandemic into the forecast outturn (FOT); this will be submitted within the M9 financial submission.

Capital resources for the year total £17.4m with expenditure of £5.2m 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.

Operational Performance

Despite significant COVID related pressures, our operational performance has remained relatively stable. We have sustained the November position of 23 key performance indicators within target. There are 6 areas of inadequate performance, 4 of which have been directly impacted by the pandemic. These include inpatient mental health capacity and out of area placements which have risen significantly. Our system partners and regional colleagues have proactively responded to the significant demand and levels of patient acuity in adult mental health services and we have been able to implement a number of additional schemes to support patient flow and discharge. Unfortunately out of area placements have continued to rise as a result of increased levels of demand and a reduction in our bed capacity due to COVID outbreak management.

Our mandatory training compliance remains a continued focus and remains below target. However it is positive to note that both mandatory and essential training compliance performance have improved within the month.

The number of areas requiring improvement reduced from 10 to 7 in December. Essex STaRS and IAPT have been particularly impacted by COVID with IAPT seeing lowered referral and affected recovery rates in December subsequent to lockdown restrictions. We have continued to closely monitor our bank/agency usage but unfortunately the rising COVID sickness absence rate impacted on our ability to progress reductions.
Our CAHMS service remains challenged. The needs of children and young people have continued to change and increase in acuity and this is representative of both the regional and national picture. There is an opportunity to work more closely with community and local authority colleagues to explore alternatives to Tier 4 admission and regional colleagues will be prioritising their time to support flow and discharge.

People

Recruitment Highlights

- The Trust (Along with other West and Herts STP) were successful on obtaining funding for international recruitment between 1 November 2020 and 31 October 2021. This could mean an additional 160 qualified RMNs for the STP. The funding is provided to enable greater capacity to recruit overseas trained nurses, and provide high quality OSCE training, induction and pastoral support.

- December 2020 data shows that 13.3% of staff promoted were from a BAME background. This has been declining month on month from August = 34.78%, September = 18.8%, October = 27.8%, November = 17.5%
- Time to hire has nearly doubled in December 2020 (89 days) since September 2020 (56 Days) most likely due to the transfer of staff from recruitment vaccination project and ongoing pressures like increase in acuity/calls
- The vaccination project has assisted in the hire of over 850 bank staff of both mixed qualified and unqualified
- About to launch project into hiring Aspirant Nurses and hopefully have the same success we did with last year's cohort
- Vacancy rate has increased sharply in December 2020 to 12.5% with Operations (14.3%) and Strategy & Transformation (15.2%) seeing the highest vacancy rates. This performance brings the vacancy rate back in line with pre-covid levels.
- Staff Turnover is well below Trust target of 12% and currently sitting at comfortable 9.3% - this was 9.4% in November
- Starters Headcount above 66 per month meaning the Trust are on track for 15% increase at year end.

Learning and Development

- The University of Essex's validation event for EPUT's Clinical Associate Psychology apprenticeship programme is scheduled for February 4th. This is a Master's level programme for this new role which will form a step on the psychology development pathway.
- We are starting the process, together with HR colleagues, for recruiting our 3rd year nursing students into Band 4 aspirant nurse posts for a placement of up to 12 weeks. We are keen to implement this as it was very successful last year in terms of recruitment.
- The team have all worked very hard on getting the workforce ready for the Vaccination Centres whether it is providing training or the administrative work done in contacting the potential vaccinators.
- We have started a project to research and then implement the latest in digital technology as a means of delivering training eg: virtual reality, simulation, augmented reality. This will be a 12 month project.
- We were awarded funding for 8 Advanced Clinical Practice masters level programmes by Health Education England.
- The first session of the Systems-Psychodynamic Approach to Leadership commissioned from the Tavistock Centre has been delivered. This is a six month programme for senior leaders across the Trust.
- We will have a Graduate Management Trainee from the NHS Leadership Academy starting with our North Essex MH teams in March.

Staff Engagement & Equality

- Wellbeing Toolkit Developed for Managers
- Wellbeing Hub (here for you) being launched January 2020 across Herts & West Essex and Mid &South Essex supporting staff wellbeing
- BAME Vaccination Webinar dispelling myths and encouraging BAME staff to get vaccinated.
- Chaplaincy Lead events marking staff wellbeing and remembrance
- Thank you Gift Voucher issued to all Trust staff in recognition of Covid019.
- Staff Engagement Champions Network Meetings and Grills.
- Strengthening Mental Health 1st Aiders Programme
- Investment in 2 Wellbeing Leads for the Trust (starting Feb 2021)
- Range of Wellbeing Webinars for staff and their families
- Increase in staff Rest Spaces (aka wobble rooms)

- Increased Flexible Working and Home Working
- New Carers Passport in place
- Equality Impact Assessments for Covid-19 and Vaccination Programme
- Close networking with the ICS on wellbeing and Diversity
- Equality Representation and Equality Discussions at all Silver Command meetings
- Live Health inequalities work stream
- LGBT Awareness Sessions and Rainbow Lanyards for staff
- Sensory Loss Awareness Sessions
- Implementation of Sunflower Lanyards Scheme for Patients and Staff
- Big Conversation sessions for marginalised groups
- Reverse Mentoring Programme Live
- Cultural Intelligence Programme for Senior Leaders

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27th January 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**	

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 9 (December 2020).

The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) have reviewed performance in detail for December 2020.

Six inadequate indicators (variance against target/ambition) have been identified at the end of December 2020 and are summarised in the Summary of Inadequate Quality and Performance Indicators Scorecard. These are key areas of improvement action.

- CPA 12 Month Reviews
- Inpatient MH Capacity
- Out of Area Placements
- Mandatory Training
- Waiting Lists, inc Patients Not Seen for 12+ Months
- Covid Staffing and Sickness

There is one inadequate indicator which is an Oversight Framework indicator for December 2020.

- Out of Area Placements

There are no inadequate indicators in the EPUT Safer Staffing Dashboard for December 2020.

Summary of Key Issues
This CQC Reset action plan is summarised in the CQC Scorecard. The plan has now been completed with all actions having been met; the final actions were marked as complete at the Executive Steering Group on the 25th September. In December 2020 the key financial risks are full utilisation of the capital resource limit and financial uncertainty going forward pending further national guidance. 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	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	
SO 3: Valued system leader focused on integrated solutions	

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk	BAF6 BAF9 BAF10 BAF13 BAF20 BAF32 BAF33 BAF34 BAF35 BAF36
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications: **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
CWP	Connecting with People	YTD	Year To Date
EIP	Early Intervention in Psychosis	PHSO	Public Health Service Ombudsman
FEP	First Episode of Psychosis	PICU	Psychiatric Intensive Care Unit
FFT	Friends and Family Test	RAG	Red-Amber-Green
RWB	Recovery & Well-Being Team	RTT	Referral to Treatment
RD	Recovery Date		

Supporting Documents and/or Further Reading

Board Integrated Quality & Performance report

Lead

Name Paul Scott
Job Title Chief Executive

NHS
Essex Partnership University
NHS Foundation Trust

Trust Board of Directors
EPUT Integrated Quality and Performance Score Cards
December 2020

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.

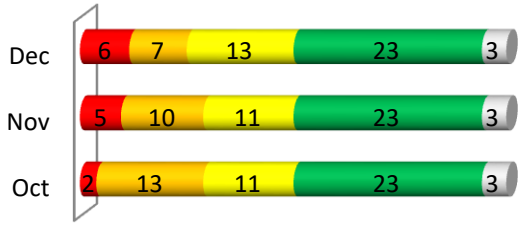
How is data presented?

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 (Pg 6)

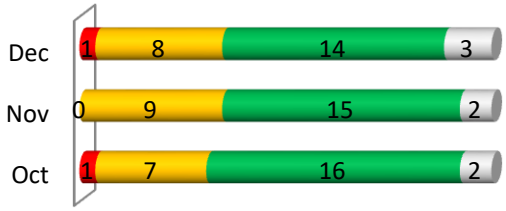


December Inadequate Performance

- CPA 12 Month Reviews
- Inpatient MH Capacity
- Out of Area Placements
- Mandatory Training
- Waiting Lists, inc Patients Not Seen for 12+ Months
- Covid Staffing and Sickness

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

Summary of Oversight Framework Indicators (Pg 11)



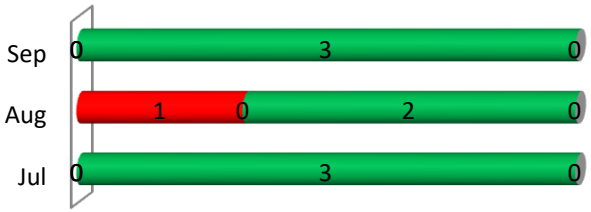
December Inadequate Performance

- Out of Area Placements

Summary of Safer Staffing Indicators (Pg 21)

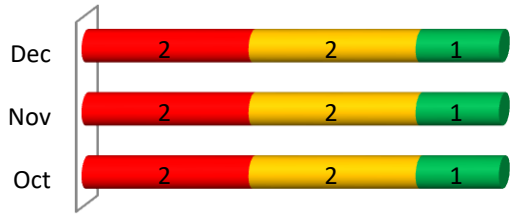
No risks identified within the Safer Staffing section.

CQC Summary (Pg 23)



The CQC Reset Action plan has now been completed with all actions having been met; the final actions were marked as complete at the Executive Steering Group on the 25th September. A new action plan will be developed following the conclusion of the next CQC inspection.

Finance Summary (Pg 25)

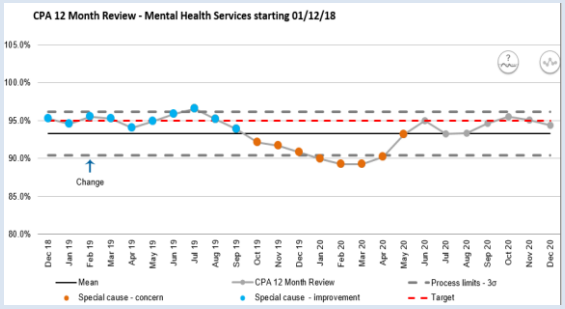


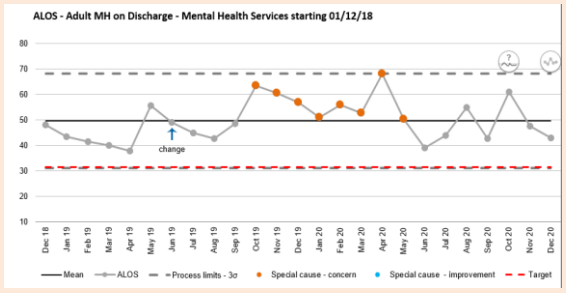
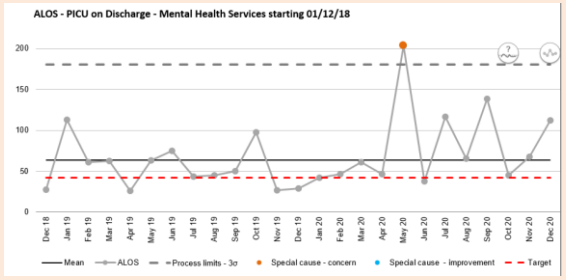
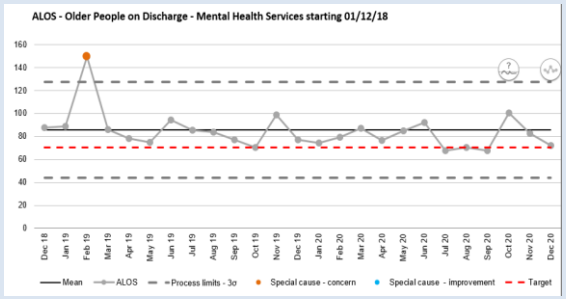
December Inadequate Performance

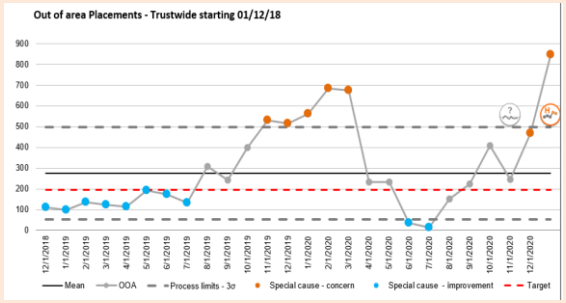
- Cost improvement Programmes
- Capital Expenditure (CDEL)

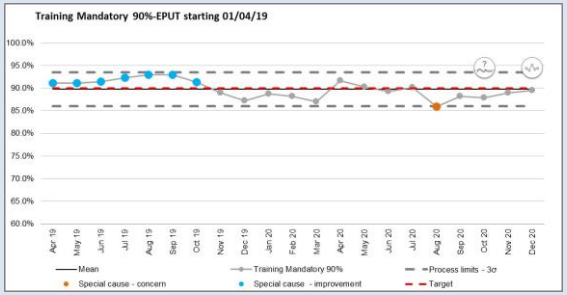
SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

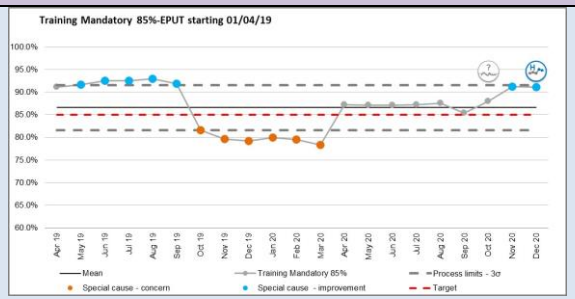
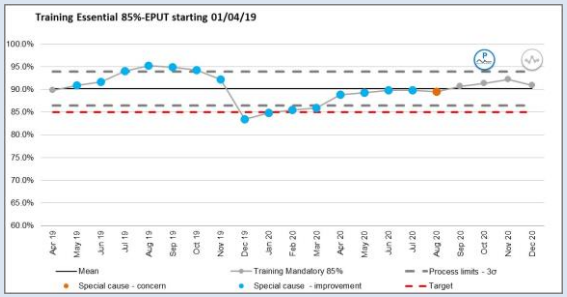
Click here to return to Summary

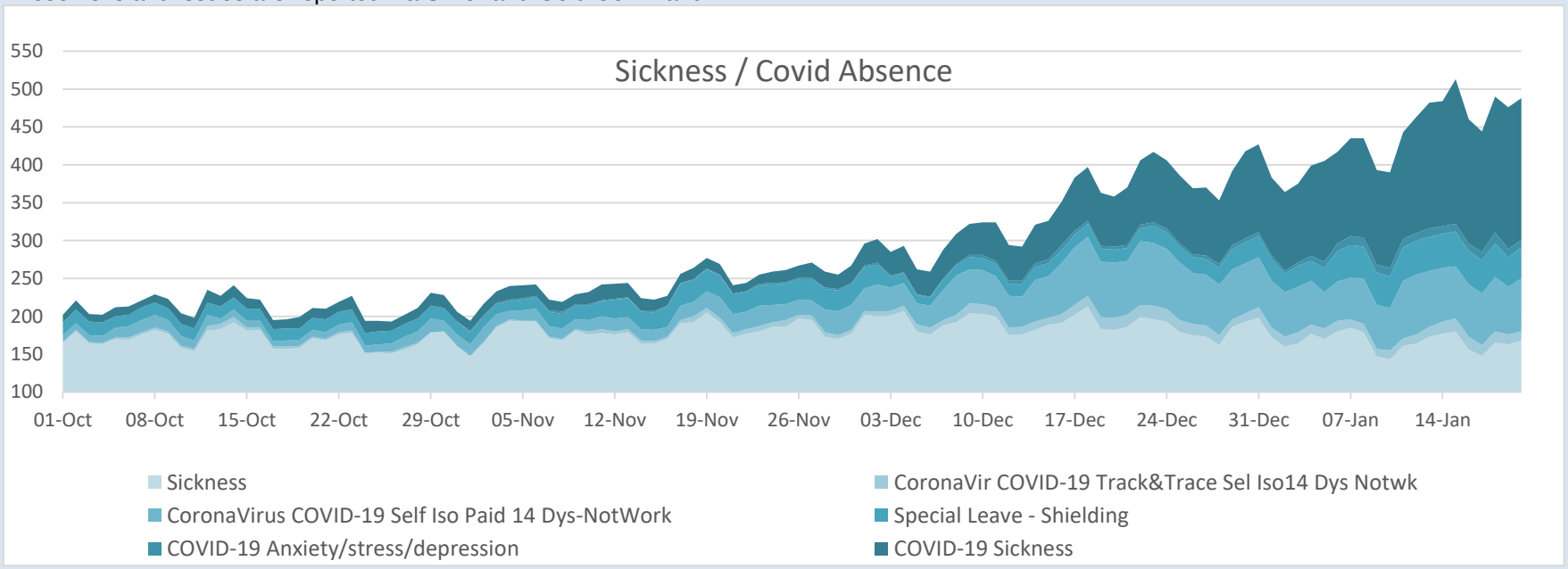
Effective Indicators							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.3 CPA Review Committee: Quality Indicator: National Data Quality RAG: Amber	**Inadequate** CPA Reviews is noted as inadequate. Performance returned to below target in December at 94.4%, this is a reduction on the position reported in November (95.1%) 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. There were seven Teams in the South, four Teams in Mid, three Teams in NE and two Teams in West below target.						
	People on CPA will have a formal CPA review within 12 months **Target 95%**	94.4%	●	Above Target = Good 	●	Performance remains inconsistent	
2.9 Inpatient Capacity Adult & PICU MH Committee: Quality Indicator: Local	**Inadequate** Adult & PICU Inpatient Capacity MH has been highlighted as inadequate due to parts of the indicator being at variance with EPUT ambition. It should be noted that bed numbers changed effective 1st September however EPUT anticipates an increase in all occupancy in line with the COVID surge and Phase 3 panning. 2.9.1 Opel Status: There were five days at Opel 4 in December (2 x North, 16/12/20 pm, 17/12/20 am, 4 x South 13/12/20 pm, 14/12/20 am & pm, 15/12/20 am & pm, 16/12/20 am & pm & 17/12/20 am) 2.9.2 ALOS Adults: has reduced in December to 43.0 days and remains outside National Benchmark of <31.6. 2.9.5 ALOS PICU: remains outside target in December at 112.3 days against benchmark of <42 days, this is due to seven discharged in December, two of whom were long stay (60+ days).						
	2.9.1 OPEL Status	5	●	five days at OPEL Four in December 2020	N/A		N/A

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: TBC	2.9.2 Adult Mental Health ALOS on discharge less than NHS benchmark **Target: 31.6**	43.0 days	●	Below Target = Good 	●	Consistently failing target	TBC
	2.9.5 PICU Mental Health ALOS on discharge less than NHS benchmark **Target: 42**	112.3 days	●	Below Target = Good 	●	Seven discharged in December (two of whom were long stay (60+ days))	
2.10 Inpatient Capacity Older People MH ● Committee: Quality Indicator: Local Data Quality RAG: TBC	**Inadequate** Older Adult Inpatient Capacity MH has been highlighted as inadequate due to one part of the indicator being at variance with EPUT ambition. 2.10.1 ALOS Discharged ALoS: has reduced from the position reported in November (82.6 days) to 72.3 days however remains outside National Benchmark of <70.3						
	2.10.1 Older People Mental Health ALOS on discharge less than NHS benchmark excluding leave **Target: 70.3**	72.3 days	●	Below Target = Good 	●	67 discharged in December (31 of whom were long stays (60+ days))	TBC

Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M8**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.5 Out of Area Placements Committee: FPC Data Quality RAG: **Amber**	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by 2021**	847 Days		Below Target = Good 		In December EPUT placed 20 new clients out of Area (14 Adult and six PICU), 23 patients were repatriated in December (21 Adult & two PICU) and 25 remain (15 Adult, one Older Adult, and nine PICU) OOA at the end of December. 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.	

Well-Led Indicators							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.4 Training, Supervision and Appraisal Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	**Inadequate** Issues in training reporting have been identified and corrected. This has resulted in an improvement across all areas and data has been refreshed. Current training figures show compliance for Mandatory training 90% at 89.5%, with three courses underperforming (Fire Safety Inpatient, and Safeguarding level 3 for both Adults and Children). Compliance for mandatory training is improving. Essential training is currently performing at 90.9% with three courses underperforming. It should also be noted that current Supervision complaince is at 80.4% against a target of 90%. This target has not been met since November 2019.						
	5.4.1 % Staff Training – Mandatory Courses **Target 90%** **Target 85%**	89.5% 91.1%		Above Target = Good 	N/A	Variation indicates inconsistently hitting and passing and falling short of the target, Common Cause – no significant change.	

Well-Led Indicators							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
						Variation indicates inconsistently hitting and passing and falling short of the target, Special Cause of improving nature of lower pressure due to (H)igher.	
	5.4.2 % Staff Training – Essential **Target 85%**	90.9%	●	Above Target = Good 	N/A	Variation indicators consistently (P)assing the target, Common Cause – no significant change.	

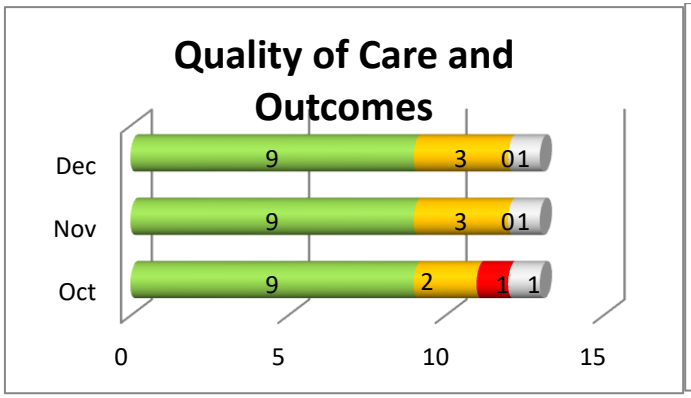
Additional Indicators	
RAG	**Narrative**
Waiting Lists	• Patients Not Seen 12 + Months; this has been included due to the patient safety risk that these clients should have been seen in 12 months but haven't been seen by any Trust service. There is 65.7% of clients on a medical caseload who have not been seen by a medic, of these 36% haven't been seen by any clinician. There are also 43.4% of clients on a Mobius non-medical caseload who have not been seen by any clinician and 6.7% on Paris who have not been seen by any clinician. • ADHD; The ADHD waiting list started with approximately 350 clients, now this number is at approximately 200. EPUT is expecting another 90 to be discharged to GP due to lack of engagement. We will then have a wait list of approximately 110 to manage. These clients will have assessments arranged via Psychiatry UK. There are an approximate 20 additional referrals from the new contract with West Essex CCG that require an assessment. • Psychology; wait times vary between 2 to 20 months depending on the different therapy and therapy stages provided, as well as the locality provided in. • MSK (West Essex); MSK urgent/post op referrals has 40% seen within 2wks.
Covid Staffing & Sickness	Since 1st November EPUT has seen significant increases in staff sickness and staff isolating due to covid. This is impacting on staffing across the Trust and these figures continue to rise. These risks and issues are reported via Silver and Gold Command. 

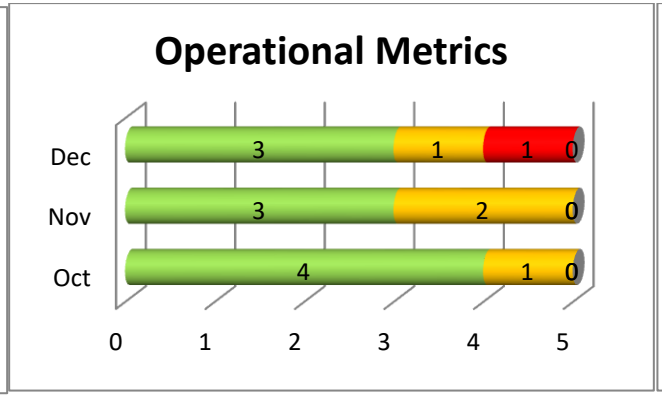
SECTION 3 – Oversight Framework

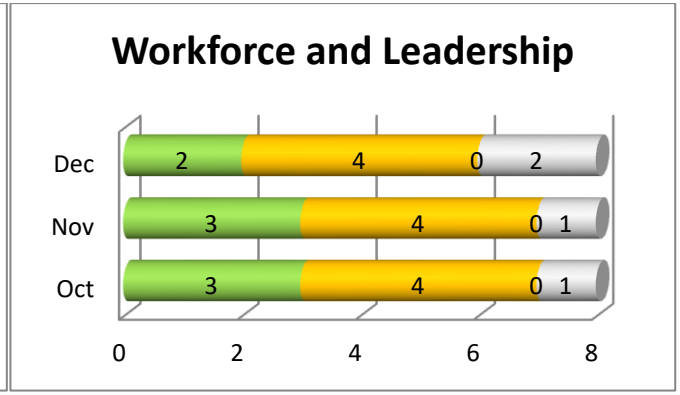
Click here to return to Summary

Summary

Please note the national Oversight Framework was revised in August 2019. Not all indicators have been issued with a target. Where there is a national target or benchmark this has been used to assess if there is inadequate performance (colour coded 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.





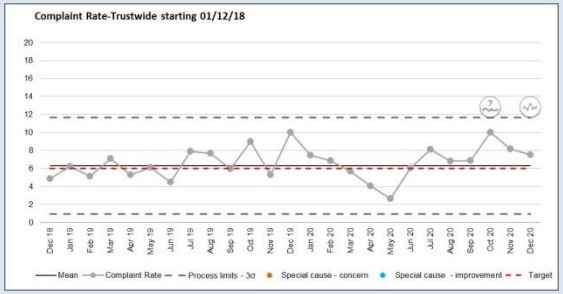


Inadequate

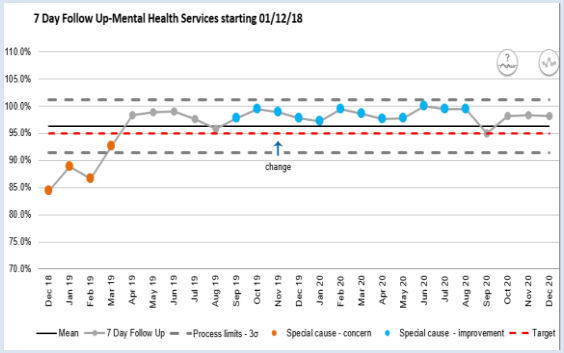
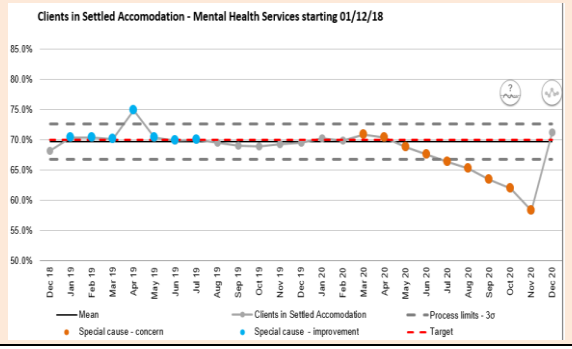
- Out of area placements

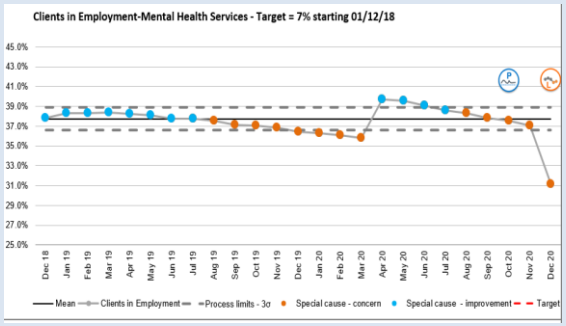
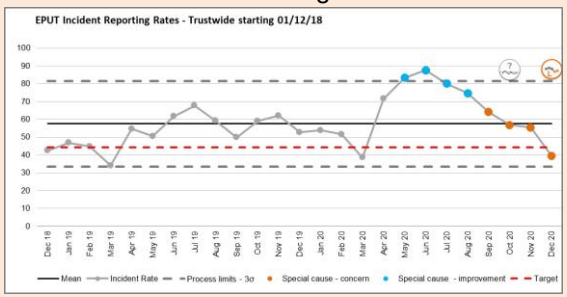
Requires Improvement

- Complaint Rate
- Clients in Settled Accommodation
- Patient Safety Incidents Reporting
- IAPT Recovery Rates
- Staff Survey indicators (4 indicators)

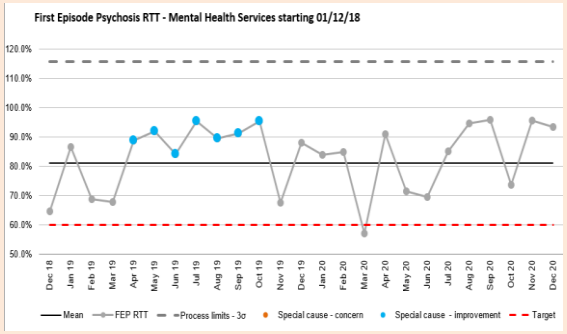
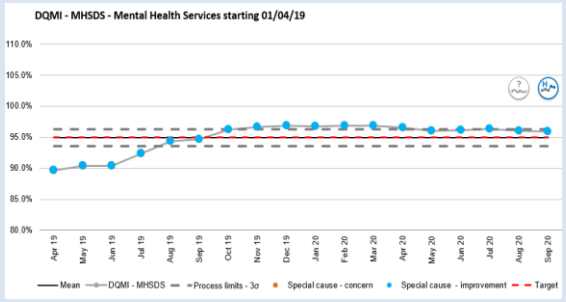
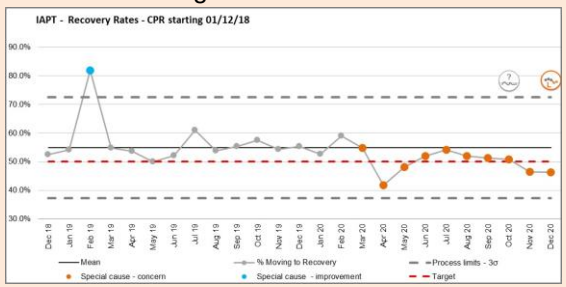
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1 CQC Rating Committee: FPC Data Quality RAG: **Green**	CQC rating of Good or above (no target set)	Good	●	CQC Unannounced Inspection (July – August 2019)			N/A
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	7.56	●	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

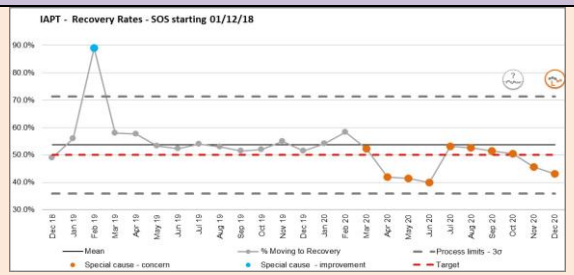
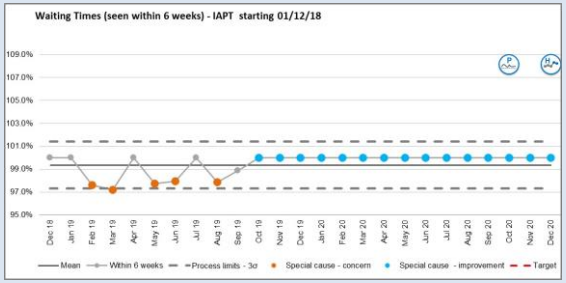
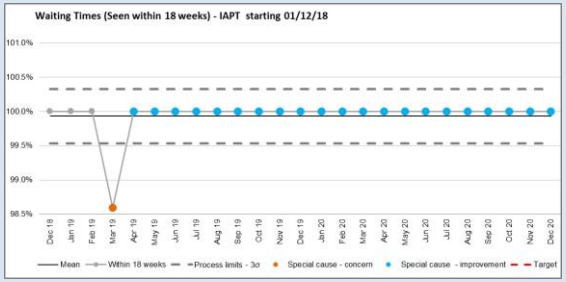
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: Oversight Framework Data Quality RAG: **Blue**							
1.6 Safety Alerts Committee: Quality Indicator: OF Data Quality RAG: **Green**	There 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 the same or better in all 11 domains in the 2019 survey	●	Responses were received from 102 people at Essex Partnership University NHS Foundation Trust.	N/A
3.3.1 Patient FFT MH Committee: Quality	Mental health scores from Friends and Family Test – % positive (extremely likely or likely to recommend) **Target = 88.3%**	100%	●	NHS England have confirmed that Data collection for the Friends and Family Test (FFT) will resume from December 2020. Since April 2020 all forms were updated to ask a new mandatory standard question "Overall, how was your experience of our service". From December 2020 any old forms submitted will be disregarded. New forms can be obtained	●	6 total responses for MH	N/A

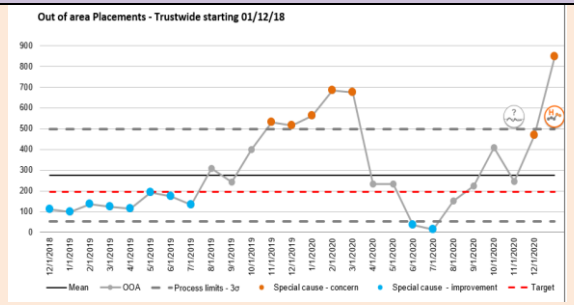
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Green**				from the Patient Experience Team.			
3.3.2 Patient FFT CHS Committee: Quality Data Quality RAG: **Green**	Community scores from Friends and Family Test – % positive (extremely likely or likely to recommend) **Target = 96%**	100%	●		●	13 total responses for CHS	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%**	98.2%	●	Below Target = Good 	●	Special Cause of improving nature due to (H)igher values. Discharge follow up forms part of EPUT's "10 ways to improve safety" initiative.	N/A
2.4 Settled Accomodation Committee: Quality Data Quality RAG: **Green**	% clients in settled accommodation (no target set) **LA Target 70%**	71.2%	●	Trend above Target = Good 	●	Improvement in Paris data noted (68.8% in December). Mobius 78.5 in December.	N/A

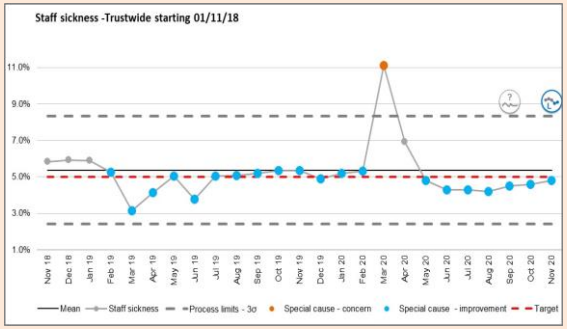
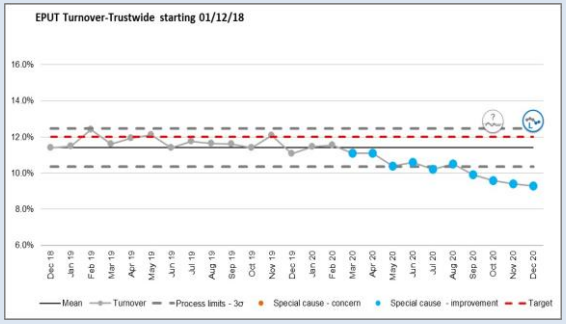
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.5 Employment Committee: Quality Data Quality RAG: **Green**	% clients in employment (no target set) **LA Target 7%**	31.2%	●	Trend above Target = Good 	●	Assurance indicates consistently Passing target. Decline in performance noted since April.	N/A
1.8 Patient Safety Incidents Committee: Quality Data Quality RAG: **Amber**	Potential under-reporting of patient safety incidents **Target >44.33**	39.4	●	Trend above Target = Good 	●	Potential concern with six months of reducing rate. **Less incidents have been signed off (by report run date) by managers in November due to earlier reporting, this has caused a decline in no/low harm rates.**	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 December and One YTD.	●		N/A

Click here to return to Summary

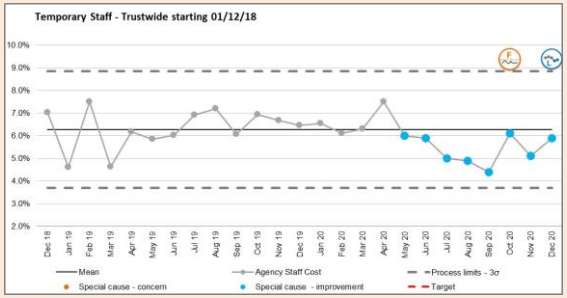
Operational Metrics							
RAG	**Ambition / Indicator**	**Position M8**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.6 First Episode Psychosis Committee: Quality Data Quality RAG: **Green**	All Patients with F.E.P begin treatment with a NICE recommended package of care within 2 weeks of referral **Target 60%**	93.3%	●	Trend above Target = Good 	●	Target change effective April 20 (from 56% to 60%) December performance represents: 14 / 15 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%**	95.9%	●	Trend above target = good 	●	Latest published figures are for September 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 46.5%	●	Trend above target = Good 	●	Remains below target for December, but decline appears to have slowed	
		SOS 45.6%	●	Trend above target = Good	●	Second consecutive month below target, and showing clear pattern of decline since July	

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M8**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
							
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 Data Quality RAG:	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by 2021**	847 Days	●	Below Target = Good	●	In December EPUT placed 20 new clients out of Area (14 Adult and six PICU), 23 patients were repatriated in December (21 Adult & two PICU) and 25 remain (15 Adult, one Older Adult, and nine PICU) OOA at the end of December. 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	N/A

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M8**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Amber						placed out of area, this was discussed and agreed at ET in July 2020.	

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M8**		**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 			N/A
5.2.2 Turnover Committee: FPC Data Quality RAG: TBC	Staff Turnover (Benchmark 2017/18 MH 12% / CHS 12.1%) **OF Target TBC** **Target <12%**	9.3%		Below Target = Good 		Special Cause of improving nature of lower pressure due to (L)ower values. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.	N/A

<table>
<tr><th colspan="7">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M8
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td>5.7.3 Temporary Staff

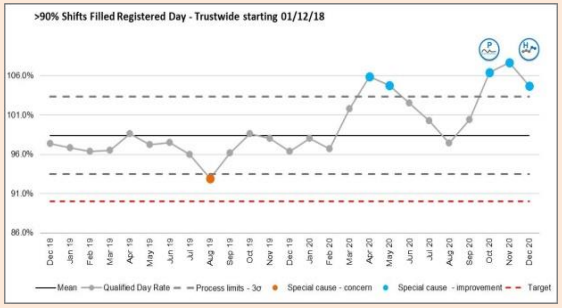
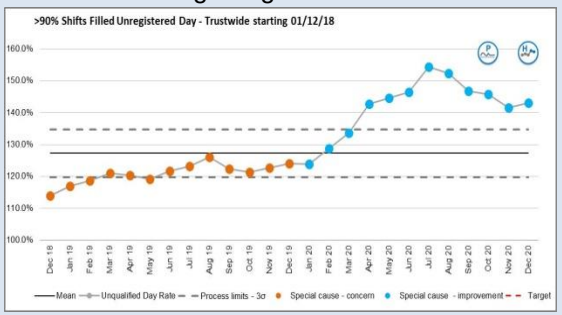
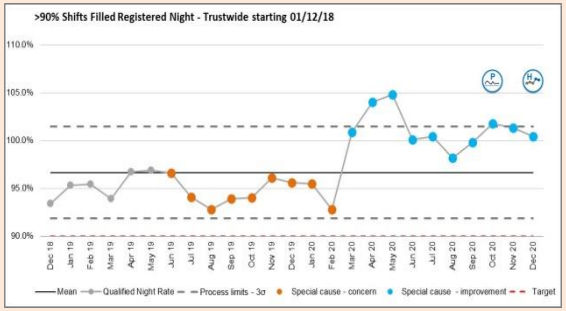
Committee: FPC
Data Quality RAG: TBC</td><td>Proportion of temporary Staff (Provider Return)
OF Target TBC</td><td>5.9%</td><td>●</td><td>Below Target = Good
 
</td><td>N/A</td><td>Special Cause of improving nature of lower pressure due to (L)ower values</td><td>N/A</td></tr>
<tr><td rowspan="3">5.5 Staff Survey

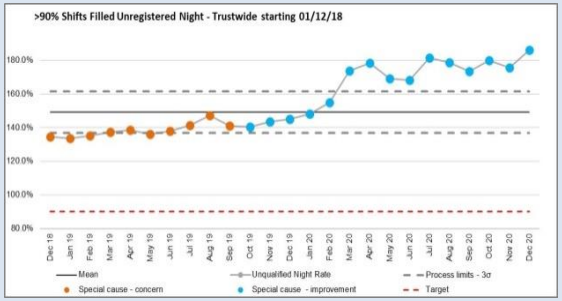
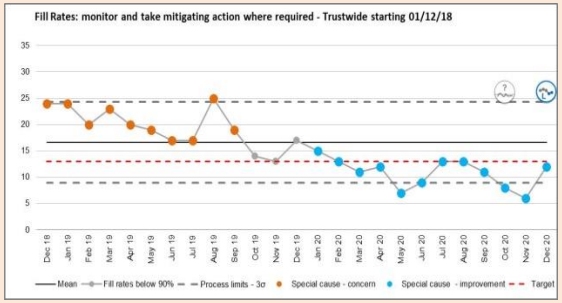
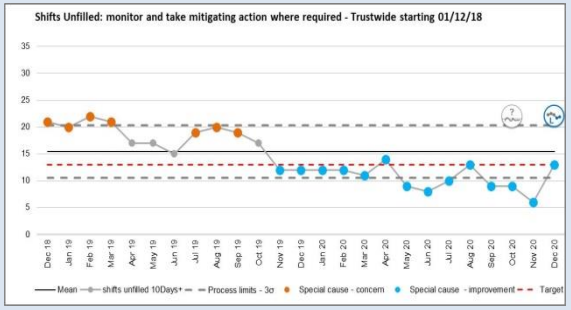
Committee: FPC
Data Quality RAG: Green</td><td colspan="6">The Staff Survey is currently underway for 2020 and will close on 27th November. As at 6th November 42% of staff have completed their survey, this is in line with 41% at this point in the 2019 survey. The aim this year is to reach a response rate of 60%. If we reach this figure, all staff members who have completed the survey will go into a prize draw ran anonymously by Quality Health to win £1000.</td></tr>
<tr><td>Place to Work of Receive Treatment</td><td colspan="5">Recommendation of the organisation as a place to work or receive treatment
<table>
<tr><th>Staff Survey 2019</th><th>EPUT</th><th>National Average</th><th>Comments</th><th></th></tr>
<tr><td>C21a Care of patients / Service users is my organisations top priority</td><td>74.3%</td><td>73.6%</td><td>Better than last year.</td><td>●</td></tr>
<tr><td>C21c I would recommend my organisation as a place to work</td><td>58.9%</td><td>62.4%</td><td>Worse than average</td><td>●</td></tr>
<tr><td>C21d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation</td><td>60.8%</td><td>67.52%</td><td>Below average</td><td>●</td></tr>
</table></td></tr>
<tr><td>Harassment, Bullying and Abuse</td><td colspan="5">Support and compassion average rating of:
• % experiencing harassment, bullying or abuse from staff in the last 12 months
• % not experiencing harassment, bullying or abuse at work from managers in the last 12 months
• % not experiencing harassment, bullying or abuse at work from managers in the last 12 months
Requires Improvement
<table>
<tr><th>Staff Survey 2019</th><th>EPUT</th><th>National Average</th><th>Comments</th><th></th></tr>
<tr><td>Safe Environment – Bullying & Harassment (high is better)</td><td>7.9</td><td>8.2</td><td>Below Average</td><td>●</td></tr>
<tr><td>Well Being and Safety at Work – Harassment, bullying or abuse at work from managers (low is better)</td><td>12%</td><td>10.8%</td><td>Above Average</td><td>●</td></tr>
<tr><td>Well Being and Safety at Work – Harassment, bullying or abuse at work from other colleagues (low is better)</td><td>18.4%</td><td>16.3%</td><td>Above Average</td><td>●</td></tr>
</table></td></tr>
</table>

<table>
<tr><th colspan="7">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M8
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td rowspan="3"></td><td>Team Work</td><td colspan="6">Teamwork Average of:
• % agreeing that their team has a set of shared objectives
• % agreeing that their team often meets to discuss the team's effectiveness
<table><tr><th>Staff Survey 2019</th><th>EPUT</th><th>National Average</th><th>Comments</th><th></th></tr><tr><td>Q4h The Team I work in has a set of shared objectives</td><td>75.4%</td><td>73.7%</td><td>Better than average and better than last year.</td><td>●</td></tr><tr><td>Q4i The Team I work in often meets to discuss the team's effectiveness</td><td>68.5%</td><td>69.1%</td><td>Below Average better than last year</td><td>●</td></tr></table>Trusts in lowest third across the sector will represent a concern</td></tr>
<tr><td>Inclusion</td><td colspan="6">Inclusion (1) Average of
• % staff believing the trust provides equal opportunities for career progression or promotion
• % experiencing discrimination from their manager/team leader
or other colleagues in the last 12 months
Requires Improvement
<table><tr><th>Staff Survey 2019</th><th>EPUT</th><th>National Average</th><th>Comments</th><th></th></tr><tr><td>Q14 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age</td><td>82.4%</td><td>85.1%</td><td>Below Average</td><td>●</td></tr><tr><td>Q15b Discrimination at work from manager / team leader or other colleagues in last 12 months</td><td>8.1%</td><td>6.4%</td><td>Above average</td><td>●</td></tr></table></td></tr>
<tr><td>Inclusion (2)
The BME leadership ambition (WRES) re executive appointments.
Later this month EPUT will be publishing its latest Workforce Race Equality Standard (WRES) data, followed by a presentation at the Board meeting on 30th September. The figures show a positive story, as EPUT has improved in a number of areas, but further work is still needed to improve the experiences of our Black, Asian and minority ethnic colleagues. EPUT's action plan for the next year will re-emphasise our zero-tolerance of racism in all its forms.</td><td colspan="6"></td></tr>
</table>

SECTION 4 – Safer Staffing Summary

Click here to return to summary page

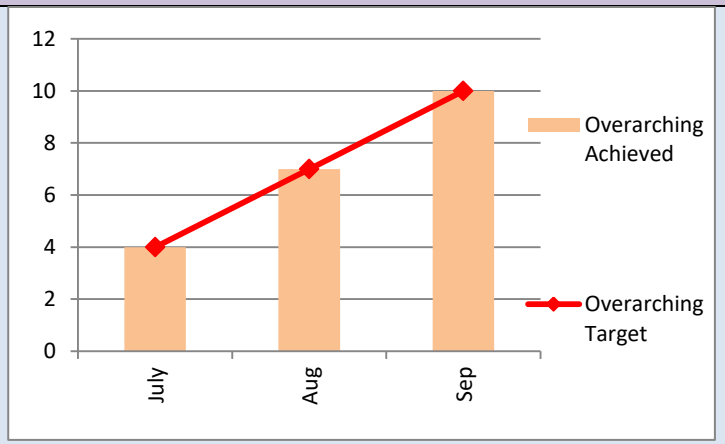
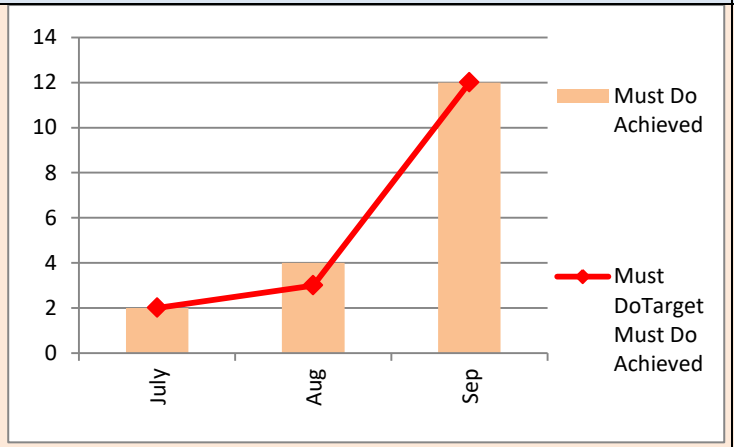
Safer Staffing							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards.							
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	104.7%	●	Trend above target = good 	●	The following wards were below target in December: Nursing Home: Clifton Lodge & Rawreth Court Specialist: Alpine, Dune & Edward House Adult: Basildon MHAU & Peter Bruff Older: Henneage & Ruby	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	143%	●	Trend above target = good 	●	The following wards were below target in December: CHS: Avocet	N/A
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	100.4%	●	Trend above target = good 	●	The following wards were below target in December: Older Adult: Kitwood, Henneage & Beech - Rochford Nursing Homes: Rawreth Court Specialist: Dune	N/A

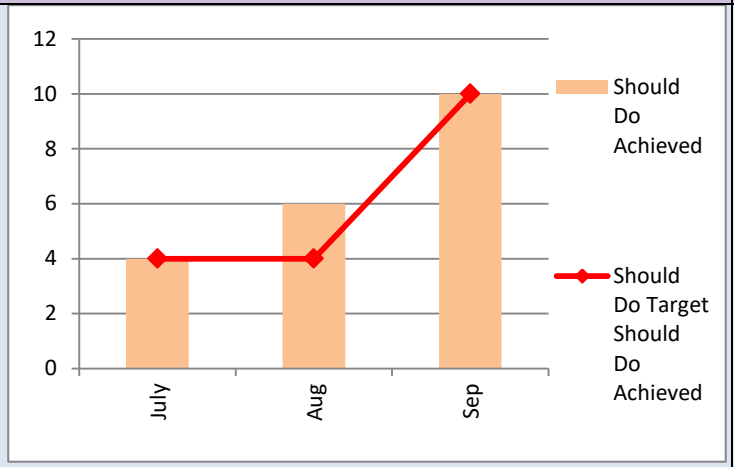
Safer Staffing							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts	186.1%	●	Trend above target = good 	●	No wards were below target in November.	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required	12	●	Below Target = Good 	●	The following wards had fill rates of <90% in December: Adult: Basildon MHAU & Peter Bruff Older Adult: Beech – Rochford, Henneage, Kitwood & Ruby Nursing Homes: Clifton Lodge & Rawreth Court Specialist: Alpine, Dune & Edward House CHS: Avocet	N/A
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	13	●	Below Target = Good 	●	The following wards had more than 10 days without shifts filled in December: Adult: Gosfield, Basildon MHAU & Peter Bruff Older Adult: Beech – Rochford, Hennage, Kitwood & Ruby Nursing Homes: Rawreth Court Specialist: Alpine, Dune & Edward House CAMHS: Longview CHS: Avocet	

SECTION 5 – CQC

Click here to return to summary page

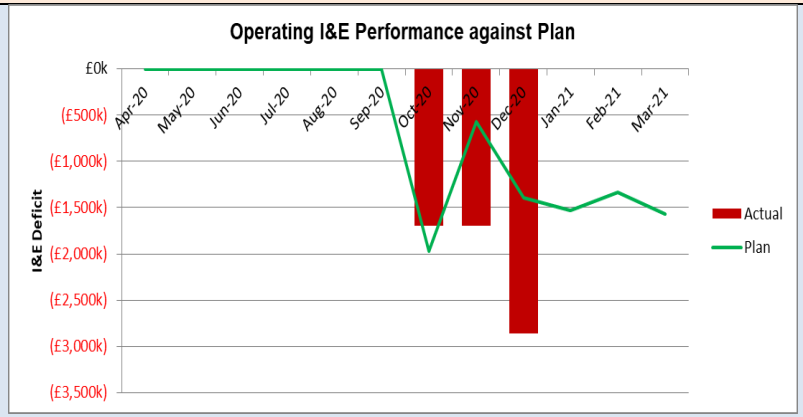
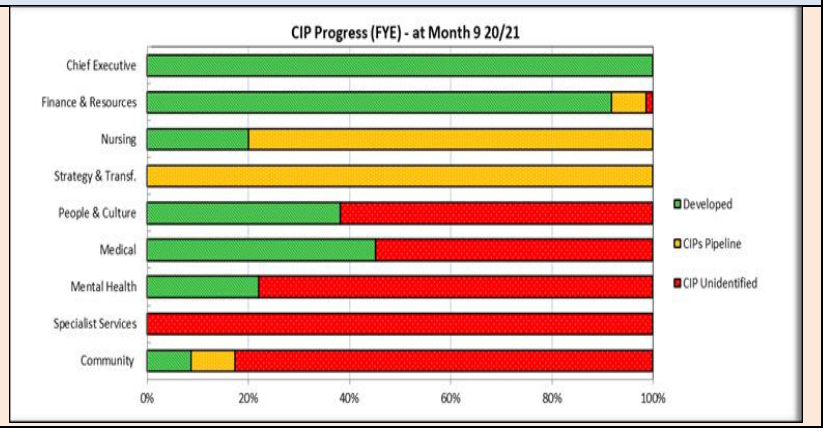
The CQC Reset Action plan has now been completed with all actions having been met; the final actions were marked as complete at the Executive Steering Group on the 25th September. A new action plan will be developed following the conclusion of the next CQC inspection.

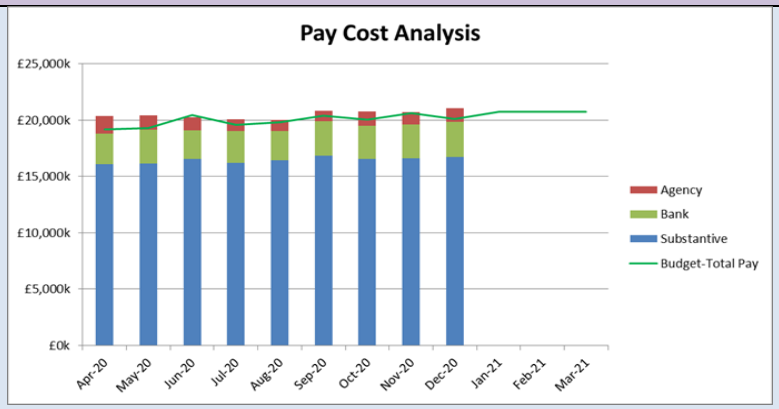
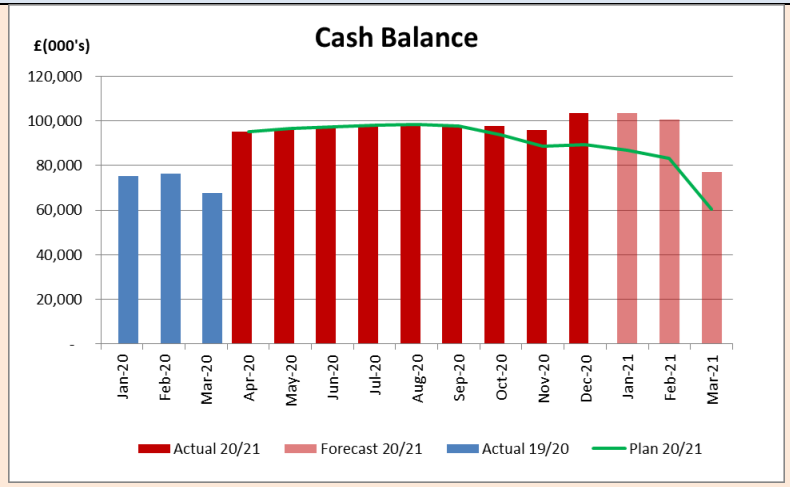
RAG	Ambition / Indicator	Position	Trend (below target = good)	Narrative
CQC Over-arching Actions	There will be 0 CQC Overarching Must Do and Should Do actions past timescale	-		The Reset CQC Action Plan is complete as at 25th September.
CQC Must do Actions	There will be 0 CQC Must Do actions past timescale	-		The Reset CQC Action Plan is complete as at 25th September.

RAG	Ambition / Indicator	Position	Trend (below target = good)	Narrative
CQC Should do Actions	There will be 0 CQC Should Do actions past timescale	-		The Reset CQC Action Plan is complete as at 25th September.

SECTION 6 - Finance

Click here to return to summary page

RAG	Ambition / Indicator	Position	Trend
Capital Expenditure (CDEL)	Maximising Capital Resources	The Trust's Capital programme has significantly increased this year to £17.4m 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 £2.9m deficit is slightly ahead of the submitted plan. During the first 6 months of the year income and expenditure have been matched under the adapted regime.	
Cost Improvement Programmes	Planned improvement in productivity and efficiency	The Trust's CIP target for 20/21 is £11.7m, including the 19/20 recurrent CIP shortfall brought forward of £5.1m. In Year savings of £8.3m have been agreed with £0.7m identified as in pipeline. Recurrent savings at Month 9 of £3.6m have been agreed.	

RAG	Ambition / Indicator	Position	Trend
Temporary Staffing	Level of Temporary Staffing Costs	Overall temporary staffing costs for the month of £4.3m includes significant Bank usage (£3.1m) (19% of total pay spend M9).	
Cash Balance	Positive Cash Balance	The cash balance at the end of December £103.5m is better than planned. The variance is mainly due to: capital spend less than anticipated due to 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**	**27 January 2021**

Report Title:	Final Charity Accounts 2019/20					
Executive/Non-Executive Lead:	Trevor Smith, Executive Chief Finance Officer					
Report Author(s):	Clare Barley, Head of Financial Accounts					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
To present the final Charity Annual Report and Accounts for 2019/20 for formal approval by 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. Approve the final Charity Annual Reports and Accounts for 2019/20
3. Approve the signing of the associated certificates and Letter of Representation on behalf of the Trust
4. Request any further information or action.

Summary of Key Issues

The auditors work around the Charity Annual Report and Accounts for 2019/20 and it is now complete and a copy of these are attached at appendix 1.

The 2011 Charities Act requires charities with gross income in excess of £1 million to be subject to a full audit and for an ISA 260 report to be presented to the Trust. Due to the charities income for the year not exceeding this threshold, an independent examination has been completed by Ernst and Young in line with guidance.

The independent examination did not require any changes to be made to the overall value of the Charity on the Statement of Financial Activities or the Balance Sheet, although a number of minor typographical changes have been made to the document. The Trustees have also been updated to include those in place throughout the 2019/20 and at point of formal approval of the accounts.

As part of the annual accounts process, the Trust is also required to submit a Letter of Representation to the Auditors which is attached at appendix 2 for the Board of Directors consideration.

Following formal approval by the Board of Directors and the signing of the necessary certificates and Letters of Representation, the Auditors will sign their certificate for inclusion in the final document. The audited accounts will then be submitted to the Charity Commission by the deadline of 31st January 2021.

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

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

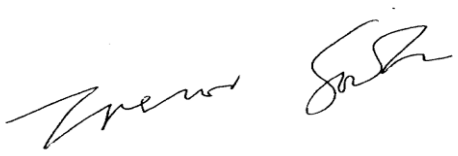
2: Compassionate	
3: Empowering	

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **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
Attached Report Appendix 1 – Final Charity Annual Report and Accounts Appendix 2 – Letter of Representation

Lead
 Trevor Smith **Executive Chief Finance Officer / Financial Trustee**

Essex Partnership University NHS

NHS Foundation Trust Charities

Annual Report and Accounts 2019-20

ANNUAL REPORT AND ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2020

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CHARITY INFORMATION

Name: Essex Partnership University NHS Foundation Trust Charities

Trustees: The Board of Directors of Essex Partnership University NHS Foundation Trust

Charity Number: 1053793

Charity Offices:
Essex Partnership University NHS Foundation Trust
Head Office
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Independent Examiners:
Ernst & Young LLP
400 Capability Green
Luton
LU1 3LU
United Kingdom

Bankers:
Lloyds Banking Group
34 High Street
Grays
Essex
RM17 6LX

Investment Brokers:
BlackRock Investment Manager (UK) Ltd
33 King William Street
London EC4R 9AS

M&G Securities Limited
Laurence Pountney Hill
London EC4 0HH

CCLA Investment Management
80 Cheapside
London EC2V 6DZ

REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2020

1. INTRODUCTION

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

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

2. GOING CONCERN

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

3. SCOPE

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

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

4. OBJECTIVES AND STRATEGY

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

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

5. **FUNDS**

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

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

6. **STRUCTURE AND GOVERNANCE**

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

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

7**. RESERVE POLICY**

During 2019/20, fund managers have again been encouraged by the Trustees to use the funds available to them. The Trustees aim to ensure the value of the overall fund value is maximised in line with the Investment Policy and will ensure that the capital value of endowment funds are maintained in perpetuity. The funds will continue to be used to improve the standards of care and facilities provided to patients and staff.

8**. INVESTMENT POLICY**

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

Funds are currently invested with the following investment managers:

BlackRock Investment Management
M&G Securities Ltd
CCLA Investment Management

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

9**. RISK STATEMENT**

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

10. FUNDING

Income is received from direct contributions from the public, in addition to income from dividends and interest receivable. In addition funds are generated from fund raising activities.

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

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

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

11. FINANCIAL REPORT FOR THE YEAR

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

The value of the Charitable Funds as at 31 March 2020 was £876,000 (2019/20: £1,010,000). The net movement in value is a reduction of £134,000 (2019/20: £428,000) and which was attributable to;

1. Unrealised loss on investment which amounted to £164,000 (2018/19: £48,000)
2. Total expenditure of £180,000 (2018/19: £213,000)
3. Total income of £210,000 (2018/19: £143,000)

The direct charitable expenditure is charged to the accounts on an accrual basis, and was in line with the objectives of the Charity. The total expenditure for the year of £180,000 can be further analysed as follows,

- Expenditure on patient welfare of £140,000 – this includes an additional palliative care support service, cycling sessions, music therapy, games and leisure activities and improvements to outside areas.
- Expenditure on staff welfare of £6,000 – this includes courses and books
- Expenditure on fundraising activities £4,000.
- Expenditure on support costs of £30,000.

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

12. **OPEN ARTS PROJECT**

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

Open Arts helps to improve and maintain mental health and wellbeing, through creative learning, social inclusion and self-expression. The service was shortlisted for national Hearts for the Arts Award, best arts project; arts, health and wellbeing in 2020.

In the past year Open Arts has delivered:

- 1,403 Client Studio and Course Sessions over 2806 hours
- 1,403 Volunteer Studio / Course & Community engagement hours
- Approximately 22271 People have attended our community engagement activities

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

A heartfelt thank you to the Open Arts team; our artists and volunteers, our steering group and to everyone that has taken part in one of our courses and studio placements; For the funding and support received from Essex County Council Cultural Strategic Fund, Waitrose Community Matters scheme, Coop, Southend Council Community Wellbeing Grant, Create98, Hadleigh Rotary club and the Trust.

'Open Arts has been my life saver, it's a safe, kind, helpful learning through creative art group without feeling pressured. I really feel it's slowly helping with my mental health and a step in the right direction, a true saviour for me, thank you.' Michele

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

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

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

Statement of Financial Activities	
	2019/20
Incoming resources from;	**£**
Essex County Council	9,260
Studio Donation	3,225
Income from other fund raising activities	1,749
Other various donation	11,828
Culture And Wellbeing Grant	2,000
Investment income	1,387
Total income	**29,449**
Resources expended on	
Charitable fund activities	(40,187)
Administration and other cost	(924)
Loss from investment valuation	(3,127)
Total expenditure	**(41,111)**
Net income/(expenditure) for the year	**(14,789)**
Fund balance at the beginning of the year	35,881
Fund balance at the end of the year	**21,092**

13. **THE TRUSTEES**

The Trustees for the "The General Charitable Fund" for the year ended 31 March 2020 are as follows:

Professor Sheila Salmon	-	Trustee
Sally Morris	-	Trustee (until 30/09/2020)
Paul Scott	-	Trustee (from 01/10/2020)
Andy Brogan	-	Trustee (until 23/10/2020)
Alex Green	-	Trustee (from 24/10/2020)
Mark Madden	-	Financial Trustee (until 30/09/2020)
Trevor Smith	-	Financial Trustee (from 01/10/2020)
Malcolm McCann	-	Trustee (until 30/06/2019)
Dr Milind Karale	-	Trustee
Nigel Leonard	-	Trustee
Professor Natalie Hammond	-	Trustee
Sean Leahy	-	Trustee (from 06/08/2019)
Janet Wood	-	Trustee
Alison Davis	-	Trustee
Amanda Sherlock	-	Trustee
Nigel Turner	-	Trustee (until 30/09/2020)
Manny Lewis	-	Trustee
Dr Rufus Helm	-	Trustee
Dr Alison Rose-Quirie	-	Trustee

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

14. **ADMINISTRATION ARRANGEMENTS**

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

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

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

15. **INDEPENDENT EXAMINERS**

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

For the year ended 31 March 2020 the Charities income was below the £1 million threshold and as such the annual report and accounts will not therefore be subject to a full audit. However, due to the Charities having income in excess of the £25,000 threshold, they will instead be subject to an independent examination as required by the Charities Act 2011.

16. ACKNOWLEDGEMENTS

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

17. APPROVAL

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

Professor Sheila Salmon
Chair

Date:

Statement of Trustees' Responsibilities

The Trustees are responsible for:

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

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

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

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

By Order of the Trustees

Signed:

Chair …… Date:

Financial Trustee …… Date:

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

FUNDS HELD ON TRUST ACCOUNTS 2019/20

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

Foreword

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

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

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

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

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

Telephone: 01268_739666

Trevor Smith
Financial Trustee

Statement of Financial Activities for the Year ended 31 March 2020

	Note	Unrestricte Funds £000	Restricted Funds £000	Endowment Funds £000	**Total Funds £000**	2018/19 Total Funds £000
Incoming Resources from:						
Donation, grant and legacies	2	24	116	-	140	65
Other trading activities	3	15	11	-	26	31
Investment income	4	20	23	-	44	47
Total income		**59**	**150**	**-**	**210**	**143**
Resources Expanded on:						
Charitable activities	5	(113)	(67)	-	(180)	(213)
Total expenditure		**(113)**	**(67)**	**-**	**(180)**	**(213)**
Net gain/(losses) on investments	6	(71)	(93)	-	(164)	48
Net income/(expenditure)		**(124)**	**(10)**	**-**	**(134)**	**(22)**
Transfers	12	-	-	-	-	(406)
Net movement in funds		**(124)**	**(10)**	**-**	**(134)**	**(428)**
Reconciliation of funds						
Total fund balance brought forward		461	521	28	1,010	1,438
Total fund balance carried forward		**336**	**512**	**28**	**876**	**1,010**

The statement of financial activities includes the income and expenditure account.
The notes are at pages 5 to 12 and form part of this document.

Balance Sheet as at 31 March 2020

	Note	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**Total Funds 2019/20 £000**	***Total Funds 2018/19*** *£000*
Fixed Assets						
Investments	7	307	472	29	808	*972*
Total fixed assets		307	472	29	808	*972*
Current Assets						
Debtors	8	-	1	-	1	*18*
Short term investments & deposits	9	4	7	-	11	*11*
Cash at bank and in hand	10	30	41	-	71	*27*
		34	49	-	83	*56*
Current Liabilities						
Creditors: Amounts falling due within one year	11	(5)	(9)	(1)	(15)	*(18)*
Net current assets		29	40	(1)	68	*38*
Total assets less current liabilities		336	512	28	876	*1,010*
Creditors: Amounts falling due after more than one year		-	-	-	-	-
Provisions for liabilities and charges		-	-	-	-	-
Total Net Assets		336	512	28	876	*1,010*
The funds of the charity						
Total restricted funds	13	-	512	-	512	*521*
Total unrestricted funds	13	336	-	-	336	*461*
Total Endowment funds	13	-	-	28	28	*28*
Total charity funds		336	512	28	876	*1,010*

The notes are at pages 5 to 12 form part of this document.

Signed:

Date:

Statement of Cash Flow at 31 March 2020

	Note	2019/20 Total Funds £000	*2018/19 Total Funds £000*
Cash flows from operating activities			
Net cash provided by/(used in) operating activities	10.1	-	*(135)*
Cash inflow/(outflow) from other activities	12	-	*(406)*
		-	*(541)*
Cash flows from investing activities			
Dividends, interest from investments	4	44	*47*
Proceeds from sale of investments	7	-	*280*
Purchase of investments		-	*-*
Net cash provided by/(used in) investing activities		44	*327*
Cash flows from financing activities			
Repayment of borrowings		-	*-*
Cash flows from borrowings		-	*-*
Net cash provided by/(used in) financing activities		-	*-*
Change in cash and cash equivalents during the year		44	*(214)*
Cash and cash equivalents at the beginning of the year		27	*241*
Cash and cash equivalents at the end of the year		71	*27*

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.1 Accounting Policies

The financial statements have been prepared under the historical cost convention and in accordance with the Statement of Recommended Practice issued in 2015 - Accounting and Reporting by Charities (FRS 102), and with accounting standards and policies for the NHS approved by the Secretary of State.

There have been no changes to accounting policy for the 2019/20 financial year.

1.2 Incoming Resources

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

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

b) Gifts in Kind

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

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

c) Intangible Income

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

1.3 Resources Expended

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

Resources expended are split into two main categories being the costs of generating funds and the actual costs of charitable activities. The costs of generating funds are the costs associated with generating income for the Funds Held on Trust, and the Charity has not recorded any of these in either 2019/20 or 2018/19. A grant is any payment which is made voluntarily to any institution or to an individual in order to further the Charity's objectives, without receiving goods or services return.

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

1.4 Tangible Fixed Assets and Donated Assets

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

1.5 Investment Fixed Assets

Investment fixed assets are shown at market value.

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

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

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

1.6 Structure of Funds

Where there is a legal restriction on the purposes to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are classified as designated funds. The major funds held within these categories are disclosed in note 11.

As at 31 March 2020 The General Charitable Fund held one endowment fund.

1.7 Pension Contributions

There have been no pension contributions made by the Charity in the financial year ended 31 March 2020.

1.8 Prior Year Adjustments

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

1.9 Pooling Scheme

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

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

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

1.10 Consolidation of Charity Accounts with EPUT Annual Accounts

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

However, IAS1 on Presentation of Financial Statements confirms that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material. The net assets of the Charity represent 1% of the Trust's total assets employed, and are therefore not considered to be material in the context of the Trusts main accounts. The Audit Committee have noted and approved that the Charity Accounts will not be consolidated into the main Trust accounts for 2019/20. This is subject to an annual materiality review.

Note 2 Analysis of donations and legacies

	2019/20				*2018/19*			
	Unrestricted	Restricted	Endowment	**Total**	*Unrestricted*	*Restricted*	*Endowment*	*Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
Donations	14	17	-	**31**	*26*	*39*	-	*65*
Legacies	-	99	-	**99**	-	-	-	-
Grant income	10	-	-	**10**	-	-	-	-
	24	116	-	**140**	*26*	*39*	-	*65*

Note 3 Analysis of income from other trading activities

	2019/20				*2018/19*			
	Unrestricted	Restricted	Endowment	**Total**	*Unrestricted*	*Restricted*	*Endowment*	*Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
Raffle tickets sales	-	-	-	**-**	-	-	-	-
Income received for courses	-	10	-	**10**	-	*6*	-	*6*
Income from other fundraising activities	8	1	-	**9**	*7*	-	-	*7*
Other Income	7	-	-	**7**	-	*18*	-	*18*
	15	11	-	**26**	*7*	*24*	-	*31*

Note 4 Analysis of income from investments

	2019/20				*2018/19*			
	Unrestricted	Restricted	Endowment	**Total**	*Unrestricted*	*Restricted*	*Endowment*	*Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
BlackRock Investment	3	3	-	**6**	*3*	*3*	-	*6*
M&G Charities	14	16	-	**30**	*17*	*15*	-	*32*
COIF Charities Investment Fund	3	4	-	**7**	*5*	*4*	-	*9*
	20	23	-	**44**	*25*	*22*	-	*47*

Note 5 Analysis of expenditure on charitable fund activities

	Unrestricted £000	Restricted £000	Endowment £000	**2019/20 Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2018/19 Total £000*
Patients Welfare & Amenities	89	51	-	**140**	*67*	*101*	-	*168*
Staff Welfare & Amenities	6	0	-	**6**	*12*	*2*	-	*14*
Support Cost (see note 5.1)	13	16	-	**30**	*16*	*15*	-	*31*
Fundraising Expenditure	4	-	-	**4**	*-*	*-*	-	*-*
	113	67	-	**180**	*95*	*118*	-	*213*

Note 5.1 Analysis of support cost by type

	Unrestricted £000	Restricted £000	Endowment £000	**2019/20 Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2018/19 Total £000*
Audit fee	1	1	-	**2**	*1*	*1*	-	*2*
Admin fee	12	15	-	**27**	*15*	*14*	-	*29*
	13	16	-	**30**	*16*	*15*	-	*31*

Note 5.2 Analysis of support cost by activities

	Unrestricted £000	Restricted £000	Endowment £000	**2019/20 Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2018/19 Total £000*
Patients Welfare & Amenities	12	16	-	**28**	*14*	*15*	-	*29*
Staff Welfare & Amenities	2	-	-	**2**	*2*	*-*	-	*2*
	14	16	-	**30**	*16*	*15*	-	*31*

Note 6 Gain/(losses) on investments revaluation

	Unrestricted £000	Restricted £000	Endowment £000	**2019/20 Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2018/19 Total £000*
BlackRock Investment	(14)	(19)	-	**(33)**	*5*	*5*	-	*10*
M&G Charities	(55)	(70)	-	**(125)**	*5*	*5*	-	*10*
COIF Charities Investment Fund	(2)	(4)	-	**(6)**	*14*	*14*	-	*28*
	(71)	(93)	-	**(164)**	*24*	*24*	-	*48*

Note 7.1 Changes in Fixed Asset Investments

	Unrestricted	Restricted	Endowment	**2019/20 Total**	*Unrestricted*	*Restricted*	*Endowment*	*2018/19 Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
Market Value at 1 April	378	565	29	**972**	*550*	*621*	*33*	*1,204*
Transfers/Disposals	-	-	-	**-**	*(129)*	*(144)*	*(7)*	*(280)*
Dividends re-invested	-	-	-	**-**	*-*	*-*	*-*	*-*
Net Gain/(Loss) on Revaluation	(71)	(93)	-	**(164)**	*24*	*24*	*-*	*48*
Total Market Value of Fixed Asset Investments	**307**	**472**	**29**	**808**	***445***	***501***	***26***	***972***

Note 7.2 Analysis of Fixed Asset Investments by Investment Manager

	Unrestricted	Restricted	Endowment	**2019/20 Total**	*Unrestricted*	*Restricted*	*Endowment*	*2018/19 Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
BlackRock Investment Managers (UK) Ltd	66	100	5	**171**	*93*	*105*	*6*	*204*
M & G Securities Ltd	163	253	17	**432**	*256*	*287*	*14*	*557*
CCLA Investment Management	78	119	7	**205**	*96*	*109*	*6*	*211*
Total Market Value of Fixed Asset Investments	**307**	**472**	**29**	**808**	***445***	***501***	***26***	***972***

Note 8 Analysis of recievables due within one year

	2019/20				2018/19			
	Unrestricted	Restricted	Endowment	**Total**	Unrestricted	Restricted	Endowment	*Total*
	£000	£000	£000	**£000**	£000	£000	£000	*£000*
Sundry Debtors	-	1	-	**1**	*4*	*13*	*2*	*18*
Value as at 31 March	**-**	**1**	**-**	**1**	***4***	***13***	***2***	***18***

Note 9 Short term investments & deposits

	2019/20				2018/19			
	Unrestricted	Restricted	Endowment	**Total**	*Unrestricted*	*Restricted*	*Endowment*	*Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
COIF Charities deposits funds	4	7	-	**12**	*2*	*8*	*1*	*11*
Value as at 31 March	**4**	**7**	**-**	**12**	***2***	***8***	***1***	***11***

Note 10 Analysis of cash and cash equivalent

	2019/20				2018/19			
	Unrestricted	Restricted	Endowment	**Total**	*Unrestricted*	*Restricted*	*Endowment*	*Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
Cash at bank and in hand	30	41	-	**71**	*6*	*20*	*2*	*27*
Value as at 31 March	**30**	**41**	**-**	**71**	***6***	***20***	***2***	***27***

Note 10.1 Reconciliation of net income/(expenditure) to net cash flow from operating activities

	2019/20	***2018/19***
	£000	***£000***
Net income/(expenditure) for the year as per the SoFA	(134)	*(22)*
(Gain) and losses of investment	164	*(48)*
Dividends, interest from investments	(44)	*(47)*
(increase)/decrease in stocks	-	-
(increase)/decrease in debtors	17	*(17)*
increase/(decrease) in creditors	(3)	*(1)*
Net cash provided by (used in) operating activities	-	*(135)*

Note 11 Analysis of Creditors

	Unrestricted	Restricted	Endowment	**2019/20 Total**	*Unrestricted*	*Restricted*	*Endowment*	*2018/19 Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
Amounts falling due within 1 year:								
Intercompany creditors	-	1	-	**1**	*1*	*2*	*-*	*3*
Accruals	5	8	1	**14**	*4*	*10*	*1*	*15*
Total Creditors	**5**	**9**	**1**	**15**	***5***	***12***	***1***	***18***

Note 12 Transfers

	Unrestricted	Restricted	Endowment	**2019/20 Total**	*Unrestricted*	*Restricted*	*Endowment*	*2018/19 Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
Cambridge Community Health Service	-	-	-	**-**	*(276)*	*(130)*	*-*	*(406)*
North Essex Partnership NHS Charitable funds	-	-	-	-	*-*	*-*	*-*	*-*
Value as at 31 March	**-**	**-**	**-**	**-**	***(276)***	***(130)***	***-***	***(406)***

Note 13 Reconciliation of fund balance at 31 March 2020

	Balance at 31/03/2019	Income	Expenditure	Unrealise gain(losses)	Transfers	Balance at 31/03/2020
	£000	£000	£000	£000	£000	£000
Restricted funds	521	150	(67)	(93)	-	512
Unrestricted funds	461	59	(113)	(71)	-	336
Endowment funds	28	-	-	-	-	28
Total funds as per balance sheet	1,010	210	(180)	(164)	-	876

Note 14 Trustee and Related Party Transaction

Essex Partnership University NHS Foundation Trust is the Corporate Trustee (the Trust) of the Essex Partnership NHS Foundation Trust General Charitable Fund (the Charity). During the year the Charity paid £27,240 to the Trust, to cover costs incurred by the Trust in administering the Charity, on its behalf.

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

Note 15 Trustees Remuneration and Benefits

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

Note 16 Staff Cost and Other Benefits

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

Note 17 Contingencies

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

Note 18 Commitments, Liabilities and Provisions

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

Note 19 Post Balance Sheet Events

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

Essex Partnership University
NHS Foundation Trust

Finance Directorate
Trust Head Office
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX
Tel: 01268 739666
Email: trevor.smith9@nhs.net

Chair: Professor Sheila Salmon
Chief Executive: Paul Scott

27th January 2021

Ms D Hanson
Ernst & Young
400 Capability Green
Luton
LU1 3LU

Dear Debbie,

This letter of representations is provided in connection with your independent examination of the financial statements of Essex Partnership University NHS Foundation Trust Charities ("the Charity") for the period ended 31 March 2020. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to complete your examination as to whether there are matters to which attention should be drawn to enable a proper understanding of the financial statements to be reached.

We understand that the purpose of your examination of our financial statements is to report whether any matter has come to your attention which gives you reasonable cause to believe that in any material respect the following requirements have not been complied with:

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

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

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

A. Financial Statements and Financial Records

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

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

3. We acknowledge, as directors of the Trustee of the Charity, our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair view of the financial position, financial performance (or results of operations) and cash flows of the Charity in accordance with UK GAAP, and are free of material misstatements, including omissions. We have approved the financial statements.

4. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements.

B. Fraud

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

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

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

C. Non-compliance with law and regulations

1. We acknowledge that we are responsible to determine that the Charity's activities are conducted in accordance with laws and regulations and that we are responsible to identify and address any non-compliance with applicable laws and regulations.

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

D. Information Provided and Completeness of Information and Transactions

1. We have provided you with:

    - Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
    - Additional information that you have requested from us for the purpose of the examination; and
    - Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.

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

3. We have made available to you all minutes of the meetings of the Trustee or sub-committees (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the period to the most recent meeting on 21st October 2020

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

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

E. Liabilities and Contingencies

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

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

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

F. Subsequent Events

1. There have been no events, including events related to the COVID-19 pandemic, subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

G. Other information

1. We acknowledge our responsibility for the preparation of the other information. The other information comprises the Annual Report of the Trustees for the year ended 31 March 2020.

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

H. Reporting to Regulators

1. We confirm that we have reviewed all correspondence with regulators, in England and Wales, which has also been made available to you, and the serious incident report guidelines issues by the Charity Commission (updated in 2017).

We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the signing of the balance sheet.

Yours faithfully

_____ _____

Trevor Smith
Chief Finance Officer

Janet Wood
Chair of the Audit Committee

							Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**						**27 January 2021**
Report title:	Learning from Deaths – Mortality Review Summary of Quarter 2 2020/21 information						
Executive Lead:	Prof Natalie Hammond, Executive Nurse						
Report Author(s):	Michelle Bourner, Mortality Project Co-ordinator						
Report discussed previously at:	Mortality Data Group (17/11/20) Mortality Review Sub-Committee (via email)						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**		

Purpose of the Report

The attached report presents: • Information relating to deaths in scope for mortality review for Q2 2020/21 (1st July – 30th September 2020) together with updated information for Q1 and for 2019/20, 2018/19 and 2017/18; and • Learning that has been identified within the Trust as a result of mortality review undertaken since the last report to the Board of Directors.	**Approval**	
	Discussion	
	Information	✓

Recommendations / Action Required

The Board of Directors is asked to:

- Note the information contained within the report; and
- Seek clarity where required.

Summary of Key Issues

This report presents information that the Trust is nationally mandated to report to public Board meetings on a quarterly basis – ie the number of deaths in scope, the number reviewed and the assessment of problems in care scores; as well as the learning realised from mortality review. The Annexes to the report present the data outlined in the report in the nationally prescribed dashboard format. The report also contains additional information over and above national requirements in order to provide the Board of Directors with information relating to actions being taken in response to trends identified from the data and assurances in terms of the timeliness of review processes.

There were **35** deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in Q2. This is significantly lower than the previous quarter which was impacted by COVID-19.

Of the 35 deaths, 2 were inpatient deaths and 5 were nursing home deaths. Of these 7 deaths, 4 deaths have been confirmed as due to natural causes. 2 causes of death are currently under determination and one has been determined as Unexpected Unnatural. This death is subject to a Serious Incident investigation.

The attached report includes details of the grade of review to which deaths are being subjected and the timeliness of completion of those reviews. It indicates that the improvement in the timeliness of consideration via the Deceased Patient Review Group has continued. It also indicates that the significant majority of deaths continue to either be closed at Grade 1 desktop review by the Deceased Patient Review Group or investigated at Grade 4 serious incident investigation, with limited use of the Grade 2 case note review option. This 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).
The attached report also includes details of the profile of problems in care scores assigned to deaths in scope. This indicates that the significant majority of deaths have been assessed

as having no problems in care (score 6).

The Mortality Review Sub-Committee also reviews data on deaths of substance misuse service users who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death. There are no issues of note / concern to report.

Details of learning from mortality review in Q2 are included in the attached report.

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

Which of the Trust Values are being delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the Board Assurance Framework affected?	Yes
If yes, insert relevant risk	Delivering the requirements of the national guidance on mortality review requires significant action and has potentially significant capacity implications.
Do you recommend a new entry to the Board Assurance Framework is made as a result of this report?	No

Corporate Impact Assessment:			
Impact on CQC Regulation Standards, Commissioning Contracts, 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 £**	NA
Governance Implications			✓
Impact on Patient Safety /Quality			✓
Impact on Equality & Diversity			
Equality Impact Assessment (EIA) Completed?	No	**If YES, EIA Score**	NA

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

Supporting Documents &/or Further Reading
Attached - Report on Mortality Information and Learning from Deaths for Q2 2020/21

Annex A – 2020/21 Dashboard (national reporting format)
Annex B – 2019/20 Dashboard (national reporting format)
Annex C – 2018/19 Dashboard (national reporting format)
Annex D – 2017/18 Dashboard (national reporting format)

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

Executive Lead

Natalie Hammond
Executive Nurse

EPUT

LEARNING FROM DEATHS – MORTALITY REVIEW PUBLICATION OF MORTALITY DATA AND LEARNING QUARTER 2 2020/21

1.0 PURPOSE OF REPORT

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

- Information relating to deaths in scope for mortality review for Q2 2020/21 (1st July – 30th September 2020);
- Updated information relating to deaths in scope for mortality review in Q1 and in 2019/20, 2018/19 and 2017/18; and
- Learning that has been identified within the Trust as a result of mortality review since the last report to the Quality Committee.

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

2.0 BACKGROUND AND CONTEXT

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

2.2 In line with national guidance, quarterly reports of the nationally mandated information are presented to the Trust Board of Directors outlining mortality data and learning from deaths. This report presents data for Q2 2020/21 (and updated data for previous quarters / years) as at the day the report was prepared (ie 22nd November 2020).

3.0 SCOPE OF DEATHS INCLUDED IN THIS REPORT

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

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

4.0 TOTAL NUMBER OF DEATHS IN SCOPE FOR REVIEW

4.1 There were **35 deaths** which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in **Q2 2020/21**. This total number of deaths is significantly lower than the previous quarter which was impacted by COVID-19. It is lower than Q2 in previous years – in order to provide assurance a check was made of the reporting query to ensure that there were no errors; it was confirmed that the extracts had correctly identified all deaths in scope reported as at the time of preparing the report.

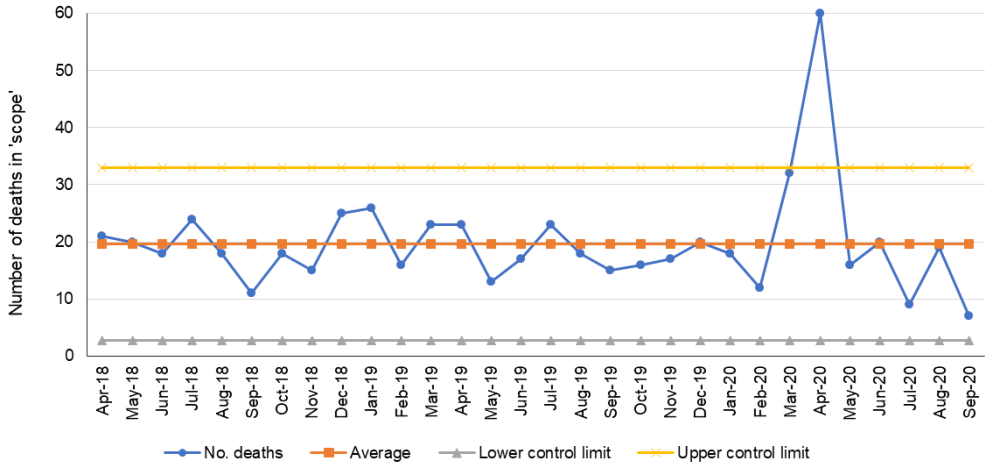
4.2 Since the last report to the Quality Committee, there has been an increase in the number of deaths in scope recorded for Q1 by 6. All these deaths are deaths identified through the clinical systems of patients diagnosed with a Severe Mental Illness. It is not unusual for these deaths to be identified the quarter after occurrence as these deaths are often identified through review of the national spine system updated by GPs rather than notified directly to the Trust for input to Trust clinical systems.

Table 1: Breakdown of total deaths in scope for review

Period	Total 2017/18	Total 2018/19	2019/20 Q1 Total	2019/20 Q2 Total	2019/20 Q3 Total	2019/20 Q4 Total	Total 2019/20	April 2020	May 2020	June 2020	2020/21 Q1 Total	July 2020	Aug 2020	Sept 2020	2020/21 Q2 Total	2020/21 YTD
Deaths in scope	**248**	**235**	**53**	**56**	**57**	**62**	**228**	**60**	**16**	**20**	**96**	**9**	**19**	**7**	**35**	**131**

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

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



4.4 Of the 35 deaths in Q2, 2 were inpatient deaths and 5 were nursing home deaths. Given the nature of the services provided by the Trust, there will be a number of deaths that occur on in-patient wards and in nursing homes which will be expected and which will be due to natural causes. Of these 7 deaths, 4 deaths have been confirmed as due to natural causes. Two causes of death are currently under determination and one has been determined as Unexpected Unnatural. This death is subject to a Serious Incident investigation.

5.0 GRADE AND PROGRESS OF REVIEWS / INVESTIGATIONS

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

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

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

Grade of review / investigation	2017/18 total	2018/19 total	2019/20 Q1 total	2019/20 Q2 total	2019/20 Q3 total	2019/20 Q4 total	2019/20 total	Apr 2020	May 2020	Jun 2020	2020/21 Q1 total	Jul 2020	Aug 2020	Sept 2020	2020/21 Q2 total	YTD 2020/21
Grade 1 Deceased Patient Review Group	148	147	32	26	36	46	140	42	7	7	56	2	8	0	10	66
	60%	63%					61%				58%				29%	50%
Grade 2 Case Note Review	11	19	6	3	3	4	16	2	0	1	3	0	0	0	0	3
	4%	8%					7%				3%				0	2%
Grade 3 Critical Incident Review	1	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0
	0.5%	0%					1%				0%				0	0
Grade 4 Serious Incident Investigation	88	69	15	26	14	10	65	7	5	5	17	5	8	3	16	33
	35%	29%					28%				18%				46%	25%
Final grade under determination	0	0	0	1	3	2	6	9	4	7	20	2	3	4	9	29
	0%	0%					3%				21%				26%	22%
TOTAL	248	235	53	56	57	62	228	60	16	20	96	9	19	7	35	131

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

- closed at Grade 1 desktop review by the Deceased Patient Review Group (60% 2017/18, 63% 2018/19, 61% thus far 2019/20 and 50% thus far 2020/21); or
- being investigated as Grade 4 serious incident investigations (35% 2017/18, 29% 2018/19, 28% thus far 2019/20 and 25% thus far 2020/21).

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

5.4 Positive progress has continued since the last report to the Quality Committee in terms of the timely consideration of deaths via mortality governance processes, with only 22% of deaths in 2020/21 and 3% of deaths in 2019/20 requiring the grade of review to be determined.

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

Level of review	Progress	2017/18		2018/19		2019/20		YTD 2020/21	
Grade 1 (DPRG)	Complete	148	100%	147	100%	140	100%	66	100%
	In progress	0	0%	0	0%	0	0%	0	0%
Grade 2 (CNR)	Complete	10	91%	14	74%	5	33%	0	0%
	In progress	1	9%	5	26%	11	66%	3	100%
Grade 3 (CIR)	Complete	1	100%	0	0%	0	0%	0	0%
	In progress	0	0%	0	0%	1	100%	0	0%
Grade 4 (SI)	Complete	88	100%	69	100%	63	97%	15	45%
	In progress	0	0%	0	0%	2	3%	18	55%
Under determin-ation	Complete	0	0%	0	0%	0	0%	0	0%
	In progress	0	0%	0	0%	6	100%	29	100%
TOTAL	Complete	247	99%	230	98%	208	89%	82	63%
	In progress	1	1%	5	2%	20	11%	49	37%

5.6 Case Note Reviews constitute all reviews still in progress for 2017/18 and 2018/19 deaths. There has been steady progress with completing Case Note Reviews this quarter as and when capacity has allowed.

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

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

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

Score	*2017/18 (Number)	*2017/18 (as a %)	2018/19 (Number)	2018/19 (as a %)	2019/20 (Number)	2019/20 (as a %)	2020/21 (Number)	2020/21 (as a %)
6 - definitely less likely than not	112	84%	189	80%	157	69%	69	52%
5 - slight evidence	14	10%	22	9%	22	10%	1	1%
4 - not very likely	3	2%	11	5%	10	4%	1	1%
3 - probably likely	1	1%	6	3%	3	1%	0	0%
2 - strong evidence	0	0%	0	0%	0	0%	0	0%
1 - definitely more likely than not	0	0%	0	0%	0	0%	0	0%
Under determination	4	3%	7	4%	36	16%	61	46%

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

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

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

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

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

8.0 LEARNING FROM MORTALITY REVIEW OF DEATHS

8.1 LEARNING FROM INDIVIDUAL MORTALITY REVIEW

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

8.1.2 Learning themes from Q2 have related to risk assessments and care plans; administration; recording of information; disengagement; engagement with families and carers; access to services; referral to drug and alcohol service; and crisis response services.

8.2 LEARNING FROM THEMATIC MORTALITY REVIEW

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

9.0 CONCLUSIONS AND FUTURE ACTIONS

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

10.0 ACTION REQUIRED

10.1 The Board of Directors is asked to:

- Note the information contained within the report; and
- Seek clarity where required.

Report prepared by:
Michelle Bourner, Project Co-ordinator

On behalf of:
Prof Natalie Hammond, Executive Nurse

January 2021

ANNEX A – MORTALITY DATA DASHBOARD 2020/21

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

Trust	EPUT
Month	Dec-20
Year	2020-21

Total Deaths in Scope:

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

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

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2020-21	Q1	96	8	88	48	0	0	3	0	0	11	6	20	0	0	0	0	1	50	37
YTD		**96**	**8**	**88**	**48**	**0**	**0**	**3**	**0**	**0**	**11**	**6**	**20**	**0**	**0**	**0**	**0**	**1**	**50**	**37**
2020-21	Q2	35	6	29	5	0	0	0	0	0	4	12	8	0	0	0	1	0	6	22
YTD		**131**	**14**	**117**	**53**	**0**	**0**	**3**	**0**	**0**	**15**	**18**	**28**	**0**	**0**	**0**	**1**	**1**	**56**	**59**
2020-21	Q3																			
YTD		**131**	**14**	**117**	**53**	**0**	**0**	**3**	**0**	**0**	**15**	**18**	**28**	**0**	**0**	**0**	**1**	**1**	**56**	**59**
2020-21	Q4																			
Total 2020-21		**131**	**14**	**117**	**53**	**0**	**0**	**3**	**0**	**0**	**15**	**18**	**28**	**0**	**0**	**0**	**1**	**1**	**56**	**59**

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

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

Trust	EPUT	**Learning Disability Deaths**
Month	Dec-20	
Year	2020-21	• All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system

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

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

ANNEX B – MORTALITY DATA DASHBOARD 2019/20

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

Trust	EPUT
Month	Dec-20
Year	2019-20

Total Deaths in Scope:

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

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

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2019-20	Q1	53	8	45	24	0	3	3	0	0	15	0	0	0	0	0	1	5	31	8
YTD		53	**8**	45	24	0	3	3	0	0	15	0	0	0	0	0	1	5	31	8
2019-20	Q2	56	3	53	23	0	1	2	0	0	26	0	1	0	0	3	4	9	31	6
YTD		109	11	98	47	0	4	5	0	0	41	0	1	0	0	3	5	14	62	14
2019-20	Q3	57	11	46	25	0	0	3	0	1	13	1	3	0	0	0	2	4	25	15
YTD		166	**22**	144	72	0	4	8	0	1	54	1	4	0	0	3	7	18	87	29
2019-20	Q4	62	8	54	38	0	1	3	0	0	9	1	2	0	0	0	1	1	40	12
Total 2019-20		228	30	198	110	0	5	11	0	1	63	2	6	0	0	3	8	19	127	41

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

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

Trust	EPUT
Month	Dec-20
Year	2019-20

Learning Disability Deaths

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

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

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

ANNEX C – MORTALITY DATA DASHBOARD 2018/19

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

Trust	EPUT	**Total Deaths in Scope:**
Month	Dec-20	• All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services) • All community Learning Disability deaths (detailed on sheet 2) • All community deaths meeting Serious Incident criteria
Year	2018-19	* Deaths subject to a complaint / claim * Deaths subject to a serious staff concern * Severe Mental Illness as defined in Policy (not already included in above categories)

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2018-19	Q1	59	7	52	34	0	4	2	0	0	12	0	0	0	0	2	0	3	44	3
YTD		59	**7**	52	34	0	4	2	0	0	12	0	0	0	0	2	0	3	44	3
2018-19	Q2	53	11	42	19	0	3	1	0	0	19	0	0	0	0	3	3	4	30	2
YTD		112	18	94	53	0	7	3	0	0	31	0	0	0	0	5	3	7	74	5
2018-19	Q3	58	4	54	27	0	4	1	0	0	22	0	0	0	0	0	5	6	42	1
YTD		170	**22**	148	80	0	11	4	0	0	53	0	0	0	0	5	8	13	116	6
2018-19	Q4	65	10	55	35	0	3	1	0	0	16	0	0	0	0	1	3	8	42	1
Total 2018-19		235	32	203	115	0	14	5	0	0	69	0	0	0	0	6	11	21	158	7

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

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

Trust	EPUT	**Learning Disability Deaths**
Month	Dec-20	
Year	2018-19	• All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system

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

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

ANNEX D – MORTALITY DATA DASHBOARD 2017/18

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

Trust	EPUT	**Total Deaths in Scope:**
Month	Dec-20	• All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services) • All community Learning Disability deaths (detailed on sheet 2) • All community deaths meeting Serious Incident criteria
Year	2017-18	Plus from Q3: * Deaths subject to a complaint / claim * Deaths subject to a serious staff concern * Severe Mental Illness as defined in Policy (not already included in above categories)

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)			1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress	Under determination							
2017-18	Q1	59	13	46	19	0	3	0	0	0	24	0	0	Please note, prior to implementation of the Mortality Review Policy from 1st October 2017 (timeframe in line with the National Guidance on Learning from Deaths), the Trust did not operate a process to assess the extent to which deaths reviewed / investigated were due to problems in care using a scale of 1 - 6. It is therefore not possible to complete this information for quarters 1 and 2. All Grade 4 (Serious Incident) investigations undertaken during this period used established root cause analysis methodology and identified learning arising from the investigation. Further information is included in the narrative report accompanying this dashboard.						
YTD		59	**13**	46	19	0	3	0	0	0	24	0	0							
2017-18	Q2	55	9	46	23	0	0	0	0	0	23	0	0							
YTD		114	22	92	42	0	3	0	0	0	47	0	0							
2017-18	Q3	58	9	49	26	0	6	0	1	0	16	0	0	0	0	1	2	5	40	1
YTD		172	31	141	68	0	9	0	1	0	63	0	0	0	0	1	2	5	40	1
2017-18	Q4	76	9	67	41	0	1	1	0	0	24	0	0	0	0	0	1	9	55	2
Total 2017-18		248	40	208	109	0	10	1	1	0	87	0	0	0	0	1	3	14	95	3

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

Learning from Deaths Dashboard - Breakdown for learning disability deaths

Trust	EPUT	**Learning Disability Deaths**
Month	Dec-20	
Year	2017-18	• All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system

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

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

	Agenda Item No: 7d

SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 January 2021**

Report Title:	**Update on NHS Charities Together Grants**					
Executive/Non-Executive Lead:	Trevor Smith					
Report Author(s):	Clare Barley, Head of Financial Accounts					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
To provide an update on the NHS Charities Together grants received to date and to approve the planned spend against the further Stage 1 (second wave) grant and proposed bids to be submitted for Stage 3 funding.	**Approval**	✓
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors are asked to:

1. Note the update on the Stage 1 Grant
2. Approve the Stage 1 Second Wave bids
3. Approve the proposed Stage 3 bids for submission to NHS Charities Together
4. Request any further information or action

Summary of Key Issues

As at month 9, the Trust has committed spend of £116k against the Stage 1 grant of £120k received from NHS Charities Together earlier in the year.

During December, the Trust successfully applied for and received a further Stage 1 (second wave) grant of £50k. As per the previous Stage 1 grant, these funds are to be used to support the immediate health and wellbeing of staff, volunteers and patients.

Following requests at the CEO brief and via the Executive Operational Committee, a number of ideas were put forward for funding from this grant. Proposals included provision of Christmas hampers for inpatient services, food and drinks for clinical areas during the pandemic and an extension of the IT Lending Library previously funded under the first Stage 1 grant to incorporate the buddy scheme and dementia services. The proposals were supported by the Executive Team. Due to the value of these bids, the Charitable Funds Committees are recommending retrospective approval by the Board.

The Trust is also eligible to bid for Stage 3 grants to support longer term recovery plans up to a value of £110k. The Committee are recommending that the Board approve the submission of four bids in respect of the provision of cycle sheds, extension of Open Arts to support staffs health and wellbeing across the Trust, a holistic / physical health / therapeutic offering to staff and further extension to the IT Lending Library. 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. If successful, funds have to be spent within two years.

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
Attached report

Lead
 Trevor Smith **Executive Chief Finance Officer / Financial Trustee**

Agenda Item: 7d
Board of Directors
Date: 27 January 2021

Update on NHS Charities Together Grants

1. Purpose of Report

The purpose of this report is update Directors on the NHS Charities Together Stage 1 grants received to date, to approve bids against a further Stage 1 (second wave) grant and to approve bids to be submitted for Stage 3 funding.

2. Stage 1 Grant – First Wave

To date the charity has received £120,000 of Stage 1 (first wave) funding from NHS Charities Together, and is on course to spend these funds in full by the end of the financial year. As at month 9, £116,000 is now committed. This includes the wobble / wellbeing rooms, pin badges for staff, physiotherapy for staff, IT lending library and support to our equality networks.

3. Stage 1 Grant – Second Wave

The Trust was advised in December by NHS Charities Together that further Stage 1 funding of £50,000 was available to those charities who were able to demonstrate an impact on services arising from the second wave of the pandemic.

The Trust provided the required evidence and was successful in its application with a further £50,000 of funding being received in December. As per the previous Stage 1 funding received, these funds are to be utilised to support the immediate health and wellbeing of staff, volunteers and patients affected by the second wave of Covid-19.

Following requests for ideas at the weekly CEO brief, and in discussion with the Executive Operational Committee, a number of ideas were put forward of how best to utilise these funds as follows:

	Project Leads	**£**
Christmas hampers to inpatient wards (enhanced contents to previous year)	Facilities	17,500
Food and beverages to clinical areas	Facilities	20,000
Further extension of the IT lending library to meet the health and wellbeing needs of our patients (including the Buddy Scheme and Virtual Cognitive Stimulation Therapy for dementia services in West Essex)	IT (with services)	12,500
		50,000

Due to the timing of the receipt of the grant and the need to quickly organise Christmas hampers, expenditure was committed through exchequer budgets.

Under the Trusts Detailed Scheme of Delegation, all charitable expenditure in excess of £10k is also requiring Board approval. As such, the Committee are recommending these bids for retrospective approval by the Board of Directors.

4. Stage 3 Grants – Recovery Grants

The Trust is also eligible for £110,000 of Stage 3 funding. This funding is to support the recovery plans of the NHS including longer term support of staff health, projects to improve well-being and mental health, and plans that help the wider economic and social recovery (eg employment and training). These funds are required to be spent within two years.

Following a request for bids, four bids have been put forward. These have also been supported by the Executive Operational Committee:

	Project Leads	**£**
Cycle sheds to support staffs physical and mental wellbeing	Estates	40,000
Extension of existing Open Arts scheme to include support for staffs health and wellbeing (as well as service users and carers) and to extend to north Essex	Jo Keay	42,000
Holistic / Physical Health / Therapeutic services to support staffs wellbeing (could include reflexology, aromatherapy, massage, weightloss support etc)	Staff Engagement	23,000 (estimate)
Further extension of IT Lending Library to support our patients	IT	5,000 (estimate)
		110,000

In line with the Detailed Scheme of Delegation, the Charitable Fund Committee is recommending the Board of Director approve these schemes and the submission of Stage 3 bids to NHS Charities Together. Unlike the Stage 1 funding, the process for Stage 3 bids is more extensive and therefore it is possible that the Trust may not receive formal notification for several months which will give Project Leads further time to refine their bids. If successful, funds are to be spent within two years of receipt.

5. Action Required

The Board of Directors are asked to:

1. Note the update on the Stage 1 Grant
2. Approve the Stage 1 Second Wave bids
3. Approve the proposed Stage 3 bids for submission to NHS Charities Together
4. Request any further information or action

Reported prepared by Clare Barley, Head of Financial Accounts

On behalf of

Trevor Smith
Executive Chief Finance Officer

		Agenda Item No: 8a
SUMMARY REPORT	**EPUT BOARD OF DIRECTORS PART 1**	**27 January 2021**

Report Title:	Board Assurance Framework 2020/21 January 2021					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Susan Barry, Head of Assurance					
Report discussed previously at:	Executive Operational Sub-Committee (December 20) and EOSC BAF Sub-Group (January 21)					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

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 27 January 2021 covering the two month period December 20 (Q3) and January 21	**Approval**	✓
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Review the risks identified in the BAF 2020/21 January summary and approve the risk scores including recommended changes (Appendix 1) taking account of actions taken by EOSC at its December meeting
2 Approve the merger of BAF45 and BAF56 and reduction of scores to BAF55 and BAF23
3 Note the Q3 Key Performance Indicators (Appendix 2)
4 Note the CRR January summary table (Appendix 3) including actions taken by EOSC at its December meeting;
5 Approve recommendations for CRR48 and CRR58
6 Note the new risks added to the Covid19 risk register
7 Identify any further risks for escalation to the BAF, CRR or Directorate risk registers

Summary of Key Issues

1 This report covers two months of reporting to EOSC and the January summary includes reference to any changes made by EOSC in December 2020.

2 A new monthly ET Board Assurance Framework Sub-Group has been established by the EOSC that held its first meeting on 19 January. Terms of reference are in place. The group has approved revisions to the EPUT Board meeting cover sheet to ensure risks are clearly identified. A revised BAF summary sheet will be in place from February. The groups initial focus will be on understanding current processes and identifying where these can be strengthened. The Group will work towards a new Board Assurance Framework by late summer as well as consolidating risks, raising the profile of the Corporate Risk Register, creating a robust interface with strategic objectives, and planning processes.

3 Board Assurance Framework (Appendix 1)

- There are currently **25 risks** on the Board Assurance Framework
- The following risk is recommended by Quality Committee and EOSC BAF Sub-Group for closure and merger with BAF45

ID	Risk	Rationale and discussion points
BAF56	If EPUT does not meet the CQC's **Fundamental Standards**, and encompassed in Trust Policy, that all patients have a right to expect then it will be held to account for failures in how care is provided resulting in further regulatory action by the CQC – recommend that we take the higher of the two risk scores – 5 x 4 = 20 Lead: Paul Scott	Quality Committee view that this consolidates with BAF45 (current risk score 12 recommended to rise to 16). BAF Sub-Group recommend merged risk score increases to 5 x 4 = 20 This is a Trust wide responsibility – demonstrate adherence through internal processes. Issue is sustainability, culture change and long-term embedded changes.

- There are two BAF risks recommended for reduction in score by BAF Sub-Group

ID	Risk	Rationale and discussion points
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	Reduce score from 5 x 4 = 20 to 5 x 3 = 15 based on progress made on the action plan (14 of 19 actions completed) and on track with 27 January CQC deadline. To remain on BAF.
BAF23	If EPUT does not assess the potential implications of **EU Exit (Transition)** as no deal or other then there may be unforeseen circumstances resulting in an impact on service delivery	Reduce score from 4 x 4 = 16 to 4 x 3 = 12 (threshold) based on EU Transition deal and no issues being raised in daily sitrep. Could de-escalate to CRR but remain as watching brief until June 2021

- There are currently ten risks sitting at a score of 20 (extreme):

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	PIT (NED) agreed no action plan required Level 4 reset and recovery, all resources targeted at incident. May be longer-term risk, impacts of C19 clinically and on system
BAF45	If EPUT does not prepare for an anticipated CQC inspection in 2021 and learn from focused inspections and incidents relating to patient safety then this may have a negative impact on the outcome of the inspection resulting in not maintaining our 'Good' rating	Linked to BAF56 discussion above - merge
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	Discussion at Command around managing the different system (internal and external) requirements and agreement to have a reduced Committee process for Dec/Jan 21 with focus remaining on patient safety related committees Discussions at Command around significant staffing risks in January 2021. Mitigating actions include staff redeployment from corporate services and wider use of agency staff.
BAF51	If EPUT does not have sufficient	Managed by Programme Board

	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	
BAF52	If EPUT does not ensure that staff have the **skills and competencies** to manage a second wave of **C19 and/or a mass vaccination programme** then appropriate care may not be delivered to patients or staff resulting in potential harm and failure to contain the virus	Managed by Programme Board
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 strategy	Safety Strategy implementation plan will monitor this risk. Quality Committee requested a better understanding of 'safety actions', the different action plans we have and how these link as well as the need to ensure plans are owned by Committees. Compliance and Assurance Directorate to discuss.
BAF54	If EPUT does not prepare for an anticipated **Independent Review** into deaths between 2000 and 2020 then the opportunity for the Trust and wider NHS to learn lessons from the inquiry will be undermined resulting in possible reputational damage for EPUT	No date yet. Publication of warning notice may influence public opinion.
BAF57	If EPUT receives a substantial fine from the **HSE** court case then there may be a financial and reputational impact resulting in a lengthy aftermath, delayed recovery from past failings, and low levels of public belief in EPUT's 'safer care, always'	Supersedes BAF15 HSE risk closed 2020. Sentencing date set for June 2021
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 Patient Safety Strategy	Fundamental shift in philosophy with 5% gap identified as patient safety risk, rather than the tolerated variance. To explore with operations and performance team (a) small percentage tolerance (b) root cause analysis and (c) revisit mitigating actions to address 5% non-adherence
BAF59	If EPUT is investigated on **recent deaths** (e.g. CQC, domestic homicide and serious case reviews) then it may be subject to additional scrutiny resulting in a downward trend in ratings and associated reputational damage	

- No BAF action plans are in place for 14 of the BAF risks. Alternative monitoring has bee identified where appropriate

4. <u>Key Performance Indicators Q3 (Appendix 2)</u>

- This is the first set of indicators produced for the BAF
- Board will receive Q4 in March 2021 and monthly from April 2021
- KPI 1 % risks with action plans completed by target completion date – RAG *Green*
- KPI 2 % stagnant risks 2a % increased scores 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 *Red*

5. Corporate Risk Register (Appendix 3)

- There are currently **20** risks on the Corporate Risk Register
- Three risks (CRR68 GWPRAs, CRR71 McKinley T34 Syringe Drivers, CRR49 urgent care pathways) are past their completion dates but not at threshold – extend dates to end March
- There is one CRR risk recommended for an increase in score

ID	Risk	Rationale and discussion points
CRR58	If EPUT's in-patient wards do not fill shifts consistently to a minimum of 90% then safer staffing is not fulfilled resulting in poor patient experience, low staff morale and non-compliance with standards C4 x 4L = 16 Leads: Alex Green	Impacted by Covid - increase score from 4 x 2 = 8 to 4 x 4 = 16 to reflect DRR

- The following CRR risks have descriptor changes (change highlighted in red)

ID	Risk
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

6. Covid19 Risk Register Summary

The Covid19 Risk Register summary is an Appendix to the Chief Executive Covid19 Assurance report. The following two new risks have been added:

ID	Risk
CVG54	If EPUT is unable to maintain a full complement of pharmacy staff then there may be delays in issuing prescriptions and no participation in MDT meetings on wards resulting in compromised service delivery 4 x 4 = 16
CVG55	If EPUT continues to experience ward closures due to Covid19 outbreaks then availability of beds to acutely ill patients may diminish resulting in additional community/virtual support and potential harm to patients 5 x 4 = 20

The following risks are recommended for reduction in score:

ID	Risk
CVG38	If EPUT is unable to maintain the provision of self-testing kits for staff due to delays by the Local Authority and/or Public Health England then weekly testing for staff visiting care homes cannot take place resulting in non-compliance with national requirements and an outbreak affecting staff and patients From 4 x 3 = 12 to 4 x 2 = 8 taking it to threshold
CVG46	If EPUT does not manage the delivery of valid server generated emails to staff outlook inboxes (following NHS mail national update) then important or urgent COVID19 emails may be missed resulting in a delay in information cascade or the submission of urgent returns From 4 x 4 = 16 to 4 x 2 = 8 and extend date to March 2021
CVG52	If EPUT does not have sufficient resource to effectively project manage and deliver the asymptomatic testing programme across the Trust then it may not meet the deliverables and timescales and potential failure of the programme From 5 x 3 = 15 to 5 x 2 = 10

The following risk is recommended for closure

ID	Risk

CVG40	If EPUT does not have clarity on the definition of aerosol generating procedures then staff may not follow the correct guidance resulting in potential infection and spread of COVID19

7. Mass Vaccinations Risk Register

Work is currently ongoing to produce an EPUT MV RR and summary

8. EU Exit Transition Risk Register

An EU Exit Transition Risk Register is in place and the action plan reported through the EU Exit report to the Board

9. Directorate Risk Registers

Directorate Risk Registers continue to be updated on a regular basis and in due course the schedule of presenting one at the BAF sub-group meetings will resume

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

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk	All – see report
Do you recommend a new entry to the BAF because of this report?	Yes – see report

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) Complete	**~~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
EOSC	Executive Operational Sub Committee	MV	Mass Vaccinations

Supporting Documents and/or Further Reading

Appendix 1 – Summary of BAF as at 27 January 2021
Appendix 2 – BAF Key Performance Indicators December Q3
Appendix 3 – Summary of CRR as at 27 January 2021

Lead

Paul Scott
Chief Executive Officer

EPUT

BOARD ASSURANCE FRAMEWORK 2020/21 JANUARY 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 27 January 2021.

UPDATE AS AT JANUARY 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 currently 25 risks on the BAF. **Appendix 1** provides a summary of BAF risks as at January 2021 (and notes of any changes made in December 2020), including mapping of risks against the 5 x 5 scoring matrix and movement on scoring from February 2019 to December 2020.

Appendix 2 introduces Key Performance Indicators and progress against these for December Q3. The Board will receive Q4 in March 2021 and then monthly from April 2021.

- KPI 1 % risks with action plans completed by target completion date – RAG *Green*
- KPI 2 % stagnant risks 2a % increased scores 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 *Red*

The Executive Operational Sub Committee set up a separate monthly Board Assurance Framework Sub-Group that held its first meeting on 19 January. Terms of reference are in place, a new Board meeting cover sheet with separate guidance, and a revised BAF summary sheet to be in place from February. Initial actions will include understanding current processes and working towards a new Board Assurance Framework by late summer as well as consolidating risks, raising the profile of the Corporate Risk Register, creating a robust interface with strategic objectives, and planning processes.

2. Recommendations for BAF consolidation and reduction in scores

The key points above iterates the recommendation to consolidate BAF56 CQC fundamental standards into BAF45 CQC and increase the score to 5 x 4 = 20.

The key points above iterate the recommendation to reduce scores on BAF23 (EU Exit transition) to 4 x 3 = 12 and BAF55 (CQC S29A Warning Notice) to 5 x 3 = 15.

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 December 20. Standing Committees reviewed their allocated

risks in January (except for Finance and Performance whose next meeting is February 21). BAF action plans are available on request.

The key points above iterate the rationale for why no action plans are in place for the following risks:

December 2020			January 2021	
No action plans in place			**No action plans in place**	
BAF41	CIPs		BAF41	CIPs
BAF42	Financial plan		BAF42	Financial plan
BAF38	Emergency planning for C19		BAF38	Emergency planning for C19
BAF46	Young people with complex care needs		BAF46	Young people with complex care needs
BAF43	Surge planning		BAF43	Surge planning
BAF35	Culture of fairness and learning		BAF35	Culture of fairness and learning
BAF51	Oversight and scrutiny of mass Covid19 vaccination programme		BAF51	Oversight and scrutiny of mass Covid19 vaccination programme
BAF52	Skills and competencies to manage second wave Covid19 and mass C19 vaccination programme		BAF52	Skills and competencies to manage second wave Covid19 and mass C19 vaccination programme
BAF53	Safety actions		BAF53	Safety actions
BAF54	Independent review		BAF54	Independent review
BAF56	CQC Fundamental standards		BAF56	CQC Fundamental standards
BAF57	Reputational risk		BAF57	Reputational risk
BAF58	Clinical activity and patient safety		BAF58	Clinical activity and patient safety
			BAF59	Investigation of recent deaths

4. Corporate Risk Register

4.1 December 2020

There were 26 risks on the Corporate Risk Register in December.

4.2 January 2021

There are currently 20 risks on the Corporate Risk Register. The Board of Directors can view the summary table of CRR risks at **Appendix 3**. Table 1 gives a summary of each risk (including notes of any changes made December 2020), and Table 2 shows the mapping of risks against the 5 x 5 scoring matrix.

Three risks (CRR68 GWPRAs, CRR71 McKinley T34 Syringe Drivers, CRR49 urgent care pathways) are past their completion dates but not at threshold – extend dates to end March.

The key points above iterate one increase in score and one descriptor change.

5. Covid19 Risk Register

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

The key points above iterate the addition of two new risks and recommendations for reduction in scores for three risks.

6. Mass Vaccinations Risk Register

Work is currently ongoing to produce an EPUT MV RR and summary

7. EU Exit Transition Risk Register

An EU Exit Transition Risk Register is in place and the action plan reported through the EU Exit report to the Board

8. Directorate Risk Registers

We continue to update Directorate Risk Registers on a regular basis and in due course, the schedule of presenting one at the BAF sub-group meetings will resume

9. Recommendations

The Board of Directors is asked to:

1 Review the risks identified in the BAF 2020/21 January summary and approve the risk scores including recommended changes (Appendix 1) taking account of actions taken by EOSC at its December meeting
2 Approve the merger of BAF45 and BAF56 and reduction of scores to BAF55 and BAF23
3 Note the Q3 Key Performance Indicators (Appendix 2)
4 Note the CRR January summary table (Appendix 3) including actions taken by EOSC at its December meeting;
5 Approve recommendations for CRR48 and CRR58
6 Note the new risks added to the Covid19 risk register
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 January 2021

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

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview / scrutiny date
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 assess the potential implications of EU Exit (Transition) as no deal or other then there may be unforeseen circumstances resulting in an impact on service delivery	NL	• EU Exit deal agree and ratified end December • Task and Finish Group continues to meet • Daily sitrep is covered during Silver Command meetings • Assessment of financial risks in supply chain have not been completed but these risks are diminishing	Risk score unchanged in December 4 x 4 = 16 Recommend reduction in score to 4 x 3 = 12	Target March 21 4 x 3 = 12	EOSC EU Exit (Transition) Group BOD Above threshold	Will be Finance and Performance Committee (Feb 21)
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	• There are currently six actions on the BAF action plan • Five actions are completed including one that is ongoing • One action has slipped and been given a revised completion date – integration of QI, research and innovation arrangements supported by appropriate governance arrangements A Task and Finish Group led by Dr Rufus Helm (NED) has made significant progress by setting key principles and is working on the following to present to its January meeting and support a paper to the Board: ○ A process map, including examples of the documentation that will be used to support the process and identified needs that may need investment/ funding ○ High-level communications strategy including launch, website, ongoing comms etc. ○ Representation from the QI Hubs who will have had a chance to contribute to the planning and provide their support for the programme.	Risk score unchanged Dec/Jan 4 x 3 = 12	Target ~~September December 20~~ January 21 4 x 3 = 12	Learning Oversight PIT At threshold	PIT Nov 20 (Jan/Mar 21)
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							

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview / scrutiny date
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	• There are now eleven actions on the BAF action plan, six actions completed, three actions in progress to timescale and two overdue (insufficient fire wardens and compliance with fire drills) • Full details of the status of compliant fire wardens throughout the Trust is now submitted to the Fire Safety Group monthly • The issue of fire wardens and fire training is also highlighted through discussions on Directorate Risk Registers where BAF risk is mirrored • Training compliance (December) is below target for category 1 and above target for category 2 • Workforce advertised part time post but did not appoint but out to advert again • Cat 1 block booking showing a slightly improved position	Risk score unchanged Dec/Jan Current Risk Score 5 x 3 = 15	Target March 2021 4 x 3 = 12	HSSC, EOSC and Board Fire Safety Group Above threshold	Finance and Performance Sept 20 (Feb 21)
BAF59	If EPUT is investigated on recent deaths (e.g. CQC, domestic homicide and serious case reviews) then it may be subject to additional scrutiny resulting in a downward trend in ratings and associated reputational damage	AG/PS supported by NL/ NH/ MK	• CQC unannounced inspection took place on Finchingfield generating a number of information requests • P&C SLT recommended that this risk be broader to cover other investigations such as domestic homicide and serious case reviews of which EPUT has seen a cluster. Approved by EOSC Dec 20 that this risk score was increased to 20 and escalated to the BAF	Escalated from CRR Dec 20 Risk score increased in Dec and unchanged in Jan 5 x 4 = 20	Target March 2021 5 x 2 = 10	At threshold	Quality Committee (March 21)

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview / scrutiny date
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.	NL supported by TS	• There are now 46 actions on the BAF action plan (ligature reduction work plan) • 34 actions completed • Two actions are due to be completed this month • Some dates have been revised due to some slippage (original dates are crossed through) • Six actions in progress to timescale, revised timescale or not due yet (including two above) • 1 new action requires a timescale – implement recommendations from garden audit • Five actions are now overdue (a) door hinges – approved list of hinges completed. Some unapproved hinges have been installed at Rochford and these are being assessed by clinical leads as to whether they should remain or be replaced (b) T&FG to assess requirements against Appendix 9 Ligature Policy standards and make recommendations on those to be implemented for dementia wards – costings awaited from estates on the actions identified (c) ensure that the requirements of the ligature work stream are included in the restructure of the Compliance and Risk Team (d) Ensure ligature inspectors undertake e-learning, compliance process training and practical test on site – some Band 6 posts outstanding in operations and estates otherwise bookings in place Jan – March 21 (e) develop a process of governance around ligature reduction work – remains ongoing while new inspections are undertaken	Risk score unchanged Dec/Jan Current Risk Score 5 x 3 = 15	Target March 2021 4 x 3 = 12	HSSC Quality Committee EERG LRRG Above threshold	Quality Committee Jan 21

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview / scrutiny date
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	• 20 actions on BAF Action Plan • 18 actions completed • Two actions in progress to timescale including one for this month • Current review of all seclusion LTS incidents between April and November 2020 is underway with a report to share learning related to Covid 19 to be complete by February 2021. • Current learning shared via the annual LTS seclusion audit. Discussed in Restrictive Practice group how we might strengthen learning opportunities without adding to operational workload. • Ward matrons who share learning in their own teams currently sign off all incidents. They complete a document to do this, uploaded on to the patient record. • Clinical Governance and Quality Committee considering a corporate collation of these to share trust wide learning	Risk score unchanged Dec/Jan 4 x 2 = 8	Target March 2021 4 x 2 = 8	Restrictive Practice Steering Group At threshold	Quality Committee Jan 21
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.	NL	• Executive Lead in place for emergency planning • BCPs under ongoing review • Gold, Silver Bronze Command well established • Sit rep daily monitoring • COVID Intranet Page and range of staff training in place	Risk score unchanged Dec/Jan Current Risk Score 5 x 2 = 10	Target Ongoing during Covid19 pandemic 5 x 2 = 10	Board of Directors Covid19 Command Structure At threshold	Live Action Log maintained daily through Command Structure

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview / scrutiny date
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 strategy	NH	• Reworded to have a patient safety focus rather than reputational (new reputational risk in place) • Executive Nurse is the lead for Safety • Patient Safety Oversight Group is now in place with terms of reference and is chaired by the Chief Executive • Revised Patient Safety Strategy discussed at EOSC in December and will be presented to Board in January for approval • Quality Committee 14/1 – agree that Safety Strategy implementation plan be used to monitor this risk • Quality Committee requested a better understanding of 'safety actions', the different action plans we have and how these link as well as the need to ensure plans are owned by Committees. Compliance and Assurance Directorate to discuss.	New risk December unchanged Jan C5 x L4 = 20	Align date with implementation plan 5 x 2 = 10	EOSC Trust Board Oversight Group Standing Committees Above threshold	Quality Committee (Jan 21)
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.	AG supported by NH / PS (FS)	• There are now eight actions on the Action Plan • Six actions completed • Two actions in progress to revised timescales • Maintain watching brief during C19	Risk score unchanged Dec/Jan Current Risk Score 5 x 3 = 15	Target date changed from July to September 2020 5 x 2 = 10	Directorate PST Mid/South Essex funding agreed Above threshold	Quality Committee Jan 21

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview / scrutiny date

BAF45	If EPUT does not prepare for an anticipated CQC inspection in 2021 and learn from focused inspections and incidents relating to patient safety then this may have a negative impact on the outcome of the inspection resulting in not maintaining our 'Good' rating	PS	• CQC Executive Steering Group is monitoring
			• The Compliance Team has developed a new work plan that is reported on monthly until such time of a CQC inspection
			• Work plan monitors progress on
			  ○ Developmental actions identified and closed in the CQC action plan
			  ○ Issues identified when ensuring practice has been embedded and sustained
			  ○ Action plans from internal inspections
			  ○ Development and potential new practices following any new CQC guidance
			• Action plan in place – there are 12 actions, 3 completed, 8 in progress and 1 not due yet
			• Quality Committee 14/1 – agreed with recommendation to increase risk score
				Risk score unchanged
				4 x 3 = 12
				Recommend increase in risk score to 4 x 4 = 16 or 5 x 4 = 20 if merged with BAF56
					Target March 2021
					4 x 2 = 8
						CQC Exec Steering Group
						Above threshold
							Quality Committee Jan 21

BAF54	If EPUT does not prepare for an anticipated Independent Review into deaths between 2000 and 2020 then the opportunity for the Trust and wider NHS to learn lessons from the inquiry will be undermined resulting in possible reputational damage for EPUT	PS	• New risk approved December 2020 • No date advised as yet • Publication of warning notice may influence public opinion	New risk December unchanged Jan 5 x 4 = 20	Target March 2021 5 x 2 = 10	EOSC Board Above threshold	Quality Committee Jan 21
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	• New risk approved December 2020 • Section 29A warning notice issued on 27 November and ten days given for factual accuracy response prior to publication by the CQC • Significant improvements are required by 27 December in four areas of the regulations and by 27 January in two areas of the regulations • A BAF action plan is in place – there are 19 actions, 14 completed, and 5 in progress to timescale	New risk December with initial risk score 5 x 4 = 20 Recommend reduction in score to 5 x 3 = 15 based on progress and on track for completion by CQC deadline	Target Jan 21 5 x 2 = 10	CQC Exec Steering Group EOSC Board Above threshold	Quality Committee Jan 21

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview / scrutiny date
BAF56	If EPUT does not meet the CQC's fundamental standards, and encompassed in Trust Policy, that all patients have a right to expect then it will be held to account for failures in how care is provided resulting in further regulatory action by the CQC	PS	• New risk approved December 2020 • Monitor through audit processes, internal audit and compliance inspections, complaints, safeguarding, serious incidents • Demonstrate adherence through internal processes to CQC Action Plans • Issue will be sustainability, culture change and long term embedding of changes • Quality Committee 14/1 request consideration of consolidation of risk with BAF45 CQC and revision to action plan • EOSC BAF Sub Group Task and Finish Group set up to take forward consolidation of BAF risks	New risk Dec unchanged Jan 5 x 4 = 20 Consolidate with BAF45 but use this score	Target March 2021 5 x 2 = 10	CQC Exec Steering Group EOSC Board Above threshold	Quality Committee Jan 21
BAF57	If EPUT receives a substantial fine from the HSE court case then there may be a financial and reputational impact resulting in a lengthy aftermath, delayed recovery from past failings, and low levels of public belief in EPUT's 'safer care, always'	NL	• New risk approved December 2020 • This risk supersedes the closed risk BAF15 HSE • Sentencing date set for June 2021	New risk Dec unchanged Jan 5 x 4 = 20	Target March 2021 5 x 2 = 10	EOSC Board Above threshold	F&PC (Feb 21)

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview / scrutiny date
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 Patient Safety Strategy	AG MK	• Finance and Resources SMT recommended escalation to the BAF with a score of 5 x 4 = 20 • This risk is made up of CRR28 and CRR30 (old and outdated risks), combined and reworded to reflect patient and staff safety • Currently the performance indicator for this is as 95% which means that 5% of clinical activity is not entered in real time, incorrectly or recorded on paper, constituting a patient safety issue • Consider the need for a very small percentage tolerance to accommodate system downtime and how we reflect delays resulting from this • 5% constitutes a patient safety risk but current C19 working should mitigate • Quality Committee 14/1 – requested a root cause analysis to be undertaken to understand the real risk and root cause • Fundamental shift in philosophy with 5% gap being identified as patient safety risk, rather than the tolerated variance • Assurance Team will explore with Operations as part of the normal RR review process and explore new ways of thinking in conjunction with performance team to address the gap • All current mitigations work towards an adherence of 95% rather than addressing the 5% non-adherence so will be reviewed	Escalate to BAF from CRR with initial risk score 5 x 4 = 20	March 21 5 x 2 = 10	EOSC Board Above threshold	Quality Committee Jan 21

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview / scrutiny date
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	• 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 and other forums including EPUT Board. This will return to EPUT Board in January for final agreement. • This is reflected at national and regional level	Risk score unchanged Dec/Jan 4 x 4 = 16	Target March 2021 4 x 2 = 8	PST Above threshold	No action plan 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, mass C19 vaccination programme, EU Exit Transition, regulatory responses, independent inquiry and increased variation of demands on corporate services then it may not achieve the deliverables on this wide range of priorities and pressures resulting in not achieving organisational objectives, unsustainability in corporate services, stagnation of risks and failure to maintain our position within the wider health economy	PS and all EDs	• There are 14 actions on the consolidated action plan • Nine actions are completed • Five actions are in progress to timescale • This risk has full engagement in the EOSC BAF sub group; the demands and pressures on EPUT are immense with very high stakes projects and issues • Participation by EPUT on system calls • Discussion at Command around managing the different system (internal and external) requirements and agreement to have a reduced Committee process for Dec/Jan 21 with focus remaining on patient safety related committees • Discussions at Command around significant staffing risks in January 2021. Mitigating actions include staff redeployment from corporate services and wider use of agency staff.	Risk score unchanged Dec/Jan C5 x L4 = 20	Ongoing during C19 pandemic 5 x 2 = 10	Command structure EOSC Trust Board PIT F&PC Above threshold	PIT (Jan/Mar 21)
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							

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview / scrutiny date
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	• This risk is monitored through People Plan, WRES, Communications & PSIRF implementation plan • The two hour session planned for the October Board Development session to feedback on EPUT's People Plan was postponed until Q4 but a half hour slot on December's session • Patient Safety Strategy now in place with Executive Lead • Disciplinary and 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 EPUT 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 February 2021	Risk score unchanged Dec/Jan 4 x 3 = 12	Target March 21 4 x 2 = 8	Workforce Transformation Group PIT F&PC Mortality Review Sub-Committee Learning Oversight Group Above threshold	No action plan required
BAF41	If recurrent CIPs for 2020/21 are not identified then delivery of the programme is compromised resulting in a challenge to the sustainability of EPUT going forward	TS (financial monitoring) supported by all Executive Leads	• The Trust's internal Cost Improvement target for 20/21 is £11.7m, including 19/20 £5.1m recurrent shortfall brought forward • **M9** a total of £6.2m has been identified against the Trust internal target of £11.7m, of the savings identified £4.4m are recurrent • 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 score unchanged Dec/Jan 3 x 4 = 12	Target March 2021 4 x 2 = 8	Finance and Performance Committee Board Above threshold	No Action Plan required

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview / scrutiny date
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	• The revised planned deficit for 20/21 is £8.3m • In December 2020 **M9**, the Trust recorded a deficit of £1.2m against the planned deficit of £1.4m (year to date deficit £2.9m against the planned deficit £3.9m) • The forecast outturn is £13m • Year to date M9 Covid19 costs of £10.1m with M7-M12 recovery anticipated from M&SE and H&CP. Cash was £103.5m in M9, which remains better than planned	Risk score unchanged Dec/Jan 4 x 3 = 12	Target March 2021 4 x 2 = 8	Finance and Performance Committee Board Above threshold	No Action Plan required
BAF43	If EPUT does not plan for an expected surge in demand for Mental Health services or physical CHS and rehabilitation during or post C19 then skills and capacity may not be in place resulting in long waiting lists and self-harm in the community	AG	• A phased plan is in place to manage the surge demand alongside winter planning • From October – April 2021 existing capacity, flow and escalation initiative are in place • From November to March 21 winter funding schemes are to be signed off, implemented and monitored, underpinned by MH Winter KLOES • Plan in place for opening of additional adult MH beds (Topaz Ward) to be operational February 21 providing additional mental health surge capacity • Contingency plans include exploring opportunities with local private providers to purchase additional inpatient capacity and exploring further use of other estate options for additional beds (Kelvedon) or a COVID19 ward for unwell patients who are not a ligature risk • Allocation of additional funding confirmed on STP/ICS footprints to support capacity and flow; schemes in development which address both process and capacity • This may be a longer term risk but all current resources are targeted at management of the pandemic incident	Risk score unchanged Dec/Jan 5 x 4 = 20	Target March 2021 5 x 2 = 10	Command Structure EOSC and Board plus Standing Committees Above threshold	PIT Nov 20 (Jan/Mar 21)
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 (Consequence) x 3 (Likelihood)							

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview / scrutiny date
= 15 risk score							
BAF44	If EPUT does not fully capture, review and embed learning from the C19 experience then this may have an adverse impact on Phase 3 planning resulting in missed opportunities in transformation	AG	• A full action plan is in place with 10 actions (two completed and eight in progress to timescale) • C19 is now in phase 4 • Executive Lead is now Executive Chief Operating Officer • Reset and recovery group currently suspended • EPUT has taken part in system learning across all systems • This risk currently has a watching brief	Risk Score unchanged Dec/Jan 4 x 3 = 12	Target March 2021 4 x 2 = 8	Above threshold	PIT Nov 20 (Jan/Mar 21)
BAF47	If EPUT limits bed occupancy to the 85% funded capacity target on mental health inpatient wards to facilitate social distancing requirements then modelling suggests there will be a shortfall in beds resulting in delays to admissions or an increase in out of area placements	AG	• Action plan will be reviewed with ECOO • 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 February 21	Risk score unchanged Dec/Jan 4 x 4 = 16	Target date March 21 4 x 2 = 8	Reset and Recovery Board EOSC Above threshold	F&PC (Feb 21)
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	• A risk register is being set up specifically related to the Mass Vaccination programme to strengthen governance around the project • Urgent work underway to develop new BCPs ready for testing as part of a table-top exercise to look at emergency planning for each centre as it comes on line • No contracts have been issued to us and at this stage we are unable to sub-contract any elements of the service to other organisations • Programme Board in place to manage this • Looking to consolidate Mass Vaccination risks on BAF	Risk score unchanged Dec/Jan C5 x L4 = 20	Ongoing during C19 vaccination programme 5 x 2 = 10	Command Structure EOSC Quality Committee Trust Board Above threshold	Quality Committee Jan 21

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview / scrutiny date
BAF52	If EPUT does not ensure that staff have the skills and competencies to manage a second wave of C19 and/or a mass vaccination programme then appropriate care may not be delivered to patients or staff resulting in potential harm and failure to contain the virus	NH AG	• Mitigation will include: ○ Increase in command frequency to monitor daily risks ○ Competency framework for C19 vaccination ○ Training on necessary skills for C19 mass vaccination • Redeployment plans are complete with a matrix for each post • The risk internally is more related to service delivery i.e. stopped, paused or reduced • Staff are present, the issue may be getting them to where they are most needed	Risk score unchanged C5 x L4 = 20	Ongoing during C19 vaccination programme 5 x 2 = 10	Command Structure EOSC Quality Committee Trust Board Above threshold	Quality Committee Jan 21

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

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2				BAF9	BAF38
	3				BAF23 BAF35 BAF42 BAF44 BAF32	BAF4 BAF36 BAF10 BAF55
	4				BAF41 BAF46 BAF47	BAF43 BAF50 BAF51 BAF52 BAF53 BAF54 ~~BAF56~~ BAF57 BAF58 BAF45 BAF59
	5					

Table 3: Movement on scoring – period from February 2019 to January 2021

Notes: Risks closed for over two years removed from table

Risk ID	Initial Score	Feb 19	Mar 19	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	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
BAF5	12	12↔	12↔																							BAF5
BAF6	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔														BAF6
BAF9	16	12↔	12↔	12↔	12↔	12↔	12↔	12↔	16↑	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	8↓	8↔	8↔	BAF9
BAF10	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF10
BAF12	12	16↔	16↔																							BAF12
BAF13	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	6↓									BAF13
BAF14	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔																		BAF14
BAF15	15	15↔	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↔	12↔	12↔																		BAF16
BAF18	15	20↔	20↔	20↔	16↓	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔									BAF18
BAF20	12	20↔	20↔	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↔	8↔	8↔																	BAF21
BAF22	16	9↓	9↔	9↔	9↔	9↔	9↔	9↔	9↔																	BAF22
BAF23	15	20↔	12↓	8↓					20↑	20↔										Esc	20	20↔	16↓	16↔	16↔	BAF23
BAF25	16	12↔	8↓																							BAF25
BAF26	16	8↔																								BAF26
BAF27	16	12↓	12↔																							BAF27
BAF28	16	12↔	12↔	12↔	12↔	12↔	12↔	12↔																		BAF28
BAF29	12	8↓																								BAF29
BAF30	12		New	12	12↔	12↔	12↔	12↔	12↔																	BAF30
BAF31	16		New	16	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	Close			BAF31
BAF32	16		New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	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↔	BAF35
BAF36	15										New	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↔	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↔	BAF41
BAF42	12															New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	BAF42
BAF43	20															New	15	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	BAF43
BAF44	12																New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	BAF44
BAF45	12																New	12	12↔	12↔	12↔	12↔	12↔	16↑	20↑	BAF45
BAF46	16																	New	16	16↔	16↔	16↔	16↔	16↔	16↔	BAF46
BAF47	16																		New	16	16↔	16↔	16↔	16↔	16↔	BAF47
BAF48	16																		New	16	16↔	16↔	Close			BAF48
BAF49	15																		New	15	15↔	15↔	8↓			BAF49
BAF50	20																					New	20	20↔	20↔	BAF50
BAF51	20																					New	20	20↔	20↔	BAF51
BAF52	20																					New	20	20↔	20↔	BAF52
BAF53	20																					New	20	20↔	20↔	BAF53
BAF54	20																						REC	20	20↔	BAF54
BAF55	20																						REC	20	15↓	BAF55
BAF56	20																						REC	20	Merge	BAF56
BAF57	20																						REC	20	20↔	BAF57
BAF58	20																						REC	20	20↔	BAF58
BAF59	20																					Esc	from	CRR	20	BAF59

Table 4: Milestones – under development (*intermittent)

Risk ID	Initial Score	Length of time on BAF	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	Risk ID
BAF4	15	> 2 years																							BAF4
BAF9	16	> 2 years						16↑								12↓						8↓			BAF9
BAF10	12	> 2 years	15↔								20↑					15↓									BAF10
BAF20	12	> 2 years	15↓																				Closed		BAF20
BAF23*	15	> 2 years	8↓					20↑													20↔	16↓			*BAF23
BAF32	16	> 1 year	16																			12			BAF32
BAF35	16	> 1 year						New	16																BAF35
BAF36	15	> 1 year								New	15														BAF36
BAF38	15	> 6 months											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								BAF44
BAF45	12	> 6 months														New	12						16	20↑	BAF45
BAF46	16	> 6 months															New	16							BAF46
BAF47	16	<6 months																	16						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			BAF51
BAF52	20	<6 months																			New	20			BAF52
BAF53	20	<6 months																			New	20			BAF53
BAF54	20	<6 months																				New	20		BAF54
BAF55	20	<6 months																				New	20	15↓	BAF55
BAF56	20	<6 months																				New	20	Merge	BAF56
BAF57	20	<6 months																				New	20		BAF57
BAF58	20	<6 months																				New	20		BAF58
BAF59	20	New																						20	BAF59

Appendix 2

Key Performance Indicators for Board Assurance Framework December 20 Q3

KPI1 Percentage of risks with action plans completed by target completion date Target 90%

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

Notes:

* recommended risks (December) 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 2a % increased scores 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 *Red*

Appendix 3 CRR 20/21 Summary of Risks as at January 21

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

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
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						
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						
CRR 51	If EPUT staff are not alert whilst on duty then high quality care will not be delivered resulting in poor patient experience	AG	• Robust observation protocol in place – for agency staff there is a 'one strike and out' rule in place • Robust performance management of substantive staff in place • Maintain monitoring – P&C recommended to EOSC to change the score to threshold – agreed Dec 20 • Fatigue resulting from 12 hour shifts • General Covid fatigue	Risk score reduced Dec unchanged Jan 3 x 2 = 6	3 x 2 = 6 ~~July~~ Dec 20	EOSC At threshold
CRR 58	If EPUT's in-patient wards do not fill shifts consistently to a minimum of 90% then safer staffing is not fulfilled resulting in poor patient experience, low staff morale and non-compliance with standards	AG	• Continues to be monitored due to CQC profile • Unfilled shifts highlighted in performance reports not aligned with acuity and occupancy. Low occupancy may mean that the ward is still well managed even with unfilled shifts • The view of Operations is that twice daily sitreps ensure that wards are safely staffed • This is not an issue for Community Health Services • Specialist Services and Mental Health have negligible vacancies and recent over-recruitment shows an improvement, as aspirant nurses now have PIN nos. • Consistent monitoring of shift fill via Safe Wards • Score on DRR is 4 x 4 = 16	Risk score unchanged Dec/Jan 4 x 2 = 8	4 x 2 = 8 March 21	Sitreps Quality Dashboard/ CQC compliance Board At threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 65	If EPUT is unable to deliver ECT to patients in a timely manner due to capacity or other restrictions resulting from Covid19 guidance then patients may experience a delay in receiving treatment, resulting in a poor patient experience, possible patient deterioration or harm and reputational damage to EPUT	MK	• Two sites are now registered for ECTAS accreditation • ECT Group chaired by Consultant and Associate Director Operations, with regular updates to EOSC on progress with ECTAS accreditation • ECT protocols in place in North Essex • Working toward accreditation within six months • Command discussions taking place about current arrangements for ECT. Further work is required around establishing airflow for ECT work, as this is an aerosol generating procedure. A piece of kit for the Trust will cost £2k or an external company via estates can check the airflow. ECT is potentially a lifesaving treatment however there is a conflict with not meeting IPC standards.	Risk score unchanged Dec 4 x 4 = 16 Recommend increase in score to 5 x 4 = 20	4 x 2 = 8 ~~September~~ ~~December~~ ~~20~~ March 21	TST Above threshold
CRR 11	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	• A campaign of awareness took place between 10 September and 10 October with a number of live events that were well supported • A plan was in place for review of the 2018-20 Suicide Prevention Strategy but may be on hold due to operational pressures	Risk score unchanged Dec/Jan 4 x 3 = 12	4 x 2 = 8 March 21	Quality Committee and sub-Committees Above threshold
CRR 39	If EPUT does not drive improvement through clinical research then an outstanding rating may not be possible resulting in the Trust not reaching its aspiration in the desired timeframe	MK	• Two new risks added to Medical DRR (1) EPUT having sufficient resources in place to manage clinical trials and (2) EPUT developing a mature research culture • Face to face research activity has been suspended due to C19 • NIHR funded staff redeployed to acute Trusts to assist with C19 research • Usual NIHR performance targets not applicable this financial year due to C19 • An Assessment and Prioritisation Panel has been set up to review the safety and feasibility of re-opening each study in the light of C19	Risk score unchanged Dec/Jan 3 x 3 = 9	3 x 2 = 6 March 21	Research and Innovation TST NIHR Clinical Trials Performance (CTP) Team Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 16	If EPUT does not manage violence and aggression then there is a risk of severe harm or death, resulting in serious incidents affecting reputation and staff survey results	PS	• General workplace risk assessments are in place • Environmental aspects are reviewed to minimise violence and aggression • Violence and aggression task and finish group continues to meet quarterly • Trial of body worn cameras completed with evaluation showing positive staff response • Ongoing work with Essex Police has resulted in improved responses and investigations and a better relationship • Staff are better supported with positive feedback • New lone worker devices in place with more staff using them • Patient acuity is high meaning that this is always going to be a risk • Body worn cameras rolled out to more wards • Evaluation report to Technical T&F group • One T&F group in place for Technical and Oxehealth	Risk score unchanged Dec/Jan 4 x 3 = 12	4 x 2 = 8 March 21	Internal audit HSSC Staff survey Task & Finish Group Above threshold
CRR 56	If blanket (global) restrictions continue to be operated in in-patient mental health services, then the experience of patients will be impacted and the CQC rating of the Trust / in-patient services is unlikely to improve	AG NH	• 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 may result in a decision to introduce rules to enforce social distancing on inpatient wards as well as staggered mealtimes. This could result in an interpretation of 'blanket restrictions' but deemed important for staff and patients at the current time	Risk score unchanged Dec/Jan 3 x 4 = 12	3 x 2 = 6 March 21	Restrictive Practice Group Quality Committee Above threshold
CRR 64	If there are new serious inpatient patient safety incidents then there is a risk that the Trust could be subject to increased regulatory scrutiny with respect to clinical care and governance processes, impacting the Trust's reputation and CQC rating	AG/ PS	• Risk closely aligned to BAF10 Ligatures and remains high risk with scrutiny by LRRG • Serious incident resulting in death related to an abscond from Finchingfield sees this risk materialise and an unannounced visit from CQC has taken place as a result • CQC will be triangulating information around the S29 warning. Joint meetings taking place across operations, suggest including specialist services	Risk score unchanged Dec/Jan 4 x 3 =12	4 x 2 = 8 March 21	Ligature Risk Reduction Group HSSC Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 48	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	• The situation is now more complex and activity has increased with cover being maintained by locum and agency • This risk has been reworded to cover all clinical services as recruiting to adult inpatient wards in all areas is challenging • There are 20 Consultant vacancies, of which Locum posts cover 16. Locums remain hard to source.	Risk score reduced Dec and unchanged Jan 4 x 4 = 16	4 x 2 = 8 Mar 21	Medical Staffing Committee Above threshold
CRR 68	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 Executives	• A Task and Finish Group within the Risk, Compliance and Assurance Directorate is currently ongoing including reviewing and simplifying risk assessment paperwork, looking at other Trusts' paperwork as well as HSE guidance • Discussions with other Trusts may lead to a forum working on achieving compliance with GWPRAs • Task and Finish Group on 12 November agreed a final draft version of the GWPRA template, and emailed out to HSSC members to test within their teams and feedback - ongoing	Risk score unchanged Dec/Jan 4 x 4 = 16	4 x 2 = 8 October 20	HSSC Quality Committee Above threshold
CRR 71	If EPUT experiences issues with the battery life on its stock of McKinley T34 Syringe Drivers then the Trust may not be able to provide effective therapeutic symptom management to service users, resulting in poor patient care, poor patient experience and non-compliance with best practice and national guidelines	AG	• A number of controls already in place • Sent out a request to all areas asking that all machines checked. The battery prongs cleaned and sent for repair if there are still issues. They should be trial tested prior to application to any patient • Duracell batteries in use across Trust • Guidance in place for battery maintenance of Series 2 & 3 devices • 8 devices to be returned from manufacturer, 6 to return to stock following Althea checks	Risk score unchanged Dec/Jan 4 x 3 = 12	December 20 4 x 2 = 8	Above threshold CHS SMT
CRR 74	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	• Recent incident on Finchingfield resulted in the death of a patient, injury to a member of staff and a focused inspection by the CQC • A report is being prepared by Estates that will make recommendations for air lock improvements at The Linden Centre, Rochford and The Lakes – expected January	Risk score unchanged Dec/Jan 5 x 3 = 15	March 21 5 x 2 = 10	Above threshold Patient Safety Oversight Group

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
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						
CRR 40	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	• Whilst this is at threshold, during Covid19, the NHS remains vulnerable to hacking and a potential fraud email from a pharmaceutical company investigated. Pharmacy staff are aware of this. • Windows 10 upgrade licences now purchased	Risk score unchanged Dec/Jan 4 x 2 = 8	4 x 2 = 8 March 20	Cyber Essentials Accreditation PSOG PST At threshold
CRR 53	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 21 which could potentially impact on CQC ratings and patient experiences.	TS	• Phases 1 and 2 completed • Phase 3 Cherrydown and Kelvedon Ward additional improvement works were approved on 11 Nov 20 including main entrance, link corridors, multi-faith/ visitors rooms, servery/ WCs, stairwells, ECT areas and Community Resource Centre waiting room. Works to complete by 31 March 21. • Phase 4 Grangewater Ward/ Thorpe Ward – works include refurbishing the ward to 16 single en-suite bedrooms. Work not planned until 21/22. Tender specification document underway with planned issue to contractors by 31 Jan 21 • 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 to reduce bed numbers to 18 and create better male and female segregation	Risk score unchanged Dec/Jan 3 x 4 = 12	4 x 2 = 8 December 21	Capital Group PIT EOSC Above threshold
CRR 34	If there are insufficient suicide prevention trainers and staff not trained effectively in suicide prevention then there is a risk that staff may not have the necessary skills for safely supporting a suicidal patient, resulting in self-harm or suicide.	NH MK	• Training is now virtual – exploring whether Connecting for People training can be delivered predominantly virtually • Suicide prevention month provided a range of events and opportunities for learning for all staff • Quality Committee is looking for an improvement trajectory on suicide prevention training. Ligature Co-ordinator picking up with Workforce to ensure trajectory and reporting in place. Consider risk rewording and rescoring	Risk score unchanged Dec/Jan 3 x 3 = 9	3 x 2 = 6 March 21	Quality Committee Suicide Prevention Group Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 49	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	• 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 • By April 21 EPUT will have more control over referrals from IAPT into core services • Community transformation is a phased model • 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 monitoring through contracting • Also impacting routine appointments • Cannot meet 28 day target • Community transformation paper signed off in NEE, redesign of CMH pathways and provision of IAPT through EPUT. Transparent monitoring through contracting.	Risk score unchanged Dec/Jan 3 x 3 = 9	3 x 2 = 6 Dec 20 ~~July 20~~	CCG QCPM Board CCGs Above threshold
CRR 72	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	• Escalated from Operations MH Specialist Services • Reinforce importance of Datix recording as part of work 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 • Plan to move to SystmOne for prescribing • Open Road not checking if patient known to MH and vice versa – poor system working and communication • 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 • EPUT ITT working towards a resolution	Risk score unchanged Jan/Dec 4 x 3 = 12	March 21 4 x 2 = 8	SSMG Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
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						
CRR 14	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	• Reviewing and refreshing communication strategies • Thank you vouchers are being sent to staff this month • Staff are saying they are tired and fatigued as opposed to having low morale • Wording of risk changed in Dec 20 with SL to reflect current position	Risk score unchanged Dec/Jan 4 x 3 = 12	4 x 2 = 8 March 21	Workforce Transformation Group Above threshold
CRR 57	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 Execs	• 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	Risk score unchanged Dec/Jan 3 x 4 = 12	3 x 2 = 6 March 21	Equality and Inclusion Committee PIT Board EOSC Above threshold
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						
CRR 45	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 Execs	• There is a 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 • Local trajectory in place for safety focused and IG mandatory training as a priority	Risk score unchanged 4 x 4 = 16	4 x 2 = 8 March 21	Training and Development Group Above threshold
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 (Consequence) x 3 (Likelihood) = 15 risk score						

Table 2: Mapping of risks against 5 x 5 scoring matrix – changes reflected by red or white text and cross through – see main report

	RISK RATING				
	Consequence				
	1	2	3	4	5
Likelihood 1					
Likelihood 2			CRR51	CRR40	
Likelihood 3			CRR34 CRR39 CRR49 CRR71	CRR11 CRR14 CRR16 CRR64 CRR69 CRR72 ~~CRR58~~	CRR74
Likelihood 4			CRR53 CRR56 CRR57	CRR45 CRR48 CRR70 CRR68	CRR65
Likelihood 5					

		Agenda Item No: 8 (b)i
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 January 2021**

Report Title:	**Finance & Performance Committee Assurance Report**					
Executive/Non-Executive Lead:	Manny Lewis Chair of the Finance and Performance Committee Trevor Smith Chief Financial Officer					
Report Author(s):	Trevor Smith, Chief Financial Officer					
Report discussed previously at:	-					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides:

Assurance to the Board of Directors that the Finance and Performance Committee (FPC) is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objective and impact on quality are being managed effectively.

Approval	
Discussion	
Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

In view of the Pandemic a reduced light touch Committee meeting was held 21 January with the Committee Chair, the Chief Operating Officer and Chief Financial Officer.

The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) reviewed the minutes, action log and key performance and financial matters in detail for December 2020.

The meeting considered the current hotspots and pressures associated with Covid together with key operational issues identified within the Integrated Performance Report:

- CPA 12 Month Reviews
- Inpatient MH Capacity
- Out of Area Placements
- Mandatory Training
- Waiting Lists, inc Patients Not Seen for 12+ Months
- Covid Staffing and Sickness

Key financial matters were discussed in detail including key financial risks, capital expenditure, cost improvements and financial planning for 2021/22.

The group considered the range of large initiatives and plans for transformation and modernisation going forward, including the Accountability Framework and Governance Review, Structures and Systems.

It was agreed that reporting would remain in reduced format due to the demands on current capacity and that there would be a particular focus would be on the actions to address CPA

reviews at the next meeting.

Relationship to Trust Strategic Priorities	
SP 1: Continuously improve patient safety, experience and outcomes	✓
SP 2: Achieve 25% performance	✓
SP 3: Co-design and co-produce service improvement plans	✓

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

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

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

		Agenda Item No 8b (ii)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 January 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:						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

At the meeting held on 17 December 2020, the Quality Committee:

Received a patient story resulting in organization learning and the benefits of taking a systems approach to patient care.

Received the following reports:

- Quality Performance Quarterly Report
- Quality Strategy Update Report
- Transformation Quality Priority: The Development of IPCC
- Update of progress against Learning Disability Standards
- CQC Exception Report
- Covid Quality Improvement Initiatives – West
- Infection Prevention and Control Testing – Guidance from NHSI/E
- Carers Framework Presentation
- IG Framework
- Review of Committee Terms of Reference

Reviewed the following policies:

- CLP1 Clinical Audit Policy Extension Request
- CLP56 NICE Policy Extension Request
- CP24 Equality, Inclusion & Human Rights Policy
- CPG75 Ligature & Risk Assessment
- ICPG1 Risk of Infection

The Committee identified:

- The difficulty securing blood tests in some areas should be escalated to a medium risk on the corporate risk register
- The risk associated with failure to achieve compliance with the Data Security and Protection Toolkit.

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

The Committee identified the following as areas of good practice:

- Positive outcome of the patient story
- The significant progress made in relation to the reduction of falls
- Transformation of the dementia/frailty pathway.

At the meeting held on 14 January 2021, the Quality Committee:

Received the following reports:

- Combined Sub-Committee Assurance Report
- Ligature Update Report
- Covid-19 Board Assurance Framework
- CQC Assurance Report
- BAF Action Plan
- Equality Annual Report

The Committee identified:

- No risks to escalate 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

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

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

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

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

Supporting Documents and/or Further Reading

Lead

Amanda Sherlock
NED and Chair of the Quality Committee

Agenda Item 8b(ii)
Board of Directors Meeting
27 January 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 12 November 2020 and 17 December 2020 were approved subject to a small amendment.

2.2 Summary of discussions and issues identified as well as assurances provided at the December and January meetings:

December 2020

2.2.1 Patient Story: Received a patient story regarding a fourteen year old female admitted under Section 3 of the MHA. The young lady had been diagnosed with Autistic Spectrum Disorder, learning disability and had presented as violent and aggressive to others with a history of self-harm. During her admission she had limited access to education, activities and therapies that were compounded by periods of seclusion and long term segregation. The team worked with specialist commissioners and the local authority to establish a community placement. Identifying the placement took some months, however once established the young person began to improve. She was successfully discharged to a community placement in early November 2020 and is reported to be doing very well.
The team identified a need for further training in relation to communication with patients and a four month period of training is now underway.

2.2.2 Quality Performance Report: The Committee received the report which gave an updated October 2020 position. One indicator in relation to inadequate performance below target/benchmark was identified in relation to admissions to adult facilities of under 16's. Serious incidents in mental health services was showing an increased position of 9 but it was noted that some incidents are on a downwards trajectory and there were no incidents reported within community health services.

There was discussion in relation to safer staffing figures. The current wave of the pandemic is starting to have an impact on staff with a number contracting COVID-19 or required to isolate. There are a number of hotspots across the Trust and some staff have expressed an unwillingness to work in those environments. Due to the rise

in infection rates across the county severe changes were anticipated. The Committee sought feedback in relation to the messages being given to staff that were unwilling to work in areas with COVID-19. Natalie Hammond assured the Committee that all staff are continuing to receive advice on prevention and protection methods and a great deal of work was taking place to support staff and their wellbeing throughout this difficult period. However, if circumstances arose where staff walked off shift due to COVID-19 related issues disciplinary action would be commenced due to the impact on patient safety.

The Committee sough feedback on the impact of staffing as a result of the vaccination programme. It was noted that the vaccination programme had not commenced but that the there was an expectation that this would have the most impact for band 5 and 6 staff.

2.2.3 Quality Strategy Update: The Committee received an update report against key quality actions identified within the Quality Strategy 2018 – 2020 and quality priorities identified for 2020/21. All key areas are showing an improvement although there is an understanding that workstreams must continue with the current levels of activity to ensure ongoing progress.

There is work ongoing to develop a Patient Safety Strategy and there are discusses ongoing to ensure quality related issues are included with a drive to identify quality related issues and embed them within the strategy.

Assurance was sought that technological advances were being used where appropriate in order to continue to reduce harm; an example was given regarding a recent presentation at EPUT Lab in relation to management of pressure ulcers. Confirmation was given that this was the case and that in relation to the app in question, capital funding had been secured to implement next year.

The Committee commended the work that had been undertaken and the improved outcomes from that work. It was agreed that a presentation should be made to the Trust Board early in the New Year.

The importance of using the Model of Improvement Framework was reiterated to ensure that there was a clear understanding of the interventions that were having the most positive impact on outcomes.

The Committee was assured that a collaborative approach would be taken with staff, service users and carers to identify quality priorities going forward.

2.2.4 Quality Priority – The Development of Integrated Primary and Community Care (IPCC): The Committee received a presentation of a systems approach that had been taken to implement IPCC. EPUT has been working across Mid and South Essex Sustainability and Transformation Partnership on the development of IPCC teams. These teams will provide specialist mental health advice, treatment and support across primary care network levels. It was noted that the aim of the new model was to reduce stagnation and fragmentation of care providing place based and mental health support, care and treatment situated and provided in the community enabling more and higher quality care.

The Committee noted that as a result of successful bids and reconfiguration, 4 primary care networks have been established in Thurrock, I in south east Essex and 6 in Basildon and Brentwood. They were advised that delivery against the model posed challenged in relation

to IT, IG and risk management.

2.2.5 Update of Progress made against Learning Disability Standards: The Committee received assurance that work was ongoing to implement the new learning disability standards in line with national timeframes. It was noted that feedback from benchmarking exercises were being used to drive change and the Trust had registered to take part in the benchmarking exercise for 2020/21.

It was recognised that 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**.**

2.2.6 CQC Compliance Report: The Committee received an update report that gave assurance that the Trust was complying with CQC requirements. Assurance was given in relation to the following:

- Confirmation regarding the required CQC notifications for the locations to be used for mass vaccination that have been added to the EPUT Statement of Purpose as they are identified.
- Confirmation that a draft action plan is in place in response to a unannounced CQC Inspection Warning Notice. The plan continues to be developed to ensure correct identification of issues and SMART action identification.
- Hotspot identified in relation to all wards not being aware of EPUT Confidential Discussion Poster. This has been reissued to all relevant teams.
- Details of two hotspots found as part of the internal compliance regime that have been escalated.
- PHSO/HSE action plan testing completed in September with aim to complete again quarterly.
- Notification of three service hotspots: Finchingfield, adult acute and PICU, CAMHS (St Aubyns).
- The October Insight Report provided minimal change, however two areas are showing as “worse” compared to national benchmarks.
- Notification that the Towards Outstanding Group has been disbanded and work is underway to identify the appropriate committee to take forward the different workstreams established.
- Details of new publications issued by the CQC
- Details surrounding the Transitional Regulatory Approach provided by the CQC at the engagement meeting.

2.2.7 COVID-19 Quality Improvement Initiatives – West This item was deferred due to the unavailability of the presenter due to work pressures.

2.2.8 Infection, Prevention and Control Testing: The Committee received a copy of a letter from Ann Radmore, Regional Director, NHE England and NHS Improvement, East of England highlighting the ongoing concern about the level of Nosocomial infection within the region. Updated guidance was also circulated setting out new requirements in relation to testing. A discussion took place regarding the guidance which consists of ten key actions and assurance was given that the Trust was complying with the guidance and engaging with regional meetings. It was noted that further iteration of actions was expected as the Trust continues to drive improvements and respond to challenges as they arise. The Chair gave her thanks to the Infection, Protection and Control Team on behalf of the Quality Committee.

2.2.9 Carers Framework Presentation: The Committee were advised that the Carers and Family Framework had been updated following wide consultation to

embrace all stakeholders. It was acknowledged that some flexibility was built into the framework to enable further engagement, although priority areas with identified outcomes and attributed actions have been identified. Work was being aligned across the Trust to ensure a consistent response across all areas.

The Committee were advised that the revised framework incorporated the following elements:

- Carers and Care Act 2014
- Communication and Engagement
- Carers for adults, children and adolescents in inpatient settings
- Training for staff and carers
- Carers and service improvement
- Suicide management and prevention
- Staff as carers
- Carer performance outcomes
- Specialist services
- Positive carer experience.

It was noted that from January 2021, service users and carers would be involved in quality improvement training to support delivery against the agenda. Actions would be triangulated against learning from PSIRF findings to embed a learning approach.

The Committee welcomed the revised framework and the approach taken to be malleable and build in feedback loops.

2.2.10 Information Governance Framework: The Committee received a report provided by the Chair of the Information Governance Sub-Committee (IGSSC). It provided assurance that the Information Governance Framework is in place and the responsibilities outlined within it are being managed effectively. It was note that information governance is an integral part of the Trust's agreed assurance system. The framework has been reviewed in line with the Trust compliance schedule and the IG work plan has been updated for the coming year. It was noted that the Trust continued to be challenged in complying with the information governance data security and protection toolkit but work was ongoing and operational directors agreed to pursue activity.

2.2.11 Review of Terms of Reference: The Committee received the Terms of Reference and was advised that there was minimal change. It was noted that a review was currently taking place of committee structures and as a result it was agreed that the Terms of Reference would be reviewed again in June 2021. An update was given at the January meeting regarding the governance review that was underway confirming that June 2021 was an appropriate date for review.

January 2021 Meeting

Due to the pandemic, a review was undertaken of all agenda items to enable a reduced meeting time whilst ensuring all key areas requiring assurance were received.

2.2.12 Combined Sub-Committee Assurance Report: The Committee received the combined report that had been prepared to provide assurance that sub-committees are discharging their terms of reference and delegated responsibilities effectively.

- Mortality – The last meeting was held on 10 December 2020 where it was noted that progress in terms of key issues continues with no matters of significant concern noted. It was noted reduced capacity of the Project Co-ordinator due to support to the Vaccination Programme may impact ability to take forward developmental mortality review work.

- Equality and Inclusion – The sub-committee has reconvened and governance/assurance processes are in place. A series of priority actions are taking place to give support to the Vaccination Team and enhance wellbeing and psychological support to staff. It was noted that a large volume of work was taking place to embed this agenda.

- MHA and Safeguarding – Positive assurance was given that progress had been made against issues raised in September, however there continues to be a delay in relation to receipt of section papers being forwarded to MHA Office, however a task and finish group is in place. Due to the impact of the pandemic, pressure was noted on clinical staff in complying with the Tribunal Service timescale. Meetings are scheduled to resolve. The Committee sought assurance that the Trust was meeting all legislative requirements and positive assurances were given.

  A range of positive assurances were given in relation to work undertaken by safeguarding teams both at local and system-wide level. There has been a surge in referral under three domains: domestic abuse, neglect and self-neglect. It was noted that a surge had been expected and support was being provided inclusive of pharmacy teams being trained to provide support if an agreed password was used.

- Restrictive Practice – Meeting arrangements continue to be place. The decrease in prone restraint has been maintained and seclusion and LTS incident numbers are returning to pre pandemic levels. A review of seclusion and LTS incidents between April and November 2020 is being undertaken to examine the effects of Covid 19 on the incident numbers. The Committee was informed that the TASID Policy, Restrictive Practice Policy and the Seclusion Policy have passed their review dates. Both policies will be ready for submission to relevant committees in February 2020.

- Information Governance - The Committee noted that information governance systems had been significantly impacted by the pandemic with increased home working and use of technological solutions. Assurance was given that systems, policies and procedures are being continuously reviewed to mitigate risks. The Cyber Essentials Plus Certificate has been achieved and work is ongoing to ensure that the compliance rate achieves 95% before the next DSPT submission with all directorates being fully engaged giving staff protected time where possible to undertake.

  The Committee were informed that sudden changes to legislation regarding information sharing – Control of Patient Information Notice have been implemented regarding data sharing. In addition, Data Protection Impact Assessments have been undertaken for all new technologies and processes.

- Clinical Governance – The Committee noted that specification guidance has been issued to teams in relation to safety pods which was identified as a hotspot at a previous meeting. A further hotspot was identified in relation to the absence of a Medical Devices Strategy, and corporate resource was identified as a hotspot in relation to the physical health agenda and device replacement. Covid 19 and staffing pressures at the present time was noted as a hotspot.

- QI and Innovation – Work to embed quality improvement into Trust systems is continuing although capacity issues are impacting on the opportunity for directorate hub meetings. QI has been embedded into Trust programmes with the aim that over the next three years all staff will have an awareness of quality improvement and tools and techniques that can be used.

- Physical Health – The Committee noted that pressure on services due to the pandemic is having an impact on the level of physical healthcare required. The 'whole person' collaborative will pick up many of the issues although the Committee was advised that meeting structures had reduced due to capacity issues.

- End of Life Care – The Committee was advised that steps had been taken to measure the quality of End of Life care within EPUT healthcare settings by undertaking an evaluation of the views of bereaved families and carers. Feedback received has been extremely positive, and where issues were raised. these have been shared with relevant teams. A hotspot has been identified relating to T34 syringe pumps but actions are currently being taken to mitigate the current risk.

- Health, Safety and Security – Throughout the pandemic meetings have taken place with all actions being progressed. The action in relation to CCTV footage is currently overdue with confirmation awaited that all areas are now able to retain footing for 28 days as per policy. A number of risks were identified for escalation:
  - Engagement and observation training is currently every 4 years which is felt to be too long and not appropriate. The Committee were advised that a suite of work was being undertaken and decisions taken would be representative of all discussions and changes to policy.
  - ACT system cards and the implication from loss of cards/monitoring/ costs and security.

  The Committee noted that the Violence and Aggression Group was to be merged into the HSCC meeting.

- Patient Experience –The Committee were given positive assurance in relation to a survey undertaken to the second hand use of technology during Covid 19 that had a high number of respondents and positive experiences were noted. Approval of the outline draft Carer's Framework had been given along with a paper setting out the Trust's approach to the relaunch of the Friends and Family Test post the pause due to Covid 19. In addition, the Committee noted that the draft action plan for the Community Mental Survey 2020 was approved. The Committee questioned the frequency of meetings and were partially assured that a recent meeting had taken place although frequency was inconsistent, however, it was noted that there is a new action plan against the new framework.

- Research and Innovation – It was noted that research activity re-opened from November. NIHR guidance is to prioritise non-Covid research for organisations not directly involved in Covid treatment and research. The Trust will be instructed by NIHR on re-directing staff to assist with urgent public health research.

- Learning and Oversight – The sub-committee last met on 5 January 2021 and positive assurance was given that learning was being taken from incidents and feedback from patient experience. It was noted that suicide prevention training uptake had been sub-optimal and discussions were taking place regarding the bespoke needs of the training and measures to improve uptake. It was noted that there were significant challenges around individuals isolating wards where suspicion of Covid 19 required transparency around pathways to utilise the Trust's Ethics Committee.

- Multi-Professional Education – Two meetings have taken place since the last assurance report. Positive assurance was given in relation to preceptorship arrangements, CPD, reverse mentoring, career lounges, EPUT contribution to National Mental Health Act training and links with medical schools.

  Risks were highlighted in relation to student placements, CPD funding and redeployment of doctors. The situation regarding student placements is being

managed but partner universities have recruited beyond the numbers originally agreed. Currently the Trust is in discussions with HEE around 85 first year students that we do not have capacity to place. All ARU requests and 115 of the 200 recruited by Essex have been placed. There remains a risk that the Trust may not be in a position to use all CPD funding this year as staff release is becoming more difficult. Due to pressures in Acute Hospitals, there is an expectation that junior doctors may need to be redeployed, some foundation year doctors have already been redeployed. In mitigation, the Trust is involved in regular system-wide meetings involving HEE and acute hospitals.

2.2.13 Ligature Update Report: It was reported that an audit had been undertaken which tested the Trust's implementation of its Ligature Risk Management Policy and Procedure. The overall conclusion was that substantial assurance was given for the design of the controls and moderate assurance on the effectiveness of the controls in place.

Two areas were reported with 3 recommendations, 2 of which had been completed and 1 not accepted. The recommendation to make suicide prevention training mandatory for appropriate staff was not agreed but in mitigation it was set as an objective through the appraisal system with compliance being monitored to achieve over 85%. The Committee were advised that there has been a change to governance arrangements. The Trust will continue to hold both a Ligature Risk Reduction Group and Estates Expert Reference Group each month. Ongoing risks will be escalated directly to the Executive Oversight Group in place of the Health, Safety and Security Committee. Enhancements to risk management arrangements were concerns with the Committee seeking further assurance in relation to management of safety alerts.

It was noted that ligature inspections continue to be undertaken in line with Trust policy which consists of annual inspections supported by a sixth monthly review. Policy arrangements are under review with expected submission to HSSC in January 2021. The Committee were assured that compliance for staff completion of ligature awareness online training is at 97%, and there are plans for a bespoke ligature risk assessment training for staff who undertake inspections has been commissioned.

2.2.14 CQC Update: The Committee received an update on all key issues associated with the Care Quality Commission. It was noted that the Trust is fully registered for all services including the new Mass Vaccination Programme. As previously notified to the Committee, the CQC completed an unannounced inspection on 29 October focusing on Finchingfield Ward following a series of incidents that resulted in a Warning Notice. 6 areas of concerns were identified, 4 of which had a timescale of 27 December 2020 which have been achieved and 2 with a timescale of 27 January 2021 that are progressing well. The Committee was given assurance that the Intensive Clinical Support Group continues to meet weekly in order to progress and test the improvements for the Warning Notice and to ensure that the issues identified from the inspection are addressed on the wider CQC action plan.

The Committee noted that the CQC has announced that there will be a joint HMI Probation Thematic Review to be undertaken in February 2021 which will include the Trust Health and Justice Services. Assurance was given that support was being provided by the Compliance Team.

The Compliance Team have continued CQC action plan testing to ensure actions taken following CQC inspections have been fully embedded. This has identified some areas where actions have not been fully embedded; the issues have been escalated to relevant directors to ensure further work is undertaken.

It was noted that the CQC has published the second report of Professor Glynis Murphy's independent review of the regulation of Whorlton Hall between 2015 and 2019. Five further recommendations have been made:

- Services should not be rated as 'Good' or 'Outstanding' if they have used frequent restraint, seclusion and segregation.
- Services should not be rated as 'Good' or 'Outstanding' if they cannot show how they support whistleblowing and reporting of concerns.
- Training of the Group Home Culture Scale tool, to evaluate whether it helps inspectors determine which settings have used closed cultures.
- Training of the Quality of Life tool to gauge whether it helps CQC move from evaluating process, towards evaluating more relevant service user outcomes.
- Development of guidelines for when evidence of the quality of care should be gathered from overt or covert surveillance.

The Committee was advised that the report was detailed and further work would be undertaken to clarify the detail associated with the new recommendations.

2.2.15 Covid-19 Board Assurance Framework: Following a previous report to the Quality Committee the assurance template was updated nationally in response to emerging Covid 19 evidence, and the effective infection prevention and control measures. It was noted that the framework would continue to operate as a live and dynamic collection of evidence, risks, gaps and mitigation. The Committee acknowledged the content of the revised framework and extended their appreciation to the teams supporting this agenda.

2.2.16 BAF Action Plan: The Committee received an update of Board Assurance Framework plans to mitigate risks reportable to the Quality Committee. The report covered up to January 2021 incorporating quarter 3. The following changes to BAF scores were noted:

- BAF53 – Patient Safety BAF introduced with a risk score of 20. It was noted that progress has been made with the formation of Patient Safety Oversight Group with terms of reference, chaired by the Chief Executive and development of Patient Safety Strategy and aligned with key action plans.
- BAF54 – A new risk identified in relation to preparation of an anticipated Independent Review into deaths between 2000 and 2020.
- BAF55 – A new risk in relation to CQC S29A Warning Notice.
- BAF56 – A new risk in relation to achievement of CQC's fundamental standards.
- BAF58 – A risk escalated to BAF in relation to recording of clinical records.

The Committee noted the content of the full report and was assured that actions were being delivered to reduce risk. It was acknowledged that the pandemic was impacting on resources, but due to the priority status of the BAF, progress continues to be made.

2.2.17 Equality Annual Report: The Committee received a report covering the period 1 April 2019 to 31 March 2010. It provided an overview of achievements in the field of equality and inclusion. Whilst the Public Sector Equality Duty is currently suspended it is considered to be important to capture progress made against this important agenda. The Committee agreed the report and its publication on the Trust's website.

2.3 The Committee approved the following policies and procedures:

- CLP1 Clinical Audit Policy Extension Request
- CLP56 NICE Policy Extension Request
- CP24 Equality, Inclusion & Human Rights Policy

- CPG75 Ligature & Risk Assessment
- ICPG1 Risk of Infection

2.4 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 progress against core items of the quality agenda that demonstrated the fruits of a lot of hard work as an area of good practice.

The Committee gave thanks to all teams that have contributed across the workstreams achieving success despite the challenges that have been faced over the last year.

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 (iii)

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	27 January 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(s):	Nigel Leonard Executive Director Strategy & Transformation					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report is provided to the Board of Directors by the Chair of the 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 meeting scheduled for 13 January 2021 was cancelled, to enable staff to focus on business critical issues during this very busy period.

The following papers were circulated to Committee members for their information/comment:

- Strategic Matters:
  - Corporate Objectives Update
- Governance:
  - EU Exit – End of Transition Period
  - BAF Action Plans 2020/21 Quarter 3

The attached report provides a brief overview of the contents of the papers, for the Board of Directors' information.

Relationship to Trust Strategic Objectives

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

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk	BAF18
Do you recommend a new entry to the BAF is made as a result of this report?	No

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
None

Lead

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

Part 1 Agenda Item: 8b (iii)
Board of Directors
27 January 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PEOPLE, INNOVATION & TRANSFORMATION COMMITTEE ASSURANCE REPORT

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 January 2021

The People, Innovation & Transformation Committee scheduled for 13 January 2021 was cancelled, to enable staff to focus on business critical issues during this very busy period.

The following papers were circulated to Committee members for their information/comment.

1. Strategic Matters

- **Corporate Objectives Update**
  Committee members received a report providing an update on the development of the Trust's Corporate Objectives for the new financial year.

  Following circulation of the papers, some minor feedback on the proposed timeline was received and noted.

  The Board of Directors will receive a presentation on 27 January 2021, outlining a proposal to extend the Corporate Objectives for 2020/21 into Quarter 1 and Quarter 2 of the 2021/22 financial year.

2. Governance

- **EU Exit – End of Transition Period**
  Committee members received a report providing an update on EPUT's position in relation to EU Exit readiness, and future arrangements following the end of the transition period.

  The report provided assurance that the Trust currently met the requirements of NHSE/I. In order to remain compliant, weekly administration meetings and the monthly EU Exit Task & Finish Group would continue to be held, and any urgent issues would be discussed during Silver Command meetings.

  The Board of Directors will receive a report on 27 January 2021, providing a detailed update on EU Exit End of Transition Period arrangements.

- **Board Assurance Framework Action Plans January 2021**
  Committee members received a report providing the Board Assurance Framework Action Plans to mitigate risks relating to the People, Innovation & Transformation Committee, for overview and scrutiny.

  The report covered the period up to January 2021, incorporating Quarter 3. It noted that, since the last report, one risk (BAF34) had been closed; and that the People, Innovation & Transformation Committee currently held responsibility for five risks (BAF32; BAF35; BAF 43; BAF44; BAF50).

  Following circulation of the papers, some minor feedback was received on this report, and it was therefore updated and recirculated.

ACTION REQUIRED

The Board of Directors is asked to:

1. Note the summary of papers circulated to People, Innovation & Transformation Committee members in January 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: 8b (iv)

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	27 January 2021

Report Title:	**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**	

Purpose of the Report

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

Recommendations/Action Required

The Board of Directors is asked to:

1 To note the contents of the report
2 To confirm acceptance of assurance given in respect of risks and actions identified
3 To request further action/information as required.

Summary of Key Issues

- Minutes of meeting held on the 16 September 2020
- Internal Audit Progress Report 2019/20 & 2020/21
- LCFS Progress Report
- External Audit
- Progress on RMAF Development Plan
- Statement of Financial Position Write Offs/Write Backs/Impaired Debt Write Offs
- Waiver of Standing Orders
- Use of Consultants/Legal Fees
- Cyber Security
- Finance Procedures
- Risk Identification

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

EPUT

1: Open	✓
2: Compassionate	✓
3: Empowering	✓

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
 **Janet Wood** **Chair of Audit Committee**

Agenda Item: 8b (iv)
Board of Directors
Meeting: 27 January 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 15 January 2021
Due to the current pandemic it was agreed to cancel the meeting on the 15 January 2021. However, papers were circulated to members and any queries received were raised with the Chair of the Audit Committee, Chief Finance Officer and Head of Financial Accounts.

Audit Committee Meeting 19 November 2020

The Audit Committee met on the 19 November 2020 and approved the minutes of the meeting held on 16 September 2020. These minutes are available to Board members on request.

At the meeting held on 19 November 2020 the following matters were discussed:

1. **Internal Audit**

Internal Audit Progress Report 2019/20
The following reports were finalised:

- Covid 19 Expenditure – Substantial Assurance
- Ligature Risks – Substantial Assurance/Moderate Assurance
- Safety Alerts – Substantial Assurance/Moderate Assurance

Site visit days have been reduced to carry out audits around Safety Alerts.

Internal Audit Plan for 2021/22
The above is due to be presented to the Executive Operational Committee on the 24 November 2020.

LCFS Progress Report
The Chair of the Audit Committee and Chief Finance Officer received an update with regards to the above outside of the meeting.

2. **External Audit**

Charitable Fund Accounts 2019/20
The above accounts are in the process of being reviewed.

3. **Reappointment of External Auditors**
The External Auditors, Ernst and Young, have been reappointed for a further year.

4**. Progress of RMAF Development Plan**
The above report was discussed and noted.

5. Statement of Financial Position Write Offs/Write Backs/Impaired Debt Write Offs

The Committee approved the write off relating to staff and bad debts totalling £7,566.57. The Committee also approved the asset write off totalling £188,454.83.

6. **Waiver of Standing Orders**
During the period 1st September to 31st October 2020 there had been two instances of standing orders for competitive quotes being waived. These totalled £86,075.

7. **Use of Consultants/Legal Services**
The legal services procured by the Trust during the period of April 2020 to September 2020, totals £141k of which £124k was with the Trust's approved legal providers.

The consultancy services purchased by the Trust for the same period above totalled £820k.

8. **Cyber Security**
The Trust has achieved the Cyber Essentials Plus Certification. This will be valid for one year and was identified by NHS Digital as the recognised auditable assessment of Cyber compliance.

9. **Finance Procedure**
The following procedures were approved subject to minor amendments.

- Petty Cash (FP02-01)
- Safe Custody of Controlled Stationery (FP02-02)
- Hospital Travel Cost Scheme (FP09-08)
- Operating Cash Management (FP09-10)
- Payments to Associate Hospital Managers (FP09-14)

10. **Risk Identification**

The following risks were identified:

- Safety issues.
- Mass Vaccination Programme - £100 million income/expenditure
- Risk Management.

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 19 November 2020.
2. Confirm acceptance of assurance given in respect of risk
3. Request further action/information as required.

Janet Wood
Non Executive Director
Chair of Audit Committee

		Agenda Item No: 8c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 January 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**	

Purpose of the Report		
This report presents an update on EPUT's position within the Trust for EU Exit and agreement being reached as to the relationship beyond the end of the transition period and assurance on EPUT's continued response to this.	**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 position within the Trust for EU Exit and agreement being reached as to the relationship beyond the end of the transition period and assurance on EPUT'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 weekly 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 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.

The risk score on the BAF in November was reduced from previous scores in November to 4(C) X 4(L) = 16 and the action plan has been revised.

The BAF action plan has been brought up-to-date with the actions identified by the task and finish group and is 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:

- Potential fuel shortages including the geographical needs of the Trust, although the current home working regime may mitigate this to an extent. BCPs will consider this and contingency planning will take place in case of a shortage. These concerns have not immediately materialised post transition and the Task & Finish Group will continue to monitor for any relevant actions that may need to be taken.
- Potential difficulties with travel, particularly on main roads that connect to ports, as any major congestion may impact on community staff. The Trust has nominated contacts within the Compliance & Assurance team who will receive any updates on travel disruption. These concerns have not immediately materialised post transition and the Task & Finish Group will continue to monitor for any relevant actions that may need to be taken.
- 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 and the risk is around operational staff not updating the Trust before June 2021. HR is writing to all relevant staff on a regular basis and encouraging them to apply to the EU Settlement Scheme. HR are working with approximately 158 staff with a high proportion of staff working Estates & Facilities, approximately 18, consideration is being given to how additional support and access to ITT can be made available to assist staff.

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

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

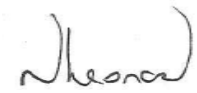
Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk	BAF23
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications:			
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			
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 8c
Trust Board of Directors
27 January 2021

EPUT

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 position within the Trust for EU Exit and agreement being reached as to the relationship beyond the end of the transition period and assurance on EPUT'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.

3.0 EU Agreement

3.1 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. The below are the key messages received to date:

- **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 information has been circulated to the Task & Finish Group members who provided assurance in the meeting held on 7 January 2021 that there were no risks or concerns from these key messages.

4.0 EU Exit Task and Finish Group

4.1 The Trusts EU Exit Task & Finish Group continues to meet on a weekly basis since the end of the transition period on 31 December 2020.

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 has been included in the daily ICC procedures covering the mailboxes between 8am-8pm Monday to Friday. Guidance received is reviewed and escalated to all relevant parties for information or action as deemed appropriate. In addition with effect from the 23 December 2020 the Trust was asked to highlight any areas of concern in our National Daily Sit Rep return to NHSEI. The areas we are asked to respond to with either a positive or negative answer are as detailed 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 Learning from COVID19

As part of our preparations, all services have been asked 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 November was reduced from previous scores in November to 4(C) X 4(L) = 16 and the action plan has been revised.

The BAF action plan has been brought up to date with the actions identified 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:

- Potential fuel shortages including the geographical needs of the Trust, although the current home working regime may mitigate this to an extent. BCPs will consider this and contingency planning will take place in case of a shortage. These concerns have not immediately materialised post transition and the Task & Finish Group will continue to monitor for any relevant actions that may need to be taken.

- Potential difficulties with travel, particularly on main roads that connect to ports, as any major congestion may impact on community staff. The Trust has nominated contacts within the Compliance & Assurance team who will receive any updates on travel disruption. These concerns have not immediately materialised post transition and the Task & Finish Group will continue to monitor for any relevant actions that may need to be taken.

- 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 and the risk is around operational staff not updating the Trust before June 2021. HR is writing to all relevant staff on a regular basis and encouraging them to apply to the EU Settlement Scheme. HR are working with approximately 158 staff with a high proportion of staff working Estates & Facilities, approximately 18, consideration is being given to how additional support and access to ITT can be made available to assist staff.

5.0 RECOMMENDATIONS

The Trust Board of Directors are recommended to:

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

Prepared by:

Lara Brooks
Head of Risk Management & Legal Services

On behalf of:

Nigel Leonard
Executive Director of Strategy & Transformation

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	Agenda item 9(i) 27 January 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 Amanda Webb, Senior Emergency Planning and Compliance Officer					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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 10 months.
- 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.
- For EPUT this means we are back under a NHS England national command and control

Command Structure

- The Gold, Silver and Bronze Command meetings initially stepped up in line with the national daily sitrep reporting to 7 days a week; however as this is continuously being reviewed with plans in place to now reduce back to a command structure of 3 full separate Silver and Gold meetings a week (Mon/Wed/Fri) and 4 joint Silver and Golds (Tue/Thur/Sat/Sun).
- The (virtual) Incident Control room operational times have increased to 7 days a week 8am until 8pm
- The Covid Risk Register is regularly reviewed and updated by Gold and Silver Command.

Impact to Date

- Over the second wave EPUT have experienced a number of outbreaks within wards/services. At

the time of writing this report there are 15 outbreaks currently open that are being continuously monitored and for which daily submissions are made to the national outbreak system. An outbreak is defined where there are 2 of more positive staff/patients based in 1 area at a period of time. All processes for an outbreak were followed as advised through joint meetings with NHSE and PHE where initial feedback has been that EPUT has managed the situation well.

- Learning from all outbreaks has been identified and shared with staff.
- We previously reported total of 18 patients who sadly passed away since the crisis began (2 in Mental Health services and 16 in Community beds); this has now increased to 32 (2 in Mental Health services and 30 in Community beds). All cases have been appropriately reported via the Covid-19 Patient Notification System (CPNS).
- At time of writing we have a total of 297 staff off sick due to covid (an increase from 64 at last report) and a total of 123 Covid-19 confirmed patients.
- The lateral flow testing for asymptomatic patient facing staff has been rolled out across the trust. We now have a total of 18,641 results recorded since commencement of the programme, from a total of approximately 2950 different staff and is proving to be a reliable indication of Covid-19 with few false positives.
- The Trust Committee and Governance Structure have continued through the utilisation of Microsoft Teams to undertake corporate meetings on a virtual basis.

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.

Covid-19 Mass Vaccinations Programme

- The roll out of the Covid-19 Mass Vaccination Programme continues at pace, with EPUT acting as the Lead Provider for the Mid and South Essex (MSE) and Suffolk and North East Essex (SNEE) systems.
- Roll out commenced initially with the Pfizer/BioNTech vaccine, with the Oxford/AstraZeneca vaccine coming on stream more recently. Information in terms of release of the Moderna vaccine into the programme is awaited.
- There are robust governance arrangements to oversee the programme and a Programme Board is in place in each system, with representation from across the different models of delivery.

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

The risks are constantly being updated to reflect the changing environment and are detailed in the summary Covid Gold Risk Register in Appendix 1. There are currently 8 Extreme Risks, 17 High Risks and 9 Medium Risks open. From this it can be seen that major risks currently facing the Trust are associated with Staffing (Skills, Resource and Capacity) due to a range of factors including:

- Mental health surge
- Staffing covid sickness / isolation
- Staff re-deployment to support local system / vaccination programme

Learning

- 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
- Following delays in some patient swabbing results the Trust has procured faster patient swabbing from the Lab at Broomfield
- In preparation of the increased Incident Control Centre hours a new staff rota was established to ensure this could be staff 7 days a week and for extended hours.

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

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes state which: • BAF38 Emergency Planning • BAF50 Skills Resource and Capacity • BAF42 Financial Plan • BAF43 Surge Planning • BAF44 Learning from C19	
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			✓
Service impact/health improvement gains			✓
Financial implications			✓
Governance 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.**			
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 Appendix 1 EPUT Changes over Covid 19 - summary Visit the Government website: https://www.gov.uk/coronavirus

Lead
Paul Scott **Chief Executive**

Agenda Item 9 (i) Board of Directors 27 27 January 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 with assurance that the actions being taken are mitigating the risks identified. This is the sixth report to be presented to the Board.

Background

Following the previously reported second lockdown put in place in November 2020 as the National Incident level was changed to Level 4 there has now been a further lockdown that was announced on 4th January 2021 and an increased incident response alert level to Level 5 alert status for pandemic. This is a reflection of the recent data showing the immense pressure that the health system is experiencing and a risk of the NHS being overwhelmed in the coming weeks.

Feedback from the Keith Willet Webinar advised that every STP in country is seeing rising numbers but it may be levelling out; all regions are at capacity and many in surge. It is reported that there are three Non-Covid patients in hospital for every one Covid-19 with an extraordinary response from everyone to manage this – much harder than wave one.

Command Structure

Since last reporting the Gold, Silver and Bronze Command meetings required a further stepped up approach with 5 days a week full command structured meetings to enable timely discussions and decisions as the system pressures increased. In addition to this there continued to be a combined Silver/Gold escalation meeting each day over the weekends. This is continuously being reviewed with plans in place to now reduce back to a command structure of 3 full separate Silver and Gold meetings a week (Mon/Wed/Fri) and 4 joint Silver and Golds (Tue/Thur/Sat/Sun).

The (virtual) Incident Control room remains operational 7 days a week and continues with the extended hours of cover from 8am until 8pm in line with the East of England Operational Centre working hours. Over the past few weeks there is a noted increase in the national and regional information and guidance into the incident control inbox which is cascaded to all appropriate Directors and through the Command meetings for information and consideration of the actions required. There is also an increase in the number of daily Sitreps being processed.

The Covid Risk Register is regularly reviewed and updated by Gold and Silver Command. In addition, the Chairs from each of the Trust's equalities networks attend the Silver Command meetings to ensure that reflection on risks and impact is undertaken to ensure that any issues are captured and that no staff group is adversely affected by decisions made, or recommendations submitted to Gold Command.

Impact to Date

Since last reporting in November there has been a significant change in our reporting of both covid positive patients and staff impacting on the Trust reaching levels higher than those experienced at the peak of the pandemic in wave 1.

Sadly the Trust has now had further patients pass away within our hospital wards due to Covid-19 as either a direct or indirect cause. Therefore the previously reported total of 18 patients who sadly passed away since the crisis began (2 in Mental Health services and 16 in Community beds) has now increased to 32 (2 in Mental Health services and 30 in Community beds). All cases have been appropriately reported via the Covid-19 Patient Notification System (CPNS).

At time of writing we have a total of 297 staff off sick due to covid (an increase from 64 at last report) and a total of 123 Covid-19 confirmed patients.

Unfortunately we have now seen a total of 26 outbreaks reported to Public Health England across our services, 11 of which have passed the 28 day period and have been closed from outbreak status. However there are 15 outbreaks currently open that are being continuously monitored for daily submissions to the outbreak system. To note an outbreak is classified by PHE when there are 2 or more cases in one area at a period of time, which was the threshold met in each of the teams where the outbreaks have occurred. All processes for an outbreak are followed as advised through joint meetings with NHSE, CCG's and PHE.

There have been commonalities of lessons learnt from each of the outbreaks that have occurred and these have been shared with staff, namely the main risks being the identified breaching PPE in staff to staff contact and attending work with symptoms.

Since last reporting the lateral flow testing for asymptomatic patient facing staff has been rolled out across the trust. We now have a total of 18,641 results recorded since commencement of the programme, from a total of approximately 2950 different staff and is proving to be a reliable indication of Covid-19 with few false positives.

The Trust Committee and Governance Structure have continued through the utilisation of Microsoft Teams to undertake corporate meetings on a virtual basis.

Trustwide Response

Since March 2020 the Trust has had to change many services in a number of ways as a response to support the system wide pressures. We have made changes to how we 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.

A couple of examples of the recent changes within the Trust include the following;

- Our stroke rehabilitation services at South East Essex, Cumberlege Intermediate Care Centre (CICC) have relocated to St Peter's Hospital, Maldon. This move will

enable them to be treated away from other patients, as they are at greater risk of complications from coronavirus. All 22 beds at CICC will be used for intermediate care patients, including positive COVID-19 patients, with appropriate infection prevention and control measures in place.

- West Essex Community Health Services are redeploying staff to support all community hospital wards and community integrated teams including Allied Health Professional's – MSK, SLT and dietetics and specialist nurses – Tissue Viability Nurses. The service has also converted 3 wards totalling 63 beds to support C19 patients (there was only 1 designated ward in wave 1) and will be actively working to implement a C19 Virtual respiratory ward, early January 2021.

- The Mid and South Essex dementia ward experienced an outbreak resulting in temporary closure. This provided an opportunity to convert it to provide Community Health provision in order to respond to the extreme challenges in the Acute and Community Health system. This will be a temporary change, only expected to be available for approximately two months whilst the system challenges peak. Meadowview converted on 8th January 2021 providing 20 beds to help with the system pressures. Dementia patients requiring admission will be admitted to the Older Peoples functional wards temporarily.

- A further Adult Acute MH ward (Topaz) will open on 25th January 2021 for all of Essex. Topaz is located in Mid Essex on the Broomfield Hospital site in the Crystal Centre. Topaz will provide 17 beds and has been transformed from older adult to adult acute, anti-ligature specification.

- Bernard Ward, Clacton Hospital temporarily closed has been offered to ACE NE Community services to be used as step down ward – therapist led (end of Jan'21);

Following the increase in demand for community beds, the increase in Covid/respiratory admissions to MSE Hospitals and the number of delays in accessing community beds, all community

providers (EPUT/NELFT/Provide) held a meeting to review the bed allocation processes to speed up the discharges and further develop the criteria for community beds. A key outcome is to further develop the Bed Bureau processes to enable a quick and seamless transfer of patients from acute to community beds.

Covid-19 Mass Vaccination Programme

Background

The roll out of the NHS COVID-19 Vaccination Programme continues at pace, with EPUT acting as the lead provider for the Mid and South Essex (MSE) and Suffolk and North East Essex (SNEE) systems. The responsibilities of the lead provider are essentially:

- Responsibility for delivery of the large vaccination centres across both systems.
- Responsibility for provision of the Workforce Bureau across both systems, set up initially to recruit, train and provide staff to the large vaccination centres (and potentially in the future for provision of support to other models of vaccination delivery).
- A co-ordinating role in terms of the roll out through a variety of different models (details of which are included below).

The MSE Health and Care Partnership and SNEE Integrated Care System are ultimately

accountable for the delivery of the vaccination programme to their populations.

Vaccination delivery

Priority cohorts
The vaccine is being rolled out sequentially to the most vulnerable of the population. The national aim is to have vaccinated all people in priority cohorts 1 – 4 by the middle of February 2021.

Vaccines
Pfizer/BioNTech, Oxford/AstraZeneca and Moderna vaccines have all been shown to be safe, offer high levels of protection and have been given approval by the Medicines and Healthcare products Regulatory Agency (MHRA), the official UK regulator. Currently, the NHS is utilising the Pfizer/BioNTech and Oxford/AstraZenaca vaccines with the Oxford vaccine allocated to the new large vaccination centres operated by the Trust.

Through the Government's Vaccine Taskforce, the UK secured early access to seven of the most promising vaccines – totalling over 367 million doses. These include:

- 40m doses of Pfizer/BioNTech vaccine
- 100m doses of Oxford/AstraZeneca vaccine
- 17m doses of Moderna vaccine

Roll out commenced initially with the Pfizer/BioNTech vaccine, with the Oxford/AstraZeneca vaccine coming on stream more recently. Information in terms of release of the Moderna vaccine into the programme is awaited.

For both vaccines in use at the moment, there is a requirement for two doses. Following a review of clinical evidence and latest public health data, the JCVI and the UK Chief Medical Officers (CMOs) have updated guidance for the NHS on the second dose for both vaccines, meaning they can be safely offered up to 12 weeks apart.

The four UK CMOs have said that, 'Prioritising the first doses of vaccine for as many people as possible on the priority list will protect the greatest number of at-risk people overall in the shortest possible time' and 'will have the greatest impact on reducing mortality, severe disease and hospitalisations and in protecting the NHS and equivalent health services'.

The latest evidence suggests the first dose of the COVID-19 vaccine provides protection for most people for up to three months and that the great majority of the initial protection comes from the first vaccination. There is a limit at the moment in terms of the amount of COVID-19 vaccine in the country and therefore it is very important we vaccinate the maximum number of people at this dangerous period over winter. As a result, and to allow more people to benefit from the protection from the first dose, the second dose which was previously 21 days after having the first dose was changed to 12 weeks after. Patients still need to receive their second vaccine, and it is important that they attend their second appointment once scheduled.

Delivery of the vaccine
The vaccine roll out is being delivered via a range of models in order to provide effective and timely access to all the population. The current models of delivery are as follows:

Hospital vaccination hubs commenced on 8th December, based on acute hospital sites. Two sites went live for MSE/SNEE in the first tranche (Basildon Hospital (MSE) and Colchester Hospital (SNEE)), followed by an additional three (Broomfield Hospital and Southend Hospital (MSE) and Ipswich Hospital (SNEE)). West Suffolk Hospital (SNEE) has

been operating as a staff vaccination hub.

GP-led Vaccination Services delivered by groups of GP practices know as Primary Care Networks (PCNs) started in late December and have been joining the programme in waves. All PCN sites are now operational across both systems.

Community pharmacies started to join the delivery programme in January, with one confirmed for MSE and four in SNEE so far. Further community pharmacies will be joining the programme in coming weeks

Vaccination centres delivered by lead providers (for MSE and SNEE this is EPUT). The intention of the large vaccination centres is to deliver vaccine at pace in large numbers to the priority cohorts. The intention is that vaccination centres will operate 7 days a week 8am – 8pm and will aim to deliver hundreds of vaccinations a day per "pod" established in the centre. EPUT has been working with the MSE and SNEE systems to identify suitable premises for vaccination centres across the areas and to mobilise these premises ready to open when required. On Monday 18th January, The Lodge in Wickford, Essex was one of ten new large-scale vaccination centres to open. It offers an additional option for people and more will be going live across MSE and SNEE in the next few weeks. We would like to thank local authorities and businesses in the community for supporting the programme to make these happen. People within the national cohorts currently being vaccinated and living up to a 45-minute drive from the centre are being written to by the national NHS with the option of choosing to arrange a vaccination at the vaccination centres or community pharmacy sites as they come on stream through a new national booking service. Alternatively people can choose to wait to be contacted by their local GP-led vaccination service.

There will be a number of large vaccination centres in localities across Essex and Suffolk. These centres will be opened over the coming weeks and all identified sites will be operational before the end of March 2021.

Roving models of delivery are being used to vaccinate care homes and housebound patients. Vaccination within care homes began in December, being undertaken predominantly by PCNs. Given the particular storage and transportation challenges of the Pfizer/BioNTech vaccine, the more recent release of the Oxford/AstraZeneca vaccine has enabled this delivery programme to be accelerated this month.

Information on the number of vaccinations delivered, by region and Integrated Care System/Sustainability Transformation Partnership, is now available on the NHS England website; https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/

Governance arrangements
There are robust governance arrangements to oversee the programme and a programme board is in place in each system, with representation from across the different models of delivery.

Governance arrangements include the formal identification of risks and mitigating actions. The biggest challenge to the delivery of the programme is securing workforce in sufficient numbers to be able to roll out the programme at pace. Significant recruitment activity has been underway since announcement of the programme for both employed staff and volunteers and this activity continues. In addition, we are working in partnership with local and national voluntary agencies to secure assistance for delivery of the programme.

Roll out of the programme continues at pace and regular reports will be provided to the Board of Directors.

Further information on the vaccination programme locally is on the EPUT website: https://eput.nhs.uk/news-events/coronavirus/coronavirus-vaccine/

Communication

Decisions made by Gold continue to be communicated to all staff through the Covid Brief which is published on Monday, Wednesday and Friday's when a full Gold Command meets and on Tuesday following the Live briefing.

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 risks are constantly being updated to reflect the changing environment and are detailed in the summary Covid Gold Risk Register in Appendix 1 however there are 8 Extreme Risks, 17 High Risks and 9 Medium Risks open.

From this it can be seen that major risks currently facing the Trust are associated with Staffing (Skills, Resource and Capacity) due to a range of factors including:

- Mental health surge
- Staffing covid sickness / isolation
- Staff re-deployment to support local system / vaccination programme

Managing outbreaks continues to be a significant risk due to the increasing numbers of outbreaks.
Outbreaks affect staff shortages and closure of wards therefore reducing bed availability to acutely ill patients.

Flow and capacity through adult social care needs to be managed to ensure the movement in and out of care homes without bed blocking

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
- Following delays in some patient swabbing results the Trust has procured faster patient swabbing from the Lab at Broomfield

- In preparation of the increased Incident Control Centre hours a new staff rota was established to ensure this could be staff 7 days a week and for extended hours.

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 risk register and mitigations
4. Request any further information and or action

Report compiled by:

Paul Scott
Chief Executive

COVID19 Gold Command Risk Register Summary of Risks as at January 2021

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

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
BAF 38	If EPUT does not implement effective emergency planning arrangements for managing the COVID19 outbreak in line with national and local requirements then the ability to deliver services reduces resulting in a lack of containment of the pandemic.	NL	• Executive Lead in place for emergency planning • BCPs under ongoing review • Gold, Silver Bronze Command well established • Sit rep daily monitoring • COVID Intranet Page and range of staff training in place	Risk Score 5 x 2 = 10	Target Ongoing during COVID19 pandemic 5 x 2 = 10	Gold, Silver and Bronze Command Structure Board of Directors COVID19 Command Structure updated daily Risk at threshold
BAF 50	If EPUT does not have the skills, resource and capacity to deliver high quality business as usual care and services, manage the C19 pandemic, mass C19 vaccination programme, EU Exit Transition, regulatory responses, independent inquiry and increased variation of demands on corporate services then it may not achieve the deliverables on this wide range of priorities and pressures resulting in not achieving organisational objectives, unsustainability in corporate services, stagnation of risks and failure to maintain our position within the wider health economy	PS and all EDs	• There are 14 actions on the consolidated action plan • Nine actions are completed • Five actions are in progress to timescale • This risk has full engagement in the EOSC BAF sub group; the demands and pressures on EPUT are immense with very high stakes projects and issues • Participation by EPUT on system calls • Discussion at Command around managing the different system (internal and external) requirements and agreement to have a reduced Committee process for Dec/Jan 21 with focus remaining on patient safety related committees • Discussions at Command around significant staffing risks in January 2021. Mitigating actions being put into place including staff redeployment from corporate services and wider use of agency staff	Risk score C5 x L4 = 20	Ongoing during C19 pandemic 5 x 2 = 10	Command structure EOSC Trust Board PIT F&PC Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
BAF 42	If the COVID19 crisis continues then EPUT may experience an adverse impact on its financial plan as a knock on from system wide financial planning resulting in additional risk for EPUT to its sustainability	TS	• The revised planned deficit for 20/21 is £8.3m • In December 2020 **M9**, the Trust recorded a deficit of £1.2m against the planned deficit of £1.4m (year to date deficit £2.9m against the planned deficit £3.9m) • The forecast outturn is £13m • Year to date M9 Covid19 costs of £10.1m with M7-M12 recovery anticipated from M&SE and H&CP. Cash was £103.5m in M9, which remains better than planned	Risk Score 4 x 3 = 12	Target March 2021 4 x 2 = 8	Finance and Performance Committee Board Above threshold
BAF 43	If EPUT does not plan for an expected surge in demand for Mental Health services (or physical CHS) during or post C19 then skills and capacity may not be in place resulting in long waiting lists and self-harm in the community	AG	• A phased plan is in place to manage the surge demand alongside winter planning • From October – April 2021 existing capacity, flow and escalation initiative are in place • From November to March 21 winter funding schemes are to be signed off, implemented and monitored, underpinned by MH Winter KLOES • Plan in place for opening of additional adult MH beds (Topaz Ward) to be operational February 21 providing additional mental health surge capacity • Contingency plans include exploring opportunities with local private providers to purchase additional inpatient capacity and exploring further use of other estate options for additional beds (Kelvedon) or a COVID19 ward for unwell patients who are not a ligature risk • Allocation of additional funding confirmed on STP/ICS footprints to support capacity and flow; schemes in development which address both process and capacity • This may be a longer term risk but all current resources are targeted at management of the pandemic incident	Risk Score 5 x 4 = 20	Target March 2021 5 x 2 = 10	Command Structure EOSC and Board plus Standing Committees Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
BAF 44	If EPUT does not fully capture, review and embed learning from the C19 experience then this may have an adverse impact on Phase 3 planning resulting in missed opportunities in transformation	AG	• A full action plan is in place with 10 actions (two completed and eight in progress to timescale) • C19 is now in phase 4 • Executive Lead is now Executive Chief Operating Officer • Reset and recovery group currently suspended • EPUT has taken part in system learning across all systems • This risk currently has a watching brief	Risk Score 4 x 3 = 12	Target March 2021 4 x 2 = 8	Command Structure EOSC and Board plus Standing Committees Above threshold
BAF 51	If EPUT does not have sufficient oversight to effectively direct and implement the mass C19 vaccination programme across MSE and SUNEE systems then it may not meet the deliverables and timescales requested by NHSE/I resulting in the potential failure of the programme	NL	• A risk register is being set up specifically related to the Mass Vaccination programme to strengthen governance around the project • Urgent work underway to develop new BCPs ready for testing as part of a table-top exercise to look at emergency planning for each centre as it comes on line • No contracts have been issued to us and at this stage we are unable to sub-contract any elements of the service to other organisations • Programme Board in place to manage this • Looking to consolidate Mass Vaccination risks on BAF	Risk score C5 x L4 = 20	Ongoing during C19 vaccination programme 5 x 2 = 10	Command Structure EOSC Quality Committee Trust Board Above threshold

BAF 52	If EPUT does not ensure that staff have the skills and competencies to manage a second wave of C19 and/or a mass vaccination programme then appropriate care may not be delivered to patients or staff resulting in potential harm and failure to contain the virus	NH AG	• Mitigation includes:
			  ○ Increase in command frequency to monitor daily risks
			  ○ Competency framework for C19 vaccination
			  ○ Training on necessary skills for C19 mass vaccination
			• Redeployment plans are complete with a matrix for each post
			• The risk internally is more related to service delivery i.e. stopped, paused or reduced
			• Staff are present, issue may be getting them to where they are most needed
				Risk score
				C5 x L4 = 20
					Ongoing during C19 vaccination programme
					5 x 2 = 10
						Command Structure
						EOSC
						Quality Committee
						Trust Board
						Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 19	If EPUT does not manage Infection and Prevention Control (IPC) during COVID19 then infections may increase resulting in a negative impact on the pandemic	NH	• Assurance visits being undertaken and clinically held action plans • IPC Board Assurance Framework (national document) updated bi-monthly • New guidance reviewed and implemented through Command structure as received • National recommendations derived from other organisations during C19 are reviewed against EPUT measures • C19 secure procedures are in line with IPC guidance	Risk Score 4 x 2 = 8	Ongoing for duration of crisis 4 x 2 = 8	Command Structure IPC Board Assurance Framework - EPUT response At threshold
CVG 20	If EPUT has insufficient PPE available, then the spread of the COVID19 virus to staff and patients may perpetuate resulting in EPUT not being able to deliver a service.	NH	• PPE sit rep provided daily to Silver and Gold Command. • PPE contingency plan in place. • There are no current concerns around PPE.	Risk Score 4 x 2 = 8	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Board of Directors Weekly auditing of stock At threshold
CVG 33	If EPUT does not ensure that staff are Fit Tested for the variation of FFP3 masks coming through the PPE push system then it may delay the utilisation of these masks resulting in lack of PPE for aerosol generating procedures	NH	• Plan in place for the ongoing requirement for fit testing	Risk Score 4 x 3 = 12	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 35	If EPUT does not implement guidance on face masks and face coverings from 15 July in all buildings then people with mild or no respiratory symptoms may transmit the virus to others resulting in a further spread of COVID19	NH	• Updated guidance provided to all Trust staff and all areas asked to review Covid Secure Building Risk Assessment • All staff at The Lodge advised to wear masks in communal areas and clear guidance issued • Staff must only work from a Trust location if it is absolutely necessary for them to complete their job effectively	Risk Score 4 x 2 = 8	Ongoing for duration of crisis 4 x 2 = 8	Command Structure At threshold
CVG 37	If EPUT is unable to ensure that premises are COVID19 secure then community based services cannot restart resulting in further delays in service delivery	PS/ TS	• COVID19 Secure guidelines – differences between organisations escalated to region • Taking forward concerns raised by teams working in NELFT buildings • Any concerns are identified via command structure	Risk Score 4 x 3 = 12	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 10	If EPUT is unable to maintain its planned capital programme through lack of contractor access then delays or deferments may occur resulting in increased pressure on the capital programme in recovery	TS	• Second lockdown impacting on capital programme	Risk Score 3 x 2 = 6	Jul-20 3 x 2 = 6	Command Structure At threshold
CVG 34	If EPUT staff are not identified as a contact of a positive patient when working in the community through the PHE track and trace system then other means of patient identification of positive COVID19 status must therefore be obtained resulting in potential delays in self-isolation	NH	• Processes in place to screen patients prior to community visits and COVID19 test results to be checked through SystmOne • Regularly reminding and updating staff on processes to be followed	Risk Score 4 x 2 = 8	Jul-20 4 x 1 = 4	Command Structure Above threshold
CVG 38	If EPUT is unable to maintain the provision of self-testing kits for staff due to delays by the Local Authority and/or Public Health England then weekly testing for staff visiting care homes cannot take place resulting in non-compliance with national requirements and an outbreak affecting staff and patients	NH	• Supplies of kits currently in place for both of EPUTs nursing homes • Lateral flow testing in place and continues following staff vaccinations • Recommend score reduction to 4 x 2 = 8 threshold	Risk Score 4 x 3 = 12 Recommend score reduction 4 x 2 = 8	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 39	If EPUT does not maintain its bed occupancy levels below the target of 85% then its ability to manage a COVID19 or other outbreak is impacted resulting in the potential for unsafe admission or discharges	AG	• Review of all wards to ascertain safety at running above 85% undertaken as part of winter planning surge planning. • Dormitory wards to maintain below 100% occupancy to ensure social distancing. Some beds closed. • Some beds closed on larger wards where social distancing would not be possible in communal areas • Decision making on closure of beds is closely monitored and communicated accurately for sit reps	Risk score 4 x 3 = 12	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 40	If EPUT does not have clarity on the definition of aerosol generating procedures then staff may not follow the correct guidance resulting in potential infection and spread of COVID19	NH	• Guidance updated on aerosol generating procedure for children • Recommend closure of risk	Risk score 4 x 2 = 8 Recommend risk closure	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 41	If staff do not call the EPUT Contact Centre if tested positive or contacted by the NHS Test and Trace Services, then management and reduction of the risk of healthcare spread of COVID19 is compromised resulting in a potentially unsafe workplace and delays in adhering to outbreak management guidance	NH	• Instructions published regularly in briefings • Clear messaging on COVID19 page and front page on InPut • Track and trace database is robust and all managers complete health roster appropriately	Risk score 4 x 4 = 16	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 42	If EPUT does not prepare for full national lockdown related to COVID19 wave 2 then the ability to deliver services reduces resulting in a lack of containment of the pandemic.	NL	• EPUT has utilised learning from phase 1 and applied appropriate guidance • Phase 2 lockdown underway	Risk score 5 x 2 = 10	Ongoing for duration of crisis 5 x 1 = 5	Command Structure Above threshold
CVG 44	If EPUT does not manage outbreaks of COVID19 within its services then there is the potential for spread of the virus resulting in a lack of containment of the pandemic and potential harm to patients and staff	NH	• Continuous reminders go out to staff to report any outbreaks (more than one constitutes an outbreak) – strong communications in place around learning and outbreaks • Daily sitreps in place, monitored and reported • New electronic outbreak tool live • Currently 20 open outbreaks	Risk score 5 x 3 = 15	Ongoing for duration of crisis 5 x 1 = 5	Command Structure Above threshold
CVG 45	If EPUT does not manage clinical waste during COVID19 then hazardous material may be stored longer at a local level resulting in the potential for spread of infection and harm to patients and staff	TS	• Procurement put in place alternative storage arrangements whilst there was an issue with the contractor • Contact maintained with contractor • Environment agency are aware of any issues and understand the necessity to store waste on site in locked cages	Risk score 4 x 3 = 12	December 20 4 x 2 = 8	Command Structure Above threshold
CVG 48	If EPUT does not manage staff levels, staff engagement and input for recording of lateral flow staff testing then resource requirements may not be met resulting in failure to deliver the staff testing project and asymptomatic testing	NH	• Range of learning from other Trusts produced regionally • NHS Lateral Flow Testing Webinar attended • Some gaps in staff reporting their LFT	Risk score 4 x 3 = 12	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 24	If EPUT does not ensure that staff have the new range of skills required to deal with the C19 crisis then appropriate care may not be delivered to patients resulting in potential harm to patients and challenges for staff	NH AG	• Competency skills assessment carried out in wave 1 reviewed • IPC competency self-assessments	Risk score 5 x 3 = 15	Ongoing for duration of crisis 5 x 2 = 10	Command Structure Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 32	If EPUT does not develop a systematic application of a risk reduction framework to protect its vulnerable workers then those staff may be disproportionately affected by increased morbidity and mortality from COVID19 resulting in EPUT breaching its duty of care in securing the health, safety and welfare of its employees	SL	• Patients risk assessed in wave 1 • Risk assessments updated	Risk Score 4 x 2 = 8	Jul-20 4 x 2 = 8	Command Structure At threshold
CVG 14	If EPUT does not manage its cyber security then systems may be interrupted or compromised resulting in a failure of business continuity	TS	• No further updates on this risk – maintain watching brief	Risk Score 4 x 3 = 12	5 x 2 = 10 Ongoing for duration of crisis	Command Structure Above threshold Six issues covered off with centre and copied to CEO
CVG 46	If EPUT does not manage the delivery of valid server generated emails to staff outlook inboxes (following NHS mail national update) then important or urgent COVID19 emails may be missed resulting in a delay in information cascade or the submission of urgent returns	TS	• ITT working with NHS Digital to resolve this issue for EPUT • Staff have been reminded to check their junk email boxes for any important missed information • National problem and all efforts being made to resolve • No further updates on this risk – maintain watching brief • Recommend reduction in score to 4 x 2 = 8	Risk score 4 x 4 = 16 Recommend reduction in score 4 x 2 = 8	Dec 20 4 x 1 = 4	Command Structure Above threshold
CVG 47	If EPUT does not manage flow and capacity through older adult social care then patients may not be moved to care homes resulting in bed blocking and challenges to containing COVID19 pandemic	AG	• Currently being monitored via Command Structure • EPUT will support opening additional Covid beds if approached by the system (currently 5 wards repurposed to support system)	Risk score 4 x 4 = 16	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 49	If EPUT does not manage the delivery of regional public testing in Essex then staff may acquire COVID19 from family resulting in the potential increase in self-isolation	NL	• Risk being reviewed together with other staff capacity risks to look at consolidated risk and action plan	Risk score 5 x 4 = 20	Ongoing for duration of crisis 5 x 2 = 10	Command Structure Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 50	If EPUT does not meet the 90% flu vaccination target for frontline clinical staff then incidents of flu together with the risk of Covid19 may increase resulting in the potential for staffing issues and harm to patients	NH	• Input page for flu giving full information for staff on the vaccine, peer vaccinators and booking appointments • Flu vaccinations continued past the November deadline	Risk score 5 x 4 = 20	March 21 5 x 2 = 10	Command structure Above threshold
CVG 51	If EPUT staff do not follow the rules and guidance issued around PPE then there will be breaches resulting in the potential for outbreaks and related staffing issues and harm to patients	NH AG	• Staff continuously reminded that they must not breach PPE by car sharing, removing masks in handover meetings etc. • Breaches have serious implications for outbreaks, shortage of staff, the potential for patient infections, and closure of wards to admissions	Risk score 5 x 5 = 25	March 21 5 x 2 = 10	Command structure Above threshold
CVG 52	If EPUT does not have sufficient resource to effectively project manage and deliver the asymptomatic testing programme across the Trust then it may not meet the deliverables and timescales and potential failure of the programme	NH NL	• EPUT distributes Covid19 swab testing kits for asymptomatic patient facing staff • Page dedicated to asymptomatic testing on InPut including video guides, manager action lists, FAQs and self-testing guide • Live event held on asymptomatic testing including the video • Recommend reduction in score to 5 x 2 = 10	Risk score 5 x 3 = 15 Recommend reduction in score 5 x 2 = 10	March 21 4 x 2 = 8	Command structure Above threshold
CVG 53	If EPUT is unable to refer patients who need continuous oxygen therapy to acute Trusts then it would not be able to maintain this treatment beyond 24 hours resulting in emergency situations and potential harm to patients	NL MC	• No oxygen issues currently reported	Risk score 5 x 3 = 15	Ongoing for duration of wave 2 5 x 2 = 10	Command structure Oxygen T&FG Above threshold
CVG 54	If EPUT is unable to maintain a full complement of pharmacy staff then there may be delays in issuing prescriptions and no participation in MDT meetings on wards resulting in compromised service delivery	NH	• New risk added 20/01 • Pharmacy staff have withdrawn from MDT meetings to focus on issuing scripts • Efforts being made to appoint Locums	New risk Initial score 4 x 4 = 16	March 21 4 x 2 = 8	Command structure Above threshold
CVG 55	If EPUT continues to experience ward closures due to Covid19 outbreaks then availability of beds to acutely ill patients may diminish resulting in additional community/virtual support and potential harm to patients	AG	• New risk added 20/01 • As at 20/01 EPUT experiencing 20 outbreaks • Mitigation in place for swabbing, lateral flow testing, ensuring patients	New risk Initial score 5 x 4 = 20	Ongoing for duration of wave 2 5 x 2 = 10	Command structure Above threshold

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

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2			CVG10	CVG35 CVG19 CVG20 CVG34 CVG32 CVG46 CVG38	BAF38 CVG42 CVG52
	3				BAF44 CVG33 CVG37 CVG39 ~~CVG40~~ CVG45 CVG48 BAF42 CVG14	CVG44 CVG24 CVG53
	4				CVG54 CVG41 CVG47	BAF50 BAF43 BAF51 BAF52 CVG49 CVG50 CVG55
	5					CVG51

		Agenda Item No: 9ii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 January 2021**

Report Title:	**Ligature Risk Management**					
Executive/Non-Executive Lead:	Paul Scott Chief Executive					
Report Author(s):	Catriona King, Ligature Risk Coordinator Nicola Jones, Deputy Director of Compliance and Assurance					
Report discussed previously at:	Executive Safety Oversight Group Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides the Trust Board of Directors with 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 in-patient estate.

Approval	
Discussion	✓
Information	

Recommendations/Action Required

The Trust Board of Directors is asked to:

- Discuss the contents of this report.
- Identify any further actions required.

Summary of Key Issues

Independent Assurance

As previous reported BOD have completed their audit which tested the Trusts implementation of its ligature risk management policy and procedure. Overall the auditors concluded substantial assurance for the design of the controls and moderate assurance on the effectiveness of the controls in place.

The Trust Compliance team have started testing wards against the new CQC ligature inspection criteria published in 2020. Findings from the ward testing are discussed at LLRG.

Governance

The Trust continues to hold both a Ligature Risk Reduction Group and Estates Expert Reference Group each month. Any risks from these are escalated to the Health Safety and Security Committee. Going forward risks will also be escalated directly to the Executive Safety Oversight Group.

Enhancements to Risk Management Arrangements

Two Safety alerts have been received relating to ligature in the period. Both have been completed and closed.

The Trust Ligature policy and procedure has continued to be revisited as new learning is identified and a full review was undertaken in October 2019.

Board Assurance Framework

Ligature risk remains on the BAF and the action plan is monitored by the Ligature Risk Reduction Group.

Ligature Inspections
Ligature risk assessment inspections continue to be undertaken in line with Trust policy. Where it is not possible to complete on site visits (due to Covid) a table top review has been undertaken.

The Environment
Work has continued to developed agreed risk reduced environmental standards.

Staff Training
Compliance for Staff completion of Ligature awareness on-line training is at 97%.

A new bespoke ligature risk assessment training programme for EPUT staff who undertake ligature inspections has been commissioned and is underway.

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

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	YES
If yes, insert relevant risk	BAF15 BAF10
Do you recommend a new entry to the BAF is made as a result of this report?	NO

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

Acronyms/Terms Used in the Report			
BAF	**Board Assurance Framework**	**LRRG**	**Ligature Risk Reduction Group**

Supporting Documents and/or Further Reading
Ligature Report Ligature BAF Action Plan

Lead
Paul Scott **Chief Executive**

EPUT

LIGATURE RISK MANAGEMENT

1.0 Introduction

This report provides the Board with an update of the action that is underway and that which is planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate.

The Trust is committed to continuously improving systems and processes that facilitate robust risk identification and management, carrying out patient safety improvement works to create safer physical environments and to creating a risk aware culture. The Board of Directors has identified the potential risk associated with this agenda as one of the most significant potential risks that may prevent achievement of the Trust strategic objectives and this potential risk is therefore recorded in the Board Assurance Framework (ref BAF10). An action plan is in place to mitigate this potential risk. Reports on the action that has been taken are provided regularly to the Board of Directors. This report aims to assure members that the focus on mitigating this potential risk continues to be a priority.

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

2.0 Independent Assurance

Internal Audit

BDO, the Trust's internal independent auditors carried out testing of the Trust's implementation of its ligature risk management policy and procedures during July, August and September 2020; the findings were shared with the Trust in December 2020. Overall the auditors concluded substantial assurance for the design of the controls and moderate assurance on the effectiveness of the controls in place at the Trust, the following was reported for improvement:

1. The mandatory eLearning training compliance rates across the Trust are not consistently being monitored by the LRRG and the suicide awareness and response training is not mandatory (Finding 1- Medium)
   Recommendation: Ensure ligature awareness training compliance (including breakdown by location) is a standing agenda item and monitored at every monthly LRRG meeting
   - Action Taken: Recommendation accepted and now standing agenda item COMPLETE

   Recommend that suicide prevention training is made mandatory for appropriate staff
   - Action: take recommendation to Executives to approve change in training status. This was not accepted by the Executive Team, who requested that instead of making it mandatory it is set as an objective through the appraisal system and compliance is monitored with a trajectory to get to 85%.

2. The policy and procedure does not state the frequency of reporting required to the Health Safety and Security Committee on outstanding actions from ligature inspections. (Finding 2-Low)

   Recommendation: Update the Ligature Risk Assessment Management procedure to include the frequency of Ligature reporting to the Health, Safety and Security Committee (HSSC).

   - Action: Recommendation accepted and P&P updated COMPLETE

It should be noted that Preventing Suicide by Ligature training is currently mandatory training for all MH inpatient staff (essential)

CQC New Inspection Criteria

As previously reported on the 20th August the CQC issued an update for NHS MH Trusts from Dr Kevin Cleary, Deputy Inspector Mental Health and Community Services. This update included a new 2020 brief guide for inspection teams, published for CQC inspectors. The CQC have confirmed that as part of their Well Led inspections they will:

- Look at the Capital Projects Allocation for each organisation and the prioritisation of the allocation.
- Explore the non-executive directors' understanding of the estates' risks and how these impact on the safety and quality of care.
- Consider the degree to which the quality and finance sub-committees of the board have considered individual notified estates risks e.g. ligature points and the actions that they have subsequently taken.
- Look at the pathway from ward to board of risk information about estates.
- Critically assess the transparency and openness of board papers dealing with quality and safety that are in the public domain.
- Seek confirmation that trusts have environmental risk assessment policies that comply with the alerts listed above and the wider guidance summarised in our brief guide for inspection teams.

As part of CQC inspections of wards the CQC will:

- Discuss concerns about patient safety with staff and people using the service.
- Assess the degree to which concerns raised about safety and quality are listened to and acted upon.
- Determine the effectiveness of ligature audits and **their mitigations**, including an assessment of the human factors involved in their mitigations and their impact upon staff. By this we mean the relationship between staff, the equipment they use in the workplace, and the environment in which they work.

Work is underway to review the EPUT position against the CQC well lead criteria above and the Compliance Team are undertaking table top reviews using the new brief inspectors guide to provide assurance that EPUT are meeting the criteria set.

Only a limited number of wards have currently gone through the review and early findings have been highlighted to the LRRG.

3.0 Governance

The Trust continues to hold a Ligature Risk Reduction Group (LRRG) each month; chaired by the Director of Mental Health (NE & W Essex). The group reports to the Health Safety and Security Committee and ensures:

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

The Estates Expert Reference Group, chaired by the Executive Chief Finance Officer, has

continued to meet at least monthly to oversee a wide range of environmental patient safety improvement works identified as a result of ligature risk assessment and setting of agreed standards by the Ligature Risk Reduction Group.

4.0 Enhancements to Risk Management Arrangements Requirements

4.1 Estates and Facilities/National Patient Safety Alerts

Two Safety alerts have been received relating to ligature in the period. Both have been completed and closed.

4.2 Learning

The Trust's approach to identifying and mitigating potential risk is constantly subject to reflection and review, informed by independent review (as detailed above), incident data and internal scrutiny.

4.3 Policy and Procedure

As previously advised the Ligature Risk Assessment and Management Policy and Procedure was launched in April 2019. Following a six month Implementation period the policy was reviewed in October 2019. The policy and Procedure has undergone a full annual review in September 2020. This has included review of ligature cutter requirements, mirror wards, patient access to bedrooms during inspections, reporting arrangements and training requirements.

4.4 Ligature Risk Assessment

As previously advised an inconsistency of ligature risk assessments carried out in wards with the same layout was identified as a potential risk earlier in the year. A review of the risk assessments in place for those wards was completed to ensure the same risks were identified and risk mitigation consistent. The outcome of this review was presented to the Ligature Risk Reduction Group (LRRG) in April 2020; an action plan was developed and has been monitored by the LRRG. One action remains open on the action log and is due for completion and closure at the LRRG in January 2021.

4.5 Co-production

As previously advised two ligature risk assessments of inpatient wards have included a person with lived experience (PWLE) in the assessment team. A protocol is in place to carry out this activity safely. Unfortunately there has been limited progress with this initiative since the last report, initially due to availability of persons with lived experience, and later due to the pandemic and the pausing of on-site inspections, one inspection with the inclusion of a PWLE has been undertaken since the last report.

4.4 Board Assurance Framework (BAF10)

The BAF is included in the Quality Committee papers and details ongoing ligature risk reduction work. BAF10 is reviewed on a monthly basis via LRRG and HSSC.

5.0 Ligature Incident Data

As previously advised ligature incident dashboards on Datix have been developed and rolled out to all mental health, LD and specialist service ward managers. The dashboard identifies all ligature incidents both with and without an anchor point by date, ward, secure fixture used and items used. This gives staff a real time picture of incident activity relating to ligature incidents to quickly identify any emerging trends for action.

A bi-monthly incident report is presented to LRRG providing an overview of ligature incidents in which a mental health inpatient has attempted/succeeded self-harm. The report details incidents using both a secured point to fix a ligature and an unsecured ligature. The report details incidents from April 2017 to current reporting period for the group.

6.0 Policy and Procedure Implementation

Ligature risk assessment inspections continue to be completed in line with policy on a bi-annual or annual inspection programme for all inpatient areas as follows:

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

A Ligature Inspections Dashboard is in place which provides a monitoring tool for all assessments undertaken and the plan for future inspections. This details inspections that could not be undertaken on site due to the pandemic as approved by GOLD Command. Currently, each ward is being assessed in relation to environmental risk, outbreaks and the number of positive patients prior to a decision being made to attend site, postpone the visit or complete a table top review.

Where a risk assessment was due during the pandemic and a table top review has been undertaken this has been led by risk management with input from the estates department and ward representative as required.

Potential ligature risks identified in risk assessments are where possible removed and replaced with a reduced ligature design at the earliest opportunity. Where this is not possible local mitigation plans are required to be confirmed and the risk highlighted on the ward heat map and hot spot photos.

Action required following a ligature risk assessment is recorded and monitored on a database held by the Risk Team through to completion. Detailed assurance is provided to the Quality Committee to ensure any overdue actions are followed up.

7.0 RISK REDUCED ENVIRONMENTAL STANDARDS

The LRRG has and continues to develop agreed risk reduced environmental standards that inform the Trust's investment and patient safety improvement works programme.

8.0 STAFF TRAINING

All staff working within a mental health/LD inpatient settings are required to complete the ligature awareness on-line training package (launched in March 2018 and reviewed December 2019) "Preventing Suicide by Ligature" on an annual basis. The training package details:

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

Compliance with training as of the 15th December 2020 was overall trust compliance 97%, broken down as follows:

- Bedford 98%

- South Essex 98%
- North Essex 95%

The Trust is now providing bespoke ligature risk assessment training for EPUT staff who undertake ligature risk inspections within out mental health wards, the training is being delivered over two days by Tidal Training; attendees include ward managers, members of the risk team, estates staff and clinical staff band 6 and above who undertake ligature risk assessments. The training is specifically designed for multi-disciplinary staff groups to understand the context of people using a ligature, both for self-harm or suicidal purposes and to risk assess their own environment to establish potential significant spots where ligature may be possible, but preventable.

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

The first session was held in December with 12 attendees successfully completing the course, a further 3 training sessions are booked for January, February and March 2021 when a further 45 staff will undertake the training.

9.0 Conclusion

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

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

10.0 Action Required

The Board of Directors is asked to:

- Discuss the contents of this report
- Identify any further actions required

Report Prepared By:
Catriona King
Ligature Risk Coordinator

On behalf of:
Nicola Jones
Deputy Director of Compliance and Assurance
06th January 2021

		Agenda Item No: 10a
SUMMARY REPORT	**TRUST BOARD OF DIRECTORS PART 1**	**27 January 2021**

Report Title:	**Trust Strategy and Corporate Objectives**					
Executive/Non-Executive Lead:	Nigel Leonard, Executive Director of Strategy and Transformation					
Report Author(s):	Gill Brice, Associate Director of Strategy and Contracting					
Report discussed previously at:	N/a					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Purpose of the Report		
The purpose of this report is to provide 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.	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Trust Board of Directors is asked to:

1 Approve the proposal to extend the 2020/21 corporate objectives into quarter 2 of 2021/22.

Summary of Key Issues

Members will recall that the Board originally agreed corporate objectives in March 2020 before the Covid-19 pandemic. The pandemic changed the priorities for the organisation and following further guidance on reset and recovery it was clear that Covid-19 would dominate the Trust's activities in 2020/21. The Executive Team therefore agreed to revisit the corporate objectives and reduce the number of them rather than add a separate Covid-19 requirement. Subsequently 4 Covid-19 related corporate objectives were approved by the Board in June 2020.

As a result of the work being undertaken on the new strategy, the ongoing situation regarding Covid-19 and that national planning guidance is not anticipated until late January 2021 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.

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

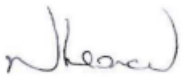
Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead

Nigel Leonard **Executive Director of Strategy and Transformation**

Agenda Item 10a
Trust Board of Directors
27 January 2021

EPUT

Trust Strategy and Corporate Objectives

1 Purpose of Report

The purpose of this report is to provide 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.

2 Executive Summary

2.1 Background

Members will recall that the Board originally agreed corporate objectives in March 2020 before the Covid-19 pandemic. The pandemic changed the priorities for the organisation and following further guidance on reset and recovery it was clear that Covid-19 would dominate the Trust's activities in 2020/21. The Executive Team therefore agreed to revisit the corporate objectives and reduce the number of them rather than add a separate Covid-19 requirement. Subsequently 4 Covid-19 related corporate objectives were approved by the Board in June 2020.

Members will also be aware that the Trust is currently in the process of developing a new five year strategy, including new strategic objectives. The process for development will include discussions with key stakeholders and some internal workshops, which will be completed by the end of quarter 1 in 2021/22. The accompanying strategic plan will then be developed. An update report will be presented to the Board in March 2021.

2.2 Annual Corporate Objectives

As a result of the work being undertaken on the new strategy, the ongoing situation regarding Covid-19 and that national planning guidance is not anticipated until late January 2021 (indicative dates for system planning suggest a draft plan submission in early March and the final plan submission at the end of April 2021) it is proposed that the current corporate objectives are extended into quarter 2 of 2021/22.

The progress update on the current corporate and directorate objectives will be completed in February 2021 as planned. As part of this process the objectives will be reviewed to ensure they are still valid and any risks to achievement or measures which are no longer relevant are identified and subsequently updated. The same process is also proposed for the directorate objectives.

The new corporate objectives will then be developed in quarter 2 to support delivery of the Trust's new strategic objectives. It is envisaged these will include objectives to deliver year one actions from the new five year strategy and the new patient safety strategy, and actions associated with the mass vaccination programme.

3 Action Required

The Trust Board of Directors is asked to:

1 Approve the proposal to extend the 2020/21 corporate objectives into quarter 2 of 2021/22.

Report prepared by

Gill Brice, Associate Director of Strategy and Contracting

On behalf of:

Nigel Leonard, Executive Director of Strategy and Transformation

		Agenda Item No: 11a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 January 2021**

Report Title:	**CQC Update**					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive					
Report Author(s):	Amanda Webb, EPRR and Compliance Officer					
Report discussed previously at:	Executive Safety Committee Group 12th January					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

Purpose of the Report

This report provides an update on the recent CQC risk focused inspection and the internal compliance activity to support the Trust in maintaining the CQC rating of Good.	**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

CQC Registration - EPUT is fully registered for all services including Mass Vaccination.

CQC Inspections – As previously reported 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 have issued EPUT with a Warning Notice (issued on 27th November 2020) and published a full report on their findings (14/01/21)

An Intensive Clinical Support Group established to ensure appropriate actions were identified and embedded in response to both the Warning Notice and CQC Report. This group has continued to meet weekly in order to progress and test the improvements required.

In the Warning Notice, the CQC identified 6 areas of concern that need significant improvement 4 of which had an improvement timescale of 27th December 2020, which was achieved and 2 with a timescale of 27th January 2021 that are progressing well.

Assurance was provided to the CQC by the required deadline of 27th December advising that the Trust had made significant improvements regarding the quality of healthcare with 4 of the 6 Warning Notices issued (Appendix1). Work is underway to ensure the remaining 2 areas of concern have been addressed fully and assurance is in place for 27th January 2021 timescale.

The CQC have announced that there will be a joint HMI probation thematic review to be undertaken in February 2021 which will include the Trust Health and Justice Services, supported by the compliance team.

CQC Action Plan Testing - The Compliance Team have continued CQC action plan testing to ensure actions taken following CQC inspections have been fully embedded. The team have found some areas where actions have not been fully embedded and this has been shared with relevant directors.

CQC Guidance/Updates - CQC has published the second report of Professor Glynis

Murphy's independent review of the regulation of Whorlton Hall between 2015 and 2019. This follows the publication of part one in March 2020. Five further recommendations have been made:

- Services should not be rated as 'Good' or 'Outstanding' if they have used frequent restraint, seclusion and segregation.
- Services should not be rated as 'Good' or 'Outstanding' if they cannot show how they support whistleblowing and reporting of concerns.
- Trialing of the Group Home Culture Scale tool, to evaluate whether it helps inspectors determine which settings have closed cultures.
- Trialing of the Quality of Life tool to gauge whether it helps CQC move from evaluating process, towards evaluating more relevant service user outcomes.

Development of guidelines for when evidence of the quality of care should be gathered from overt or covert surveillance.

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

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	YES
If yes, insert relevant risk	BAF45
Do you recommend a new entry to the BAF is made as a result of this report?	No

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

Supporting Documents and/or Further Reading
CQC Compliance Update Appendix 1

Lead
Paul Scott **Chief Executive**

Agenda Item 11a
Board of Directors
27 January 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Compliance Update

1.0 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.

1. Meeting Registration Requirements

As previously reported EPUT has been appointed as one of three lead providers in the East of England region for the COVID-19 vaccination programme and are responsible for delivering the vaccine in two system areas: Mid and South Essex Health and Care Partnership, and Suffolk and North East Essex ICS.

The Trust is required to notify the CQC of any locations used to deliver the regulated activity 'Treatment of disease, disorder or injury' by the submission of an updated Statement of Purpose.

The Statement of Purpose has been regularly updated as new sites have been identified and this has been submitted to the CQC as each location is added. The last submission being 18th December and currently lists 10 sites from which the mass vaccination progamme will be delivered with overarching registration being held by the Trust Head Office.

2. CQC Inspections

2.1. 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). A draft report of the inspection for EPUT was also provided for which factual accuracy checking was undertaken and no required challenges to the draft report were identified. The report was published on 14th January 2021.

Within the warning notice the CQC identified 6 areas of concern that required significant improvement. 4 of the improvements had a timescale of 27th December which were achieved and progress of the action plan was submitted to the CQC on 26th December as required (Appendix 1). The remaining 2 improvement actions relating to record keeping and handover meetings have a timescale of 27th January 2021. Progress of the actions for each of these is being regularly monitored as part of the Intensive support group to ensure completion by the due date.

Within the CQC report the CQC identified 6 'Must Do' actions. The Intensive Support Group has developed an action plan to address the 6 'Must Do' issues. These link with the warning notice and the action is devised to ensure that action taken is across the core service and that the work already undertaken via the intensive support group is included as evidence of immediate action taken.

2.2 HMI Probation Joint Thematic Review (due February 2021)

The CQC have announced that there will be a joint thematic review to take a wider look at the services involved from arrest through to imprisonment, given the prevalence of poor mental health among the offending population. The thematic inspection will be led by HMI Probation and will include inspectors from the CQC, HMI Prisons, HMI Constabulary Fire & Rescue Services, and HM Crown Prosecution Service Inspectorate.

To prepare for the fieldwork due to be undertaken in April and May 2021 the CQC intend to pilot their case sampling methodology in Chelmsford during week commencing 8th February 2021 and as such will involve EPUT Health and Justice Teams.

The requirements are identified as set out below:

1. A review of a small number of cases where mental health problems have been highlighted in custody, whether at the police station, courts or in prison. These will be identified by HMI Probation in advance of the site visit. This should amount to around ten cases to test the sampling methodology which is designed to follow a case through the justice system.
2. Interviews with staff who have experience of working in police custody, courts and prison with patients who are experiencing mental health problems. Their experience of delivering services to this group of individuals would provide valuable insight as CQC develop their approach. CQC suggest a maximum of eight staff across all settings.

The team leads details have been provided to the CQC as requested in preparation for the inspection and any information requirements will be supported by the Compliance Team.

3. CQC Action Plan Testing

The action plan and reset action plan developed as a result of the CQC unannounced inspection (July – August) was reported as complete at the end of September. The Compliance Team collated evidence as the action plan progressed to confirm that the action was completed as reported.

The Compliance Team is currently undertaking a further testing regime using a mix of table top evidence reviews, virtual interview and focussed site visits to confirm that actions have been embedded and sustained. Since last reporting the following updates are provided:

Substance Misuse core service has now been fully tested virtually and it has been established that 2 internal actions for a ‘Must do’ action and 1 internal action for a ‘Should do’ action could be more robustly embedded:

- **M16** The trust must ensure client deaths are investigated fully and learning is disseminated to teams for all client deaths. Trust policy was confirmed as in line with the ECC policy for the partnership, however not all staff spoken with were aware of this policy or where to locate it. The Policy will be highlighted to staff. In relation to the Mortality reviews, all staff were aware of the mortality data group and how deaths were discussed at the mortality review subcommittee, however this is not routinely evidenced at local meetings. It was therefore agreed to include feedback from the subcommittee as an agenda item going forward.

- **S22**. The trust should ensure all staff understand recovery. It was agreed with commissioners to amend the current recovery plan to work with principles of my care, my recovery and to be jointly facilitated with STaRs however staff did not appear to be aware of the principles of my care, my recovery.

Acute Adults and PICU's action plan testing has been undertaken using mix of virtual review and focussed site visits. The results are in the process of being analysed.

CAMHS action plan testing scheduled for December was not able to take place due to an outbreak on the wards and has been rescheduled for January as requires site visits.

4. CQC Guidance / Updates

4.1 Independent review into CQC's regulation of Whorlton hall – update December 2020

CQC has published the second report of Professor Glynis Murphy's independent review of the regulation of Whorlton Hall between 2015 and 2019. This follows the publication of part one in March 2020.

The second report outlines the progress that CQC has made to implement the recommendations. This includes publication of the final report of its review of restraint, seclusion and segregation; work on closed cultures and the development of a tool for rating support plans.

Professor Murphy makes a further five recommendations relating to:

- Services should not be rated as 'Good' or 'Outstanding' if they have used frequent restraint, seclusion and segregation.
- Services should not be rated as 'Good' or 'Outstanding' if they cannot show how they support whistleblowing and reporting of concerns.
- Trialing of the Group Home Culture Scale tool, to evaluate whether it helps inspectors determine which settings have closed cultures.
- Trialing of the Quality of Life tool to gauge whether it helps CQC move from evaluating process, towards evaluating more relevant service user outcomes.
- Development of guidelines for when evidence of the quality of care should be gathered from overt or covert surveillance.

The compliance team will be reviewing the full report to identify areas of learning for the Trust.

5 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

Finchingfield - October 2020 Inspection
(Approved) Action Plan
Updated 23rd December 2020

Introduction

The CQC undertook an unannounced focused inspection on the 29th October 2020 to Finchingfield Ward. The visit was based on concerning information and incidents relating to patient safety and as such specifically focused on the Safe domain. In particular following the incident on the evening of Friday 23rd October 2020.

During the inspection the CQC:
- completed a tour of the environment
- looked at eight records of patient care, we did this on the ward and via video conferencing
- spoke with five staff
- spoke with three patients
- reviewed closed circuit television footage of two incidents
- and reviewed policies, procedures, data and documentation relating to the running of the service.

Patients told the CQC that they felt safe on the wards and that staff treated them with respect. They said staff gave them support when they needed it and they were involved in their care.

The CQC identified 6 areas of concern that need significant improvement and have issued a Warning Notice which requires immediate action.

This was an unrated inspection.

The CQC have issued a draft inspection report and Warning Notice. EPUT is required to:

1. Complete factual accuracy checks against report and warning notice
2. Develop an action plan to meet the 6 areas outlined within the Warning Notice and to meet the requirement notice (must do) actions as outlined in the inspection report

Action Plan Development
Following the incident on the evening of Friday 23rd October a number of immediate actions were taken including reflective investigation with staff to understand the root cause of the incident, the removal of the smoking shelter in the garden and upgrading of the lock at the front entrance of the Linden Centre. An Intensive Clinical Support Process and Group was established immediately to identify issues that lead to the incident and develop a clinical support framework for the ward and action plan to address issues identified. The clinical support group was established as a multi-disciplinary group with representatives from the ward, ward leadership team, medical team, AHPs, corporate services, quality services and senior Trust leadership. The group has been established working on a "Plan – Do – Study – Act" principle and has been structured to ensure full engagement and empowerment of the ward staff and leadership. This group has utilised a range of expertise within the trust. The intensive support group has established clear ward to board identification of issues. Part of this support programme has been senior nursing staff presence on the ward to provide support to staff and to review processes being followed. This has given a fresh view of the processes and the robustness of embedding of previous learning The CQC undertook their unannounced inspection on 29th October 2020. Initial findings were feedback to the Trust and these were developed into the Intensive Clinical Support Group Plan. On receipt of the CQC draft inspection report and Warning Notice a formal action plan has been developed (see below) including actions already taken by the Intensive Clinical Support Group. The Intensive Clinical Support Group has meet weekly to ensure actions are progressing and clinical support was established for the ward over the improvement period. The scope of this group has been further than the ward involved in the incident and the group has identified where there is wider organisational learning in an extended plan. Through the intensive clinical support work undertaken EPUT has identified that at longer term review of leadership is required and this work will be linked with the existing Safety First, Safety Always strategy work underway.

Risks Identified
EPUT Reputational risk Staff Morale at the Linden Centre Failure to embed learning Observation and Engagement Record keeping (MHA, Timeliness, Completeness) Bank staff induction and training Robust Handover

Action Plan Structure
Part 1 : Immediate Actions to address Warning Notice Part 2 : Under development - Actions to address CQC report findings currently in draft and awaiting final report from CQC when actions will be finalised

Key Leads:			
Alex Green, Interim Chief Operating Officer	AG	Lynn McGhee, Associate Director of Inpatient & Emergency Care (Mid & South)	LM
Trevor Smith, Chief Finance Officer	TS	Doreen Mhone, Matron	DM
Jan Leonard, Director of IM&T, BAR	JL	Pamela Muhera, Ward Manager	PM
Sue Waterhouse, Director Mental Health Mid & South	SE	Chloe Cawston, Service Manager South West & Mid	CC
Nicola Jones, Deputy Director Compliance & Assurance	NJ	Jane Cheeseman, Head of Compliance & Emergency Planning	JC

Key
Green – actions complete
Amber – actions in progress
Red – actions passed timescale / risk identified

This action plan is part of a wide clinical intensive support framework and focuses only on the issues raised by the CQC in their Warning Notice and Inspection Report. Wider organisational learning has been identified as part of the wider clinical intensive support framework.

Action Plan – Part 1 Immediate Actions to Address Warning Notice (Focus on Finchingfield Ward)

Details from the Warning Notice	Identification: What is the issue?	Action to be taken to resolve the issue	Lead	Time-scale	Progress	
Warning Notice 1. Individual staff did not carry out their duties as required by patient care plans and Trust policy. Staff did not carry out observations as prescribed by environmental risk assessments, care plans and instructions from leaders (S29A) Timescale 27th December 2020						
On 23 October 2020 patient A was able to abscond over the garden fence. Closed circuit television showed a member of staff observing the garden from the hallway inside the ward. This meant they were unable to see all patients in the garden. The environmental risk assessment dated June 2020 records the need for staff to be present in the garden with patients due to ligature risks and the fence posing an absconsion risk. Team meeting minutes from July, August and September 2020 record instructions to staff that the garden area was defined as a 'hotspot' and required staff to be present when patients accessed it. This requires significant improvement in the quality of healthcare as care was not being provided in a safe way. Staff were not doing all that was practicable to mitigate the risks to the health and safety of Patients.	Staff member did not follow Garden Observation protocol so could not see all patients. Staff member was a bank staff member who was verbally told what to do but misinterpreted. Staff member had worked elsewhere in EPUT but not at Finchingfield Ward for a number of months	Immediate action taken: Removal of garden shelter to reduce ability to climb over fencing	TS (RC)	28.10.20	Immediate action taken to ensure that the garden shelter was removed.	**E**
		To further explore and address issue of observation with specific member of staff	AG (CC)	07.12.20	Discussion held with staff member	
		Meeting to be held with all ward staff to ensure all are aware of correct process for observation of garden areas	AG (DM)	24.11.20	**Update 24.11.2020** Discussed in staff meeting and documented within the meeting notes **Update 04.12.2020** Learning from Serious Incident memo sent regarding Garden Access	**E**
		Ensure garden risk assessment protocol is included in local induction template.	AG (LM)	07.12.20	**Update 08.12.2020** Induction checklist updated to include supervision of patients in the garden.	**E**
		Increase frequency of induction for bank workers, to ensure local induction is carried out for anyone who has not worked for over one month on the ward	AG (LM)	07.12.20	**Update 04.12.2020** Induction checklist (HRPG21 – Appendix 3) updated to advise timeframe of local induction for staff who have not worked on the ward for over a month.	
		To further develop and implement the garden risk assessment protocol across services.	AG LM	07.12.20	**Update 02.12.2020** Circulated at Inpatient Quality & Safety meeting for comments/ any changes required prior to approval and roll out. **Update 08.12.2020** Associate Director of Inpatient & Emergency Care confirmed amendments made following consultation with various staff groups. Final version has	E

Details from the Warning Notice	Identification: What is the issue?	Action to be taken to resolve the issue	Lead	Time-scale	Progress	
					been circulated and implemented across inpatient services along with memo guidance and competency checklist questionnaire.	
		To develop a competency check in regards to following the garden risk assessment protocol for all staff to complete.	AG (DM)	10.12.20	**Update 02.12.2020** Team continue to discuss and document in Team Meetings the garden risks whilst questionnaire for competency for gardens is developed. **Update 08.12.2020** Associate Director of Inpatient & Emergency Care confirmed competency checklist questionnaire has been developed and circulated to all inpatient services. Confirmed that this is for permanent and bank staff.	E
		Assurance in place to confirm issue resolved via Compliance Audit	NJ (JC)	22.12.20	**Update 14.12.2020** Staff are able to confirm the process. Further visit scheduled 14.12.2020 **Update 15.12.2020** Ward Manager provided evidence of the garden competency check completed by staff for garden observation principles as assurance. **Update 22.12.20** Compliance assurance from visits: Have observe staff in garden at physical visits Seen reference in Care plans Spoken to staff who are very aware of requirements	E

Details from the Warning Notice	Identification: What is the issue?	Action to be taken to resolve the issue	Lead	Time-scale	Progress	
Warning Notice 2. Roles and Responsibilities - Staff made clinical decisions which were outside of their role and responsibility (29A) Timescale 27 December 2020						
Warning Notice (S29A) Patient B's observation level was reduced from Level two to Level one by a band five registered nurse. This clinical decision, in line with Trust policy, should have been made by a band six nurse or above, or decided by multi-disciplinary review. This requires significant improvement in the quality of healthcare as care was not being provided in a safe way. The trust must ensure that systems and processes operate effectively to improve the quality and safety of services provided.	Ward staff acted outside of Trust Policy for Observation and Engagement	Ensure all staff are up to date with Engagement and Observation training and include as a learning note in Matrons Memo and share at Inpatient and Quality Meeting	AG (DM)	10.12.20	**Update 02.12.2020** Associate Director of Inpatient & Emergency Care confirmed all staff are up to date with Engagement and Observation Training This will be included in the monthly local learning document, shared with teams and displayed on performance stations. **Update 08.12.2020** Evidence seen within learning document/Matrons Memo.	E
		Ensure all staff complete/ revisit Engagement and Observation competency checklist.	AG (DM)	18.12.20	**Update 08.12.2020** Project Nurse (LV) has been working through the observation competency checklist with all staff. Majority of staff now completed. **Update 15.12.2020** Ward Manager confirmed that it is just Night staff left to complete asking site officer to cover this off by 18th and will confirm as soon as completed. **Update 22.12.20** DM confirmed all complete with exception of staff off sick	
		Develop and implement a process for Ward manager to carry out weekly assurance check on observation changes.	AG (DM)	10.12.20	**Update 08.12.2020** Confirmed that this is part of the Ward Manager records checks and included in Matron Assurance/Perfect Ward App that relevant risks and observation levels are recorded.	
		Undertake a review of how decisions to change observation level is recorded.	AG (DM)	10.12.20	**Update 08.12.2020** Director of IM&T, BAR confirmed that the current form within PARIS EPR is being used by staff. **Update 15.12.2020** Associate Director of Inpatient & Emergency Care reviewed this function and confirmed to be a good	

Details from the Warning Notice	Identification: What is the issue?	Action to be taken to resolve the issue	Lead	Time-scale	Progress	
					system and is being used by the staff in conjunction with the need to be documented in the patient's notes with rationale and who was involved in the decision.	
		Assurance in place to confirm issue resolved via Compliance Audit	NJ (JC)	22.12.20	**Update 22.12.20** Compliance assurance complete and overall found actions taken.	

Details from the Warning Notice	Identification: What is the issue?	Action to be taken to resolve the issue	Lead	Time-scale	Progress	
Warning Notice 3: Competent Staffing - Managers did not ensure that they allocated experience staff to shifts to meet patients' needs (S29A) Timescale 27th December 2020						
On 23 October 2020 there was one registered nurse (who had qualified in February 2020 and had not completed their preceptorship) and one registered nurse, employed via an agency, had not worked any previous shifts on the ward. This requires significant improvement in the quality of healthcare as care was not being provided in a safe way. The trust must ensure that there are suitably qualified, competent, skilled and experienced staff deployed to meet the needs of the patients.	Roster on 23rd October breached Trust policy Bank member of staff was familiar with EPUT and had worked on other wards within the Linden Centre but had not worked at Finchingfield since March 2020	Undertake a review of all shifts for the coming 3 month schedule to ensure appropriate skill mix of staff rostered for duty.	NH (RP)	18.12.20	**Update 02.12.2020** Matron confirmed that the review of all shifts has been completed and skill mix appropriate. Quality Team to undertake check. **Update 08.12.2020** Associate Director of Inpatient & Emergency Care confirmed that the roster has been signed off in line with principles however there are still some shifts to fill over the next 3 months. Looking to fill earlier with bank staffing taking into account skill mix. **Update 10.12.2020** Quality Team Review undertaken SafeCare/Rostering Team supporting the ward to review rosters from January onwards . New tool will be used for March's rota **T**o be added to Matrons assurance and checked 2 weekly. **Update 22.12.2020** Findings of review considered by ward and made changes to shifts. However this is a challenge and working to get preceptee signed off as qualified for over 1 year now. Target 15th Jan 2021. Will continue to have senior oversight and support to preceptee	E
		Develop principles for rostering as guidance for staff on shift allocation and management	NH (KG)	18.12.20	**Update 08.12.2020** KG confirmed that the clinical guidelines for rostering are already in place (CG22) and have recently been reviewed and approved. These will be checked for any further changes required as a result of issue raised and shared with staff.	E

Details from the Warning Notice	Identification: What is the issue?	Action to be taken to resolve the issue	Lead	Time-scale	Progress	
					Update 10.12.2020 KG Confirms she has sent to MG to make the necessary amendments by end of next week – these will then need to go through the relevant ratification processes before uploading on intranet but we will try and fast track these where possible **Update 15.12.2020** to HR policy sub group 23rd and other committees for chairs action 17th for final sign off. **Update 18.12.20** – review complete	
		Rostering refresher training to be provided to staff who undertake the rostering for the ward	NH	16.12.20	**Update 02.12.2020** Arrangement made for E-rostering manager to visit ward **Update 08.12.2020** SH (E-rostering Manager) has been undertaking training with the staff. Management Development Programme (MDP) session on Rostering also in place for staff of Band 6 and above to attend. Team to consider if further sessions required staff that are not on the MDP. **Update 15.12.2020** training completed on 9th Dec by E-roster management team	E
		Ward Manager to have oversight of roster which is checked and signed off by Matron to ensure experienced staff are allocated each shift prior to the roster being visible to the team	AG (DM)	10.12.20	**Update 08.12.2020** Ward Manager confirmed process in place whereby she completes the first approval of the roster and this is added to Matron assurance for final sign off. Confirmation seen that this has been added to Perfect Ward App for Matron Assurance.	E
		Assurance in place to confirm issue resolved via Compliance Audit	NJ (JC)	22.12.20	**Update 14.12.2020** Correct number of staff identified on shift however no checks identified in regard to experience To further review if this had been part of	

Details from the Warning Notice	Identification: What is the issue?	Action to be taken to resolve the issue	Lead	Time-scale	Progress	
					the Matrons assurance process (2 weekly) **Update 22.12.2020** Compliance assurance in place (RP) audit	

Details from the Warning Notice	Identification: What is the issue?	Action to be taken to resolve the issue	Lead	Time-scale	Progress	
Warning Notice 4: Record keeping - Staff did not keep accurate high quality records of patient care (S29A) Timescale 27 January 2021						
Warning Notice (S29A) Inaccurate records of MHA status increases the risk patients may be restricted with no legal framework in place to do so. Staff signed off their own notes as accurate. There was no process in place to assure ward leaders notes were of good quality and accurate. This requires significant improvement in the quality of healthcare as care was not being provided in a safe way.	Not recording MHA status correctly and staff signed off own notes as accurate Staff using the copying and pasting function within the patient electronic record which copied incorrect section. Notes checking process not robust enough.	Staff to ensure record keeping is robust and avoid the use of copying and pasting.	AG (LM)	11.11.20	**Update 06.11.2020** All staff were reminded of importance for accurate record keeping and asked to stop practice of 'copy and paste' at the team meeting held on 06/11/20. Also added to agenda for SMT on 3rd December and for local SMTs in December. Confirmed as complete. **Update 17.11.2020** Internal Safety alert circulated via Datix system INT 2020 036	
		All nursing entries completed by unqualified staff to be countersigned by a qualified nurse.	LM/ DM	04.12.20	**Update 02.12.2020** Director of Inpatient & Emergency Care confirmed all staff have been advised and countersigning is now in place.	
		Undertake assurance audits to check MHA recording and that copy and paste practice has stopped.	AG (LM) / JL	15.01.21	**Update 15.12.20** MHA Audit – perfect ward weekly and have asked for extra question to be added to this specific to this issue (added) Monthly record keeping audit (question added) **Update 22.12.2020** Perfect ward weekly being undertaken Ward managers audit weekly being undertaken	E
		Add to MHA audit currently in place the checking of all patients under a MHA section at random points during their admission to ensure correctly documented within records and handover tool.	NH (NA)	18/12/20	**Update 08.12.2020** Mental Health Act office have been asked to pick up on this issue via the regular audits of MHA patient records undertaken by their team.	
		Put assurance process for checking counter signing in	NH	18/12/20	**Update 08.12.2020** Counter signing checks will be part of the shift checklist	

Details from the Warning Notice	Identification: What is the issue?	Action to be taken to resolve the issue	Lead	Time-scale	Progress	
Warning Notice 4: Record keeping - Staff did not keep accurate high quality records of patient care (S29A) Timescale 27 January 2021						
		place			and signed by staff on duty. Monthly record keeping audit to have this added to. Issue found when there are agency staff as they are not checking – must be following shift when missed (wider action) Ward manager to undertake regular checks **Update 15.12.2020** Confirmed added to perfect ward app	
		New action Compliance audit found Bank/Agency problems with counter signing. Action to look at options for solving this			**Update 22.12.2020** JL to review and see how we can address as problems having a login on Paris. Can regular agency have own log in – list to go to Jan	
		Assurance in place to confirm issue resolved via Compliance Audit	NJ (JC)	22.12.20 15.01.21	**Update 14.12.2020** Copy and pasting still identified in further records audits Records lacked evidence of countersigning by RMN or NIC **Update 22.12.2020** MHA status correctly recorded Still seeing indications of copying and pasting seeing identical wording and front pasting Not seeing counter signing in the records, new action see above	

Details from the Warning Notice	Identification: What is the issue?	Action to be taken to resolve the issue	Lead	Time-scale	Progress	
Warning Notice 4: Record keeping - Staff did not keep accurate high quality records of patient care (S29A) Timescale 27 January 2021						
Warning Notice (S29A) Staff met with patient B for a ward review on 20 October 2020 at 15:30. Staff recorded the content of the meeting on 24 October 2020 (post notification of death) and the record was not completed in full. This requires significant improvement in the quality of healthcare as care was not being provided in a safe way. The trust must ensure that staff maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.	Multi-disciplinary meeting notes not added timely and information was not completed in full Completed by an ST5 Doctor. Patient had been asleep during review, so was not reviewed properly. Review was undertaken in patient room rather than MDT room. Medical cover nor robust with doctors shared with Rainbow ward and two junior doctors for Finchingfield shielding. There is a locum Consultant.	Issue of contemporaneous recording keeping to be addressed with individual medical staff member	MK (FW)	29.10.20	Escalated to Medical Director and forwarded to Medical Staffing. As the matter involves a trainee doctor, Director of Medical Education taking forward	
		Review of medical cover across the Linden Centre	MK	01/12/20	Additional medical cover now on Finchingfield (17th November 2020) Medical cover strengthened with a Speciality Doctor on Finchingfield Ward.	
		Increase records quality assurance checking (inc Medical focus)	MK AG	08/12/20	**Update 08/12/20** For MDT records the medical secretary now present to ensure they are recorded timely. MDT risk assessments are completed by nursing staff and the Consultant checks the Drs review notes **Update 15/12/20** Director of Inpatient & Emergency Care confirmed memo sent out to remind of the need to also document when MDT does not happen. Medical Quality lead appointed who is undertaking focused work reviewing medical records. This will include regular assurance quality checking Quality of notes existing audits on perfect ward app have been strengthened as outlined above	

Details from the Warning Notice	Identification: What is the issue?	Action to be taken to resolve the issue	Lead	Time-scale	Progress	
Warning Notice 4: Record keeping - Staff did not keep accurate high quality records of patient care (S29A) Timescale 27 January 2021						
		Assurance in place to confirm issue resolved via Compliance Audit	NJ (JC)	22.12.20 15.01.21	**Update 14.12.2020** MDT entries found to be entered at the time of the MDT or immediately following Check ward review notes Concerns identified with the level of details within patient records **Update 22.12.2020** Checks have found - No consistency in recording management plan. No leave status. Inconsistent capacity recording *Share review with GM (CC to share with GM) and invite to future meetings*	

Details from the Warning Notice	Identification: What is the issue?	Action to be taken to resolve the issue	Lead	Time-scale	Progress	
Warning Notice 5: Observation records - Documentation did not support staff in recording accurate times they observed patients (S29A) Timescale 27 December 2020						
Warning Notice (S29A) The service provided staff with pre populated hourly observation records. Times were pre populated on the hour, every hour. Therefore, records showed that one staff member, allocated to hourly observations, observed all patients (17 at the time of inspection), as the same time, on the hour, every hour. This was not physically possible due to the number of patients on the ward and their different locations within the environment. Observation records for patient A showed their absconsion was not discovered by staff for 27 minutes (absconsion occurred at 20:33 on 23 October 2020) as staff signed observation records at the pre-populated time of 21:00. Closed circuit television recordings show staff discovered the absconsion at 20:45. This requires significant improvement in the quality of healthcare as care was not being provided in a safe way. The trust must ensure that staff maintain securely an accurate record in respect of each service user.	Pre-population with the hours was added by the ward to assist with ensuring staff did hourly obs this is not part of Trust Policy and Procedure Engagement & Supportive Observation Policy & Procedure reviewed and this does not include a pre populated sheet.	Immediate action to instruct staff to ensure they record the actual minutes observed on the Level 1 observation forms	AG (LM)	17/11/20	**Update 17.11.20** Instruction added to Level 1 observation form to be clear about recording the actual minutes. All staff advised to use new form. **Update 02.12.20** Director of Inpatient & Emergency Care confirmed all staff instructed and change of practice implemented.	
		Pre-Populated forms to be removed and replaced with version which provide correct space to add minutes to the time	AG (LM)	09/12/20	**Update 08.12.2020** Form development meeting being held 09/12 to agree a new format. **Update 22.12.2020** Still have pre-populated form indicating hour we are covering, but clear narrative instructing staff to add time in each box.	**E**
		Learning to be shared via Matron's Memo and monthly local learning document which is shared with the team and displayed on the Performance Station	AG (LM/ DM)	09/12/20	**Update 08.12.2020** Associate Director of Inpatient & Emergency Care confirmed added to learning/Matrons memo, shared with team and in place on performance station.	**E**
		Undertake audit to ensure correct completion of the observation form on a daily basis and Matron to check as part of weekly Matron's Assurance	AG (LM/ DM)	09/12/20	**Update 08.12.2020** Checking of the observation forms has been added to Matron assurance/perfect ward app and the Nurse in Charge on duty each day checks the completion of the forms.	**E**
		Assurance in place to confirm issue resolved via Compliance Audit	NJ (JC)	22.12.20	**Update 14.12.2020** Improvement identified with the use of the observation sheets. Correct time noted. **Update 22.12.2020** Compliance complete, immediate change of practice evident	**E**

Details	Identification: What is the issue?	Action to be taken to resolve the issue	Lead	Time-scale	Progress	
Warning Notice 6: Handover Meetings - Staff did not always reflect risk in morning handover meetings (S29A) Timescale 27 January 2021						
Wording from Warning Notice: We reviewed the handover notes from 19 October 2020 to 29 October 2020. Staff recorded daily risks for three out of 17 patients. In the remaining 14 records staff recorded risk on the record for 'Monday' only. The remaining days were blank. This increases the risk that patient risk information is not up to date and accurate for it to inform their care. This requires significant improvement in the quality of healthcare as care was not being provided in a safe way. Staff were not doing all that was practicable to assess and mitigate the risks to the health and safety of patients.	Handover form did not include risks each day. Practice was to print off SBARD on a Monday with the risks updated as at Monday. This was then used for the rest of the week.	Change to electronic handover sheet and have one central place for all sheets to be saved	AG (PM)	06/11/20	Electronic handover was commenced on 29/10/2020. Handover sheets are being saved on the shared drive. Sheets are no longer printed on a Monday and used for the week	
		Address finding with individual staff involved via supervision	AG (LM)	06/11/20	Complete and increased supervisions to 2 weekly	
		Inform all ward staff of CQC finding and changes made to handover sheet	AG (PM)	11/11/20	The issue regarding handover was discussed with staff during Team Huddle on 2/11/20 and during Team meeting on 06/11/20.	
		Assurance process for ensuring learning is embedded via revision to handover audit tool and increase frequency to weekly audit	AG (LM)	07/12/20	Frequency changed to weekly on the ward. Wider action to have this changed on Perfect Ward app (see CQC action plan)	
		Ensure patient risks are updated on the handover documentation and SBARD on a daily basis			**Update 02.12.2020** Confirmation received that Patient risk is updated for handover on a daily basis SBARD training has/is taking place **Update 15.12.2020** Change in practice to now use the SBARD tool updated daily, printed out and scanned into the handover folder.	
		Assurance in place to confirm issue resolved via Compliance Audit	NJ (JC)	22.12.20 15.01.21	**Update 22.12.2020** Some inconsistencies in the SBARD forms seen and some referred to see admission notes (this is to point people to original	

Details	**Identification:** What is the issue?	**Action to be taken to resolve the issue**	**Lead**	**Time-scale**	**Progress**	
					background to stop people document same thing each time)	

		Agenda Item No: 11b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 January 2021**

Report Title:	**Inpatient Safety Strategy: Safety First, Safety Always**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Natalie Hammond, Executive Nurse					
Report discussed previously at:	Executive Team, Executive Safety Group, Quality Committee					
Level of Assurance:	**Level 1**	**X**	**Level 2**		**Level 3**	

Purpose of the Report

This report provides:

The draft Inpatient Safety Strategy, *Safety First, Safety Always,* has been presented to the Executive Team, Executive Safety Group and Quality Committee during November and early December where the seven strategic themes were accepted. Since early December, there has been widespread engagement with internal and external stakeholders from across the system and the roadmap for implementation and outcomes have been developed.

The supporting document presents the final version of our high-level strategy to improve safety at EPUT, that puts *Safety First, Safety Always*.

Approval	X
Discussion	
Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Approve the strategy and associated themes
2. Approve and agree the approach to measuring outcomes and high-level measures

Summary of Key Issues

Engagement

The philosophy of the strategy is that safety must be at the heart of everything we do – that it is everyone's responsibility and everyone's business. For this reason, we know that we cannot develop or deliver this strategy in isolation and have engaged with a wide range of stakeholders including patients, governors, local commissioners, partners and staff throughout the organisation to gather thoughts and feedback on the key themes of the strategy. Engagement has included, but is not been limited to:

- 1:1 sessions with approximately 30 medical and corporate staff from across the organisation
- Staff workshop with medical and corporate staff including consultants, nurses, Executive Team, quality team and Estates Team that focussed on measuring outcomes of the strategy
- Governors focus group
- 1:1 sessions with local commissioners and partners including CCGs and local authorities

- Executive Team workshops to determine priority initiatives and resources

Measuring Outcomes

The strategy has used the 'principles of measuring patient safety' guidance from the NHS National Patient Safety strategy to design the outcome measures. The strategy has five key outcomes and a series of secondary technical measures. The five key outcomes are shown in the supporting document.

Resourcing

The programme management and delivery mechanism will to be confirmed once the strategy is agreed. Funding to support the delivery will form part of the annual planning process.

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

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk	BAF6 BAF10 BAF15 BAF16 BAF30 BAF32 BAF36 BAF45 BAF53 BAF58
Do you recommend a new entry to the BAF is made as a result of this report?	No

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

1. Inpatient Patient Safety Strategy: Safety First, Safety Always

Lead

Natalie Hammond
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

Safety First, Safety Always.

2020 – 2023

Our strategy for ensuring inpatient safety

Foreword

Delivering high quality and safe care is our Trust's top priority. This strategy sets out our approach to ensuring *Safety First, Safety Always.*

Safety is challenging in any mental health setting, and this has been no exception for EPUT and its predecessors. We have been on a journey of improvement with patient safety and have made some good progress. On behalf of the whole Executive Team and the Trust Board, our thanks goes to all of our staff for the dedication they have shown in supporting this vital agenda.

This strategy sets out how we will continue our journey of improvement and take this to the next level of ambition. Included in this is our plan to provide consistently safe, good quality care that is person-centred and puts patients and families at the heart of everything we do. Themes of this strategy will run through the organisation like a golden thread and be supported by our new Accountability Framework and organisational culture. They belong to every member of staff. We all need to know them, own them and deliver them together.

We are committed to learning from our complaints, incidents, staff and patient feedback and will also take learning from the outcomes of national incident enquiries. We will also learn from the best of what happens nationally and globally, whether from exemplar healthcare providers or other innovative and high-risk sectors. We will use this learning to continuously review our actions and improve our outcomes. To ensure delivery we are committed to Trust-wide continuous quality improvement and are working to embed this within our culture.

Delivery of safe and high quality services relies upon having the right culture throughout the organisation. To support this, the Trust has adopted a 'just culture' philosophy. This has changed the way we think about patient safety and quality and is complemented by the new Patient Safety Incident Response Framework (PSIRF) for which the Trust is an early adopter. EPUT will be an exemplar for safety, quality

and innovation – this is no less than our patients, their families, our staff and partners deserve.

As we move through challenging times, we will balance our ambition for quality services, patient safety, productivity and efficiency with grassroots support and development. In this way we will aim to ensure that every member of our staff feels engaged, valued and empowered in helping to continuously drive us towards providing consistently outstanding care.

Whether you are a patient, carer, member of staff or anyone else with an interest in the quality and safety of local health care, we hope you find in this document a clear statement of our intent, a strong commitment to continuous improvement and an easy to follow road map of the next stages of our improvement journey.

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Chief Executive

Professor Natalie Hammond
Executive Nurse

Alex Green
Chief Operating Officer

Dr Milind Karale
Executive Medical Director

Sean Leahy
Executive Director of People and Culture

Trevor Smith
Chief Finance Officer and Resources Officer

Nigel Leonard
Executive Director of Strategy and Transformation

Our Strategy

7 Themes to ensure Safety First, Safety Always

Our Ambition

EPUT will be an organisation that consistently places patient safety at the heart of everything we do. Over the three year life cycle of this strategy, we will embed this through a culture and mindset of *Safety First, Safety Always.*

This will show in everything we do and in all decisions that are made, from ward level to board level and builds upon the national NHS Patient Safety Strategy.

We will have got the balance right between a just and low blame culture and having zero tolerance for risks with patient safety.

EPUT will be recognised as one of the leading Trusts nationally for safety.

Our priorities to achieve this ambition

- Leadership
- Culture
- Continuous Learning
- Wellbeing
- Innovation
- Enhancing Environments
- Governance and Information

Safety never stops and our continuous journey towards excellence will see...

- Patients, carers and families telling us they trust us to provide good quality, safe care
- A reduction in serious incidents and readmissions
- Commissioners and partners having confidence in the quality of services we provide and that these are safe, effective and innovative
- Staff telling us that they have the skills, tools and time to do their jobs effectively and confidence in the Trust's commitment to providing quality and safe care
- Staff being attracted and retained by our culture of safety
- CQC reflecting the progress we have made

7 Themes for Improvement

Leadership

Ensuring there is buy-in, ownership and accountability across the Trust for putting *Safety First, Safety Always* and delivery this through leadership at all levels – from ward to board

Culture

Creating a culture of accountability and ownership, where safety, quality and improvement is everyone's responsibility

Continuous Learning

Establishing an approach to learning and development that is ongoing by sharing lessons, reflecting and empowering staff

Wellbeing

Creating a working environment where staff feel safe, happy and empowered to provide the best quality of care

Innovation

Facilitating and inspiring patient safety initiatives through new ways of working

Enhancing Environments

Ensuring our buildings and estates support the *Safety First, Safety Always* agenda

Governance and Information

Building the foundations for safety through governance, processes and availability of information that put safety first

Leadership

We will be leaders in patient safety, advocating *Safety First, Safety Always.* Leadership in patient safety will take place at all levels of the Trust, ensuring patient safety is everyone's responsibility.

We will do this by:

- Partnering with a leading quality improvement organisation to rapidly implement this strategy and urgently and systematically address required improvements
- Making patient safety visibly the top priority for the Trust, communicating this strategy to all staff and working with them to apply its principles to their roles
- Recruiting a Patient Safety Specialist to champion patient safety and drive the *Safety First, Safety Always* approach
- Incorporating the National Patient Safety Strategy as core business and becoming an exemplar implementation site
- Implementing Patient Safety Incident Response Framework (PSIRF) and using the thematic learning it generates to lead our approach to quality improvement
- Embedding safety improvement tools such as Safety WalkRounds and safety huddles

Related strategies and policies

- Accountability Framework
- Organisational Development Framework
- Workforce Framework
- PSIRF

Existing initiatives

- Leadership development pathways
- Chief Executive live sessions
- Early adopter of PSIRF

Culture

We will continue to build on a Safety Culture incorporating the 'just' culture work to drive a strong patient and staff safety agenda. We will continue to pursue a working environment where staff are encouraged to report incidents and near misses and where anyone can raise concerns over standards of care.

We will achieve this by:

- Continuing to create a 'just' culture, including a low blame environment where people can learn from mistakes
- Embedding safety huddles into everyday practice
- Ensuring a culture of co-production, so that patients, families and partner organisations are systematically involved in improving services
- Instilling a culture of reflective supervision and practice
- Using improvement tools to drive a culture of continuous learning and improvement, e.g. PDSA methodology
- Celebrating what goes right as well as learning from what's gone wrong
- Embracing a culture of transparency and openness to learn from others through benchmarking, peer reviews and peer challenge

Related strategies and policies

- Staff Engagement Framework
- Organisational Development Framework
- Workforce Framework
- Co-production Framework

Existing initiatives

- 'Just' culture
- Reverse mentoring
- 'Heroic efforts' by staff shared on social media
- Quality Academy

Continuous Learning

Safety and improvement are continuous processes and so is the learning that underpins them. We will view every event as an opportunity to learn and ensure lessons are shared across the trust and with partners, not just applied within the area in which an incident takes place.

We will do this by:

- Developing a culture of continuous improvement so that the Trust becomes a learning organisation
- Encouraging reflective practice and observations through techniques such as Schwartz Rounds
- Empowering more managers with the skills and tools to undertake reflective supervisions with staff
- Creating a centre of excellence for training in supervision, clinical practice and collaborative learning
- Using 'collaboratives of learning'
- Promoting and living the 'just' culture principles
- Empowering staff with the skills to undertake Quality Improvement through training in a range of tools, e.g. PDSA, QSIR
- Learning from those with lived experience
- Using a structured feedback programme (such as 'I want great care') to provide feedback to our clinicians to continuously improve their performance

Related strategies and policies

- Organisational Development Framework
- Workforce Framework
- PSIRF

Existing initiatives

- Virtual 'Lunch and Learn' sessions attended by over 200 staff
- Reflective Practice
- Job transfer scheme
- Leadership development pathways
- Collaboratives of learning

Wellbeing

Patient safety begins with a workforce who are happy, healthy, safe and equipped to do their job. We will ensure the wellbeing of staff so that they are best placed to provide care for patients, carers and families.

We will do this by:

- Implementing Royal College of Psychiatrists' guidance on individual and organisational wellbeing
- Implementing ward dashboards and using insight into staffing levels, workloads, vacancies and absence rates to address risks to staff wellbeing
- Ensuring that staff consider the 'total wellbeing' of patients, including physical and mental health; this must include looking for early signs of deterioration in physical health, assessing these, monitoring and responding appropriately
- Ensuring staff are offered reflective learning and the opportunities to discuss their own health and wellbeing, without it necessarily becoming a formal management process
- Ensuring we support our staff after a serious incident

Related strategies and policies

- Staff Engagement Framework
- Workforce Framework
- Supervision and appraisal

Existing initiatives

- Considering health and wellbeing in supervisions
- Introducing reflective practice into supervisions

Innovation

We will trial new ways of working and new technologies to enhance patient safety. This includes, but is not limited to, digital innovations. We want to engage more with partners, patients, carers and families to improve services and, in turn, improve safety.

We will do this by:

- Continuing to use EPUT Lab as a test bed for new innovations that can enhance patient safety, e.g. Oxehealth
- Using technology to reach the most relevant groups, e.g. apps for younger people
- Involving partners, patients and families in quality improvement and safety initiatives to provide insight from lived experience and build 'a patient safety system' as outlined in the national strategy
- Driving innovative practice through the Quality Academy and Quality Champions
- Learning lessons from small scale innovation trialed by Quality Champions that could be rolled out more widely
- Looking to unconventional examples outside of the healthcare sector for innovation, e.g. Great Ormond Street reached out to Formula 1 for process improvements

Related strategies and policies

- IM&T Strategy
- Research Strategy
- Quality Improvement Framework

Existing initiatives

- PSIRF
- EPUT Lab
- Oxehealth

Enhancing Environments

As a mental health and community Trust, our estate is diverse, geographically spread and helps us deliver a wide range of services. Our buildings and the facilities within these are central to keeping patients and staff safe.

We will work to improve the standard and quality of our estate to ensure there is no risk to patient safety.

We will do this by:

- Implementing CCQI and Royal College of Psychiatrists standards for inpatients wards
- Urgently addressing any outstanding security issues across the estate
- Ensuring that our physical environment supports good physical health as well as good mental health
- Enhancing environments for recovery, therapy and wellbeing
- Learning from people with lived experience to prioritise safety improvements in the estate, such as ligatures
- Incorporating best practice on physical environment considerations from relational security

Related strategies and policies

- Suicide Prevention Strategy
- Estates Strategy
- Security Services Framework

Existing initiatives

- Oxehealth
- Ligature reduction

Governance and Information

The foundations of a safe organisation are built on solid governance, process and access to information. This will inform actionable areas for quality improvement, create an environment of responsible reporting and intelligence-led decision making.

We will do this by:

- Using ward dashboards to track workforce, incidents and quality metrics, inform quality improvement and embed a culture of insight-led improvement 'from ward to board'
- Embedding SBAR method of communication and relaying safety reports at shift handovers
- Ensuring that information is shared to prevent gaps in handovers between individual clinicals, teams and agencies
- Ensuring rigorous scrutiny of the implementation of this strategy through establishing an Executive Safety Group as well as using existing groups including Executive Team, Quality Committee and Trust Board
- Ensuring external involvement in, and oversight of, the strategy and its delivery by engaging patients, families and partner organisations

Related strategies and policies

- Accountability Framework
- IM&T Strategy
- National NHS Patient Safety Strategy – Insight workstream
- Co-production Framework

Existing initiatives

- Establishment of Executive Safety Group
- PSIRF implementation

Five Key Outcomes

There is a long list of targets and trends that can be set to measure safety, many of which are already in place and being reported as part of national or regulatory requirements. There is an even greater number of supporting initiatives and evidence that can help to deliver and demonstrate safe care. This detail is provided in the Implementation Appendices to the strategy.

At the highest level, there are five key outcomes this strategy must deliver:

1. Patients and families feel safe in EPUT's care
2. Stakeholders have confidence that EPUT is a safe organisation
3. No preventable deaths
4. A reduction in serious incidents
5. A reduction in self-harm

Measuring Improvement: Five Key Outcomes

Outcome	Measure	Risks/Challenges	Level of Control (H/M/L)	Proxy Measures and Evidence
Patients and families feel safe in EPUT's care	An upward trend in the number of patients and families that say they feel safe in EPUT's care	· Facts do not always change perceptions · Each experience will be individual · and personal	M	· Anecdotal feedback
Stakeholders have confidence that EPUT is a safe organisation	An upward trend in the confidence of commissioners and partners that EPUT is a safe organisation	· Facts do not always change perceptions · Baseline to be established	M	· Anecdotal feedback · Increase in contracts awarded or extended · Nature of media coverage
No preventable deaths	Zero instances of preventable deaths	· Lack of patient co-operation · No standard definition of a preventable death	M	· 100% of patients have safety plans · 100% of inpatients have been involved in completing their safety plans · Suicide awareness training targets achieved
A reduction in serious incidents	A downward trend in the number of serious incidents	· We must not achieve this outcome as a consequence of under-reporting	M	· 100% of patients have safety plans · 100% of inpatients have been involved in completing their safety plans
A reduction in self-harm	A downward trend in instances of self-harm	· Lack of patient co-operation · We must not achieve this outcome as a consequence of under-reporting	M	· 100% of patients have safety plans · 100% of inpatients have been involved in completing their safety plans