Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public via Teams Live Event
Wednesday 29 July at 12:30

Vision: Working to Improve Lives

PART ONE: MEETING HELD IN PUBLIC via Teams Live Event

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
PRESENTATION: End of Life: Our Commitment & Achievements **Tracy Reed and Dr Fiona McDowall**				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 27 May 2020	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report including Governance Update	SS	Attached	Noting
6	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	SM	Attached	Noting
(b)	PLACE Annual report	MM	Attached	Noting
(c)	Learning from Deaths – Mortality Review Summary of Quarter 4	NH	Attached	Noting
(d)	Mental Health Act Annual Report	NH	Attached	Noting
(e)	Infection Control Annual Report	NH	Attached	Noting
(f)	Safeguarding Annual Report	NH	Attached	Noting
7	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework	SM	Attached	Approval
(b)	Standing Committees:			
	(i) Finance & Performance Committee – including Terms of Reference approval	ML	Attached	Approval
	(ii) (a) Quality Committee – June (b) Quality Committee - July	AS	Attached	Noting
	(iii) People, Innovation & Transformation Committee – including Terms of Reference approval	ARQ	Attached	Approval

(c)	**Risk Assurance Reports**			
	(i) COVID 19	SM	Attached	Noting
	(ii) Flow and Capacity	AB	Attached	Noting
	(iii) Female patients with personality disorders	AB	Attached	Noting
	(iv) No Force First	NH	Attached	Noting
8	**STRATEGIC INITIATIVES**			
(a)	Mental Health & Community Services Transformation	NL	Attached	Noting
9	**REGULATION AND COMPLIANCE**			
(a)	CQC Update	SM	Attached	Approval
(b)	PHSO and HSE Steering Group	NL	Attached	Noting
(c)	Quality Account 2019/20 – Interim version for publication	NH	Attached	Noting
10	**OTHER**			
(a)	Use of Corporate Seal - **not used**	SM	verbal	Noting
(b)	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
(c)	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
(d)	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
(e)	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
11	**ANY OTHER BUSINESS**	All	Verbal	Noting
12	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
13	**DATE AND TIME OF NEXT MEETING** Wednesday 30 September 2020 - Virtual 9:30			
14	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** - 25 November 2020 – Time TBC			

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held in Public
Wednesday 27 May 2020
Held Virtually via MS Teams Video Conferencing

Attendees:

Prof Sheila Salmon (SS)	Chair
Sally Morris (SM)	Chief Executive
Prof Natalie Hammond (NH)	Executive Nurse
Mark Madden (MM)	Executive Chief Finance Officer
Andy Brogan (AB)	Executive Chief Operating Officer / Deputy CEO
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
Nigel Turner (NT)	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:

Faye Swanson (FS)	Director of Compliance and Assurance/ Trust Secretary
Angela Horley (AH)	PA to Chief Executive, Chair and NEDs (minutes)
Tina Bixby (TB)	Assistant Trust Secretary
Gillian Brice (GB)	Associate Director of Planning (Items 064/20 and 065/20 only)
Pam Madison (PM)	Head of Complaints (Item 063/20 only)
John Jones	Lead Governor
Pippa Ecclestone	Public Governor
Paula Grayson	Public Governor
Sam Rakusen	Public Governor
Gillian Lock-Bowen	Public Governor
Judith Woolley	Public Governor
Kirsty Neil	CQC Inspector

SS welcomed Board members, Governors, members of the public and members of staff that were viewing the live broadcast. The meeting commenced at 13:00.

047/20 APOLOGIES FOR ABSENCE

There were no apologies received.

048/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

049/20 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 25 March 2020 were agreed as an accurate record of discussions held.

050/20 ACTION LOGS AND MATTERS ARISING

Signed: …… Date: ……

In the Chair

The action log was reviewed and it was noted that there are no outstanding actions.

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

The Board discussed and approved the Action Log.

060/20 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.

061/20 QUALITY AND PERFORMANCE SCORECARD

SM presented the Quality and Performance Scorecard advising that due to the Covid pandemic, full performance reporting had been suspended nationally; as such this had allowed the Trust to focus on current hotspots and national indicators. Indicators have also been suspended during this time due to a large staff redeployment programme and the reduction of resource for validation and reporting. Information for all suspended indicators continues to be captured and monitored by other teams and services and where possible by live dashboards and reports. It is anticipated that full performance reporting should resume by July. Within the report, 6 hotspots have been identified; 5 of these are consistent with those identified in the previous month and are as at end of April 2020:

- Timeliness of Data Entries (MH Services)
- CPA 12 Month Reviews
- Inpatient Capacity (Mental Health Adults and PICU)
- Inpatient Capacity (Mental Health Older Adults)
- Continued Reduction in Out of Area Placements
- Sickness Absence

In light of the impact of the Covid pandemic, sickness absence has been identified as a new hotspot.

There are two hotspots which are Oversight Framework indicators:

- Continued Reduction in Out of Area Placements
- Sickness Absence

SM confirmed that the Finance and Performance Committee (as a standing committee of the Board of Directors) had reviewed and discussed the hotspots in detail.

AD noted a decline regarding CPA review over the past year and whilst acknowledging that Board sub-committees have monitored this, sought clarity on areas of assurance and measures being taken to improve performance. AB shared his disappointment regarding this, advising that there had been a lack of ownership in some areas and a clear message had been given to operational teams that this is a quality issue and teams must work together differently to seek to resolve this critical piece of work. SS sought clarity as to the expectation for improvement; AB confirmed that it would be expected to see improvement within the next three months.

RH observed that the decline of out of area placements may be as a result of the Covid pandemic, and queried whether the underlying issue had been addressed. MK acknowledged that due to the Covid pandemic there had been a move to reduce inpatient capacity and as such had allowed repatriation of out of area placements, and noted that the impact on inpatient services would be monitored as part of the recovery process. AB noted there had been less demand on services

during the Covid pandemic, however suggested there are multiple factors that could also have had an impact. For example, the urgent care pathway had been introduced at the beginning of the pandemic. It had been acknowledged that the introduction of this pathway was expected to reduce admissions to hospital; a second consultant on call was also available to review admissions. AB confirmed that as part of the reset programme consideration will be given to how to keep bed occupancy to the national standard of 85% as this has had an impact on the quality of care patients receive.

MM advised that there is a completely different financial regime this financial year, with the NHS being funded differently from previous years. There is one financial hotspot at present which is the Cost Improvement Programme (CIP), where there has been no notable delivery against this programme in this financial year thus far due to responding to the Covid pandemic. It is important that the CIP programme is addressed as this will affect our recurrent expenditure rate.

ARQ noted that during the response to the Covid pandemic, inpatient capacity was reduced with many patients being treated effectively in the community, ARQ sought assurance that as services return to normal, length of stay and capacity would not increase dramatically as it is evident throughout the pandemic that patients could be treated effectively without inpatient stays in many cases. SM responded that prior to the Covid pandemic, the Trust had identified that there were cohorts of patients that inpatient stays were not necessarily the best treatment setting, e.g. patients with Emotionally Unstable Personality Disorder (EUPD) and post Covid would continue to treat these patients in the community setting where appropriate. SM also noted that there was concern nationally that there may be people who while isolating due to the pandemic, are not accessing help and treatment they may need and therefore a surge in activity is expected.

SS noted that issues identified within the report would continue to be reviewed and monitored by the Finance and Performance Committee and Quality Committee.

The Board of Directors received and noted the report.

062/20 DUTY OF CANDOUR ANNUAL REPORT

NH advised that the Board are asked to approve the Duty of Candour Annual Report and confirmed that the Trust was compliant with Duty of Candour timeframes and requirements for all applicable incidents during 2019/20. NH was pleased to note that this was the third consecutive year of achieving 100% compliance with statutory obligations in regards to being open and transparent stating that this links with our Trust values. NH advised that training for Family Liaison Officers has been extended as the Trust continues to work with and involve family and carers as part of the investigation process.

AD commented that whilst currently involved in a serious investigation panel, she had witnessed the strength of the family liaison connection and it was reassuring to see the role of this position in keeping families up to date and involved.

The Board of Directors received and approved the Duty of Candour Annual Report.

063/20 COMPLAINTS ANNUAL REPORT

SL welcomed Pam Madison, who had recently retired from the position of Head of Complaints, to present the report. PM advised that the Trust received 293 complaints during the financial year 2019/20. This comprised of 61 from Mental Health (increase of 2 from the previous year) and 32 from Community Services (increase of 6 from the previous year). All complaints were acknowledged within the Department of Health's statutory three working days. A total of 288

complaints were investigated and closed within the financial year, with 49 complaints remaining open and carried over to this financial year. Of the 288 closed complaints, 201 were either upheld or partially upheld and 93.2% were completed within agreed timescales with the complainant. 19 complaints were referred to the Parliamentary Health Service Ombudsman (PHSO) which is an increase from the previous year, however it should be noted that the PHSO has changed the way in which they review cases, introducing an 'Assessment Stage', which is used to decide whether to investigate further or not. Of the 19 referrals, the PHSO decided not to investigate 10 of the cases; no complaints investigated by the PHSO were fully upheld.

The Trust continues to monitor of themes and trends of complaints received and over the year, complaints in regards to staff attitude have risen each quarter. This is being closely monitored to try and establish a reason for this rise.

The PALS function is now part of the Complaints Team and received 998 enquiries; over 281 were in relation to other organisations and were signposted accordingly. The Non-Executive review process was reviewed to provide a more robust review by concentrating more on the learning of the complaints as well as the impact the concern raised has had on the complainant.

The Trust received 4,269 compliments throughout the year which equates to almost 15 compliments to each complaint received.

SS thanked PM for the comprehensive report. ARQ noted that Mid and South MH Services received the largest share of complaints, however was concerned by the number of complaints upheld or partially upheld in that area compared to other areas across the Trust and queried whether consideration had been given to a 'deep dive' to understand any issues. SL confirmed that a 'deep dive' was scheduled to take place and the results of this would be reported to the Patient Experience Committee.

MK noted that the number of compliments received for medical staff appeared lower compared to other areas and highlighted that compliments and feedback from patients are captured as part of the revalidation process.

NL queried whether there had been a shift in terms of themes identified from complaints received or whether the main themes and trends remained the same in comparison to previous years. PM advised that in general themes remain consistent however as mentioned there has been an increase in complaints received regarding staff attitude and this is being looked into.

ML noted the increase in complaints regarding staff attitude and queried what staff training and development may be available. SL advised that prior to the Covid pandemic he had been requested by the CEO to explore stakeholder training, SL confirmed that it is intended for such training to be implemented across the Trust which will include an element of customer support learning and tools to manage challenging situations, including tone of voice and conflict de-escalation. AB agreed that this is an area to focus on as it is acknowledged that how staff approach patients does affect and impact on patient behaviour, and it is important for staff to be aware of this. Work has been piloted within the CAMHS service, where patients have been asked how they would like to be treated in certain situations to ensure an effective therapeutic relationship and environment is maintained.

MK advised that the theme for the Royal College of Psychiatry was 'kindness' and anticipated that this may help medical staff focus and be cognisant of how behaviour and approach impacts the patient experience.

JW referred to the number of complaints investigated and closed within agreed timescales and suggested it may be helpful to have comparative figures for previous years. JW also sought assurance that the Board were happy with the time taken to resolve complaints, and if there was any

additional resource that may help. AB responded that timescales are there to try and resolve complaints satisfactorily as quickly as possible, however some complaints are complex and take longer and can put additional pressure onto operational services. AB confirmed that additional resource has been available, however suggested there is a need to focus on resolving the less complex complaints in a more timely manner.

NH highlighted the importance of focussing on staff attitude and agreed that this can impact on the therapeutic environment, adding that there is a strong focus at corporate induction for new staff around the Trust values of being Open, Compassionate and Empowering. NH continued that all staff contribute to the patient experience from front of house to direct nursing care and by challenging each other and setting examples we can improve the therapeutic environment.

SL thanked PM for her contribution to EPUT over the years and wished her a long happy retirement. SS echoed SL's comments and wished PM well in her retirement.

SM noted that during the Covid pandemic, a different approach has been taken to complaints due to staff resource being focussed to respond to the pandemic, and as such the next annual report may reflect this. SM provided assurance that complaints continued to be acknowledged and responded to.

The Board of Directors received and approved the Annual Complaints Report for 2019/20

064/20	**FREEDOM TO SPEAK UP REPORT NHS ENGLAND AND NHS IMPROVEMENT'S SELF REVIEW**

GB advised that the report is in relation to the NHS England / Improvement self-review tool which had been discussed previously with the Board at a development session in January. At this development session, Board members completed the self-review, with Principal and Local Guardians then asked to review the document to ensure that all areas had been covered. The Trust fully meets the criteria in all but two areas, those being 1) the Board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian Office (NGO); 2) the Executive Team can evidence they actively support their FTSU Guardian. Evidence should demonstrate they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes.

To complete these actions it was agreed that reports from the NGO regarding full investigations undertaken will be presented as part of Board Development / Seminar Sessions in 2020 and it was agreed that the Principal Guardian will attend the Workforce Transformation Group to ensure receipt of employee relations data. A review of these actions will be undertaken in July 2020.

ARQ reflected on the impact the Board felt the FTSU Guardian post was having on improving staff willingness to speak up and whether there was any specific learning from its operation over the last year or so that that could demonstrate learning has been embedded into the organisation in regards to freedom to speak up. SL advised that the Principal Guardian has met with many services across the Trust and continues to remain visible and promote her role; SL acknowledged that there is a need to recruit more local guardians and work is being undertaken to promote a further FTSU campaign.

ARQ suggested that there is still some way to go to embed the principle of FTSU and ensure staff are aware and use the resource in the correct way. ARQ commended Yogeeta Mohur for her work to date; however suggested further support and promotion of the role is necessary. ARQ acknowledged that the Board also have a responsibility to promote FTSU to enable staff to feel confident to raise issues without fear.

MK highlighted that the report does not make reference to medical staff raising issues and highlighted the role of the Guardian for Safe Working and suggested that junior doctors often raise issues via this route.

The Board of Directors approved the contents of the self-review and the improvement actions identified.

Action:

1. **Review two actions agreed to bring the Trust into compliance with the F2SU self-review tool at a future Board Seminar Session.**

065/20 FREEDOM TO SPEAK UP ANNUAL REPORT

Due to a technical issue, Yogeeta Mohur was unable to join the meeting, however SL was encouraged by the progress made since Yogeeta was elected as Principal Guardian and was proud of the inroads made to open channels and encourage staff to speak up as well as the support available from the number of staff networks established.

SS was encouraged by the insight and analysis YM brought to the role and the drive to recruit more local guardians. SS agreed that it was important to ensure the role was supported appropriately. ARQ agreed that YM was passionate regarding the FTSU agenda and that passion will gain momentum. ARQ was confident for the future however reiterated the importance of ensuring there was appropriate support available. ARQ referred to the theme of complaints received regarding staff attitude and suggested that FTSU was one element that may contribute to remodelling the culture of the organisation.

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

066/20 LEARNING FROM DEATHS

NH presented information relating to deaths in scope for mortality review for quarter 3 2019/20 (01 October – 31 December) together with updated information for previous quarters. NH advised that this report would have been presented at the March Board meeting had it not been for the Covid pandemic and provided assurance that there have been no delays and the work has continued throughout the pandemic.

NH advised that there were 53 deaths that fell within scope for review which is consistent with other quarters and remains in statistical control levels. Of the 53 deaths, 6 were inpatient and 8 were nursing home deaths. Of these 14 deaths, 13 have been confirmed as due to natural causes. One death has been categorised as an unexpected natural death and is currently subject to Serious Incident investigation.

The Mortality Review Sub-Committee has now agreed a dashboard format for collating information on deaths of substance misuse service users who had contact with the EPUT element of the substance misuse services in the six months preceding their death. This is a new development and as such the dashboard has been updated to reflect this.

NH was pleased to report that any backlog of reviews had now been addressed; however it is worth noting that this is reliant on staff resource and their capacity to undertake reviews which may be compromised by the Covid pandemic. The ability to maintain a robust review process is being closely monitored.

Following the success of a range of live webinars during the Covid pandemic, the Trust is exploring the use of this technology to share learning and inform our staff.

AS was proud of the work EPUT had undertaken as part of this agenda.

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

067/20 BOARD ASSURANCE FRAMEWORK

SM presented the Board Assurance Framework and Corporate Risk Registers as at 21 May. SM advised that the BAF has been updated following discussion at the Board Seminar Session held in April 2020. The current risks on the BAF have been categorised into two types of risk for the duration of the Covid 19 pandemic. The summary table identifies those risks that continue to have high focus at the current time and those risks that remain a risk to achieving our objectives but will not be a focus during the Covid 19 pandemic. There are 18 risks on the BAF currently, including two recommended for closure and three new risks. SM advised that the report gives assurance that the Trust continues to monitor risks in the Trust during the Covid pandemic.

AD referred to the reduction of BAF9 regarding restraints, however noted the slight increase in the number of restraints and queried whether it was premature to reduce this risk until investigation of the reason for the increase has taken place. NH advised that over the past year the Trust has reduced the number of restraints and prone restraints; however it has been noted that there has been a slight increase. NH confirmed that this is being explored to understand the cause and the risk will be reviewed again as appropriate.

The Board of Directors:

1. **Reviewed the risks identified in the BAF 2020/21 and approved the risk scores.**
2. **Approved the closure of BAF13 and BAF33 and approved new risks BAF41, BAF42 and BAF43.**
3. **Approved the risk scores drafted for Strategic and Corporate Objectives**
4. **Noted the Corporate Risk Register summery.**
5. **Approved the closure and reduction in scores of CRR risks.**
6. **Did not identify any further risks for escalation to the BAF, CRR or Risk Registers**

Action:

1. **Review BAF9 risk in light of review of data for Q1 (NH)**

068/20 STANDING COMMITTEES

(i) Audit Committee

JW presented the Audit Committee assurance report and advised that work had been commissioned around assurance on record keeping for Cardio Metabolic Assessment. JW was pleased to report that this audit had been completed prior to lockdown and moderate assurance had been received regarding the design and effectiveness of the recording system; this is the second best level of assurance. There were two recommendations made within the audit regarding accuracy and effectiveness which have been accepted and implemented, the third recommendation was around how this would continue to be audited going forward and it has been agreed to include this within the clinical audit programme for 2021. Internal audit carried out a further exploration of data, and concluded that there was no evidence of data manipulation and the exclusion of some information indicates that the performance is better than that reported through the KPI. JW confirmed that based on the sample internal audit took, the Trust reached the 90% target with early intervention and

inpatients and were a few percentage points away from the target within Community Services.

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

(ii) Finance and Performance Committee

ML highlighted that the F&P Committee received assurance regarding executive level monitoring of Covid related expenditure; the NHS as a whole is currently within an unusual unexpected financial regime due to the Covid pandemic, with 'top up' funding available from the centre and as such it is important to account for any spend that has been triggered by the pandemic.

There are circa £5.9m unidentified CIP; MM provided assurance to the F&P Committee that this is being taken forward by Executive Directors, and a 'deep dive' of progress of CIPs will take place at the July F&P Committee meeting.

ML confirmed that Governors were consulted on their reviews regarding self-certification against the FT licence, these comments were discussed at the F&P Committee with one Governor raising concern that with the number of hotspots that have not been addressed successfully over the past 12 months, was it legitimate for the Trust to declare full compliance. The F&P Committee reviewed this and specific reasons hotspots hadn't been addressed as well as the actions taken to mitigate them and took the view that on balance the Trust was compliant with the licence, but this goes to show that a strong watching brief on hotspots and performance was essential. SS commented that it was helpful to have the challenge and be assured that the Trust had undertaken due diligence around key areas to justify the self-certification.

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

(iii) Quality Committee

AS presented the assurance report; AS thanked NH and team for preparing papers for the meeting at the height of the Covid pandemic and advised that the Quality Committee will continue to meet virtually and focus on using the action log monitor and take forward priority quality items whilst the organisation moves through the Covid working.

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

069/20 RISK ASSURANCE REPORTS

i) Covid 19

SM advised that the purpose of the paper was to give an update and provide assurance as to how the Trust is responding to and mitigating risks associated with Covid. SM confirmed that this remains a level 4 incident and therefore there are some specific implications for us as an organisation. SM advised that the regional director can instruct the Trust to open / close services or redeploy staff and resources to other areas (e.g. Nightingale hospitals); however this has not been required to date, but it is important to be cognisant of this, particularly if there is a second peak. A control system is in place within the Trust with Bronze, Silver and Gold command teams meeting daily till very recently to remain up to date on the changing situation and review guidance received. To date, 272 items of guidance or instruction from region or the centre have been

discussed. Due to the large amount of guidance / instruction received, a Covid specific risk register has been developed and is managed through the control / command structure.

It is acknowledged that the 'peak' has now passed and as such the regularity of the command / control meetings have been reduced to every other day, this will enable the ability to focus on the 'reset' as we move out of this crisis. At the time of writing the report, there were 34 members of staff off sick and 259 members of staff self-isolating due to Covid; SM confirmed that as of today this has reduced to 30 members of staff off sick and 230 members of staff self-isolating. In terms of patients within our services, SM confirmed that there are currently two patients within MH inpatient services that have tested positive for the Covid virus and 12 patients in community inpatient services (i.e. physical health services provided from St Margaret's Hospital and Saffron Walden Hospital). SM was sorry to report that to date 16 patients within EPUT inpatient services had sadly died from Covid, all of which had underlying health conditions. SM also reported that two members of staff had sadly lost their lives to Covid; the Trust continues to support staff members affected by Covid. Additional costs incurred up to March due to Covid have been honoured and funded and it is anticipated that this will continue.

Communication at this time is essential, with various communications mechanisms being put in place to update staff and provide an opportunity for feedback / questions. Board members and Governors have also received regular briefings from the Chair and CEO.

SM highlighted one of the main risks facing the Trust in light of the current situation as infection prevention and control, and advised that Appendix 2 of the report presented the Trust's compliance with NHSE/I's infection prevention and control (IPC) assurance framework which the Board was asked to approve.

SM advised that availability of PPE was another high risk for the Trust; however there was currently sufficient PPE available to manage services safely within current PPE guidelines. A system is in place whereby Trusts can request mutual aid when stocks are low and when needed supplies have been available. PPE will continue to be monitored closely as we move out of the Covid crisis and face to face contact increases.

Oxygen is being managed within the Trust, but should there be a second peak with greater demand, this will be a risk that will grow in concern.

SM referred to availability of patient and staff testing and advised that the Trust was close to a solution that would address any concerns that may arise. SM also referred to antibody testing and the announcement that this would be available to NHS staff, advising that the Trust is awaiting information and guidance as to how to enable staff to access this. It is worth noting that while the antibody test will identify whether a person has had Covid and if there are antibodies present, there is no evidence to suggest that a person who has antibodies has any additional immunity to the virus. SM advised that with the relaxation of lockdown guidance, a group has been established to discuss and agree the safe return to work of our staff; however it is acknowledged that to enable compliance with social distancing guidelines, a number of staff will continue to work from home as appropriate. Face to face meetings continue to be suspended with meetings taking place via Microsoft Teams.

There is an expectation of a surge in mental health demand; there is no modelling for this at the moment as the government and Public Health England have focussed thus far on modelling for demand of respirators / PPE etc to respond to the initial Covid crisis.

SS thanked SM for presenting the report and thanked SM for the regular communication and assurance to Board members and Governors during the pandemic.

ML expressed the Board's deepest condolences and sympathies for those patients and staff that have sadly lost their lives during the pandemic; stating that it was incredibly humbling that NHS staff are risking their lives to help tackle this pandemic. ML added that the Board have been impressed by the Executive leadership during this time and acknowledged the momentous effort of all staff working together. Despite the tragic circumstances, the Trust has led its response very well. SS agreed that NHS staff have been heroes during this crisis.

NH wished to make the Board aware that the IPC Assurance Framework has been updated by NHSE/I over the past few days with new additions. A deeper drill down will take place at the Quality Committee.

As NED Champion for Emergency Preparedness, JW praised the Executive Team and staff for the speed in responding to the pandemic.

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 risk register and mitigations;**
4. **Noted and approved the IPC Assurance Framework.**

ii) Fire

MM advised that the report provided assurance to the Board in regards to Fire risk mitigation across the Trust. The Trust has a robust fire risk assessment process in place and an active remedial programme to address any issues identified within the risk assessment process. There have been minor delays in progress due to the Covid pandemic with some work due to take place having to be halted due to access restrictions; MM confirmed that this schedule of work will resume as soon as social distancing guidance allows. Fire training has been affected by the Covid pandemic, with face to face training being suspended. The Trust is looking at whether fire training can be delivered via Microsoft Teams including demonstrating of equipment.

SS extended thanks to the Fire Safety Group and noted the positive progress made to date.

The Board of Directors received and noted the contents of the report, accepting assurance provided.

iii) Ligature Risk Management

SM presented the Ligature Risk Management report advising that this relates specifically to the BAF10 risk identified on the Board Assurance Framework. SM requested feedback on the format of the report.

SM wished to emphasise that ligature risk management remains a priority for the organisation, during the Covid pandemic, the Trust has continued to ensure as much as possible that any risks are addressed. SM acknowledged that it is rare to be entirely free of fixed ligature points in patient areas because most were not designed to mitigate the potential risks being identified currently or there are no design solutions to eliminate identified potential risk entirely from all infrastructure, fixtures and fittings. It is important

to consider the physical environment in the wider context of care provision which includes staffing, security, patient risk assessment, observation and care planning.

SM noted that an action had been identified regarding ceiling fixtures and fittings to be completed by 26 May and confirmed that this action had been addressed within the agreed timescale. SM confirmed that two wards remain outstanding in terms of the window replacement schedule, however confirmed that work had begun to address this.

ARQ thanked SM for the informative report and queried how body worn cameras may mitigate a suicide risk. SM confirmed that often this contributed to the de-escalation of a situation and the Trust has seen a positive impact on wards trialled on. AB added that it has been noted in areas that body worn cameras have been piloted, the cameras have contributed to the de-escalation of situations involving patients who exhibit risky behaviour but do not have suicidal intent. Evaluation of the cameras continues, however it is noted that nationally they have contributed to a decrease in incidents.

The Board of Directors received and noted the contents of the report, accepting assurance provided.

070/20 MENTAL HEALTH AND COMMUNITY HEALTH SERVICES TRANSFORMATION

NL presented the report highlighting that in response to the Covid pandemic all crisis response teams across Essex have been up and running from April 2020. The Trust is in the process of recruiting to a number of posts; however during the Covid crisis a cohesive system response has been seen with staff, including clinical commissioning staff, deployed to the service to keep the crisis line operational.

NL reiterated SM's concern that a surge in mental health demand is expected nationally. NL was pleased to note that the CCGs are now in receipt of the mental health investment standard for this year in full, resulting in funding being available to draw upon once agreement is reached around business cases. A number of pilot projects are also up and running in relation to primary care. NL noted that there is a drive to move towards reset and recovery and build on innovation that has taken place during the crisis.

It is key that transformation reflects the phase two and three reset and recovery planning that is taking place across the system and processes are in place to ensure that we can meet the challenge of any mental health surge.

SS thanked NL for the comprehensive report, noting both the challenges and opportunities that have arisen from the Covid crisis.

ML noted the updates across the Transformation programme and noted the effect of Covid has meant that progress appears fragmented and sought assurance that this remains a coherent programme. NL responded that this links with one of the Trust's corporate objectives regarding influencing the system, stating that there is a degree of planning required at CCG and system level looking at how to embed changes and lessons learned in terms of speed and governance; NL believed there will inevitably be changes to the way services are delivered. Discussions are taking place with commissioners to emphasise areas where collaboration is particularly important to ensure organisations are working together and not against each other. NL continued that EPUT are keen to ensure that partnership working is successful with all parties heard and having an equal say in the delivery of services to benefit the population. There was recognition at the beginning of the pandemic that a number of decisions had to be taken at speed, however with the reset and

transformation programme we need to ensure that governance structures across the system are robust and a key executive has been identified within EPUT for each system.

SS agreed that it is important to reflect with partners to ensure that systems are reset appropriately and learning embedded.

AD reflected on how staff have responded to the crisis and suggested there may be benefit to strengthening input from 'grass roots' staff in terms of transformation. NL agreed that there is benefit in bringing a range of people together and empowering staff to join discussions. NL reiterated that while there is a need to work at pace, it is equally important to ensure system working with representation from all parties. SL advised that leadership events are scheduled to take place regarding the reset programme and enabling the employee voice.

MK advised that within west Essex, clinical teams have moved away from psychosis and non-psychosis teams and are aligned with primary care networks; a move to PCN alignment is also taking place within Mid and South Essex.

SS noted that there has been progress and change, however there was significant work to be undertaken and it was important for EPUT to be in a position of influence. SS thanked NL and the Executive Team for the work undertaken.

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

071/20 CQC UPDATE

SM presented the report which provided an update on progress in driving the Trust ambition to be rated as 'outstanding' by 2022 or earlier. As expected, because of Covid, a number of meetings and inspections by the CQC have been delayed. During this time the CQC has focussed on areas with significant concerns and SM was pleased to note that EPUT did not fall under this category. SM continued that an annual CQC inspection is anticipated before November 2020 and reiterated the importance of ensuring that any actions identified at previous inspections had been addressed.

Covid has had an impact and some slippage has been seen on identified actions, however SM confirmed that this did not present any additional patient safety concerns. Progress was monitored via the Quality Committee; however SM had reinstated an Executive CQC Steering Group to ensure that actions are addressed. SM was pleased to note that a solution has been proposed in relation an issue that has been noted for some time around single sex accommodation at Hennage Ward. SM continued that this proposal had been accepted as appropriate by the CQC and a programme of works is now being developed.

SM noted that a new registered manager had been identified at Rawreth Court nursing home, and the post holder had undertaken a fit and proper person's interview.

SM gave assurance that despite some slippage on identified actions, this remains a priority for the Executive Team.

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

072/20 NHSI SELF CERTIFICATION 2019/20

SM advised that NHS Foundation Trusts are usually required to make annual self-certifications to NHS Improvement under the NHS Provider Licence, Risk Assessment Framework and the Health and Social Care Act 2012. It is unclear if the requirement has changed this year as a result of Covid

19 as no information has been received from NHSI; however EPUT has taken the decision to proceed as business as usual in the context of maintaining our well led and governance arrangements.

SM confirmed that a self assessment of compliance with Licence Condition G6 had been undertaken and the Finance & Performance Committee had considered this and subsequently recommended that a positive declaration as set out in the report could be made by the Board of Directors. She confirmed that the views of the Council of Governors had been sought and feedback was noted but not considered to be material.

SM suggested that during the Covid pandemic the Trust had attempted to maintain business as usual as much as possible and thanked colleagues for the support in achieving this.

The Board of Directors received and noted the contents of the report, approving the recommended declaration.

073/20	**SAFE WORKING OF JUNIOR DOCTORS QUARTERLY REPORT**

MK presented the quarterly and annual report submitted by the Guardian of Safe Working. MK confirmed that the Trust was fully compliant with the Junior Doctor contract. It was noteworthy that since last year the Trust has not used any locum doctors for on call cover as was previously the practice in some areas of the organisation.

The Board of Directors received and noted the contents of the report, and considered assurance provided by the Guardian.

074/20	**SAFE WORKING OF JUNIOR DOCTORS ANNUAL REPORT**

As above.

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

075/20	**CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING**

There were no items of correspondence circulated to the Board.

076/20	**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.

077/20	**ANY OTHER BUSINESS**

There was no other business.

078/20	**DATE AND TIME OF NEXT MEETING**

SS thanked all for joining the live broadcast and sought feedback from viewers; noting that there were up to 27 viewers during the broadcast.

Signed: …… Date: ……

The next meeting of the Board of Directors is to be held on Wednesday 29 July 2020, 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.

079/20 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.

The meeting closed at 15:05.

Signed: …… Date: ……

In the Chair

Appendix 1: Governors / Public / Members Query Tracker (Item 079/20)

Governor / Member / Public	Query	Response provided by the Trust
John Jones	**On Timely Data Entry:** I quote from the Report ". . . that late data entry has a significant impact on Trust reported performance and internal figures being at variance with national figures." This is a continuing problem and, when raised before, the explanation has been that staff have more urgent matters to attend to. So far this appears to have been accepted. Is it not now time for the Finance and Performance Committee (who has responsibility for this) to take a more radical approach and determine if a simpler method of data entry can be brought in?	SM responded that unfortunately a lot of data used is taken from the Electronic Patient Record and we cannot change the method for collection of information. The Finance and Performance Committee have reviewed and set targets for achievement in terms of responsiveness and how quickly the data is presented. Before Covid, services in the north of the Trust, North East and West were beginning to achieve the set target with services in the South also improving. Unfortunately because of Covid we are likely to see a dip again, but services are working with clinicians and staff to ensure entries are completed on time. SM reiterated that we cannot change the way the information is collected but was confident that had the Covid pandemic not occurred, we would be close to, if not achieving targets.
John Jones	**On First Episode Psychosis:** There is a drop in the figure from February to March from 80% to 57% and unlike other metrics there are no figures published for April 2020. Is this drop a one-off or is there an emerging problem which needs to be addressed?	AB referred to the SPC chart stating that the target has been achieved or exceeded for 10 months of the year. AB confirmed that this drop for one month equated to 5 patients and was assured that the five patients have been seen within the timescale. AB added that it would be impossible to determine if there was a trend from one month's performance but this would be monitored.
John Jones	**Inpatients who require to go to an acute hospital for urgent non-Covid treatment.** Are they tested for Covid-19 before being returned to our care?	NH confirmed that this was the case and that a swabbing protocol was in place that ensured that all patients coming into our care are swabbed and tested. If patients are then referred onwards to other services they are then subject to further testing and this is similar to our system partners approach.

John Jones	**Complaints Report:** I note that complaint review by NEDs are "signed off by the Trust Chair". What is the effect of this particularly, but not exclusively, in terms of learning from complaints?	SL advised that this adds to the scrutiny of the complaint and encourages debate and contributes a valuable part of the process. SS added that JW had been undertaking a review of the process to ensure the appropriate level of scrutiny is given. SS advised that NEDs review a certain number of complaints each month and noted that the feedback form completed by the NEDs allows an opportunity for them to flag up where they believe more could have been done or approached in a different way and this is fed back to services as part of the overview and scrutiny process. JW added that the process has been reviewed and will be looking at additional hard evidence that lessons have been learned and cascaded.
Pippa Ecclestone	Ref. Quality Committee Report - 2.2.9 MHAct and Safeguarding sub-committee assurance report. "All tribunal hearings for patients subject to CTO or that have been Conditionally Discharged have been postponed" What is being done to assist sectioned service users who wish to contest their Renewal hearings or appeal against their section to the Associate Hospital Managers?	NH advised that in light of Covid and following government advice, the issue around hospital manager review hearings was postponed. The Trust investigated and sought advice not only from the London Mental Health Network, but the Director of IT and subsequently successfully piloted and are now holding virtually by MS Teams. In terms of clinical information being out of date, NH advised that this may be due to the pilot focussing on those hearings that were originally suspended until we found an alternative way to hold hearings. The Trust are now in the process of developing a standard operating procedure that incorporates learning from the pilot; all tribunal hearings for patients subject to CTO or conditionally discharged were suspended by the tribunal service itself and following a legal challenge, that decision has now been rescinded.
Paula Grayson	Does this mean that Cardo Metabolic Assessments have finally reached the target?	Yes, apart from one area. We believed that in the main we have always been hitting the target. As reported it is the complexity of reporting that has been the issue. The audit gives us assurance that patients are being checked.
Paula Grayson	On the BAF is CRR12 physical health related to cardio metabolic assessments?	Primarily it is, but covers a wide range of physical health care checks.
John Jones	On Complaints Report: A deep dive is on the agenda into the high upheld rate in Mid and South – when will this be reported to Board?	Results will be brought to the Board in September along with the progress on resolution.

Signed: …… Date: ……

Paula Grayson	Picking up on the very good plan for future training around attitudes, particularly responding to patient complaints and staff comments about bullying and then the key need for staff to understand patients to reduce risks including from ligatures, can the training be around emotional intelligence which can address the control of projection of views as well as responding to behaviours and the underlying causes?	Emotional intelligence in most cases is a gift and highly untrainable, however creating an awareness as described in our attitude for futures programme (which is in development) will highlight poor emotional intelligence and give delegates food for thought which should see an increased level of EQ.
Paula Grayson	Yesterday, engaging with members of the public, they were resistant to group talking therapies which have been used in Bedfordshire. Understanding we will need to continue with virtual services, can they be individual?	Where we can we will do this, however for some therapy, group therapy is the best and evidence approach to this. We are looking at how we can continue groups utilising social distancing.
Anonymous	Can Sally confirm that she said Saffron Walden Community Hospital has Covid affected patients – I thought it was being kept clean?	SM referred to Saffron Walden and St Margaret's hospitals to define context / type of community beds. It was not identified within which wards Covid patients were residing.

Signed: …… Date: ……

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 27 May 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
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		Open	
May 068/20 (1)	Board Assurance Framework – Review BAF9 risk in light of review of data for Q1	NH	July 2020	Risk reviewed. Satisfied that progress is being made to mitigate. No Force First Assurance report provided to Board on the 29th July..	Completed	

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

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
January 004/20	ARQ to visit the Perinatal Service	ARQ	Mar 20	Visited on 20 February.	Completed	
January 004/20	CB to be invited to Mortality Committee to agree how the perinatal suicide agenda is incorporated into the Trust's Suicide Prevention Strategy	NH	Mar 20	Actioned	Completed	
January 005/20	Clarify progress with development of dashboards as referenced in the Quality Priorities update in the Performance Report .	NH	Mar 20	There is now a dashboard against each priority that can be measured. Ward level dashboards are also in place and training has been undertaken in this respect by both matrons and ward managers.	Completed	
January 007/20	There is a need to agree which standing committee will take responsibility for detailed monitoring and discussion in respect of Cardio Metabolic Assessment (CMA).	AS/ML	Mar 20	AS advised Finance and Performance.	Completed	
January 007/20	Drop in RTT performance in south Essex to be investigated.	MM	Mar 20	FS confirmed that there had been confusion as to which RTT target had been referred to, however SEE data had been reviewed with no variation noted. FS reported however that a slight underperformance is noted in the report presented to Board this month.	Complete	
January 007/20	CMA deep dive report considered at Finance and Performance Committee in January to be circulated to Board members.	MM	Mar 20	Finance and Performance assurance report presented to January Board. Chair of Finance and Performance Committee gave praise for the work carried out on the CMA. It was noted that a further audit would be carried out on the CMA.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
January 008/20	Confirmation to be provided of the timescale for completing ligature risk reduction works to bedroom and bathroom doors and soap/towel dispensers.	MM	Mar 20	Door Top Alarms to be fitted to communal bathroom and shower room doors started 24/02 and are to be completed by mid-April. All bedroom door top alarm installation has been completed in accordance with ligature policy standards. Soap/towel dispensers to be trialled at Basildon MHU week commencing 9th March having been initially tested at AFC. If this testing in a live ward is successful then the revised fittings will be rolled out to all locations in a programme lasting 4 months.	Completed	
January 009/20	A detailed report of the financial implications of the nursing establishment review be provided to the Finance and Performance Committee.	NH	Mar 20	Establishment Review paper will be presented to F&P on 19 March 2020.	Completed	
January 010/20	Content and format of mortality / learning from deaths report to be reviewed/ improved to focus on learning and simpler presentation of data.	NH	Mar 20	Data presentation has now been simplified with more focus on learning. Quality Committee have been asked to comment on the new format at their next meeting on 13 March prior to it being presented to the Board.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
January 012/20	Confirm whether CMA is a CQUIN and if so, what is the financial implication of non-achievement.	NL	Mar 20	The answer is that the full CMA CQUIN ended last financial year. This year there is CQuin that followed on with part of it, Alcohol and Tobacco, assessment and follow up/referral on for treatment, and this one we are highly likely to fully achieve because we have surpassed the requirements every quarter, with Q4 to go. In the very unlikely event we missed the target the financial implication would be 28k based on today's figures, but these figures improve every day and the financial implications consequently improve every day.	Completed	
January 012/20	Identify learning from EU Exit planning and present this to the Board of Directors.	NL	Mar 20	On agenda for Board meeting March 20. FS to develop this	Completed	
January 012/20	Board seminar discussion regarding transformation to be scheduled.	FS/NL	Mar 20	Included on Agenda for Seminar 29 April 2020.	Completed	
January 023/20 (i)	Confirm current data and forecast for achieving target of 20% reduction in prone restraint to J.Jones	NH	Feb 20	Current data confirmed with J Jones. Reduction currently stands at 14% of all restraints and 6% specifically on prone although we are awaiting updated data from Performance following the introduction of safety pods etc.	Completed	
October Public Q	Share CQC guidance regarding long term segregation with PE and have discussion following the Board meeting.	NH	November 2019	CQC guidance sent to PE 20 November. NH and PE discussed issue at the COG meeting 13 November	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
October 200/19	The timescale for developing the suicide prevention and QI dashboards to be confirmed.	NH/ MM	November 2019	Quality Account content reviewed in respect of suicide prevention dashboard as misleading. By August 2019 a suicide prevention dashboard will be in place to track and monitor progress on the ten key parameters for safer mental health services. Revised wording now: By August 2019 a suicide prevention action plan will be in place to track and monitor progress on the ten key parameters for safer mental health services. Action plan in place supported by work streams to ensure delivery. New separate action (with Mar 20 timescale) is: Dashboard to be developed against action plan to monitor delivery at service level. QI dashboard: Quality Account action is - By September 2019 to have in place a dashboard against all quality priorities. Update: Dashboard is in place against a number of priorities with further work scheduled for roll out against all areas.	Completed	
October 207/19	Future transformation progress reports to explore workforce risks and mitigation in more detail.	NL/SL	November 2019	Transformation report presented November has focus on workforce issues	Completed	
September 174/19	Quality Committee Terms of Reference to be revised to reflect establishment of new QI and Innovation sub-committee.	AS/NH	November 2019	TOR revised and approved by Quality Committee 14 November 2019	Completed	
July 149/19	Quality Committee to be provided with an update on implementation of the LD Improvement Standards.	AS/NH	November 2019	Quality Committee 14 November received update	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
October 209/19	CQC Update – the Board delegated authority to the Quality Committee to approve the CQC action plan as a result of the Well Led Inspection held July/August 2019, prior to submission on 20 November 2019.	AS/NH	November 2019	Draft action plan considered by Quality Committee 14 November 2019. Final action plan approved by Chairs action and submitted to CQC by deadline of 20 November 2019. Presented to Board of Directors at agenda item 9a.	Completed	
July 150/19	Ensure that any target dates missed within Quality Priorities include an explanation in future reports.	NH	September 2019	Update 25/9: Addressed in report presented to September Board of Directors.	Completed	

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

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
- Service Visits
- CEO Transition
- Executive Appointments
- Medical Education and Student Nursing / Anglia Ruskin University
- Governor Elections

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
29 July 2020

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

You will be fully aware of the Coronavirus infection spreading in the UK and abroad in the media, with the situation regarding Covid-19 changing rapidly. 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 several times a day as the situation develops further. The Trust is fully engaged with 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 wish to extend our thanks to our dedicated staff who have continued to provide services to our patients and service users in light of tremendous challenges and uncertainty.

2.2 CEO Transition Arrangements

I am delighted that our new CEO, Paul Scott, will be taking up his CEO designate role full time with EPUT from 24 August. He will be undertaking orientation and a systematic programme of service visits over the first three weeks, including strategic meetings with our partners and stakeholders. Paul is eager to meet as many staff as possible across our service footprint. Sally Morris will formally hand over CEO responsibilities and accountability to Paul at the end of September, when she will move into her accrued leave period. I am hugely indebted to both Sally and Paul who are already actively working together to ensure business continuity and seamless leadership transition.

2.3 Chair and NED Service Visits

Service visits, including fifteen steps quality visits with Governors, have had to be temporarily suspended in light of government guidance due to Covid-19. These will be restored at the earliest safe opportunity. However, in line with the Trust's ambition to utilise digital technology, there is the potential for 'virtual' service visits whereby Non-Executive Directors have the opportunity to speak to staff via Microsoft Teams; Sally announced this during her weekly brief broadcast, advising that any teams that would like a 'virtual visit' make contact with the Communications Team for this to be arranged. This is being actively taken forward and the first "pilot" visits are arranged. The clear intention is to evaluate the effectiveness and roll these out more widely to also include Governor representatives as feasible in the next round.

2.4 Executive Appointments

Following the announcement that our current Executive Chief Finance Officer Mark Madden intends to retire in October 2020; the Trust worked with an executive search consultancy to assist with the recruitment process for his successor. We had a strong short list of four and following a robust interview process, I believe we have made an excellent appointment in Trevor Smith. Trevor brings a wealth of experience and system knowledge; and we look forward to welcoming Trevor to the Trust in September t.b.c.

Andy Brogan, Executive Chief Operating Officer and Deputy Chief Executive will also be leaving the Trust in the autumn. Andy is returning to his nursing roots and will be

taking up the position of Chief Nurse at St Andrew's Healthcare. Andy has been with the Trust for 11 years, having joined EPUT's predecessor organisation SEPT in 2009. Andy will be greatly missed, and I'm sure you will join me in wishing him every success in his new role. The incoming Chief Executive, Paul Scott, will confirm operational arrangements over the next few weeks to ensure that there is a smooth leadership transition and that service delivery is appropriately managed and protected.

2.5 Medical Education and Student Nursing / Anglia Ruskin

Sean Leahy and I recently had a fruitful meeting with the senior team from the Faculty of Health at Anglia Ruskin University. We discussed how we can work together to significantly grow the nursing student numbers and also discussed mutually beneficial developments in postgraduate medical education. The undergraduate medical school continues to flourish.

2.6 Governor Elections

The election process for new Governors has commenced. I extend sincerest thanks on behalf of the whole Board of Directors and the Trust Secretary's Office team to all retiring Governors for everything you have done to support EPUT and its predecessor organisations during your terms of office. To those of you who are standing for re-election, we wish you well. I look forward to working with the refreshed Council of Governors on confirmation of the election results and updated membership in September.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

3.1 Chief Coroner's Guidance No. 37 – Covid-19 Deaths and Possible Exposure in the Workplace

The Chief Coroner's Guidance No 37 – "COVID-19 Deaths and possible exposure in the workplace" was amended on 1st July 2020. This updates the original Guidance NO 37 which was issued on 28 April 2020. The Guidance is designed to assist coroners to continue to exercise their judicial decisions independently and in accordance with the law. For Information: Link

3.2 Liberty Protection Safeguards Delay Unit April 2021

The new regime of Liberty Protection Safeguards, replacing DoLS, will now not come into force this October and implementation has been put back to April 2022. For information: Link

3.3 NHS Outcomes Framework Indicators – May 2020 Release

The Framework provides an overview of how the NHS is performing. For information: Link

4.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by

Angela Horley
PA to Chair, Chief Executive and NEDs

On behalf of

Professor Sheila Salmon
Chair

		Agenda Item No: 6a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29th July 2020**

Report Title:	**Quality and Performance Scorecards**					
Executive/Non-Executive Lead:	Sally Morris 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 "hotspots". 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

Due to the current COVID-19 pandemic full performance reporting has been suspended leaving focus on hotspots and national indicators. Information for all other indicators continues to be captured and monitored by other teams and services, and where possible via live dashboards and reports. With the continued monitoring of these indicators through other means, any risks identified will continue to be highlighted to the organisation. This consistent monitoring is evidenced in our reporting of ligature incidents which whilst suspended in this report, are still being reviewed case by case and monitored through the Ligature Risk Reduction Group.
Full reporting is expected to resume gradually in August 2020.

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

One hotspot (variance against target/ambition) has been identified at the end of June 2020 and is summarised in the Quality and Performance Reporting Hotspots Scorecard. This is a new hotspot identified for June:

- Timeliness of Data Entry

There are no Hotspots which are Oversight Framework indicators for June 2020.

There are no hotspots in the EPUT Safer Staffing Dashboard for June 2020.

The CQC Action Plan has been revised and redeveloped to ensure it is reflective of the current position. This new Reset action plan is summarised in the CQC Scorecard. There are no hotspots identified and no actions past timescale for June 2020.

In June 2020 there remains one hotspot identified within the Finance scorecard which is Cost improvement Programmes. The CIP Programme continues to be affected by the response to COVID-19 and the emergency finance regime.

Summary of Key Issues
Please note the Quality Account is no longer a part of Quality & Performance reporting. The Quality Account action plan is now held and reported by members of the Quality Committee. 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**	

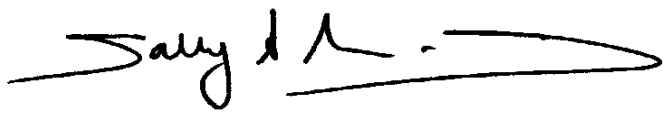
Acronyms/Terms Used in the Report			
ALOS	Average Length Of Stay	FRT	First Response Team
AWoL	Absent without Leave	FTE	Full Time Equivalent
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies
CHS	Community Health Services	MHSDS	Mental Health Services Data Set
CPA	Care Programme 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 Sally Morris
Job Title Chief Executive

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

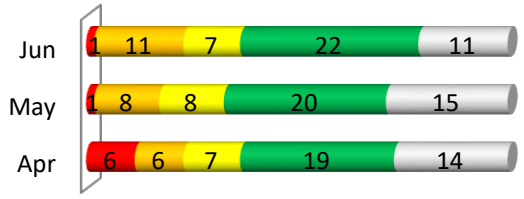
How is data presented?

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	Emerging Risk EPUT is performing under target in current month/ Emerging Trend	Hot Spot 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	Trend Depicts current trend and colour coded accordingly

SECTION 1 - Performance Summary

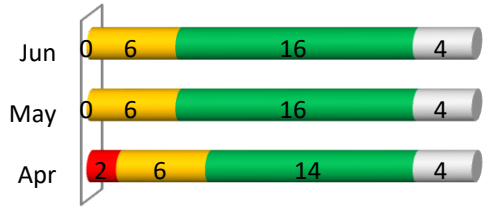
Hotspots Summary of Quality and Performance Indicators (Pg 6)



June Hotspots

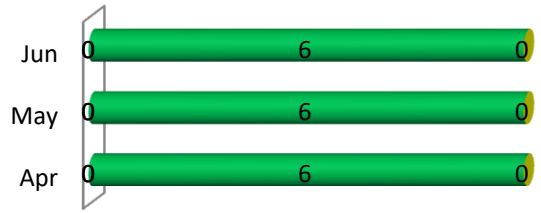
- 2.3 Timeliness of Data Entry (Pg 6)

Summary of Oversight Framework Indicators (Pg 7)



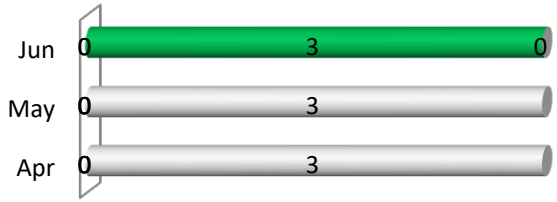
No hotspots are identified within the Oversight Framework.

Summary of Safer Staffing Indicators (Pg 18)



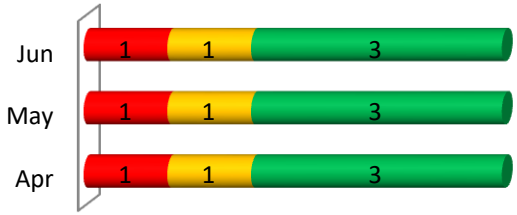
No hotspots identified within the Safer Staffing scorecard.

CQC Summary (Pg 20)



No hotspots are identified within the CQC Summary.
The CQC Action Plan has been revised and redeveloped to ensure it is reflective of the current position. This CQC progress is now monitored as a Reset Action Plan.

Finance Summary (Pg 22)



June Hotspots

- Cost improvement Programmes

SECTION 2 - EPUT Quality and Performance Reporting Hot Spots Scorecard

For Note:

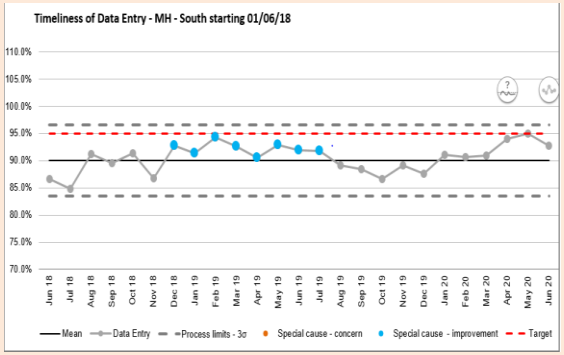
- MH Serious Incidents: In June there were 11 Mental Health serious incidents within the Trust, this represents an increase from our position in May however overall EPUT is continuing to see a reducing trend.
- CHS Serious Incidents: Zero Community Health serious incidents were reported in June and year to date, and there is no significant trend following analysis.

Click here to return to Summary

<table>
<tr><th colspan="8">Effective Indicators</th></tr>
<tr><th rowspan="2">RAG</th><th rowspan="2">Ambition / Indicator</th><th colspan="2">Position M3</th><th rowspan="2">Trend</th><th rowspan="2">Nat RAG</th><th rowspan="2">Narrative</th><th rowspan="2">Recovery Date</th></tr>
<tr><th>Perf</th><th>RAG</th></tr>
<tr><td rowspan="2">2.1 Timeliness of Data Entry

Committee: FPC
Indicator: Local
Data Quality RAG: TBC</td><td colspan="7">Hotspot
Timeliness of Data Entry has again increased to a hotspot risk as Mobius MH data has reduced to 92.8% in June.

Data Entry MH services (on Mobius) achieved 92.8% in June 20 against target of 95%. Trend analysis shows improvement had been made against this target in April and May. In June there were six (out of 11) MH Services below target. There is one service below 90%.

Late data entry has a significant impact on Trust reported performance and internal figures being at variance with national figures.
Timeliness of Data Entry is monitored on a weekly basis via reports that are displayed on the Intranet, the Performance team work with those staff who have missing Diary Sheet entries for the days showing on the report.
This indicator is measuring the % of Diary Sheets that have been submitted for the period. This indicator is dependent on teams ensuring the staff within the team are correct along with the days they work, this prevents the process believing there is activity missing when there isn't due to incorrect days submitted for the staff member.</td></tr>
<tr><td>2.2.2 Timeliness of data entry - Continuation Sheets Completed (Mobius)
Target 95%</td><td>92.8%</td><td>●</td><td>Above Target = Good
 
</td><td>●</td><td>Improvement in April & May noted</td><td>N/A</td></tr>
</table>

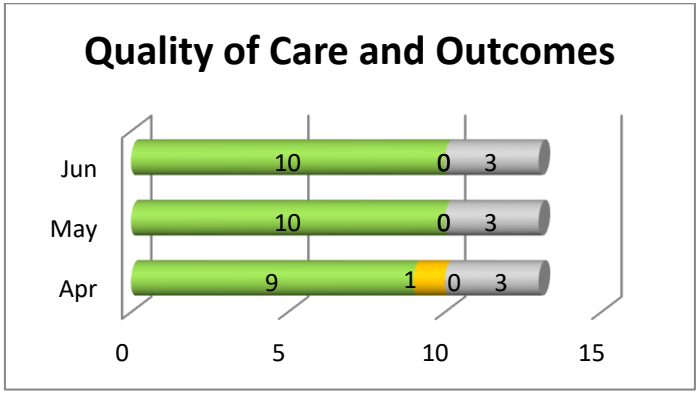
Click here to return to Summary

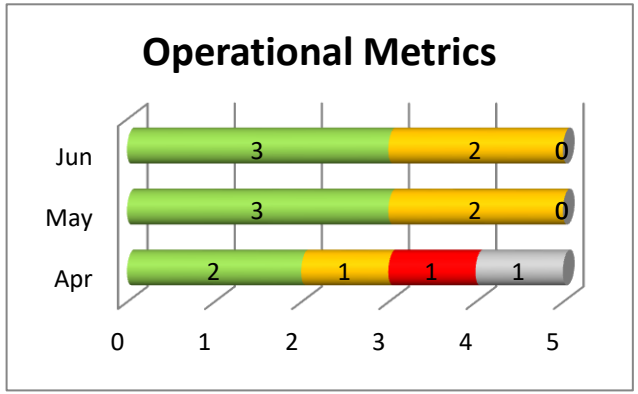
SECTION 3 – Oversight Framework

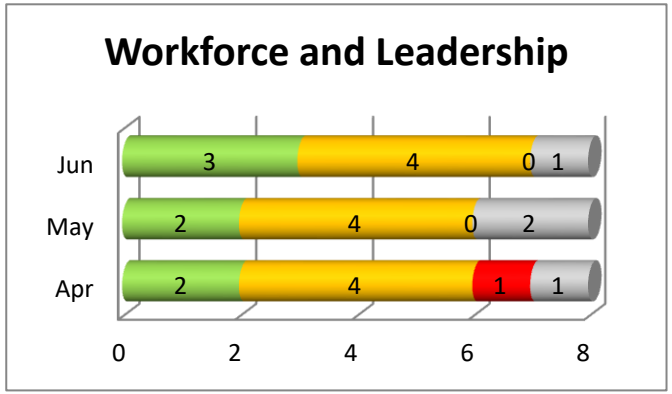
Click here to return to Summary

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 potentially an emerging risk (colour coded Amber) or risk (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.





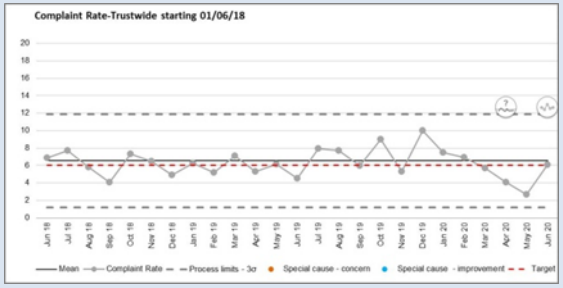


Hotspots

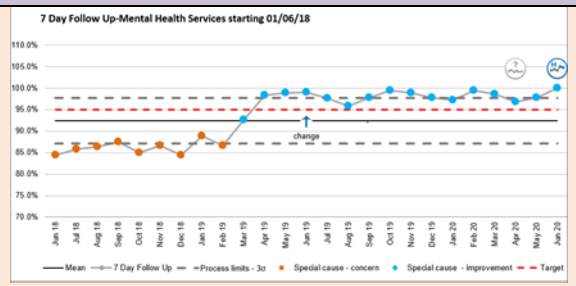
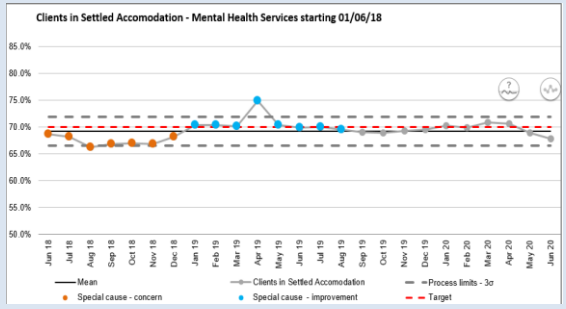
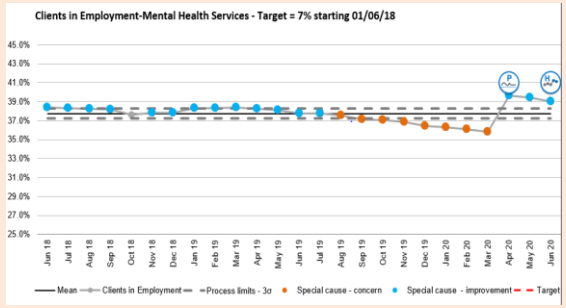
There are no Oversight Framework hotspots identified for June 2020.

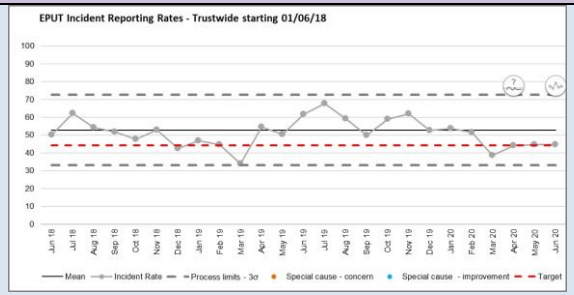
Emerging Risks (6 emerging risks)

- Data Quality Maturity Index (DQMI)
- Out of Area Placements
- Staff Survey indicators (4)

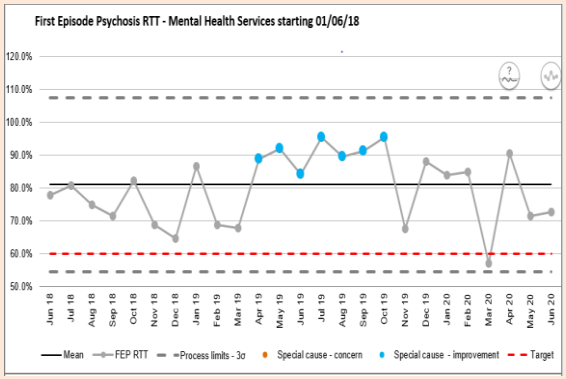
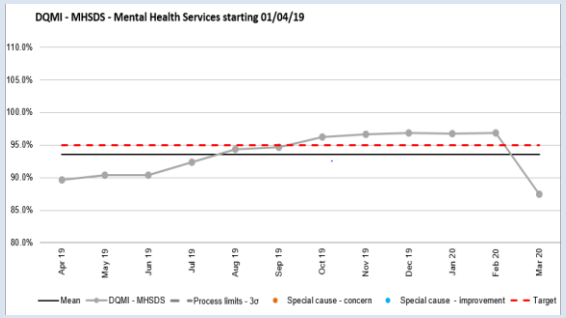
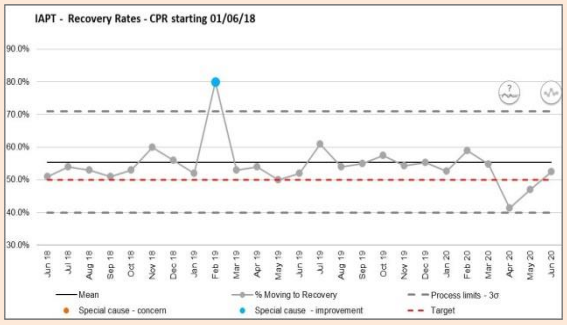
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1 CQC Rating Committee: FPC Data Quality RAG: **Green**	CQC rating of Good or above (no target set)	Good	●	Achieved overall “Good” with Outstanding for Caring Oct 2019			N/A
4.1 Complaints Committee: FPC Data Quality RAG: **Green**	Written Complaint Rate (no target set)	6.1	●	Below Target = Good 	●	An improving emerging trend of reduction	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 Data Quality RAG:	Occurrence of a Never Event in last 6 months (no target set)	0	●	Year to Date 0	●	Monitored over six-month rolling period	N/A

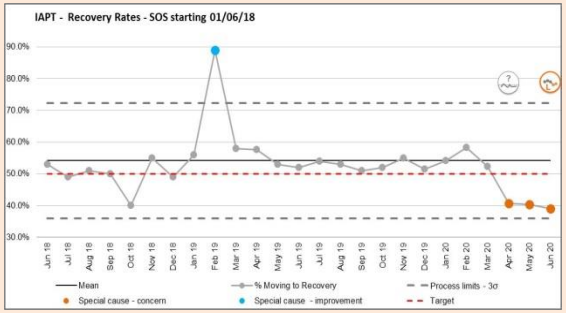
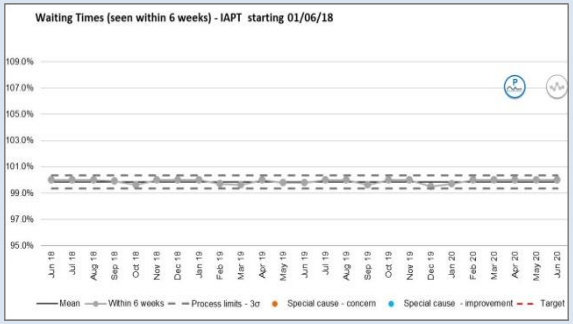
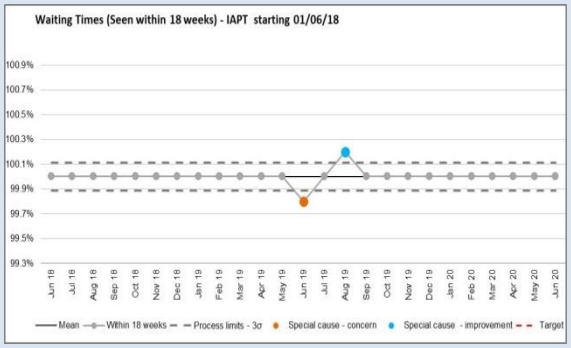
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Blue							
3.1 Patient MH Survey Data Quality RAG: **Green**	CQC community mental health survey (no target set)		●	EPUT achieved the same or better in all 11 domains in the 2019 survey	●	Action plan in place and all actions within timescales	N/A
3.3.1 Patient FFT MH Committee: Quality Data Quality RAG: **Green**	Mental health scores from Friends and Family Test – % positive (extremely likely or likely to recommend) **Target = 88.3%**		●			Publication suspended over Covid period	N/A
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%**		●		●	Publication suspended over Covid period	N/A
2.8.1 7 Day Follow Up	95% of people on Care programme approach (CPA) are followed up within 7 days of	100%	●	Below Target = Good	●	Trend analysis shows Special Cause Variation of improving nature	N/A

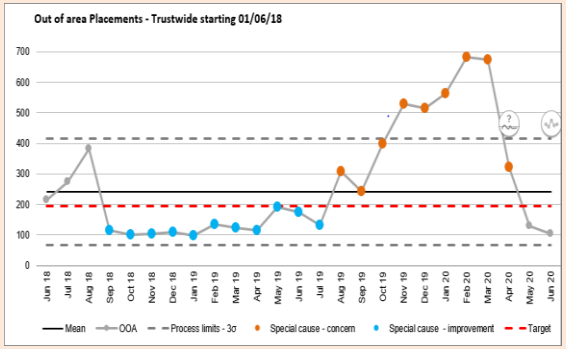
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Data Quality RAG: **Green**	discharge from hospital **Target 95%**						
2.4 Settled Accomodation Committee: Quality Data Quality RAG: **Green**	% clients in settled accommodation (no target set) **LA Target 70%**	67.8%	●	Trend above Target = Good 	●	Below target in June 2020. Reduction in Paris data noted (67.0% in June)	N/A
2.5 Employment Committee: Quality Data Quality RAG: **Green**	% clients in employment (no target set) **LA Target 7%**	39.0%	●	Trend above Target = Good 	●	Assurance indicates consistently meeting target.	N/A
1.8 Patient Safety Incidents	Potential under-reporting of patient safety incidents **Target >44.33**	44.8	●	Trend above Target = Good	●	No significant trend noted however performance is inconsistent. A 6 monthly audit refreshed the data, therefore the stable numbers observed in Q1 are likely to change. CQC Insight Report April 2020: Mar 19 – Feb 20 Potential Under	N/A

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Data Quality RAG: **Amber**						Reporting of Incidents shows EPUT with a ratio of 0.4, above National average of 0.2.	
1.15 Under 16 Admissions Committee: FPC Data Quality RAG: **Green**	Admissions to adult facilities of patients under 16 years old	0	●	Zero admissions in June and YTD.	●		N/A

Click here to return to Summary

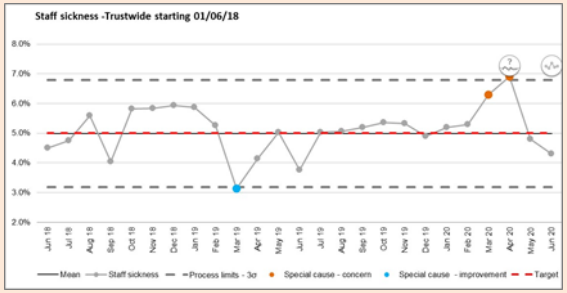
Operational Metrics							
RAG	**Ambition / Indicator**	**Position M2**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.6 First Episode Psychosis Committee: Quality Data Quality RAG: **Green**	>56% of people with a first episode of psychosis (FEP) begin treatment with a NICE-recommended care package within two weeks of referral	72.7%		Trend above Target = Good 		Target changed effective April 20 (from 56% to 60% 6 / 22 Breached in June : 1 / 2 Mid Essex CCG 1 / 2 North East Essex CCG 1 / 6 West Essex CCG 1 / 4 Basildon & Brentwood CCG 1 / 2 Southend CCG 1 / 3 Thurrock CCG Teams are currently experiencing issues with clients engaging via Video Calls during COVID19 pandemic	N/A
2.2 DQMI Committee: FPC Data Quality RAG: TBC **Green**	Data Quality Maturity Index (DQMI) – MHSDS dataset score above 95% **Target 95%**	87.5%		Trend above target = good 		Reduction in compliance due to seven new fields required in the national submission, that are included in the overall score from March 2020	Dec 20
2.16.3/4 IAPT Recovery Rates Committee: FPC Data Quality RAG: **Green**	Improving Access to Psychological Therapies (IAPT) /talking therapies 50% of people completing treatment who move to recovery **Target 50%**	CPR 52.5%		Trend above target = Good 		In April the IAPT service saw a higher than usual rate of self-discharges mid therapy. This was due to patient concerns around Covid-19.	Part of Reset Plan

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M2**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
		SOS 39%	●	Trend above target = Good 	●	In April the IAPT service saw a higher than usual rate of self-discharges mid therapy. This was due to patient concerns around Covid-19.	
2.16.5/6 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	Improving Access to Psychological Therapies (IAPT)/talking therapies b. waiting time to begin treatment: i) 75% within 6 weeks ii) 95% within 18 weeks	i) 100%	●	Trend above target = Good 	●	Consistently passing target	N/A
		ii) 100%	●	Trend above target = Good 	●		

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M2**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.5 Out of Area Placements Committee: FPC Data Quality RAG: **Amber**	Continued reduction in Out of Area Bed days to 0 by 2020/21	104		Below Target = Good 		Out of Area Placements has been downgraded to an Emerging Risk due to trend analysis showing a reducing number of OOA placement Occupied Bed Days however, this is in part due to the current COVID19 pandemic. In June EPUT placed one new client out of Area (PICU), Four remain (two in locked Rehab & two in PICU) OOA at the end of June. No patients were repatriated in June. The total Occupied bed days for all out of area placements in June was 104. Action plan is in place to address OOA placements in addition to the Flow & Capacity principles and daily SITREPS. It has been noted that Locked Rehab will not be counted towards this figure going forward. The Phase 3 return for the Trust confirms the approach of 85% bed capacity for social distancing, this increases the risk of need for OOA in the event of a covid driven demand surge.	N/A

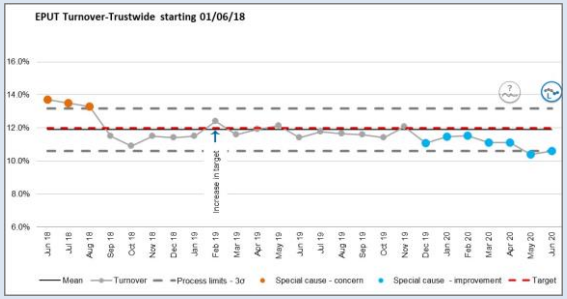
<table>
<tr><th colspan="7">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M3
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td>5.3.1 Staff Sickness

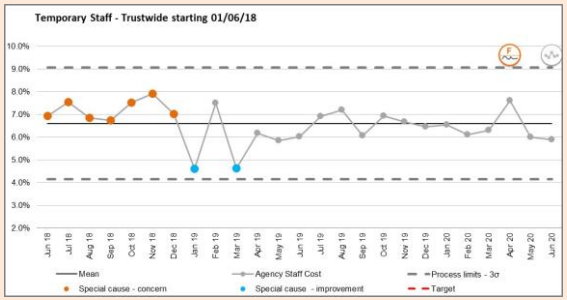
Committee: FPC
Data Quality RAG: TBC</td><td>Staff Sickness Rates
(no target set)

MH Benchmark 6%</td><td>May 4.8%
June Draft 4.3%</td><td>●</td><td>Below Target = Good
  </td><td>●</td><td></td><td>N/A</td></tr>
<tr><td>5.2.2 Turnover

Committee: FPC
Data Quality RAG: Blue</td><td>Staff turnover rates
(no target set)

(Benchmark 2017/18
MH 12%/CHS 12.1%)

EPUT Target <12%</td><td>10.6%</td><td>●</td><td>Below Target = Good
  </td><td>●</td><td>Special Cause of improving nature of lower pressure due to (L)ower values.</td><td>N/A</td></tr>
<tr><td>5.7.3 Temporary Staff

Committee: FPC
Data Quality RAG: Blue</td><td>Proportion of temporary staff Agency staff costs
(no target set)</td><td>5.9%</td><td>●</td><td>Below Target = Good
  </td><td>N/A</td><td>No significant trend noted</td><td>N/A</td></tr>
<tr><td>5.5 Staff Survey

</td><td>Place to Work of Receive Treatment</td><td colspan="3">Recommendation of the organisation as a place to work or receive treatment

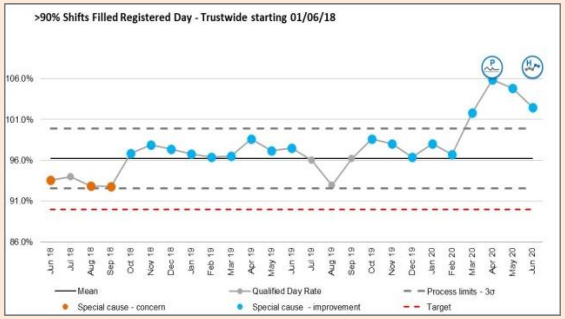
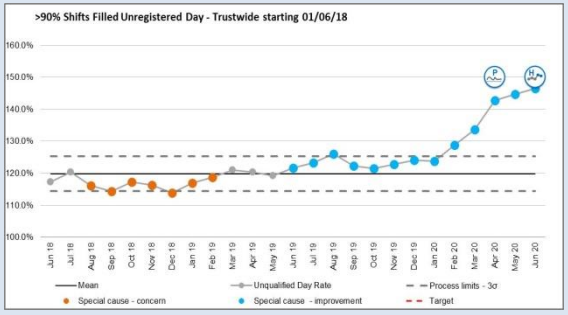
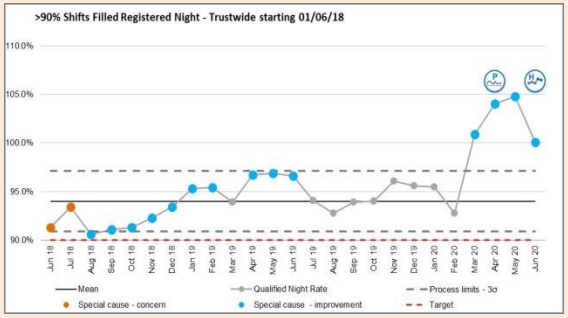
<table><tr><th>Staff Survey 2019</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr><tr><td>C21a Care of patients / Service users is my organisations top priority</td><td>74.3%</td><td>76%</td><td>Better than last year.</td><td>●</td></tr><tr><td>C21c I would recommend my organisation as a</td><td>58.9%</td><td>62.4%</td><td>Worse than average</td><td>●</td></tr></table></td><td></td><td></td></tr>
</table>

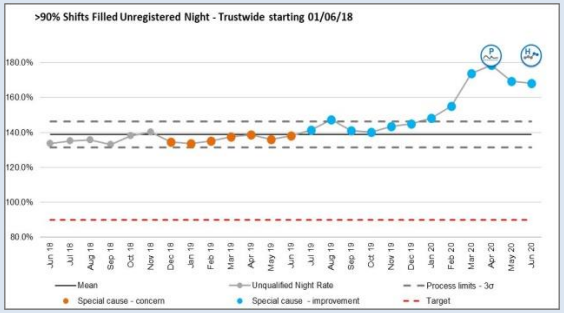
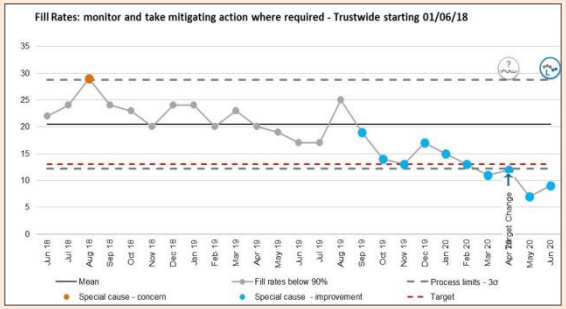
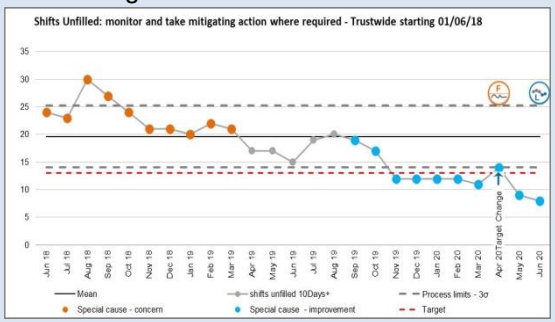
<table>
<tr><th colspan="8">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M3
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td rowspan="4">Committee: FPC
Data Quality RAG:
Green</td><td></td><td colspan="6"><table>
<tr><td>place to work</td><td></td><td></td><td></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><td></td></tr>
<tr><td>Harassment, Bullying and Abuse</td><td colspan="6">Support and compassion average rating of:
• % experiencing harassment, bullying or abuse from staff in the last 12 months
• % not experiencing harassment, bullying or abuse at work from managers in the last 12 months
• % not experiencing harassment, bullying or abuse at work from managers in the last 12 months
<table>
<tr><th>Staff Survey 2019</th><th>EPUT</th><th>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><td></td></tr>
<tr><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>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><td></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
<table>
<tr><th>Staff Survey 2019</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr>
<tr><td>Q14 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age</td><td>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>Trusts in lowest third across the sector will represent a concern</td><td></td></tr>
<tr><td></td><td colspan="6">Inclusion (2)
The BME leadership ambition (WRES) re executive appointments.
Trusts in lowest third across the sector will represent a concern</td><td></td></tr>
</table>

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
		This indicator will form part of the Workforce Race Equality Action Plan (This is due to be devised in the summer 2020 when new set of WRES results become available).					

SECTION 4 – Safer Staffing Summary

Click here to return to summary page

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	102.5%	●	Trend above target = good 	●	The following wards were below target in June: Nursing Homes: Clifton Lodge Older: Ruby	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	143.5%	●	Trend above target = good 	●	The following wards were below target in June: Older: Kitwood CHS: Avocet & Poplar	N/A
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	100.1%	●	Trend above target = good 	●	The following wards were below target in June: Older Adult: Kitwood, Henneage, & Gloucester Nursing Homes: Rawreth Court CHS: Poplar	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts	168.1%		Trend above target = good 		The following ward was below target in June: Adult: Kelvedon	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required	9		Below Target = Good 		The following wards had fill rates of <90% in June: Adult: Kelvedon Older Adult: Gloucester, Henneage, Kitwood, & Ruby Nursing Homes: Clifton Lodge & Rawreth Court CHS: Avocet & Poplar	N/A
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	8		Below Target = Good 		The following wards had more than 10 days without shifts filled in June: Adult: Kelvedon Older Adult: Kitwood, Ruby, & Henneage Nursing Homes: Clifton Lodge & Rawreth Court CHS: Avocet & Poplar	

SECTION 5 – CQC

Click here to return to summary page

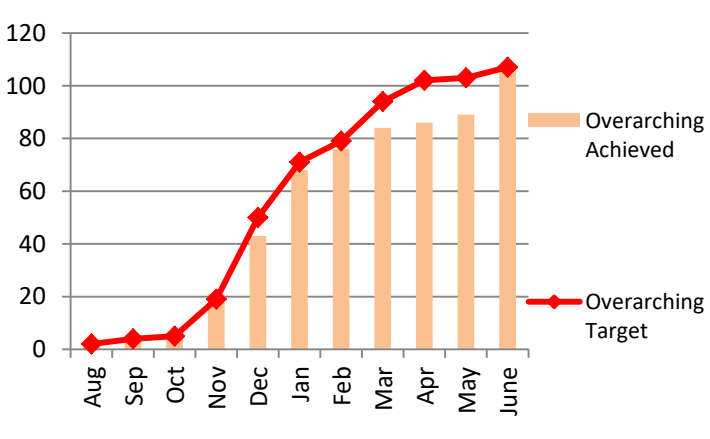
At the Executive CQC Steering Group on 2nd June the Trust CQC action plan was discussed in detail and it was agreed this needed to be revised to ensure it was fully reflective of the current position. Following this discussion and review, the Trust has developed a reset of the original action plan, which aims to resolve the remaining issues identified by the CQC from the inspection and to ensure actions have been fully embedded in practice and facilitates change. The action plan has been developed with consideration of all previous actions taken and those that remained open to ensure these continued to be taken forward to address the original issues identified.

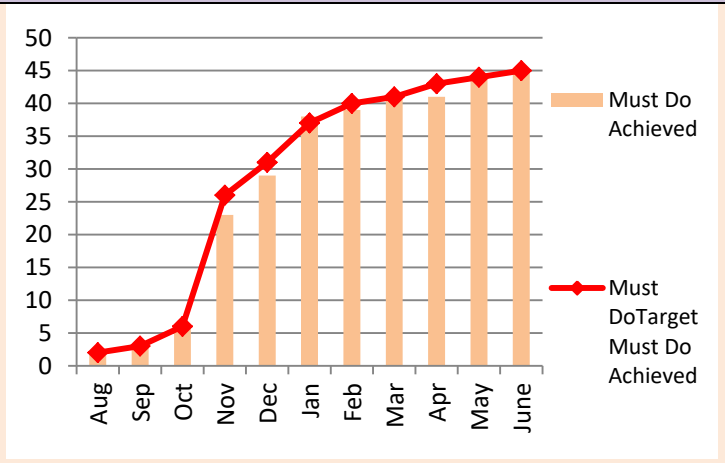
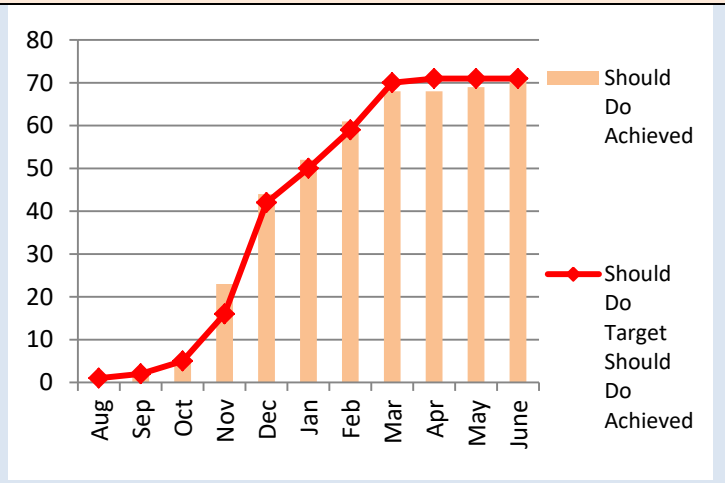
It should be recognised that tremendous learning and innovation has occurred as part of responding to the pandemic that will contribute to the Trust's outstanding ambition and as such the reset of the action plan has taken some of these changes into new actions to reflect on the practice changes that took place during Covid19 and to identify the different actions needed going forward.

At the Trust CQC engagement meeting on the 10th June; the plans for the reset approach were shared with the CQC, it was agreed to be a pragmatic approach and one which the CQC would endorse.

As at the end of June 2020, all 223 internal actions on the original action plan were closed. 13 internal actions were considered still relevant therefore transferred onto the reset action plan, some with some minor adjustments in order to fully meet the CQC issues identified. 3 internal actions were previously closed, however following review, were re-opened due to the current measures not being sufficient to cover the issue originally highlighted by the CQC. 4 internal actions were closed as it was identified that the actions would not be progressed and new actions developed; within the reset action plan, to address the final areas remaining from the original issues identified.

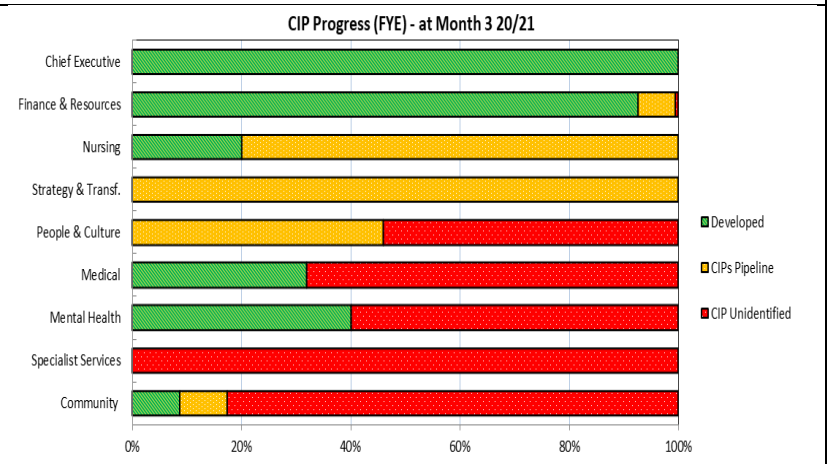
The Reset Action plan consists of 31 Internal Actions to ensure the remaining 14 CQC Requirement Actions are fully met.

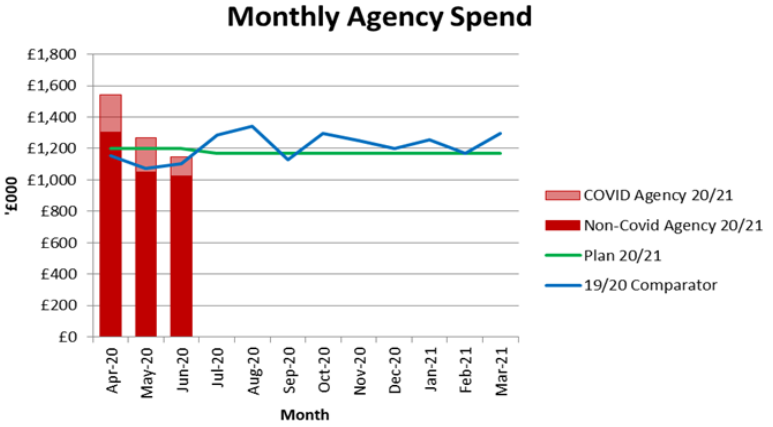
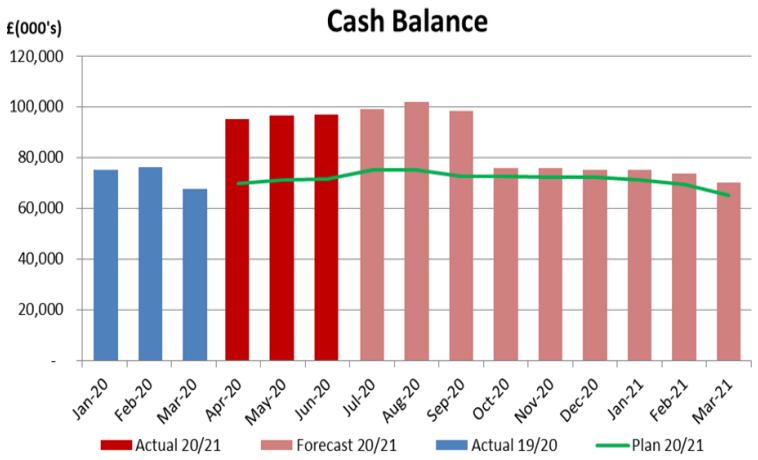
RAG	Ambition / Indicator	Position	Trend (below target = good)	Narrative
CQC Over-arching Actions	There will be 0 CQC Overarching Must Do and Should Do actions past timescale	At the end of June 0 actions were past timescale		0 Overarching CQC Must Do and Should do actions were past timescale at the end of June 2020.

RAG	Ambition / Indicator	Position	Trend (below target = good)	Narrative
CQC Must do Actions	There will be 0 CQC Must Do actions past timescale	At the end of June 0 actions were past timescale		0 CQC Must Do actions were past timescale at the end of June 2020.
CQC Should do Actions	There will be 0 CQC Should Do actions past timescale	At the end of June 0 actions were past timescale		0 CQC Should Do actions were past timescale at the end of June 2020.

SECTION 6 - Finance

Click here to return to summary page

RAG	Ambition / Indicator	Position	Trend
Financial Risk Rating / Use of Resources	NHS Improvement's metric of financial risk	Due to the COVID-19 pandemic, for 2020/21 the Trust is operating under an Emergency Financial Regime and currently NHSI is not monitoring Trust's against the Use of Resources Rating.	
Year to Date Operating Deficit	Operating Income and Expenditure	Due to the COVID pandemic, the Trust continues to operate under an Emergency Financial Regime which is expected to be in place for Months 1 - 5 inclusive and potentially also Month 6. The Trust's draft Continuing Operating performance at the end of Month 3 - June 2020 is break-even (£0). The draft 20/21 plan submitted in March 2020, forms the basis of the budgets the Trust is currently reporting against internally. During the Emergency Financial Regime, all NHS provider organisations reporting a deficit will receive Top Up Payments to adjust their reported position to breakeven. The financial arrangements for the second half of the second half of the year are still being developed.	
Cost Improvement Programmes	Planned improvement in productivity and efficiency	The Trust's CIP target for 20/21 is £11.7m, including 19/20 recurrent CIP shortfall brought forward of £5.1m. The CIP Programme is affected by the response to COVID-19 and the Emergency Financial Regime. As at Month 3, Recurrent savings of £5.0m has been identified; £4.2m is delivered and £2.5m actioned in the general ledger. In Year savings of £6.3m has been identified; £5.5m is delivered and £3.9m actioned in the general ledger. The Trust focus must be on the Recurrent savings for when the emergency finance regime ends.	

RAG	Ambition / Indicator	Position	Trend
Agency Costs	Control of Agency Costs	The Trust's Agency target for 2020/21 is £14,118k. The total expenditure at the end of Month 3 on Agency Staff was £3,960k against the Trust plan of £3,594k giving an adverse variance of £366k. The impact of COVID expenditure in Month 3 was £582k. The 19/20 comparator is last year's agency spend.	
Cash Balance	Cash Balances	The cash balance at the end of June is £97,160k compared to an adjusted plan of £68,155k. This variance largely relates to the impact of the current cash regime, whereby the Trust received an additional block payment in April. NHSI have confirmed that the current NHS block income arrangements will remain in force until the end of month 6 at least. For the forecast cash position, the Trust has not factored in any block income during month 7 with payments reverting to monthly contract payments thereafter.	

END

		Agenda Item No: 6b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	**Patient Led Assessment of the Care Environment PLACE 2019 Results**					
Executive/Non-Executive Lead:	Mark Madden, Chief Finance Officer					
Report Author(s):	Fiona Benson, Head of Estates and Facilities					
Report discussed previously at:	Estates; Facilities Property and Project Senior Management Team					
Level of Assurance:	**Level 1**		**Level 2**	√	**Level 3**	

Purpose of the Report		
This report is to inform the Board of Directors of the results of the 2019 Patient Led Assessment of the Care Environment (PLACE)	**Approval**	
	Discussion	
	Information	√

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

Summary of Key Issues

To inform the Board of Directors of the Trust's scoring of PLACE for 2019/20. The report notes the approach and scoring as a benchmark from the previous year, 2018/19 and against national standards.

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	
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			

Supporting Documents and/or Further Reading

Lead

Mark Madden
Executive Chief Finance Officer

Agenda Item: 6b
Board of Directors
Meeting: 29 July 2020

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Patient Led Assessment of the Care Environment PLACE 2019 Results

1.0 Purpose of the Report

The Trust is required to undertake a mandatory annual review assessing the quality of the hospital environment. Patient Led Assessment of the Care Environment (PLACE) is intended to put the perspective of the Service User at the centre of the assessment process. Teams of PLACE assessors evaluate the care environment reporting on how well the Trust is performing against the published criteria.

The purpose of this report will provide the Board of Directors with a detailed overview of how the Trust is performing against last year's results and benchmarked against other similar Trusts on a national level.

2.0 Executive Summary

In 2009/10 the Department of Health (DoH) made it mandatory for all NHS Trusts to declare their level of compliance through the "*Standards for Better Health*" initiative with three of the identified domains focusing on the patient experience.

The nature of PLACE assessments is to identify specific areas of improvement that require further investment by the Trust. It provides a 'snapshot' of how the Trust is performing against a range of non-clinical activities which impact on the Service User experience. The process recognises that areas highlighted for improvement are documented and addressed as either remedial maintenance or placed on a rolling Backlog Maintenance Programme to ensure that standards are maintained trust wide. 2018's PLACE assessment recorded areas for improvement and investment, which have been addressed and should be reflected in 2019's PLACE scores.

The Board of Directors have ultimate responsibility for ensuring that Service Users dignity, privacy, cleanliness, food and general building maintenance standards are not compromised or directly impacting clinical care provisions.

3.0 Inspection

2019's PLACE Assessments were carried out on twenty in-patient unit between the 24th September 2019 and the 26th November 2019. Each PLACE Assessment was coordinated by Estates and Facilities and the Trust Secretary's Office, to ensure that each PLACE Assessment Team has appropriate representatives including Service Users / Service User representatives (Volunteers) and Trust Governors and are following guidance received from NHS Improvement. Each PLACE Assessment team were briefed by Estates and Facilities representatives leading the assessment with the emphasis firmly placed on providing an accurate reflection of the views of Service Users and clinical staff.

Outcomes were discussed and agreed amongst members of each of the PLACE Assessment Teams. Areas not meeting the current standards were acknowledged and documented by each Estates and Facilities representative. Actions that were identified as Estates and Facilities responsibilities were logged onto the local task management system, for follow up by an Estates and Facilities hard or soft services maintenance staff to confirm and action route to resolution.

Actions have been discussed with clinical colleagues and a collaborative approach to address the local care environment has been established. Estates and Facilities staff are required to undertake a monthly audit of the care environment alongside a clinical representative. Through adopting this approach, the actions continue to be documented and monitored with mutual agreement regarding temporary measures, timescales, prioritisations and least restrictive practices to ensure that actions are addressed. It is essential that a collaborative approach is maintained, as the actions can have a direct impact on clinical service provisions and associated funding of clinical services. This should ensure that enhancements to the patient environment can be undertaken without compromising existing service standard.

The agreed actions arising from the detailed questions raised during the visits form part of a detailed action plan. The Estates and Facilities SMT is accountable for completion of the action plan in liaison with other departments.

It is important that the Trust recognises that an annual PLACE Assessment provides evidence toward compliance with regards to Infection Control, Hygiene, Privacy and Dignity elements identified as part of the published CQC Standards.

4.0 Results

NHSI published the PLACE scores into the public domain on the 30th January 2020 and the scores for EPUT as a whole are as follows:

Non Clinical Domain	2019 Score	National Average	2018 Score	National Average
Cleanliness	99.5%	98.6%	99.7%	98.5%
Food & Hydration	90.5%	92.2%	90.0%	90.2%
Privacy, Dignity & Wellbeing	84.9%	86.1%	89.2%	84.2%
Condition, Appearance & Maintenance	97.2%	96.4%	96.7%	94.3%
Dementia Friendly	95.1%	80.7%	87.5%	78.9%
Disability Access	84.7%	82.5%	90.4%	84.2%

A breakdown of the scores by site can be found in Appendix 1 & 2

5.0 Conclusion

It is noted that Food & Hydration did not achieve the national average by 1.7% and Privacy, Dignity & Wellbeing missed the national average by 1.2%.

Some of the generic issues raised against the two domains which did not achieve the national average included:

Privacy and dignity domain: Smoking on sites, seating in reception and outside the entrance, general appearance of outside areas to encourage usage and cleaning of window sills and frames.

To address the issue the Trust is reviewing the signage at site level to discourage smoking, and working with operational colleagues to raise awareness at a local level, is encouraging all areas to make suitable bids for charitable funds to improve the softer elements of the environment and is reviewing the trust specification for window cleaning.

Food and Hydration: the issues raised include the availability of hot meals at lunchtime, the availability of finger food and snacks throughout the day, how frequently the menu cycles are updated and whether the Trust is using ISO compliant packaging. The Trust is carrying out a review of its external food provider in November 2020 when these issues will be considered and changes to the overall specification across the Trust could be made. Any changes to the specification would need business case approval from the Trust Board.

It is important to note that different assessors must be taken into account when assessing the results. A number of assessors were new to the process this year and therefore differing perceptions on some of the answers supplied against the previous year's return.

Overall the 2019 PLACE Assessments had deteriorated on 2018's submission highlighting that Food & Hydration needs to be reviewed and the Privacy, Dignity & Wellbeing element need to be addressed over the coming months to ensure that the Trust continues to exceed the national average.

6.0 Recommendations

The Board of Directors is asked to consider the contents of this report.

7.0 Action Required

The Board of Directors are asked to:

1. Discuss and note the contents of this report

Report prepared by Fiona Benson, Head of Estates and Facilities

On behalf of

Mark Madden
Executive Chief Finance Officer

Appendix 1 - PLACE SCORE Compared Against the National Average

Site Name	Cleanliness (%)		Food Score (%)		Organisation Food Score (%)		Ward Food Score (%)		Privacy, Dignity & Wellbeing (%)		Condition, Maintenance & Appearance (%)		Dementia Friendly (%)		Disability Access (%)	
	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
National Average (%)	**98.58%**	**98.74%**	**91.25%**	**92.86%**	**89.85%**	**91.11%**	**92.71%**	**94.64%**	**86.33%**	**87.40%**	**94.20%**	**95.92%**	**81.77%**	**84.34%**	**86.21%**	**83.80%**
St. Margaret's Hospital	100.00%	100.00%	94.65%	90.95%	89.89%	83.70%	100.00%	100.00%	94.85%	90.76%	94.26%	99.07%	93.40%	97.05%	93.63%	92.16%
Rochford Community Hospital	100.00%	99.56%	89.66%	89.71%	87.16%	84.06%	91.34%	97.14%	93.70%	85.29%	99.74%	98.50%	91.26%	93.03%	94.48%	90.53%
Robin Pinto Unit	99.58%	98.67%	92.06%	90.95%	87.05%	83.70%	96.73%	100.00%	90.63%	76.60%	93.12%	98.08%	81.99%	-	77.72%	77.70%
Thurrock Community Hospital	100.00%	100.00%	94.34%	90.39%	89.45%	82.25%	100.00%	100.00%	95.95%	81.25%	98.28%	98.72%	92.92%	94.41%	95.58%	87.32%
The Brambles	98.68%	100.00%	-	-	-	-	-	-	83.87%	82.93%	97.13%	97.30%	-	-	75.00%	78.57%
Broomfield Hospital	99.36%	99.09%	83.64%	98.04%	72.88%	94.02%	87.01%	100.00%	76.54%	90.08%	93.70%	98.21%	69.62%	98.70%	78.27%	84.51%
Kings Wood Centre	100.00%	100.00%	83.83%	90.95%	72.16%	83.70%	96.92%	100.00%	70.93%	81.67%	94.30%	98.39%	72.73%	90.38%	83.87%	76.61%
The Lakes	99.86%	99.21%	81.18%	90.95%	72.09%	83.70%	88.44%	100.00%	70.00%	86.44%	96.70%	97.58%	-	-	80.57%	77.68%
Rawreth Court	100.00%	100.00%	92.15%	91.57%	87.16%	83.70%	96.79%	100.00%	95.59%	78.72%	99.30%	94.23%	93.95%	96.64%	96.87%	90.45%
Clifton Lodge	100.00%	98.23%	90.49%	93.04%	87.16%	86.23%	93.58%	100.00%	92.65%	76.60%	97.18%	90.38%	91.54%	95.15%	93.72%	90.45%
Brockfield House	99.80%	99.39%	95.26%	90.53%	89.73%	91.11%	99.36%	90.00%	97.62%	92.09%	99.07%	97.85%	-	-	96.82%	79.44%
St. Aubyns Centre	99.70%	100.00%	76.05%	88.48%	68.73%	83.70%	84.45%	94.44%	69.79%	86.21%	92.47%	98.44%	-	-	78.42%	76.85%
Wood Lea Clinic	99.79%	100.00%	91.51%	90.23%	86.41%	82.41%	100.00%	100.00%	87.50%	86.67%	97.46%	97.12%	-	-	82.99%	80.26%
Christopher Centre (Linden)	100.00%	98.53%	78.33%	90.52%	70.16%	83.15%	87.56%	100.00%	70.45%	78.79%	96.20%	95.16%	-	-	82.27%	61.36%
Landermere Centre	99.46%	100.00%	79.06%	91.06%	70.59%	84.06%	89.17%	100.00%	84.52%	83.05%	95.00%	98.44%	85.20%	95.55%	87.27%	88.64%
Mountnessing Court	98.95%	100.00%	92.30%	91.04%	87.16%	81.88%	97.43%	100.00%	94.87%	76.60%	94.67%	95.28%	94.10%	-	97.26%	77.98%
Basildon Mental Health Unit	99.30%	98.69%	91.45%	86.35%	87.16%	80.19%	95.72%	94.29%	91.23%	82.73%	99.18%	95.52%	91.36%	-	94.67%	86.11%

Essex Partnership University NHS Foundation Trust																
Chelmer and Stort	100.00%	100.00%	91.32%	91.06%	86.12%	84.06%	100.00%	100.00%	94.20%	86.15%	94.02%	98.75%	92.63%	-	84.25%	84.76%
Byron Court - 5 Health Close	100.00%	100.00%	95.36%	85.25%	89.73%	84.06%	100.00%	86.59%	92.98%	84.44%	98.91%	98.04%	-	-	92.80%	76.61%
Cumberledge Centre	100.00%		95.01%		88.91%		100.00%		88.89%		94.03%		-		93.38%	
Saffron Walden Community Hospital	100.00%	100.00%	90.91%	90.75%	86.31%	83.51%	96.80%	100.00%	93.80%	84.44%	94.97%	92.31%	96.55%	95.12%	96.26%	90.22%

Appendix 2 - PLACE SCORE Compared Against 2018

Site Name	Cleanliness (%)		Food Score (%)		Organisation Food Score (%)		Ward Food Score (%)		Privacy, Dignity & Wellbeing (%)		Condition, Maintenance & Appearance (%)		Dementia Friendly (%)		Disability Access (%)	
	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
St. Margaret's Hospital	100.00%	100.00%	94.65%	90.95%	89.89%	83.70%	100.00%	100.00%	94.85%	90.76%	94.26%	99.07%	93.40%	97.05%	93.63%	92.16%
Rochford Community Hospital	100.00%	99.56%	89.66%	89.71%	87.16%	84.06%	91.34%	97.14%	93.70%	85.29%	99.74%	98.50%	91.26%	93.03%	94.48%	90.53%
Robin Pinto Unit	99.58%	98.67%	92.06%	90.95%	87.05%	83.70%	96.73%	100.00%	90.63%	76.60%	93.12%	98.08%	81.99%	-	77.72%	77.70%
Thurrock Community Hospital	100.00%	100.00%	94.34%	90.39%	89.45%	82.25%	100.00%	100.00%	95.95%	81.25%	98.28%	98.72%	92.92%	94.41%	95.58%	87.32%
The Brambles	98.68%	100.00%	-	-	-	-	-	-	83.87%	82.93%	97.13%	97.30%	-	-	75.00%	78.57%
Broomfield Hospital	99.36%	99.09%	83.64%	98.04%	72.88%	94.02%	87.01%	100.00%	76.54%	90.08%	93.70%	98.21%	69.62%	98.70%	78.27%	84.51%
Kings Wood Centre	100.00%	100.00%	83.83%	90.95%	72.16%	83.70%	96.92%	100.00%	70.93%	81.67%	94.30%	98.39%	72.73%	90.38%	83.87%	76.61%
The Lakes	99.86%	99.21%	81.18%	90.95%	72.09%	83.70%	88.44%	100.00%	70.00%	86.44%	96.70%	97.58%	-	-	80.57%	77.68%
Rawreth Court	100.00%	100.00%	92.15%	91.57%	87.16%	83.70%	96.79%	100.00%	95.59%	78.72%	99.30%	94.23%	93.95%	96.64%	96.87%	90.45%
Clifton Lodge	100.00%	98.23%	90.49%	93.04%	87.16%	86.23%	93.58%	100.00%	92.65%	76.60%	97.18%	90.38%	91.54%	95.15%	93.72%	90.45%
Brockfield House	99.80%	99.39%	95.26%	90.53%	89.73%	91.11%	99.36%	90.00%	97.62%	92.09%	99.07%	97.85%	-	-	96.82%	79.44%
St. Aubyns Centre	99.70%	100.00%	76.05%	88.48%	68.73%	83.70%	84.45%	94.44%	69.79%	86.21%	92.47%	98.44%	-	-	78.42%	76.85%
Wood Lea Clinic	99.79%	100.00%	91.51%	90.23%	86.41%	82.41%	100.00%	100.00%	87.50%	86.67%	97.46%	97.12%	-	-	82.99%	80.26%
Christopher Centre (Linden)	100.00%	98.53%	78.33%	90.52%	70.16%	83.15%	87.56%	100.00%	70.45%	78.79%	96.20%	95.16%	-	-	82.27%	61.36%
Landermere Centre	99.46%	100.00%	79.06%	91.06%	70.59%	84.06%	89.17%	100.00%	84.52%	83.05%	95.00%	98.44%	85.20%	95.55%	87.27%	88.64%
Mountnessing Court	98.95%	100.00%	92.30%	91.04%	87.16%	81.88%	97.43%	100.00%	94.87%	76.60%	94.67%	95.28%	94.10%	-	97.26%	77.98%
Basildon Mental Health Unit	99.30%	98.69%	91.45%	86.35%	87.16%	80.19%	95.72%	94.29%	91.23%	82.73%	99.18%	95.52%	91.36%	-	94.67%	86.11%
Chelmer and Stort	100.00%	100.00%	91.32%	91.06%	86.12%	84.06%	100.00%	100.00%	94.20%	86.15%	94.02%	98.75%	92.63%	-	84.25%	84.76%

Essex Partnership University NHS Foundation Trust																
Byron Court - 5 Health Close	100.00%	100.00%	95.36%	85.25%	89.73%	84.06%	100.00%	86.59%	92.98%	84.44%	98.91%	98.04%	-	-	92.80%	76.61%
Cumberledge Centre	100.00%		95.01%		88.91%		100.00%		88.89%		94.03%		-		93.38%	
Saffron Walden Community Hospital	100.00%	100.00%	90.91%	90.75%	86.31%	83.51%	96.80%	100.00%	93.80%	84.44%	94.97%	92.31%	96.55%	95.12%	96.26%	90.22%

					Agenda Item No: 6c	
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**				**29 July 2020**	
Report title:	Learning from Deaths – Mortality Review Summary of Quarter 4 information					
Executive Lead:	Prof Natalie Hammond, Executive Nurse					
Report Author(s):	Michelle Bourner, Mortality Review Project Co-ordinator					
Report discussed previously at:	Mortality Data Group (virtually via email) Mortality Review Sub-Committee (22/05/20) Quality Committee (22/06/20)					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	
Risk Rating	**Low**		**Medium**		**High**	✓

Purpose of the Report

The attached report presents: • Information relating to deaths in scope for mortality review for Q4 2019/20 (1st January – 31st March 2020) together with updated information for previous quarters in 2019/20 and for 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 Quality Committee.	**Information**	✓
	Discussion	
	Decision	

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 62 deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in Q4. Whilst this is broadly consistent with other quarters (and with Q4 2018/19) in terms of overall numbers and remains within statistical control limits, some apparent variances in terms of deaths within particular functions have been identified and are explored within the attached report.

Of the 62 deaths, 14 were inpatient deaths and 18 were nursing home deaths. Of these 32 deaths, 30 deaths have been confirmed as due to natural causes. Two causes of death are currently under determination; both appear to be likely to be confirmed as natural causes.

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 there has been an improvement in the timeliness of consideration via the Deceased Patient Review Group. 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 further reviewed as part of implementation of the new national Patient Safety Incident Reporting Framework.

The attached report 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).

As reported in the last report to the Board of Directors, the Mortality Review Sub-Committee has now agreed a dashboard format for collating information on deaths of substance misuse service users who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death. This information for Q4 has been considered by the Sub-Committee to ensure an overview of such deaths.

Monitoring of deaths within the Trust has continued throughout the COVID-19 pandemic in order to ensure timely identification of any possible problems in care. This is demonstrated by the improvement in timeliness of consideration via Deceased Patient Review Group processes. However, progressing long term learning from mortality review in Q4 has been limited as the Trust has focussed capacity on essential activity during pandemic response. As such, it has not been possible to progress developmental work arising from mortality review significantly since the last report to the Board of Directors was prepared (March 2020). This work has recently been recommenced and further details are included in the attached report.

The Trust took early proactive steps to establish processes for monitoring and reviewing deaths related to COVID-19 and a working group, reporting to the Mortality Review Sub-Committee, was set up to oversee these processes. This working group is undertaking data analysis of all deaths which have occurred to date with a view to identifying any trends for further exploration / assisting with the identification of immediate learning. The initial analysis was presented to the Mortality Review Sub-Committee meeting in June and actions to ensure identification and implementation of learning agreed. This work is continuing.

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	
Are any existing risks in the Board Assurance Framework affected?	No
If yes, insert relevant risk	
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 Q4 2019/20
Annex A – 2017/18 Dashboard (national reporting format)
Annex B – 2018/19 Dashboard (national reporting format)
Annex C – 2019/20 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

Agenda item: 6c
Board of Directors
29 July 2020

EPUT

LEARNING FROM DEATHS – MORTALITY REVIEW PUBLICATION OF MORTALITY DATA AND LEARNING QUARTER 4 2019/20

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 Q4 2019/20 (1st January – 31st March 2020);
- Updated information relating to deaths in scope for mortality review in previous quarters in 2019/20 and for 2018/19 and 2017/18; and
- Learning that has been identified within the Trust as a result of mortality review in Q4 2019/20.

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 Q4 2019/20 (and updated data for previous quarters / years) as at the day the report was prepared (ie 12th June 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 As reported in the last report to the Board of Directors, the Mortality Review Sub-Committee has also now agreed that the deaths of patients who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death would be subject to mortality review processes within the Trust. A separate dashboard for these deaths has been created and is monitored by the Sub-Committee. Consideration will be given in the future as to whether to integrate this data with overarching Trust data for deaths "in scope" of the Mortality Review Policy.

4.0 TOTAL NUMBER OF DEATHS IN SCOPE FOR REVIEW

4.1 There were 62 deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in Q4 2019/20. This total number of deaths is broadly consistent with other quarters in 2019/20 and with Q4 in 2018/19 (65). However, the detailed breakdown of deaths by month (Table 1 below) indicates a significant increase in the number of deaths in March 2020. This is currently being explored further to understand the situation and identify whether any actions are required. In addition, there have been significant fluctuations in terms of the number of deaths in certain categories – further detail is outlined under paragraphs 4.3 and 4.4 below. There have been some minor adjustments to numbers of deaths falling within scope in previous quarters (Q3), wholly due to four additional deaths falling within the Severe Mental Illness (SMI) category being identified retrospectively via the clinical systems.

Table 1: Breakdown of total deaths in scope for review

Period	Total 2017/18	2018/19 Q1 Total	2018/19 Q2 Total	2018/19 Q3 Total	2018/19 Q4 Total	Total 2018/19	2019/20 Q1 Total	2019/20 Q2 Total	2019/20 Q3 Total	Jan 2020	Feb 2020	Mar 2020	2019/20 Q4 Total	Total 2019/20
Deaths in scope	**248**	**59**	**53**	**58**	**65**	**235**	**53**	**56**	**57**	**18**	**12**	**32**	**62**	**228**

4.2 Figure 1 below shows the total number of deaths that fell within the scope of the policy each month in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2017 – November 2018). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. Figure 1 below indicates that the number of deaths continues to remain within the control limits. However, the total number of deaths for March 2020 is only marginally within control limits and further work is underway to establish and understand the reasons for the significant increase.

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

4.3 There have also been some significant fluctuations in the number of deaths in each category for Q4. Particularly of note is an increase in nursing homes deaths. This increase is currently being reviewed as a matter of priority by the Trust's Consultant in Public Health Medicine and Consultant in Older Peoples Mental Health Services.

4.4 As this is the end of year report, a review of death numbers for the full year 2019/20 has also been undertaken. It would appear that, whilst monthly data surveillance does not indicate significant monthly variances, there has been an increase in the number of inpatient deaths across the full year in Mental Health Services for Older People as compared to 2018/19 and a decrease in inpatient deaths in Community Hospitals (West Essex) across the full year as compared to 2018/19. This is being explored further to understand possible reasons and to identify whether any actions should be taken forward in relation to these variances.

4.5 Of the 62 deaths in Q4, 14 were inpatient deaths and 18 were nursing home deaths. Given the nature of the services provided by the Trust, there will be a number of deaths that occur on in-patient wards and in nursing homes which will be expected and which will be due to natural causes. Of the 14 inpatient deaths, 12 deaths have been confirmed as due to natural causes. Two causes of death are currently under determination; both appear to be likely to be confirmed as natural causes. Of the 18 nursing homes deaths, all have been confirmed as due to natural causes. However, as detailed above, a review of these deaths is being undertaken to assist in understanding the significant increase in the number of deaths in Q4.

4.6 Two of the 14 inpatient deaths in Q4 were of inpatients who tested positive for COVID-19.

4.7 The Trust took early proactive steps to establish processes for monitoring and reviewing deaths related to COVID-19 and a working group, reporting to the Mortality Review Sub-Committee, was set up to oversee these processes. This working group is undertaking data analysis of all deaths which have occurred to date with a view to identifying any trends for further exploration / assisting with the identification of immediate learning. The initial analysis was presented to the Mortality Review Sub-Committee meeting in June and actions to ensure identification and implementation of learning agreed. This work is continuing. Deaths of patients who tested positive for COVID-19 and which fall within the scope of the Trust's Mortality Review Policy have continued to be considered via the Deceased Patient Review Group in accordance with normal Trust mortality governance.

4.8 As this is the year-end report, a retrospective review of categories of causes of inpatient deaths in Q1 – Q3 has been undertaken on the basis that a number, at the time of quarterly reporting to the Board of Directors, were deemed to be "under determination". Of the 26 inpatient deaths occurring in Q1 – Q3, 20 have now been confirmed as natural causes, 3 have been confirmed has Unexpected Unnatural deaths (all of which have been/are being subjected to a Serious Incident Investigation) and 3 are still under determination. Of the 16 nursing homes deaths occurring in Q1 – Q3, all have now been confirmed as natural causes.

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 2: 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 Q1 total	2018/19 Q2 total	2018/19 Q3 total	2018/19Q Q4 total	2018/19 total	2019/20 Q1 total	2019/20 Q2 total	2019/20 Q3 total	Jan 2020	Feb 2020	Mar 2020	2019/20 Q4 total	2019/20 total
Grade 1 Deceased Patient Review Group	148	41	30	31	45	147	32	26	31	12	2	17	31	120
	60%					63%								53%
Grade 2 Case Note Review	11	6	4	5	4	19	6	3	2	1	2	0	3	14
	4%					8%								6%
Grade 3 Critical Incident Review	1	0	0	0	0	0	0	0	1	0	0	0	0	1
	0.5%					0%								1%
Grade 4 Serious Incident Investigation	88	12	19	22	16	69	15	26	14	1	4	4	9	64
	35%					29%								28%
Final grade under determination	0	0	0	0	0	0	0	1	9	4	4	11	19	29
	0%					0%								13%
TOTAL	248	59	53	58	65	235	53	56	57	18	12	32	62	228

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 and 53% thus far 2019/20); or
- being investigated as Grade 4 serious incident investigations (35% 2017/18, 29% 2018/19 and 28% thus far 2019/20).

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 and 6% thus far in 2019/20). This is being kept under review and will be further reviewed as part of implementation of the new national Patient Safety Incident Reporting Framework (PSIRF) which is likely to impact on the proportions of levels of review / investigation undertaken.

5.4 Positive progress has been made since the last report to the Board of Directors was prepared (March 2020) in terms of the timely consideration of deaths via mortality governance processes, with only 13% of deaths requiring the grade of review to be determined. In the Q3 report, this stood at 5% of 2018/19 deaths (now 0%) and 25% of 2019/20 (now 13%) deaths.

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

Level of review	Progress	2017/18		2018/19		Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	YTD 2019/20	
Grade 1 (DPRG)	**Complete**	148	100%	147	100%	32	26	31	31	120	100%
	In progress	0	0%	0	0%	0	0	0	0	0	0%
Grade 2 (CNR)	**Complete**	9	82%	12	63%	2	0	0	0	2	14%
	In progress	2	18%	7	37%	4	3	2	3	12	86%
Grade 3 (CIR)	**Complete**	1	100%	0	0%	0	0	0	0	0	0%
	In progress	0	0%	0	0%	0	0	1	0	1	100%
Grade 4 (SI)	**Complete**	88	100%	69	100%	15	26	4	2	47	73%
	In progress	0	0%	0	0%	0	0	10	7	17	27%

Level of review	Progress	2017/18		2018/19		Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	YTD 2019/20	
Under determin-ation	Complete	0	0%	0	0%	0	0	0	0	0	0%
	In progress	0	0%	0	0%	0	1	9	19	29	100%
TOTAL	Complete	246	99%	228	97%	49	52	41	33	169	74%
	In progress	2	1%	7	3%	4	4	16	29	59	26%

5.6 Due to the clinical capacity impact of the Trust's response to COVID-19, there has been limited progress of Grade 2 Case Note Reviews since the last report to the Board of Directors was prepared (March 2020). Case Note Reviews constitute all reviews still in progress for 2017/18 and 2018/19 deaths. The progress of Case Note Reviews is being kept under review and reviews progressed as quickly as it is possible to do so.

5.7 Reviews / investigations have been completed for 74% of deaths year to date in 2019/20. There has been a significant increase in the timeliness of consideration via the Deceased Patient Review Group which has continued to meet throughout the pandemic to ensure timely review of deaths within scope of the Mortality Review Policy. Thanks are extended to members of the Group for their work in this respect under difficult circumstances.

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 %)
6 - definitely less likely than not	112	84%	188	80%	133	58%
5 - slight evidence	14	10%	21	9%	18	8%
4 - not very likely	3	2%	11	5%	7	3%
3 - probably likely	1	1%	6	3%	3	1%
2 - strong evidence	0	0%	0	0%	0	0%
1 - definitely more likely than not	0	0%	0	0%	0	0%
Under determination	4	3%	9	4%	67	29%

* 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. Learning themes from Q4 have included risk assessments and care plans; recording of information; engagement with families and carers; transfers of care; and disengagement.

8.2 LEARNING FROM THEMATIC MORTALITY REVIEW

8.2.1 Since the last report to the Board of Directors was prepared (March 2020), progressing long term learning from mortality review has been limited as the Trust has focussed capacity on essential activity during the pandemic response. As such, it has not been possible to progress developmental work arising from mortality review significantly. This work has recently been recommenced and further information will be included in the Q1 2020/21 report to the Board of Directors.

8.3 THEMATIC LEARNING EMERGING

8.3.1 The thematic learning emerging from all elements of mortality review was presented to the Learning Oversight Sub-Committee in June 2020, with a view to considering how this learning can be taken forward across the Trust and actions aligned with other activity on learning across the Trust.

9.0 CONCLUSIONS AND FUTURE ACTIONS

9.1 This report provides assurances that all deaths in Q4 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 this report; and
- Seek clarity where required.

Report prepared by:
Michelle Bourner, Project Co-ordinator

On behalf of:
Prof Natalie Hammond, Executive Nurse

July 2020

ANNEX A – MORTALITY DATA DASHBOARD 2017/18

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

Trust	EPUT	**Total Deaths in Scope:** • All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services) • All community Learning Disability deaths (detailed on sheet 2) • All community deaths meeting Serious Incident criteria 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)
Month	Jun-20	
Year	2017-18	

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2017-18	Q1	59	13	46	19	0	3	0	0	0	24	0	0	Please note, prior to implementation of the Mortality Review Policy from 1st October 2017 (timeframe in line with the National Guidance on Learning from Deaths), the Trust did not operate a process to assess the extent to which deaths reviewed / investigated were due to problems in care using a scale of 1 - 6. It is therefore not possible to complete this information for quarters 1 and 2. All Grade 4 (Serious Incident) investigations undertaken during this period used established root cause analysis methodology and identified learning arising from the investigation. Further information is included in the narrative report accompanying this dashboard.						
YTD		59	**13**	46	19	0	3	0	0	0	24	0	0							
2017-18	Q2	55	9	46	23	0	0	0	0	0	23	0	0							
YTD		114	22	92	42	0	3	0	0	0	47	0	0							
2017-18	Q3	58	9	49	26	0	5	1	1	0	16	0	0	0	0	1	2	5	39	2
YTD		172	31	141	68	0	8	1	1	0	63	0	0	0	0	1	2	5	39	2
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	9	2	1	0	87	0	0	0	0	1	3	14	94	4

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	Jun-20	• All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system
Year	2017-18	

Financial Year	Quarter	Total Number of Learning Disability Deaths (inc inpatient and community)	Total number of these LD Deaths subjected to national LeDeR programme	Number of these LD deaths subjected to review by the Trust								Extent that these LD deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
				Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CI)		Grade 4 (SI)								
				Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress	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
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

ANNEX B – 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	Jun-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	2	3	0	0	22	0	0	0	0	0	5	6	40	3
YTD		170	**22**	148	80	0	9	6	0	0	53	0	0	0	0	5	8	13	114	8
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	12	7	0	0	69	0	0	0	0	6	11	21	156	9

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
Month	Jun-20
Year	2018-19

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								
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 C – MORTALITY DATA DASHBOARD 2019/20

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

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

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2019-20	Q1	53	8	45	24	0	2	4	0	0	15	0	0	0	0	0	1	5	30	9
YTD		53	**8**	45	24	0	2	4	0	0	15	0	0	0	0	0	1	5	30	9
2019-20	Q2	56	3	53	23	0	0	3	0	0	26	0	1	0	0	3	4	9	30	7
YTD		109	11	98	47	0	2	7	0	0	41	0	1	0	0	3	5	14	60	16
2019-20	Q3	57	11	46	20	0	0	2	0	1	4	10	9	0	0	0	2	4	20	20
YTD		166	**22**	144	67	0	2	9	0	1	45	10	10	0	0	3	7	18	80	36
2019-20	Q4	62	8	54	26	0	0	3	0	0	2	7	16	0	0	0	0	0	26	28
Total 2019-20		228	30	198	93	0	2	12	0	1	47	17	26	0	0	3	7	18	106	64

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	Jul-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	5	0	0	0	0	0	0	0	3	0	0	0	0	0	5	3
Total 2019-20		30	30	27	0	0	0	0	0	0	0	3	0	0	0	0	0	27	3

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

		Agenda Item No: 6d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	**Mental Health Act Annual Report 1 April 2019 to 31 March 2020**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Lynn Proctor, Mental Health Act Senior Management Support (Bank) on behalf of Angela Butcher, Associate Director – Professional Development					
Report discussed previously at:	Quality Committee and Mental Health & Safeguarding Sub Committee					
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 Mental Health Act & Safeguarding Sub-Committee to inform of the Mental Health Act activity in 2019-2020.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Discuss the content of this report
3 Request any further information or action

Summary of Key Issues

Mental Health Act activity:

- There has been an increase in the use of Section 2's and a decrease in the use of Section 3's, demonstrating the use of least restrictive practice.
- The usage of a Section 5(2) can fluctuate from month to month demonstrated as common variation. This may indicate a least restrictive option in that patients are coming into hospital informally.
- A high percentage AWOLs relate to a small number of patients in Child and Adolescence Mental Health Services. Measures are being put in place to secure the physical environment and manage the patient's leave to mitigate against them going AWOL, e.g. escorted as opposed to un-escorted leave.
- The Trust has had 11 CQC MHA focussed visits since April 2019. It is to be expected that Covid-19 may have impacted on the lack of visits during March 2020 but there was a 60% reduction in the number of visits that took place during 2019/20 compared to 2018/19 when there were 27.

Positive Assurance

- Extensive work was undertaken during 2019 with Princess Alexandra Hospital in Harlow and a Service Level Agreement was duly completed and signed. Further work is in the final stages with East Suffolk and North Essex NHS Foundation Trust to secure a Service Level Agreement.
- In order to strengthen Information Governance Associate Hospital Managers have been allocated with NHS.Net Accounts
- A Section 131 Informal Patient Rights Monitoring Form has been introduced for when an informal patient is admitted to an in-patient ward.
- In response to Covid-19 and to meet the requirements of the Act, the Trust has

undertaken virtual hearings for both AHM and Mental Health Tribunals.

Hotspots

- Tribunal Room Specifications Audit as required by the Mental Health Tribunal Service has not been completed due to Covid-19;
- Increased demands on Ward Managers/Clinical Managers to complete CQC Monitoring Reports.
- Outstanding Associate Hospital Manager Appraisals which will be completed using the current platform – Microsoft Teams.
- PARIS Clinical System – currently the Mental Health Act Administration Team are unable to renew Section 3's on the system. The issue has been identified and discussed with the PARIS Technical Team and as a planned update of PARIS is not due until November 2020 this has been placed on the Risk Register.

Forward Plan

The Mental Health Act Senior Team members and the Mental Health Act Team meet on a monthly basis to review each respective area of practice.

Plan for 2020 is the development and introduction of the 'Mental Health Act Team Core Competencies Booklet' for Mental Health Act Team staff and Nursing Staff.

Mental Health Act Managers will continue to deliver planned Mental Health Act Training across the Trust

A detailed Audit Programme has been devised for 2020/2021. Any identified themes will be addressed by bespoke training delivered by a Mental Health Act Manager.

A shadow implementation plan has been prepared in light of the proposed changes to legislation in the Mental Health Act following the publication of the Wessely Report. Unfortunately these changes have not been acted upon given the General Election in December, 2019 and the recent COVID-19 outbreak.

Following the resignation of one of the Mental Health Act Administrators in the team, it has been agreed that three years on from amalgamation of the two Trusts, it is now timely to undertake a detailed review of the Mental Health Act Administration Team in order to provide stability and structure in regards to succession planning.

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	BME	Black Minority Ethnicity
MHA	Mental Health Act	AWOL	Absent without leave
IMHAs	Independent Mental Health Advocates	AHM	Associate Hospital Manager
NHS	National Health Service	EPUT	Essex Partnership University NHS Foundation Trust
SOAD	Second Opinion Appointed Doctor		

Supporting Documents and/or Further Reading

Lead
 **Natalie Hammond** **Executive Nurse**

Essex Partnership University
NHS Foundation Trust

Mental Health Act Annual Report
1 April 2019 to 31 March 2020

Author: Lynn Proctor, Mental Health Act Senior Management Support
on behalf of Angela Butcher, Associate Director – Professional Development

Contents

Foreword

This year's 2019/20 Mental Health Act Administration Annual report again confirms the Trust's commitment to ensuring the effective delivery of its statutory responsibilities across all service areas. This commitment remains at the heart of our core business.

As an organisation that provides high quality mental health care we come into contact on a daily basis with some of the most vulnerable adults and children in society. We take our responsibility to promote the safety of those in our care very seriously and in order to positively impact on this we provide high level consistent support, guidance and training to our front line staff to equip them with the daily challenges they face in this area of their practice.

The COVID-19 pandemic has tested our response to lead this agenda and it is recognised that it has never been more important to demonstrate strong leadership and management ensuring that throughout our services we demonstrate high levels of support, intervention and expert guidance. Partnership working with our colleagues from neighbouring services including the Police, Clinical Commissioning Groups and local authorities remains vital. Effective communication is the cornerstone to making sure that we deliver on our commitment to protect out vulnerable populations.

To meet our commitments the Trust has the following ambitions:

- To unify the clinical system to streamline Mental Health Act processes
- Embedding a robust succession planning system to provide stability
- Continue developments to achieve recognition as a centre of excellence

Natalie Hammond
Executive Nurse

Executive Summary

This is the third Annual Report prepared on behalf of EPUT's Mental Health Act & Safeguarding Sub-Committee. It sets out the framework within which the Committee operates, provides an overview of its activities in 2019/20 and the outcomes of its deliberations, and looks ahead to developments and challenges anticipated in 2020/21.

The Board recognises that high standards of governance throughout the Trust are essential for the delivery of the identified strategic objectives, the safety of its services, the quality of service user and carer experience, and the long term protection of stakeholder interests. Good governance emanates from the Board but pervades the entire organisation, being reflected in its operating practices, policies and procedures.

The Mental Health Act & Safeguarding Sub-Committee ensures the organisation is working within the legal requirements of the Mental Health Act (1983)), as amended by the 2007 Act and Mental Capacity Act 2005.

This report reviews the operation of the Mental Health Act for the year 1st April, 2019 to 31st March, 2020. It will provide an overview of the work undertaken in the administration of the Mental Health Act 1983 as amended by the Mental Health Act 2007.

Patient Story

My story by JA - written in his own words

I was ill, paranoid, scared and trusted no one at Brockfield House, this was all a new environment to me. Slowly I was trying out new activities on the ward with the encouragement of the OT, one being self-catering having gained my Food and Hygiene certificate.

After 2-3 months I was put on medication which helped with my paranoia and delusional thoughts. Again I found myself engaging in activities outside the ward with the support of the activity co-ordinators. This helped with my fitness taking part in the football groups, gym and volleyball.

I then started to think about my future and what I could possibly do once discharged. I had wondered about a Plumbing or Barbering course and spoke to the Education and Voluntary Co-ordinator Sue Cotgrove. The advice was to gain my maths and English, as this is provided by the ACL tutors who come onsite to teach. I was referred to the maths class which I attended on and off for approximately 2 years. I struggled at first with my self-belief despite the tutor and Sue encouraging me and letting me know I could do this. After 2 years I had attained my level 2 and now started to believe in my abilities. After a year I had attained my level 1 English, and felt ready to apply for the Barbering course. I applied with the help of Sue and attended an interview at Southend College to be accepted, again with support from the staffs at the college and Sue . The course is fully funded and I could start because I had my maths and English. I have now finished my first term at Thurrock college having passed all my exams so far and been classed as a Blue star pupil, which is their top grade. I am thoroughly enjoying the course and hope to maybe attend and do my level 3 next year once I have completed my level 2.

I also attend volunteering once week with Shared Spaces. This has helped my confidence and will help with a reference for future work. I have attended Recovery College courses which have been varied and interesting. I have started a Customer Service course fully funded by the Lightbulb Company who provides Vocational courses preparing you for the world of work with City and Guilds qualifications, recognised by employers. Brockfield House provide all of this wonderful courses.

There have been ups and downs (Mainly ups) whilst residing at Brockfield House. I now feel I can trust the staff and know they are on my side. I have worked hard and gained so much. I have insight now into my mental health and with the help of the staffs especially my psychologist, I know what the triggers are and have coping strategies in place to help stay well.

Detentions under the Mental Health Act – 2019/2020

Data Source

As there are currently two clinical systems being used for the administration of the Mental Health Act in the Trust – Mobius in the Basildon/Rochford/Thurrock Area and Paris in the Chelmsford/Colchester/Harlow Area, this report provides details for both systems which are provided by the Trust's Information and Performance Team.

People may come into hospital under a detention order or they may have been admitted informally then assessed and detained. It is possible for one person to have been subject to numerous detention orders for example; Section 5(4), Section 5(2), Section 2 and Section 3. It is each of these individual sections that make up the detention figures.

The main facts and figures in this report has been benchmarked against national government figures reported on 26 May 2020

Main Facts and Figures

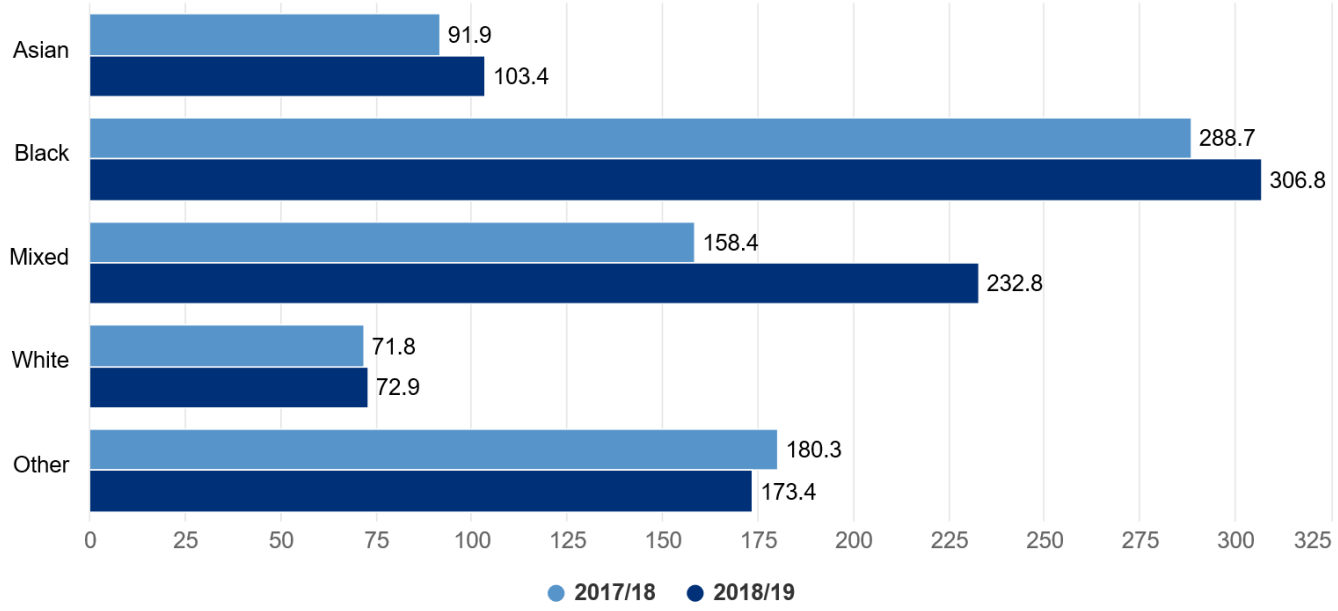
The Care Quality Commission in their 2018/19 report stated:

'*People from Black and minority ethnic (BME) groups experience a higher use of the Mental Health Act. There have been many attempts to explain this and the reasons why this is happening are not completely understood. A person from a BME group who has been subject to the powers of the Mental Health Act is likely to experience this as a discriminatory act. There is little evidence that this situation is improving or that there is a system-wide commitment to effect change'.*

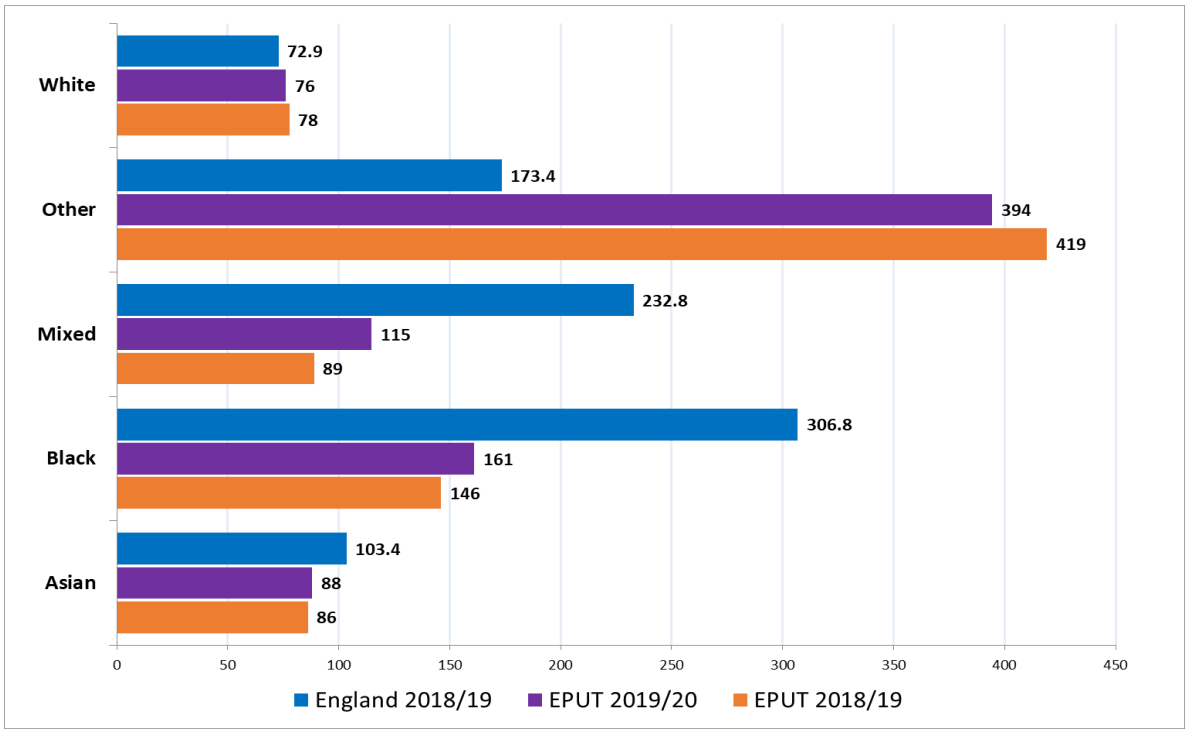
This is in line with key findings as set out below:

- National benchmarking has demonstrated that Black people are 4 times as likely as White people to be detained under the Mental Health Act
- Out of the 16 specific ethnic groups, Black Caribbean people had the highest rate of detention out of all ethnic groups (excluding groups labelled 'Other')
- The highest rate of detention was for people in the Black Other ethnic group, followed by those in the Mixed Other ethnic group – however, these rates are considered to be overestimates because 'Other' categories may have been used for people whose specific ethnicity wasn't known.
- Overall, it is estimated that detentions increased by 2.0% over the year.

Number of detentions under the Mental Health Act per 100,000 people, by specific ethnic group (standardised rates)

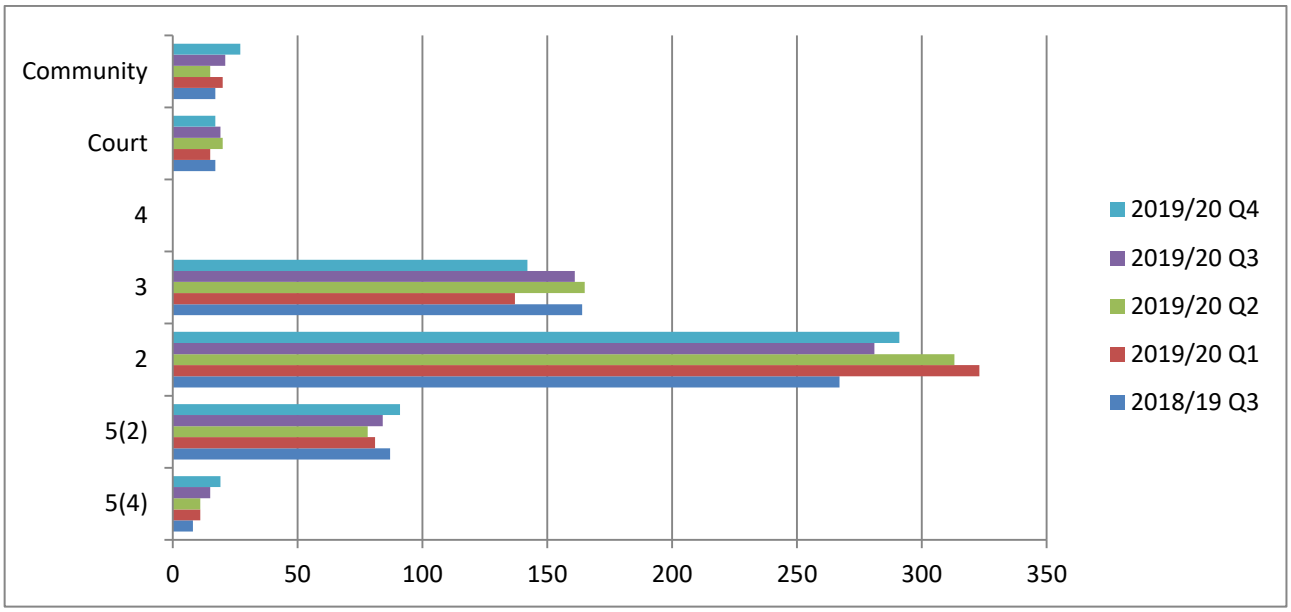


EPUT's detained patients by ethnic group have been compared with the national data per 100,000 population in the chart below. Further work will be taken to analyse the category classified as 'Other' to ensure the measurement is consistent with national categories.

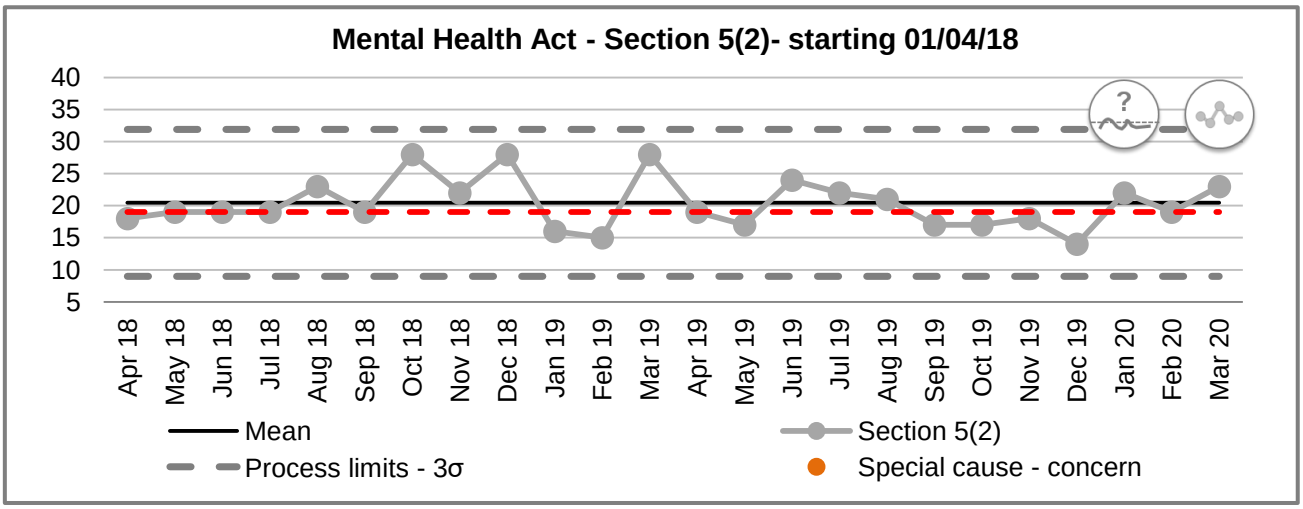


The data in relation to ethnicity has been collated since April 2019, providing a benchmark for future reports in relation to any increases in detentions. In addition, future reports will inform the total number of patients of BME ethnicity admitted in the Trust both informal and detained. This will identify the percentage of BME patients are that are detained under the MHA. This can then be monitored for possible trends.

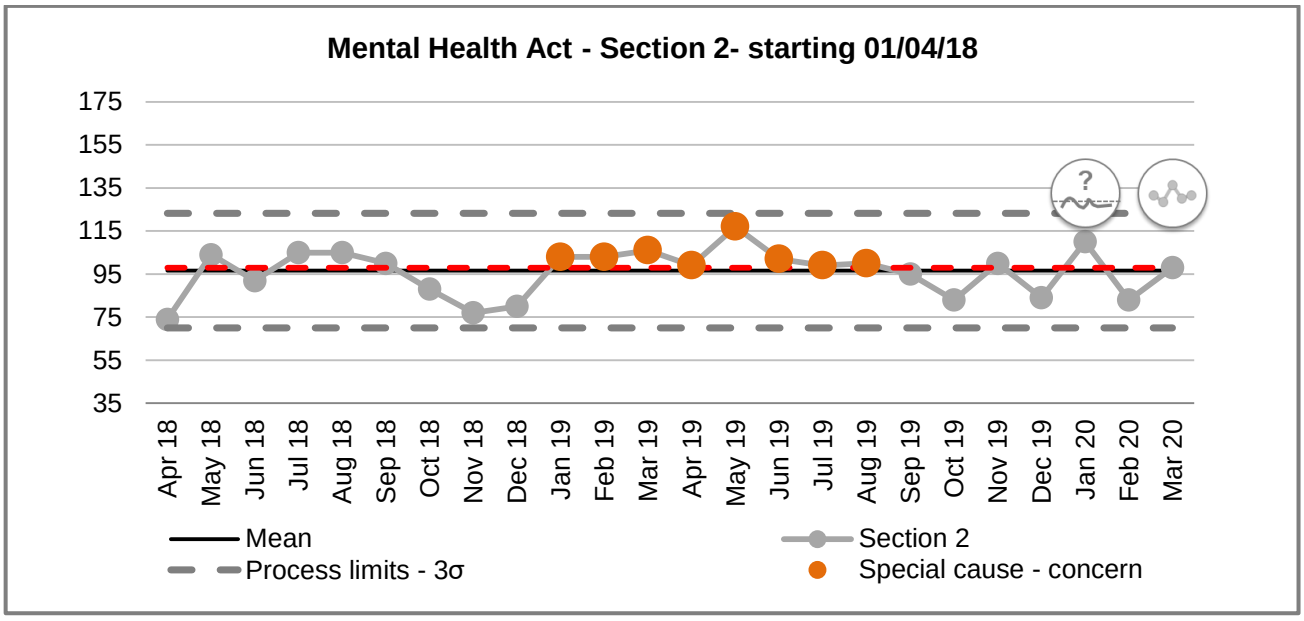
People may come into hospital under a detention order or they may have been admitted informally then assessed and detained. It is possible for one person to have been subject to numerous detention orders for example; Section 5(4), Section 5(2), Section 2 and Section 3. It is each of these individual sections that make up the detention figures.



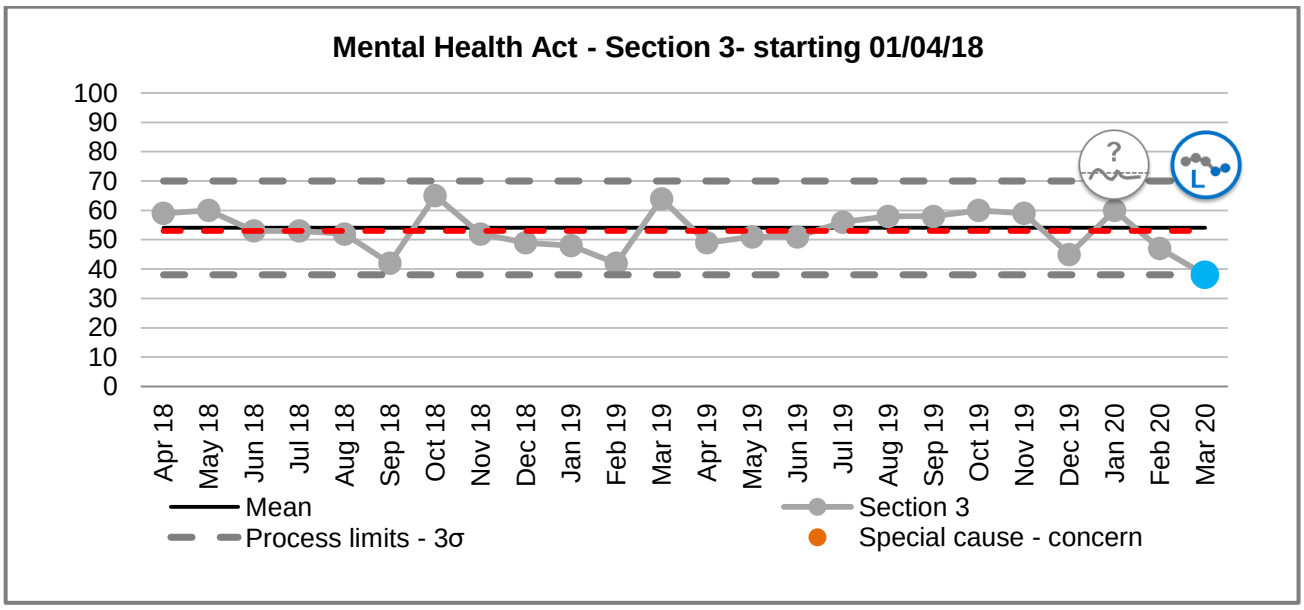
Section 5(2) is a holding section of an informal or voluntary patient on a mental health ward in order for assessment to be arranged under the Mental Health Act 1983.
A Section 5(2) is only used where the patient has expressed the intention to discharge themselves and there is an assessed risk to themselves or others should they do so. The usage of a 5(2) can therefore fluctuate from month to month demonstrated as common variation.



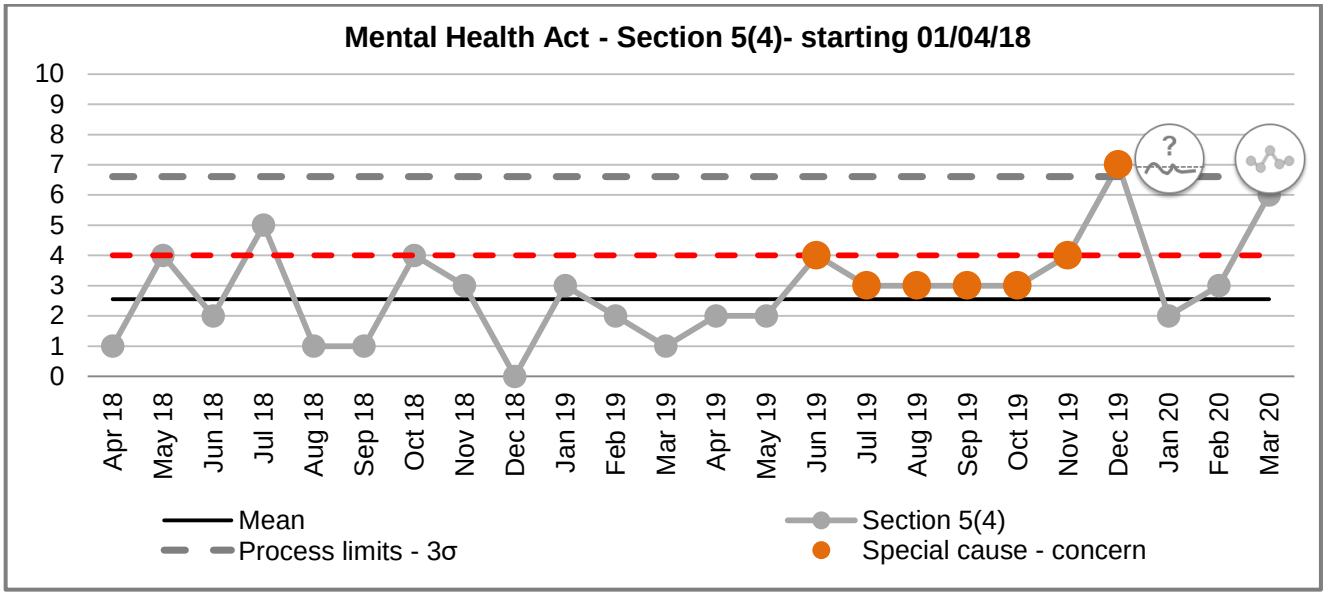
A Section 2 is an assessment & treatment section for detention up to 28 days. Clinicians during the period of assessment will be looking for an improvement in the patient's mental state and would towards the end of the twenty eight day period be looking for the least restrictive option of the patient remaining in hosptial informally rather than being detained further under section 3.



Section 3 is a longer term treatment section for up to six months, renewable at six months and then yearly. The charts highlight the reduction the movement towards least restrictive care options for patients that come under the care of the Trust. The increase in October and February could be attributed to patients requiring longer term treatment, hence the requirement to be placed under a Section 3.

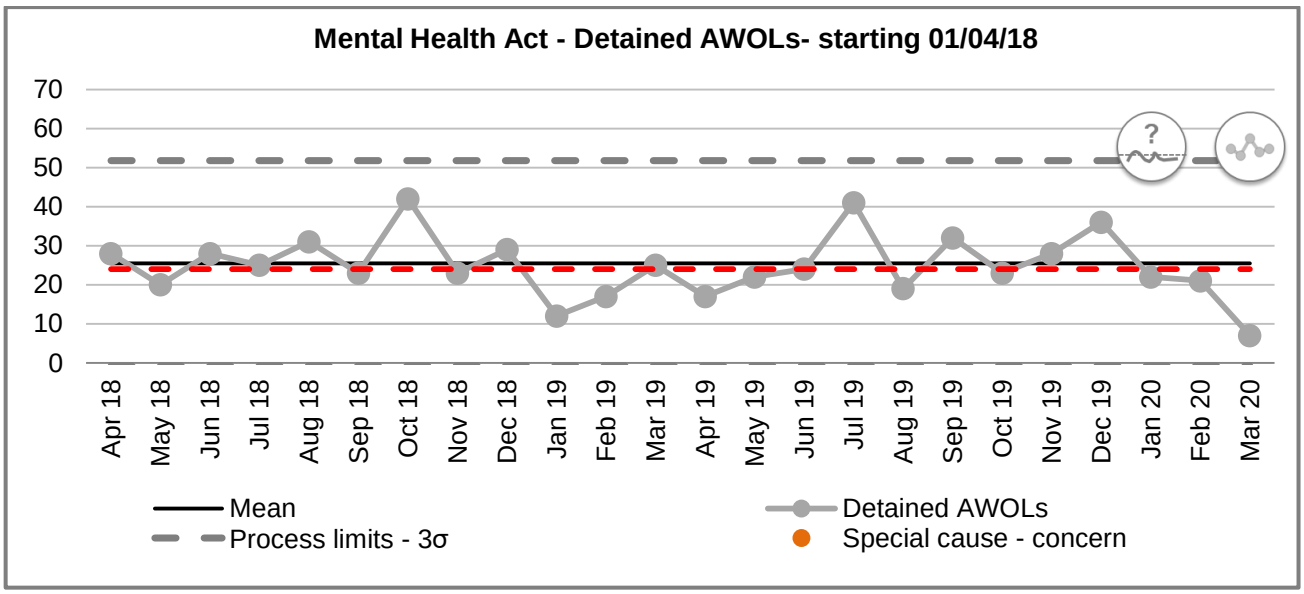


A Section 5(4) allows a nurse of the 'prescribed class' to detain an in-patient who is already receiving treatment for mental disorder. The definition of 'prescribed class' is any nurse registered in sub-parts 1 or 2 of the register maintained by the Nursing & Midwifery Council (NMC) whose entry on the register indicates that their field of practice is either mental health or learning disability. A Section 5(4) lasts for up to six hours or until the doctor attends to assess the patient



Absence Without Leave

Section (18) of the MHA sets out the definition and the powers available when a person is absent without leave**.** A high percentage AWOLs relate to a small number of patients in Child and Adolescence Mental Health Services. Measures are being put in place to secure the physical environment and manage the patient's leave to mitigate against them going AWOL, e.g. escorted as opposed to un-escorted leave.



Care Quality Commission

The Care Quality Commission produced their 2018/2019 annual report 'Monitoring the Mental Health Act' in February 2020. It looks at how providers are caring for patients and whether patients' rights are being protected.

In order to produce the report the CQC undertook visits to providers across the country and found the following themes:

- Services must apply human rights principles and frameworks. Their impact on people should be continuously reviewed to make sure people are protected and respected.
- People must be supported to give their views and offer their expertise when decisions are being made about their care.
- People who are in long-term segregation can experience more restrictions than necessary. They also may experience delays in receiving independent reviews. This is particularly true for people with a learning disability and autistic people.
- People do not always get the care and treatment they need. Some services struggle to offer appropriate options, both in the community and in hospital.
- It is difficult for patients, families, professionals and carers to navigate the complex laws around mental health and mental capacity

As a result, the following actions have been implemented to address the emerging themes and are monitored:

- The use of human rights principles and frameworks;
- Involvement in care;
- People in long-term segregation;
- Access to care and treatment;
- The interface between the Mental Health Act, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards is complex and difficult to navigate.

The following visits were made to the Trust by the Care Quality Commission from the 1st April, 2019 to the 31st March, 2020:

- 3rd April, 2019 — Gosfield Ward
- 17th June, 2019 — Peter Bruff
- 17th June, 2019 — Henneage Ward
- 9th July, 2019 — Byron Court
- 6th August, 2019 — Gloucester Ward
- 21st October, 2019 — Stort Ward
- 23rd October, 2019 — Chelmer Ward
- 5th December, 2019 — Robin Pinto Unit
- 30th January, 2020 — Longview Ward
- 3rd February, 2020 — Kitwood Ward
- 6th February, 2020 — Edward House

It is to be expected that COVID-19 may have impacted the lack of visits during March 2020 but there was a 60% reduction in the number of visits that took place during 2018/19.

A number of emerging themes were identified by the CQC, all of which form part of the CQC Monitoring Action Plan.

All emerging themes have been addressed with the following actions:

- Patient centred care plans and consent to share information forms are completed for all patients
- Family involvement in the development of care plans wherever possible
- Admitting nurses ensure compliance with Section 132 requirements with appropriate measures for those that lack capacity
- Weekly audits are in place to ensure care plans are in place to ensure compliance
- Stronger partnership working with Mental Health Advocacy Service
- Mental Health Act training adjusted to reflect emerging themes.

EPUT Governance

Electronic Medical Scrutiny

Electronic medical scrutiny was introduced in January, 2019. The new process introduced a more efficient process which managed the risk of any potential loss of section papers being sent out in the internal post system.

The electronic process continues to work well with any operational issues where Consultant colleagues are unable to carry out allocated Medical Scrutiny are dealt with on case by case basis. In addition, a comprehensive rota is now in place for the allocation of Medical Scrutiny documents managed by one of the Mental Health Act Administration Team Managers.

Mental Health Act Training in EPUT

Mental Health Act training of staff within the organisation continues to be delivered by the Mental Health Act Managers. Training needs are usually highlighted through results from ongoing Mental Health Act Audits, Mental Health Act Care Quality Commission visits and requests from Ward Managers to address team or individual needs. In most cases, bespoke training is delivered to individual ward teams in consultation with Ward Managers.

Mandatory Mental Health Act Training is available via the Trust's on line training system. Completion of the training is automatically tracked via the online management system as well as the Trust's training tracker.

Mental Health Act Team Development

As an organisation EPUT supports development of its workforce and aims to ensure that staff are fully competent to undertake their role. One member of the Mental Health Act team has recently completed a Masters in Mental Health Law and another has completed a Certificate in Mental Health Law and Practice. They have supported through their studies wider development with the team and have delivered comprehensive training to staff.

In addition, members of the Mental Health Act Team have continued to enhance their knowledge of the Mental Health Act by receiving regular distributions regarding changes to the Mental Health Act through Mental Health Law Online, the Care Quality Commission, The London Mental Health Network and the Law Society.

Associate Hospital Managers

Section 145 of the Mental Health Act advises upon the Managers of hospitals various powers and duties which should not be confused with tasks undertaken by individuals employed by organisations in managerial roles. The identity of the 'Hospital Managers' depends on the nature of the organisation concerned. In an NHS Trust or NHS Foundation Trust, the 'Hospital Managers' will be the Trust or Foundation Trust as a body. In practice many duties within the Act for which 'Hospital Managers' are responsible will be delegated. Delegation is authorised within the Mental Health Act Regulations and in the case of discharge powers, under Section 23 of the Act. Many of the functions will usually be delegated to Mental Health Act Administration. Organisations may delegate the Section 23 role to a group of people referred to as 'Associate Hospital Managers'. 'Hospital Managers' retain overall responsibility for any delegated duties.

The Trust currently has thirty-five Associate Hospital Managers. Three Associate Hospital Managers resigned during 2019/2020 and the Trust appointed two new Associate Hospital Managers.

Associate Hospital Manager Training

The Trust has facilitated the following training sessions for Associate Hospital Managers:

- **11th July, 2019** – An overview of the most common mental disorders – Facilitated by Dr Khan.
- **18th November, 2019** – The interactions between a solicitor and his client in the preparation at an Associate Hospital Manager Review Hearing – Facilitated by Mr Umar Kankiya, Mental Health Solicitor.
- **4th February, 2020** – Personal Safety Training – De-escalation techniques using verbal and non-verbal communication skills aimed at preventing potential or actual behaviours of concern from escalating. Facilitated by the Trust's TASI Training Team.

- **14th February, 2020** – Personal Safety Training – De-escalation techniques using verbal and non-verbal communication skills aimed at preventing potential or actual behaviours of concern from escalating. Facilitated by the Trust's TASI Training Team.

Associate Hospital Manager Audit

Two audits a year are undertaken of Associate Hospital Manager decision forms. The decision form audit took place during January 2020. The process involves scrutinising a number of decision forms (12 in total) to ensure that the forms give sufficient evidence to justify the decision to discharge or not, the patients' detention under the Mental Health Act. The majority of the forms were completed appropriately, they were well documented and demonstrated that the criteria had been fully considered. The forms evidenced that processes had been followed with a good overall standard. It was identified that there were a limited number of omission of errors, but the auditor (Independent Chair of the Associate Hospital Managers) felt that although these should not be a cause for concern, it was important that the form was fully completed.

The full panel audit was convened on the 27th September, 2019 with a Non-Executive Director, two Associate Hospital Managers, Mental Health Act Senior Manager, Responsible Clinician, Approved Mental Health Professional and a Nurse to review a case of a patient that had been discharged from section by the original Associate Hospital Manager panel. All panel members received copies of the reports submitted, the decision form and any notes that were taken at the hearing. The panel then reviewed the reports, identifying if they had sufficient information in to enable the hearing panel to come to a reasonable decision.

The full panel audit highlighted that a number of addendum reports may not be helpful and that one report should be submitted. Reports should give comprehensive detail identifying what the risks are, and how they should be managed. The decision form had some omissions and minor errors, although these would not have made the decision ineffective, attention to detail is important.

A number of actions were raised and are due to be reported through to the Mental Health & Safeguarding Sub-Committee on 20th May, 2020.

Associate Hospital Manager Agreement

A detailed piece of work was undertaken and completed into the review of the Associate Hospital Manager Agreement. Revised Agreements were sent out, duly signed by Associate Hospital Manager colleagues and returned to the Trust.

Associate Hospital Manager Operational Manual

The revised Associate Hospital Manager Operational Manual was circulated to individual Associate Hospital Managers to use as a reference to guide them in their understanding of the role.

Associate Hospital Manager Chair & Vice-Chair Elections

In September 2019 Associate Hospital Manager colleagues were invited to participate in the Associate Hospital Manager Meeting Election process to elect an Independent Chair of the Associate Hospital Manager Meeting following the retirement of the current chair. A new Chair was appointed with effect from 1st November, 2019 with tenure of two years and a Vice-Chair appointment was subsequently made enhancing the role of Associate Hospital Mangers within the Trust.

Audits 2019/2020

The Mental Health Act Managers jointly undertake random sample audits using a specially devised audit tool. All wards were audited prior to the CQC visit in July/August 2019 using the Mobius electronic patient system, Paris electronic patient system, as well as visits to inpatient wards

These audits enable trends to be identified and redressed appropriately, as well as identify training needs in relation to compliance under the Mental Health Act. In addition, during these audits the Mental Health Act Managers have audited the statutory paperwork of patients detained under the Mental Health Act 1983.

In February 2020 the Mental Health Act Office introduced an additional electronic audit of two wards per week. This audit checks that all the necessary detention paperwork has been scanned to the electronic system and is evident on the patient record. Eight wards per month are audited over a six weekly programme. Of the audits carried out to date, only minor irregularities were noted and corrected with feedback to Mental Health Act Administration staff through supervision. The Trust has recently introduced Perfect Ward an app that is accessible to all staff undertaking an audit providing real time information to view data/outcomes and drive quality improvements

A revised audit tool looking at the Mental Health Tribunal Room Specifications will be circulated in light of the introduction of video conferencing following changes introduced by the Ministry of Justice during COVID-19.

Independent Mental Health Advocates (IMHAs)

The presence of Independent Mental Health Advocates (IMHAs) on the wards has improved the access and quality of Tribunal applications, as patients are often supported placing applications for Appeal by the Independent Mental Health Advocate (IMHA). Previously Care Quality Commission Monitoring Reports confirm the presence and availability of IMHAs across the Trust.

New Innovations

Service Level Agreement

As reported in previous Mental Health Act Annual Reports, it has been acknowledged that the lack of a Service Level Agreement with Acute General Hospitals in our Trust area is of great concern in relation to Mental Health Act functions. Without the necessary contract in place, Consultant Psychiatrist colleagues acting as Responsible Clinicians risk functioning outside the Mental Health Act Framework. The identified issue is specifically around detained patients requiring treatment in Acute Hospitals and about Consultant Psychiatrists acting as Responsible Clinicians, as well as the Mental Health Act Administration Team providing support.

Extensive work was undertaken during 2019 with Princess Alexandra Hospital in Harlow and a Service Level Agreement was duly completed and signed. The Service Level Agreement provides a bespoke service, which will include dedicated Mental Health Act training for staff at Princess Alexandra Hospital, facilitated by a senior team member of the Mental Health Act Team. Further work is in the final stages with East Suffolk and North Essex NHS Foundation Trust to secure a Service

Level Agreement for admission of patients who are suffering from a mental illness, as well as being treated for a physical illness. Looking forward, senior members of the Mental Health Act Team intend to explore a comparable Service Level Agreement with the newly amalgamated Mid & South Essex NHS Foundation Trust.

Associate Hospital Managers allocation of NHS.Net Accounts

Following Information Governance Training it was agreed to change the process by which Associate Hospital Managers receive reports. A number of options were considered with the preferred option to allocate NHS.net accounts. Work is on target date for completion of the rollout of NHS.net accounts is the end of June, 2020.

Section 131 Informal Patient Rights Monitoring Form

Following a CQC visit, the Trust was advised that a Section 131 Informal Patient Rights Monitoring Form should be introduced when an informal patient is admitted to an in-patient ward. This piece of documentation will provide evidence that the patient understands their rights whilst being in hospital. The Section 131 form will be completed on admission, or if there is a significant change in the patient's mental state or following a Mental Health Act Assessment the patient is not subsequently detained under the Act and on transfer. Informal patients are also given a leaflet 'Your Rights as an Informal Patient'. Evidence of completion of the Section 131 Rights Monitoring Form is now included in the Mental Health Act Audit Programme.

COVID-19

The onset of COVID-19 and the administration of the Mental Health Act across the Trust was changed in order both compliance and safety. New ways of working were introduced with daily sit rep calls with members of the team via Microsoft Teams.

The Mental Health Tribunal issued Pilot Practice Directions that made changes to practice and procedure during COVID-19. The introduction by the Tribunal Service of video conferencing during the pandemic may influence and change the practice of how Tribunals will be held in the future.

The Care Quality Commission introduced a new remote method of working, including the collection of data from a range of sources via telephone, 'e' mail and video conferencing. Changes were introduced in regards to the Second Opinion Appointed Doctors (SOAD) provision.

Amendments to the Mental Health Act 1983 were introduced by the Coronavirus Act 2020 and were only to take effect if, and when the Secretary of State made the relevant Commencement Order. These amendments were:-

- Admission to Hospital;
- Section 5 Holding Powers;
- Remand to Hospital;
- Transfer Directions;
- Conveyance;
- Detention in a Place of Safety;
- Treatment;
- Transitional Provisions;
- Hospital Managers' Review Hearings

Following the guidance issued by the Government in response to COVID-19, Associate Hospital Manager Review Hearings were temporarily suspended due to Associate Hospital Manager colleagues being unable to attend hospitals.

The Trust recognised how important these hearings and working together the Mental Health Act Administration Team and IT developed an alternative solution to hold hearings remotely using the approved secure platform, Microsoft Teams. Twenty-five Associate Hospital Managers are now able to participate in supporting remote hearings and a number of remote hearings have now taken place with no technical problems identified.

In addition, and a first in terms of Trusts being able to facilitate remote hearings, a Nearest Relative Barring Discharge Hearing will be held using Microsoft Teams as well as consideration being given to listing Contested hearings in the future.

It should be acknowledged, as with Mental Health Tribunals, the way the Trust has been conducting Associate Hospital Manager hearings during the pandemic, may influence

practice during 2020/2021 and beyond. Feedback from stakeholders has been extremely positive supporting wellbeing and engagement as noted below:

Following receipt of an application for a nearest relative discharge, the Mental Health Act Administration Office were able to facilitate the hearing using Microsoft Teams given the current restraints of COVID-19. Extensive work by the Mental Health Act Administrator responsible for arranging Associate Hospital Manager Hearings was undertaken with all parties involved including the patient, the nearest relative, the solicitor and associate medical staff.

The legal representative for the patient wrote to the Senior Mental Health Act Manager for the team and was very complimentary in regards to how the hearing had been arranged and conducted throughout.

'Can I just say that Wendy Cracknell was absolutely amazing to get so many people on the video to do a hospital managers hearing today. I have done a number of Tribunals using their video system and not one hearing has had everyone using the video, it normally ends up with me looking at the judge and everyone else has to phone in.

Hotspots

- Tribunal Room Specifications Audit as required by the Mental Health Tribunal Service has not been completed due to COVID-19;
- Increased demands on Ward Managers/Clinical Managers to complete CQC Monitoring Reports. There are a number of concerns in regards to the quality of the responses provided which will be addressed through:
    - Training;
    - Support from the Senior Mental Health Act Manager prior to the distribution of the monitoring report;
    - 'Frequently Asked Questions' item on the Mental Health Act Teams page on the Trust's Input system;
- Outstanding Associate Hospital Manager Appraisals which will be completed using the current platform – Microsoft Teams.
- PARIS Clinical System – currently the Mental Health Act Administration Team are unable to renew Section 3's on the system. The issue has been identified and discussed with the PARIS Technical Team and as a planned update of PARIS is not due until November 2020 this has been placed on the Risk Register.

Forward Plan

As in previous years work will continue going forward in continuing to address and streamline the functions of the Mental Health Act Administration.

The 'Mental Health Act Team Core Competencies Booklet' for Mental Health Act Team staff and Nursing Staff is under currently under development and is expected to be available during Autumn 2020 This will aid staff in what is expected of them in regards to individual roles and responsibilities.

The Mental Health Act Senior Team members and the Mental Health Act Team meet on a monthly basis to review each respective area of practice. This provides an opportunity to discuss any changes to the Mental Health Act Code of Practice and Case Law as well as devising and developing monitoring tools/training packages to redress themes identified from 2019/2020 Care Quality Commission Inspections

Mental Health Act Managers will deliver planned Mental Health Act Training across the Trust regarding the administration and compliance of the Mental Health Act, including identified themes from previous Care Quality Commission Inspections, as well as promoting lawful practice compliant with the Mental Health Act Code of Practice 2015.

The Mental Health Act Team remains committed to meeting deadlines from actions plans set following visits from the Care Quality Commission. In addition the Mental Health Act Business Meeting which is attended by senior members of the Mental Health Act Administration Team along with senior Operational Managers will continue adopt a comprehensive approach to identifying operational needs in regards to Mental Health Act Compliance.

A detailed Audit Programme has been devised for 2020/2021. Any identified themes will be addresses by bespoke training delivered by a Mental Health Act Manager.

A shadow implementation plan has been prepared in light of the proposed changes to legislation in the Mental Health Act following the publication of the Wessely Report. Unfortunately these changes have not been acted upon given the General Election in December, 2019 and the recent COVID-19 outbreak. It is understood that a White Paper detailing future reform of the Mental Health Act is due to be released in 2020; however, the current situation with COVID-19 may influence this.

Following the resignation of one of the Mental Health Act Administrators in the team, it has been agreed that three years on from amalgamation of the two Trusts, it is now timely to undertake a detailed review of the Mental Health Act Administration Team in order to provide stability and structure in regards to succession planning.

Conclusion

The MHA Administrators will continue to support the Associate Hospital Managers to perform their role/duties by providing robust training in relation to the Mental Health Act and Mental Health Act Code of Practice 2015.

As always, this report acknowledges the commitment of the Trust and in particular that of the Mental Health Act Senior Manager, Mental Health Act Managers, Mental Health Act Officer and Mental Health Act Administrators who work within the legal framework which continues to challenge and change the way that Mental Health Services are delivered.

Assurance Statement

This report provides assurance that the Trust has robust systems, comprehensive policies and robust training in place to work within the parameters of the Mental Health Act 1983 as amended by the Mental Health Act 2007. In light of COVID-19, policies are being continually reviewed to ensure compliance with any changes in legislation and national guidance. The Mental Health Act Team continues to experience difficulties and duplication in relation to the current usage of the two clinical information systems Mobius and Paris to aid Mental Health Act Administration compliance. Going forward, the Mental Health Act Team will be charged to continue to embrace continued changes in the way they work, promotion of equal workload, a standardised way of practice and enhancement of knowledge.

		Agenda Item No: 6e
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	**Infection Prevention and Control Annual Report**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Kim Shaw on behalf of Angela Wade DIPC					
Report discussed previously at:	Quality Committee July 2020					
Level of Assurance:	**Level 1**	x	**Level 2**		**Level 3**	

Purpose of the Report

This report provides:

Assurance that the Trust provides a robust, proactive and effective Infection Prevention and Control (IPC) service. Additionally the report provides assurance that the Trust is compliant with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. This assurance also extends to the Care Quality Commission's Fundamental Standards and other related standards

Approval	
Discussion	
Information	x

Recommendations/Action Required

The Board of Directors are asked to:

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

Summary of Key Issues

The report outlines the achievements and activities of the Infection Prevention and Control team during the year and also includes the work and audit programme for 2020/2021.

Audit Programme:
The Audit Programme for this year was not completed due to the resource pressure of the Coronavirus Pandemic commencing in February 2020. The audit programme for the coming year will be re-arranged so that those currently outstanding will be carried out first. There are some scores under 95% in some areas in relation to IPC environmental audits. This is not specifically indicative of poor clinical practice, but partly due to the fabric of the buildings they are working in. The IPC team work in close liaison with clinical and Estates and Facilities teams and, on occasion, Where issues are noted to be clinical or facilities related, repeat audits are carried out to gain assurance that non-compliant areas achieve compliance.

Surveillance of Infection:
It is confirmed that of identified MRSA and Clostridium difficile cases in 2019/20 that involved EPUT services, there were no incidents with noted lapses in care that resulted in attribution to EPUT.

Invasive Group A streptococcus Outbreak:
EPUT's involvement began in July when two affected patients were identified in a Dunmow care home served by one of the West Essex Community Services Integrated Care teams.

EPUT co-operated with all requests for both meeting all mitigating actions, and providing all required information and reports. Sadly, one of the two patients died. Following a full review and investigation there were no gaps in care identified for EPUT and the two cases were linked to the main outbreak – i.e. same strain.

Training:
There has been a notable improvement in training compliance figures since last year. This has been addressed by Service Managers and the monitoring of mandatory training figures is a key responsibility for them.
The IPC team will continue to offer targeted training to teams when requested to ensure compliance levels are reached, focus given to the 1 area that fell under the 85% compliance target

Staff Flu Vaccination Programme:
The total percentage of uptake amongst frontline staff was 62% - a significant increase from last year's disappointing uptake of 36.8%.

Safe Water Systems:
Successful management of a discovery of high levels of Legionella bacteria in the Derwent Centre in Harlow. This was due to a failed pump which has since been replaced.

In line with the Trust's policy, a sampling and works programme is ongoing. This includes the fitting of anti-legionella filters to 2 showers, the rebalancing of the water system between the Stort and Chelmer Wards and re-piping to 2 sink outlets. Sampling continues with new schematics planned to be implemented. With help from our contractors and external partners such as Public Health England, the situation continues to be promptly and efficiently managed. As a result of the actions taken to identify and isolate the source of the contamination, no staff or patients were affected.

Key Achievements for 2019/20:
Rapid and robust response and mobilisation to requests from the CCG and Regional team to prepare for the management of the iGAS outbreak
Review of the EPUT Sepsis guidelines to be in line with current Sepsis UK guidelines
Key participants in Flu campaign to reach best Trust compliance to date
Rapid response and continued IPC leadership with clinical expertise from the onset of the Covid-19 pandemic

Work Programme for 2020/21
The Infection Prevention & Control team has supported all aspects of IPC in order to promote and maintain the continuation of excellent standards across the Trust.
In light of the Covid-19 pandemic, it is clear that IPC standards will be the foundation of all care provision. Therefore, the IPC work programme will continue to provide a responsive approach to interpret evolving clinical evidence, ensuring learning and standards of care support the reduction of nosocomial spread of Covid-19. The IPC team will work collaboratively with local Health protection teams and regional processes to monitor and take action on any potential Covid-19 outbreak, so that our patients and staff are protected as far as possible by IPC standards.Covid-19 Board assurance will be provided in accordance with national and regional guidance with close working collaboration with operational colleagues for assurance of standards.

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	

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

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?	

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

Acronyms/Terms Used in the Report			
IPC	Infection Prevention and Control		
MRSA	Methicillin resistant Staphylococcus aureus		
Cdiff	Clostridium difficile		
iGAS	Invasive Group A streptococcus		

Supporting Documents and/or Further Reading

Lead
Natalie Hammond Executive Nurse

Infection Prevention and Control Annual Report

2019 - 2020

Report prepared by
Kim Shaw, Head of IPC
on behalf of Angela Wade, Director of Nursing and Infection Prevention and Control
June 2020

Contents

1. Background

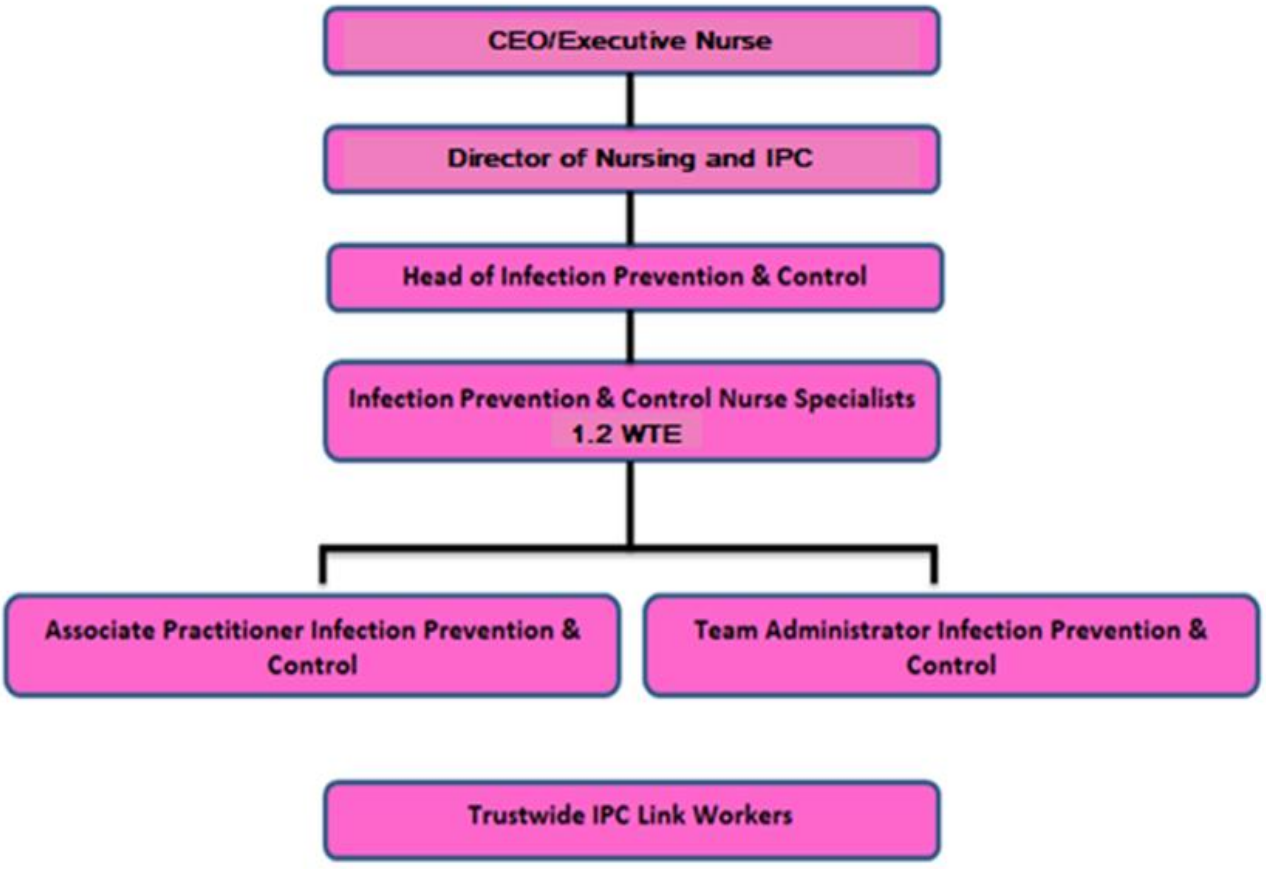
The purpose of this report is to provide assurance that the Trust provides a robust, proactive and effective Infection Prevention and Control (IPC) service. Additionally, the report provides assurance that the Trust is compliant with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. This assurance also extends to the Care Quality Commission's Fundamental Standards and other related standards.

The report outlines the achievements and activities of the Infection Prevention and Control team during the year and includes the work and audit programme for 2020/2021.

These programmes are founded on key documents and legislation including:

- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015
- Care Quality Commission (Registration) Regulations 2009
- Care Quality Commission Fundamental Standards 2015
- Code of Practice for health and adult social care on the prevention and control of infections and related guidance (July 2015)
- All relevant NHS / DH / NPSA Guidance
- All relevant expert guidance / evidence-based practice / NICE Guidelines

The aim of the IPC service is to ensure that all Trust staff members recognise how they can contribute to achieving and maintaining a safe, clean environment and adopt best practice to do this. Infection prevention and control depends on everyone in the organisation knowing their role and fulfilling it. The IPC team also supports the Physical Health Care Agenda across Mental Health.



2. Compliance

The Trust has declared full compliance with the Code of Practice and maintained registration for 2019/2020. Compliance is monitored and maintained via the infection prevention annual work programme, which is agreed and signed off by the Infection Prevention and Control Group. The group meets quarterly and membership includes commissioners and representatives from the wider health economy.

Trust compliance is monitored via a selection of audits. The results are fed back to the Executive Team, Service Heads and senior management to action where required and cascade to frontline staff. Audit data is reported on at all Infection Prevention and Control Meetings. Should it be noted that standards fall below acceptable practice; an action plan is implemented and monitored accordingly.

The Key Performance Indicator Reports provide quarterly internal assurance of compliance with the 10 compliance criteria (as below) of 'The Health and Social Care Act 2008 - *Code of Practice on the prevention and control of infections and related guidance'* and associated commissioning contractual requirements (2015).

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

The IPC team welcomed the appointment of a new Director of Nursing and Infection Prevention and Control in November 2019. Angela Wade, a RGN with a wealth of experience in the Acute Trust sector, has managed to make a rapid transition to the world of Mental and Community Services. Angela has embraced challenges such as the Flu vaccination programme and advising on the management of the Coronavirus pandemic with enthusiasm, professionalism and continued support for the IPC team.

3. Audit

Audits undertaken during 2019/20 are detailed below:

101 IPC environmental audits were undertaken in 2018/19, broken down across the Trust as follows:

- 23 - South East Essex Community Services,
- 18 - West Essex Community Services,
- 43 - Essex Mental Health,
- 15 - Specialist Services.

The challenge of auditing clinic sites which are shared with other community providers continues. The IPC team communicate with other providers where possible as well as NHS Property Services, to address as many issues as possible, within budget.

Year-end results for all IPC-related audits are detailed in the table below:

Audits undertaken this year include:

- MRSA screening on admission (in-patient services (according to risk), podiatric surgery and community high risk patients – Monthly and/or Quarterly
- Hand Hygiene audits – both peer and patient-observed across all service areas.
- Environmental IPC audits (all areas undertaking med-high risk clinical services) - Annually
- Mattress integrity audit (in-patient services) – 6 monthly in all inpatient areas
- Antimicrobial audits – audits carried out by Medicines Management team and shared at IPC
- High Impact Interventions via care bundle audits (invasive device audits) - Quarterly
    - Enteral feeding lines
    - Catheter care
    - Peripheral line insertion and care
    - Central line care

Audit results year-end 2019/20:

Please note: The Audit Programme for this year was not completed due to the resource pressure of the Coronavirus Pandemic commencing in February. The audit programme for the coming year will be re-arranged so that those currently outstanding will be carried out first.

Area:	**Hand hygiene:**	**Care bundles for invasive**	**MRSA screening:**	**Environment** Rating Scale : Compliant – 95-100% Partial compliance – 80-
Nursing Homes	100%	100%	100%	**93%**
Specialist services Bedford and Essex	Patient observed: 86% Inpatient: 98%	N/A	N/A	**94%**
Learning Disability Services Essex	Patient observed: Nil Received Inpatient: 96%	N/A	N/A	Not Done
South Essex MH Inpatient and Community Services	Patient observed: 100% Inpatient: 98.8%	N/A	N/A	**89.2%**
North Essex MH and Community Services	Patient observed: 76.9% Inpatient: 97.6%	N/A	N/A	**89.9%**
South East Essex Community Services	Comm: 97.7% Inpatient: 100%	100%	100%	**94.3%**
West Essex Community Service	Comm: 97.2% Inpatient: 98%	94%	100%	**92.8%**

The table above indicates low scores in some areas in relation to IPC environmental audits. This is not specifically indicative of poor clinical practice, but partly due to the fabric of the buildings they are working in. The IPC team work in close liaison with clinical and Estates and Facilities teams and, on occasion, NHS Property Service Managers to highlight issues with a view to achieving resolution. However, it is acknowledged that it is not always possible to undertake all remedial/ refurbishment works due to budget constraints. Where issues are noted to be clinical or facilities related, repeat audits are carried out to gain assurance that non-compliant areas achieve compliance, as far as possible.

The IPC team continues to liaise with other healthcare providers to ensure high-risk findings in shared premises are communicated and addressed. Audit data has at times been shared with a neighbouring Trust in Essex; this has been beneficial in terms of supporting/progressing remedial actions required.

Environmental cleaning audits are undertaken monthly by the Facilities team. Facilities issues are also highlighted by the annual IPC environmental audits. Where failing standards of cleanliness are evidenced, action plans are sent to the relevant Facilities Officer (FO) to address them. Sometimes, the FOs accompany the IPCN during the audit, allowing for some issues to be addressed at the time. The IPC team is available to attend external Patient Led Audit of the Care Environment (PLACE) audits when requested to do so and capacity allows. None were attended in 2019/20 due to capacity issues.

The IPC team has achieved set objectives and the majority of the targets set within the Key Performance Indicators (KPIs).

Antimicrobial Stewardship and Audits:

Antimicrobial prescribing continues to be monitored in the organisation on an annual basis, as part of the code of practice which supports compliance with the Health and Social Care Act (2008). All prescriptions of antimicrobials within the organisation are governed by national and local prescribing guidelines, which advocate the use of specific antimicrobials for a specified period of time. Non-formulary antimicrobials are only available following advice from consultant microbiology colleagues in the local acute trusts. These are not dispensed by pharmacy unless assurances are received that the prescription has been discussed and agreed.

Education relating to antimicrobial stewardship is promoted by the Annual Audit on Antimicrobial prescribing, taught in the mandatory Medicines Management training courses and is a standing agenda item on the non-medical Prescriber's Forum. It is also an agenda item on the IPC Group and the Antimicrobial Stewardship Committee Group has been incorporated as part of this group. Any new policies, guidance or information is discussed at the Medicines management groups for both mental health and community health services, as well as the quarterly IPC meeting.

4. Surveillance of Infections

The Trust is required to report Healthcare Associated Infections (HCAI) where the causative organism is identified as Methicillin Resistant *Staphylococcus aureus* (MRSA) or *Clostridium difficile.* The 2019/2020 annual set objective ceilings for these organisms remain unchanged from 2018/2019. The IPC team continues to monitor existing control measures, including ensuring that all strategies aimed at minimising risk are adhered to. EPUT works in partnership with members of the wider health economy to share best practice and information. The IPC team attends quarterly HCAI/IPC network meetings in South and North Essex. Additionally, the team participates in various task and finish groups to support care pathway work.

On identification of an HCAI, the relevant service and senior management team are advised. The lead clinician is contacted and a full investigation either via root cause analysis (RCA) or post infection review (PIR) is commenced, led by the clinical staff with support from the IPC team. Investigations include all service providers (health & social care) who have been involved in the care of the patient. Investigations undertaken support assurance for the Commissioners that relevant control measures were adhered to with the aim of avoiding potential infection. Additionally, those issues identified and lessons learned are fed back to all healthcare providers involved. It must be emphasised, particularly with *Clostridium difficile*, that antibiotics prescribed may be wholly appropriate as an essential part of treatment; in these cases the resultant *Clostridium difficile* infection will be viewed as unavoidable.

Of the identified MRSA and *Clostridium difficile* cases in 2019/20 that involved EPUT services, there were no incidents with noted lapses in care that resulted in attribution to EPUT.

Incidence of Mandatory Reportable HCAI (MRSA) 2019-2020			
	Community Services (Including 6 Inpatient Units)	Mental Health, LD and Secure Services (Inpatient Units)	Nursing Homes (2)
Incidence of Mandatory Reportable HCAI (MRSA) 2019-2020			
MRSA Bacteraemia **Avoidable cases**	0	0	0
MRSA Bacteraemia **Unavoidable**	0	0	0
HCAI (MRSA) **Cases with EPUT involvement**	0	0	1
Incidence of Mandatory Reportable HCAI (*C. difficile*) 2019-2020			
Clostridium difficile **Avoidable cases**	0	0	0
Clostridium difficile **Unavoidable**	0	0	0
HCAI (*C.diff*) **Cases with EPUT involvement**	2	0	0

The Trust reports all outbreaks of infections to the commissioners - an outbreak being defined as two or more connected cases of infectious disease either in patients, staff or visitors. The outbreaks seen within the Trust are reflective of trends in the wider community.

Debriefs are conducted on the ward following an outbreak of infection, such as diarrhoea and vomiting. A full and extensive analysis is carried out to identify causative factors, good practice and learning points which feed into an action plan and identify any training issues. Any learning from the outbreaks is shared at the IPC meeting and link nurse training.

There are local arrangements to support Public Health England with screening for influenza and provision of prophylactic treatment in *Influenza* outbreaks in residential care homes. This process is led by some of the District Nursing teams in Essex.

	2018-2019		2019-2020		
	Community Services (Including 6 Inpatient Units)	Mental Health, LD and Specialist Services (Inpatient Units)	Community Services (Including 6 Inpatient Units)	Mental Health, LD and Specialist Services (Inpatient Units)	Nursing Homes
Disease/condition	4x diarrhoea and vomiting 1 x Influenza A	1x Scabies 6x diarrhoea and vomiting 1x diarrhoea	1x Influenza A 1x Parainfluenza 2x Diarrhoea	4x Diarrhoea and vomiting 4x scabies	Influenza like illness
Lost bed days	27	31	37	28	10

Invasive Group A streptococcus Outbreak

During the first half of the year, Essex regional IPC teams, under the guidance of Public Health England, were heavily involved in managing an Invasive Group A strep outbreak. This was primarily in the Braintree/Mid Essex areas, involving a significant number of community patients being served by Provide District nursing teams.

EPUT's involvement began in July when two affected patients were identified in a Dunmow care home served by one of the West Essex Community Services Integrated Care teams.

EPUT co-operated with all requests for both meeting all mitigating actions, and providing all required information and reports. Sadly, one of the two patients died. Following a full review and investigation there were no gaps in care identified for EPUT and the two cases were linked to the main outbreak – i.e. same strain.

5. Training

Training for staff with patient contact was delivered primarily via an OLM e-learning package, developed by the IPC team, in conjunction with the Workforce Development Department.

The figures are monitored by the training department and reported to the Executive team on a monthly basis. The IPC team has continued with the programme of face-to-face training on request to support compliance and will continue to provide these sessions for 2020/21.

Other infection prevention and control training sessions delivered during the year include Trust Induction, aseptic technique for the AP training course, topic-specific ad hoc sessions (e.g. sepsis awareness, wound swabbing, clinic room management) to teams and ward staff and volunteer training, all provided by the IPC team.

Following the issue of the NHS England Safety Alert regarding raising awareness around the prompt recognition and management of sepsis, the IPC team and will continue to deliver training sessions on the topic to all clinical services across the organisation. Work is also in progress to update the tools available for staff to use with regards the prompt recognition of sepsis, in line with, and with the approval of, the UK Sepsis Trust.

The IPC team continues to work towards maintaining an active link worker network with clinical updates and

teaching sessions. Demands on staff time in clinical areas means that it has proved challenging for the link workers to attend training days. The IPC team was in the throes of planning an IPC conference when the Coronavirus Pandemic forced the postponement of the event. The team is hoping to be able to hold the event later in the forthcoming year.

Area (Rating Scale: Red =/<84% Green =/>85%)	**IPC Training –** Annual for all clinical staff		**IPC Training –** 3 yearly for all non-clinical staff	
Specialist services - Bedford and Essex	Bedford	Essex	Bedford	Essex
	90.4%	91.3%	94.2%	93.4%
Learning Disability Services	95.8%		100%	
South Essex MH inpatient and Community Services	91.3%		94.8%	
North Essex MH inpatient and Community Services	84.3%		92.%	
South East Essex Community Services	89.3%		95.2%	
West Essex Community Services	87.3%		86.3%	

There has been a notable improvement in training compliance figures since last year. This has been addressed by Service Managers and the monitoring of mandatory training figures is a key responsibility for them. The IPC team will continue to offer targeted training to teams when requested to ensure compliance levels are reached.

6. Sharps Injuries

The IPC team is alerted to sharps injuries via the on-line Datix reporting system. These are followed up by the Occupational Health and Wellbeing Team and external OH provider – Optima, and where necessary, the IPC team if there are any clinical practice issues.

	2017/2018	2018 /2019	2019/2020
South East Essex Community Health Services			
Needle Stick Injury - Dirty Needle	11	9	12
Needle Stick Injury - Clean Needle	0	0	1
Sharps Injury - Other Instrument	3	1	0
Needle Stick Injury - Unknown Source	0	2	0
Exposure to Blood and/or Body Fluids e.g. Splash	4	0	0
South Essex Mental Health, Secure Services & Learning Disability		**South Essex Mental Health only**	**All Mental Health Services**
Needle Stick Injury - Clean Needle	1	-	-
Needle Stick Injury - Dirty Needle	6	2	7
Sharps Injury - Other Instrument	-	-	1
Exposure to Blood and/or Body Fluids e.g. Splash	-	-	2
North Essex Mental Health, Secure Services & Learning Disability		**North Essex Mental Health only**	
Needle Stick Injury - Dirty Needle	8	3	
Exposure to Blood and/or Body Fluids e.g. Splash	1	2	
Specialist Services & Learning Disability			
Needle Stick Injury - Dirty Needle	-	1	1
Sharps Injury - Unknown Source	-	1	-
Sharps Injury - Other Instrument	-	-	1
Exposure to Blood and/or Body Fluids e.g. Splash	-	2	-
West Essex Community Health Services			
Needle Stick Injury - Dirty Needle	8	2	6
Sharps Injury - Other Instrument	1	-	-
Total	**50**	**25**	**31**

Sharps Injuries/Body Fluids Exposure Incidents

The use of sharp safe products as per the EU Directive (May, 2013) has been successfully embedded across the Trust and the continued reduction in the number of sharps injuries reflects this. With the help of the Procurement and Clinical teams, this market is constantly under review and new/improved products are introduced when appropriate. The se of pre-filled medication/syringes that cannot be decanted into a safety device continues, but regular review, in conjunction with the procurement team, is maintained to support identification of alternative safety products that can be introduced.

The non-availability of sharp safe products for insulin administration in patient's homes remains an issue and the high number of needle stick injuries in Community Services reflects this. This has been addressed by the IPC team with the relevant teams.

Bites and Scratches (Assault)

Incidences of bites and scratches are in general related to the mental health and learning disability client areas covered by the Trust. Minimising the risk is difficult due to the unpredictable nature of the injury. Staff are however vigilant to the potential of sustaining bite injuries and care plans are developed as appropriate to support this.

Body Fluid Exposure	Bite	Scratch	Total
36 (spitting)	14	88	138

Bite and scratch injuries (assault) are followed up, where required, by both the IPC team and Occupational Health Services. Also, if required, by the Trust's Local Security Management Specialist.

7. Staff Flu Vaccination Programme

In conjunction with the CQUIN team, The IPC team led the delivery of the Staff Flu Vaccination programme again this year. This programme was delivered in-house with Optima input (held 17 drop in clinics) utilising staff within the Infection Prevention and Control Teams, Immunisation teams, Medicines Management team and support from other areas i.e. operational teams.

Drop-in clinics were held in venues all over the organisation over a 10-week period, as well as 65 members of staff trained as peer vaccinators to vaccinate colleagues in their work bases. A set of promotional posters was designed and disseminated Trust-wide, and an incentive programme of a raffle was offered.

The uptake figures are outlined in the table below and the total percentage of uptake amongst frontline staff was 62% - a significant increase from last year's disappointing uptake of 36.8%.

This year, the Staff Health and Wellbeing CQUIN associated with the programme had a challenging target of 80% uptake in frontline staff for full payment to be received. This was unfortunately not met in any areas of the Trust, but partial payments were received.

Flu Uptake Figures: 2019-2020

	South Community	West Community	Bedfordshire Community	South Mental Health	Mid Mental Health	West Mental Health	North East Mental Health	Specialist	Pharmacy	Infrastructure	EPUT Compliance
Doctor	67%	80%		78%	64%	47%	66%	56%			67%
Nurse	69%	64%	91%	57%	73%	46%	60%	50%			61%
Qualified scientific, therapeutic & technical staff	72%	71%	11%	57%	67%	63%	58%	61%	67%		63%
Support to Clinical Staff	64%	73%	76%	62%	73%	59%	57%	50%	100%		62%
GP	100%							100%			100%
Social Workers	67%	100%		95%	83%	62%	54%	50%			76%
Central Function	100%			89%		100%	100%	48%		56%	56%
CQUIN Compliance	68%	69%	71%	61%	71%	53%	59%		69%		64%
Trust Frontline Compliance	68%	69%	71%	61%	71%	53%	59%	52%	69%		62%
Total Compliance	**68%**	**69%**	**71%**	**61%**	**71%**	**54%**	**59%**	**51%**	**69%**	**56%**	**61%**

8. Safe Water Systems

The Trust has dedicated roles within the organisation that act as responsible persons (R/P) for water, appointed in writing. There are 3 R/P's across the North, South and West of EPUT's property portfolio based within the Estates, Facilities & Property Department. In the event of the role becoming vacant or the R/P being on sick leave, Deputy R/P's have also been appointed by the Trust. The Compliance Manager is responsible for ensuring overall compliance for water safety legislation is met for the Trust. This responsibility is partly shared with the IPC team and the Head of IPC who have successfully completed the training to become the Responsible Officer to provide valuable knowledge and experience as part of the Water Quality group.

In line with HTM04-01 and L8 ACOP (Approved Code of Practice), in 2019 the Trust commissioned an Authorised Engineer (A/E). The A/E is an external contractor whose role is to offer impartial day-to-day support as well as the completion of site audits for the EPUT responsible property portfolio. The A/E is also a member of the Trust's Water Safety Group.

EPUT employ specialist contractors to support the safe water agenda, to undertake the water risk assessments, planned preventative maintenance and Water Risk Assessment remedial works. EPUT also has an in-house maintenance team of plumbers who support EPUT's water maintenance programme. This work is managed and monitored by the Estates & Facilities team. All staff and contractors undertaking the work are trained in legionella and water systems to ensure they understand the risks involved. This work is audited and managed by the Estates & Facilities team, including the Water Task & Finish Group.

Work & Health and safety issues relating to safe water systems are overseen and resolved by the Water Quality Group, where there is representation from the clinical services as well as Estates& Facilities, Risk Management, Consultant Microbiologist and PHE. The group meets bi-monthly.

The aim of the group is to develop, monitor and maintain the Trust water safety policy/procedure to include, but not limited to:

- Control of legionella
- Control of pseudomonas aeruginosa
- Safe working temperatures
- Anti-scalding measures

Outcomes and concerns of the group are raised in the IPC group meeting. The water quality group feeds directly into the HSSC which is the Trust's most senior Health and Safety committee, to ensure the group is sufficiently managing the risk associated with water.

The importance and efficiency of this group was evidenced recently following their successful management of a discovery of high levels of Legionella bacteria in the Derwent Centre in Harlow. This was due to a failed pump which has since been replaced.

In line with the Trust's policy, a sampling and works programme is ongoing. This includes the fitting of anti-legionella filters to 2 showers, the rebalancing of the water system between the Stort and Chelmer Wards and re-piping to 2 sink outlets.

Sampling continues with new schematics planned to be implemented. With help from our contractors and external partners such as Public Health England, the situation continues to be promptly and efficiently managed. As a result of the actions taken to identify and isolate the source of the contamination, no staff or patients were affected.

NHS Property services have also alerted EPUT to positive legionella counts at Saffron Walden Community Hospital, leading to filters being installed on all showers within Avocet ward. Again, prompt action has been taken and extensive work is ongoing, in conjunction with NHS Property Services, to remedy the situation.

9. Partnership Working

Effective prevention and control of infection is achievable with robust partnership working both within the organisation and with the wider health economy. Specifically, these include the Infection Prevention and Control Networking/HCAI Meetings in North and South Essex, joint working with our procurement services and the day-to-day liaison with our Estates and Facilities teams. In addition to this, the IPC team makes every effort to work in

collaboration with the Estates department to ensure Trust premises, and those our staff provide services from, are fit for purpose from an IPC perspective.

In addition to this, where premises/rooms are shared by multiple providers, the IPC team liaise closely with neighbouring IPC teams, NHS Property Services, external contracted Estates and/or Cleaning teams to address actions identified within IPC environmental audit.

Furthermore, clinical advice and support is provided as and when required. Continued access into SystmOne, Remedy and Mobius records has enabled the IPC team to support root cause analysis and post-infection review investigations.

The IPC team has also worked collaboratively with Essex County Council colleagues this year, providing Urinary Catheter Care training sessions for nursing home/care home staff, as part of the Council's PROSPER project.

10. Key Achievements

Key achievements for 2019/20 have included:

- Rapid and robust response and mobilisation to requests from the CCG and Regional team to prepare for the management of the iGAS outbreak
- Review of the EPUT Sepsis guidelines to be in line with current Sepsis UK guidelines
- Key participants in Flu campaign to reach best Trust compliance to date
- Rapid response and continued IPC leadership with clinical expertise from the onset of the Covid-19 pandemic

Work Programme for 2020/21

The Infection Prevention & Control team has supported all aspects of IPC in order to promote and maintain the continuation of excellent standards across the Trust.

In light of the Covid-19 pandemic, it is clear that IPC standards will be the foundation of all care provision. Therefore, the IPC work programme will continue to provide a responsive approach to interpret evolving clinical evidence, ensuring learning and standards of care support the reduction of nosocomial spread of Covid-19. The IPC team will work collaboratively with local Health protection teams and regional processes to monitor and take action on any potential Covid-19 outbreak, so that our patients and staff are protected as far as possible by IPC standards.Covid-19 Board assurance will be provided in accordance with national and regional guidance with close working collaboration with operational colleagues for assurance of standards.

The IPC team pledges to maintain the provision of a proactive, supportive and responsive service for all areas of the Trust. We will achieve this, in part, through liaison and networking with the wider health economy, ensuring that safety is maintained for our patients on their pathway through the local healthcare system.

Patient and staff safety remains a primary focus for the team; this will be demonstrated through our continuing audit and work programmes which will provide assurance to the Board of Directors that Infection Prevention and Control obligations are being met. Furthermore, to demonstrate the interventions we provide as a team in relation to treatment support and advice for staff, patients and carers.

It will be presented at the June 2020 Clinical Governance meeting, and will be circulated for approval from members of the Infection Prevention and Control group.

In addition to the work programme, the team focus will be a continued impetus to support Trust services to meet the KPI's as set by our various commissioners, ensuring that monthly reports to evidence the Trust's current position are provided.

Appendix 1

ESSEX PARTNERSHIP NHS FOUNDATION TRUST
ANNUAL INFECTION PREVENTION AND CONTROL WORK PROGRAMME 2020/2021

CODE CRITERIA	ACTION	TIMETABLE	LEAD	REVIEW/PROGRESS	HOT SPOTS	COMPLETE / IN PROGRESS / INCOMPLETE			
						Q 1	Q 2	Q 3	Q 4
1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.	**Appropriate management and monitoring arrangements will include:** • Submission of the Annual Infection Prevention and Control Report to Board	June 2020	AW	Completed and submitted on schedule – circulated to all IPC group members.					
	• Quarterly quality reports submitted to the appropriate commissioners.	Quarterly	IPCT	Sent via Performance team – IPC info incorporated within Quality Reports.					
	• Collation and submission of Key Performance Indicator data through surveillance programme.	Monthly - KPI's shared with all service areas monthly via performance reports, IPC group meetings, monthly Quality and Safety meetings.	IPCT						
	• Water safety group and water safety plans are in place. • Head of IPC attend meetings	Quarterly	AW						

	• Collaborative working with CCG's and other providers in area.	31/3/2021	IPCT	IPC team attends CCG/STP network meetings, collaborative work on community outbreak management, MRSA and C.diff investigations.					
	• Infection Prevention and Control Group meetings. • Chaired by DIPC. • Attendees include Occ Health, CCG & PHE rep's, and Microbiologist	Quarterly	AW						
	• Raise awareness and inclusion of risks on appropriate Risk Registers	31/3/2021	IPCT						
	• Keep up to date with emerging national guidance on the management of Coronavirus and risks posed to patients and staff and advise on mitigation actions.	31/3/2021	!PCT						
2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection	**Environmental Cleanliness and hygiene** • Monitoring and maintaining a clean and safe patient environment and cleanliness culture through audit and partnership–working with Clinical Leads and Facilities Department. Also includes meetings and liaison with external cleaning contractors	31/3/2021	IPCT/ Facilities team/ External Contractors	All areas feed in monthly environmental cleaning scores and these are reflected on the KPI performance sheets. IPC environmental annual audit reports are also shared with facilities teams for their action on relevant issues identified.					

	in community clinic settings for assurance purposes.								
	• Involvement in drawing up and monitoring of cleaning/laundry/waste contracts, particularly with regards the merging of the two organisations and drawing up of new service contracts.	Ad Hoc	IPCT	See above					
	• inclusion in planning for new builds and refurbishments	Ad Hoc	IPCT						
	• Advise on environmental and medical device decontamination.	31/3/2021	IPCT	Head of IPC attends Medical Devices meeting where approval is sought for purchasing of all new medical devices – this approval includes decontamination methods.					
	Audit Programme: • Environmental and IPC audits on all inpatient units and high risk community service clinics – review audit process across all areas and standardise audit frequencies and annual programme of audit.	Rolling Annual Programme	IPCT	Audit programme was not completed last year due to resource challenges resulting from the Coronavirus pandemic. This year's audit programme will be rearranged to ensure those that are overdue will be completed first.					
	• Hand hygiene audit programme – collation and presentation of nurse and patient observed audits. Review and standardise the process for hand hygiene audit data collection	Quarterly/Bi-annually	IPCT	1. Quarterly peer-observed hand hygiene audits on Perfect ward App in all inpatient units (10 observations per quarter) 2. Bi-Annual patient-observed paper-based feedback across all areas including Mental Health and Community Services (inpatient and community teams) Questionnaires are to be handed out to all patients seen by the team / on the ward on: 1. World Hand Hygiene Day 5th May, each year					

				2. International Infection Prevention week - the third week of October, each year (team to choose most suitable day of that week)					
	• Mattress audit programme	31/3/2021	IPC AP	On Perfect Ward App 6 Monthly in all inpatient settings.					
	• Invasive Device Care Bundle Audits – CHS and nursing homes only.	Quarterly	IPCT	On Perfect ward App.					
3: Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Systems to manage and monitor use of antimicrobials.	31/3/2021	MMT	Meds Management Team leading on this. Audit process in place, and feeds results into IPC Group meeting.					
	• Antibiotic Stewardship Committee/Group – incorporated as part of the IPC Group Agenda	31/3/2021	MMT/IPCT						
	• Local antimicrobial stewardship policy	31/3/2021	MMT						
	• Access to testing results is available via the local Acute Services pathology labs.	31/3/2021		IPC team working with IT team to gain access to all partner Acute Trust's pathology results.					
	• Prescriber induction and training in prudent antimicrobial use, antimicrobial resistance and stewardship competencies	31/3/2021	MMT						
	• Work with and assist Meds Management team to raise awareness for European Antimicrobial Awareness day in Nov 2017	31/3/2021	IPCT						

4: Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.	• Enhance public awareness through media communication as necessary	31/3/2021	IPCT						
	• Provide Patient information leaflets, hand hygiene posters, Isolation posters, Information sheets at reception desks • Posters/data re: appropriate use of antimicrobials • Posters re: reporting hygiene and cleanliness (Inc. HH) issues. • Review all existing information formats and refresh and standardise to suit all new areas of the organisation.	31/3/2021	IPCT IPCT						
	• Issue timely and appropriate audit feedback to teams – for display in public areas	31/3/2021	IPCT						
	Clinical IPC support: • Telephone advice for clinical staff in relation to treatment for identified infection and preventative measures to minimise risk from infection	31/3/2021	IPCT						
	• Lead on providing all staff in the Trust with the most up to date national guidance on the management of Coronavirus	31/3/2021	IPCT						

	and risks posed to patients and staff and advise on mitigation actions.								
5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	• Provision and regular review of policy/guidelines to support infection outbreaks	31/3/2021	IPCT						
	• Co-ordinate (in liaison with clinical leads) and advise on management of outbreaks	Ad Hoc	IPCT IPCT						
	• Mandatory reporting of Clostridium difficile infection cases and MRSA bacteraemia cases	Monthly	IPCT						
	• Carry out/support Root Cause Analysis studies on all Clostridium difficile and MRSA bacteraemia infections, and any other major infection incident • Support lessons learned cascade process	Ad Hoc	IPCT						
	• Attend scrutiny panel and Post Infection review Meetings as and when required.	Ad Hoc	IPCT						

	• Support and monitor the MRSA screening programme	31/3/2021	IPCT						
	• Support and advise clinical staff with known colonised/infected patients	31/3/2021	IPCT						
	• Continue work with the Tissue Viability Team to deliver wound infection presentation at wound care training days • Continue to support the MH wards, as required, with the management of infected wounds/wound care.	Ad Hoc	IPCT/Tissue Viability						
	• Carry out investigative case reviews and identify learning on any patients believed to have acquired nosocomial Covid 19 infection.	31/3/2021	IPCT						
6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	**Maintain Infection Control Link Workers (ICLW) Forum with continued support and training**	Quarterly	IPCT	IPC Conference to be held					
	Ongoing work with purchasing to standardise equipment/products used across Trust, with regard, to IPC, in order to ensure consistency of equipment provision and reduce cost • Roll out standardised IPC related disposable products to all areas.	Quarterly	IPCT						

	Continued monitoring and review of Datix sharps injuries. Information sharing with regards to sharp safe products for staff to trial. Liaise with Occupational Health & Wellbeing as appropriate.	31/3/2021	IPCT						
	Develop and deliver training programmes for: • Mandatory Trust Induction for all staff	Monthly	IPCT	A member of the team attends every Trust Induction to deliver a session to new employees.					
	• Report on uptake of e-learning training programme, which was developed in-house by the IPC team/workforce development and provide targeted adhoc face to face training sessions.	Monthly	IPCT	Training figures reported on monthly KPI sheets					
	• Deliver topic specific sessions when requested.	Ad Hoc	IPCT						
	• Raise Trust wide awareness of sepsis recognition and treatment	31/3/2021	IPCT						
	Co-ordinate hand hygiene training programme: • Deliver light box training sessions on the wards for staff and service users. Maintain training records	Ad hoc		IPC AP					

	Attend individual team meetings to cascade information and training	Ad Hoc		IPCT					
7: Provide or secure adequate isolation facilities.	**Monitor isolation times –** infectious patients to be isolated within 2 hours	31/3/2020	IPCT	Reported on Community inpatients KPI's.					
8: Secure adequate access to laboratory support as appropriate.	• Review and monitor new organisation wide contract with Microbiology department in CHUFT	31/3/2021	DIPC/IPCT						
	• Advise on the collection, storage, transport and interpretation of specimens/samples, including Coronavirus swabs.	31/3/2021	IPCT						
	• Promote collaborative working with acute trust laboratory and microbiological partners, particularly with regard to effective antimicrobial stewardship.	31/3/2021	IPCT						
	• Continue to explore ongoing issues surrounding MH units accessing electronic microbiological results and information for patients.	31/3/2021	IPCT						

9: Have and adhere to policies designed for the individual's care and provider organisations, which will help to prevent and control infections	**Review and monitor Infection Control Guidelines** • Amend, as and when national guidance alters, or new guidance is issued. Ensure information is cascaded Trust wide.	31/3/2021	IPCT						
	• **Antimicrobial prescribing –** programme of audit and staff/management feedback. • Work with Meds Management team to amalgamate and standardise processes.	31/3/2021	MMT/IPCT						
	• **Control of outbreaks** Have in place alert organism system.	31/3/2021	IPCT	When this guideline is due for review, changes will reflect learning from involvement in the iGAS outbreak.					
	• **Provide guidance and support to staff in the event of a Coronavirus outbreak in inpatient units.**	31/3/2021	IPCT						
10: Providers have a system in place to manage the occupational health needs of staff in relation to infection.	**Collaborative working with Occupational health services in particular with regards to:** • Sharps injury / body fluid exposure incident prevention & monitoring	31/3/2021							
	• Planning and coordinating the Influenza vaccination programme. • Develop method for capturing data relating to staff accessing	31/3/2021	IPCT/ CQUIN team						

	vaccination outside of the Trust.								
	• Planning and coordinating a Coronavirus vaccination programme, when vaccine available.	31/3/2021							
	Physical Healthcare Agenda								
	In collaboration with the Head of Physical Healthcare, support Mental Health wards as requested/appropriate with clinical and physical health care issues: • Recognising the deteriorating patient • Wound care advice • Diabetes care advice and basic training • General advice about physical health care e.g. Waterlow hypertension / hypotension • Other aspects of physical healthcare – patient specific	31/3/2021		IPCT in liaison with relevant specialist nurses.					

		Agenda Item No: 6f
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	**Safeguarding Annual Report**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Tendayi Musundire, Head of Safeguarding					
Report discussed previously at:	Quality Committee & MHA & Safeguarding Sub-Committee					
Level of Assurance:	**Level 1**		**Level 2**	**X**	**Level 3**	

Purpose of the Report		
This annual report has been set up to look at how the legislation in relation to Safeguarding is used within EPUT and to consider how practice can be improved.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

1. Consider the issues and hotspots and where appropriate the mitigating actions as identified in the report.
2. Note the Trusts position in relation to national trends and action being taken.
3. Request further action / information as required.
4. To be aware of matters of concern with regards to safeguarding and actions being taken.

Summary of Key Issues

The annual report provides evidence of the Trust's achievements and its continued commitment to the safety, protection and prevention of harm to its service users.

This annual report looks to review and understand the reasons for Safeguarding legislation being applied and how processes can be reviewed to ensure the best standards of care at all times.

Whilst a number of achievements have been accomplished this year, we continue to challenge ourselves and others so that we develop and improve the quality of service provided. As a result of the Covid-19 virus, the year has ended with the service adapting the way it delivers its business; including offering new ways of working that enhance the service offered.

The report is divided into the following key areas;

- Safeguarding Strategic Direction and Development
- Safeguarding Adults
- Safeguarding Children
- Looked After Children
- Serious Case Review and Domestic Homicide Reviews
- Forward Plans

Key Risks

- Training Compliance
- Backlog of Deprivation of Liberty Assessments being carried out by Essex County Council
- Impact of Covid-19 with regards to safeguarding adults and children at risk

Key Assurances

- Good collaborative working with partner agencies to safeguard families
- Use of Datix as a recording system for all safeguarding concerns
- Successful implementation of a Duty System
- Safeguarding adults and children policies were reviewed

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	
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:			
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

Natalie Hammond
Executive Nurse

Essex Partnership University
NHS Foundation Trust

Safeguarding Annual Report 2019 - 2020

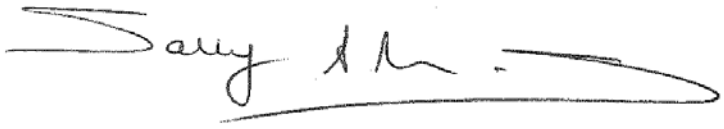
Contents

Foreword

I am delighted to introduce the 2019/20 Safeguarding Annual Report. This demonstrates the Trust's continued commitment to safeguarding as a key organisational priority within the Trust Corporate Objectives.

Safeguarding children and adults is at the heart of the services we provide. Good practice examples are presented in this report to show that our staff are committed to the safeguarding agenda, take pride in delivering safe services and continually strive to develop their skills and knowledge in order to keep people safe and protect them from harm. The end of the year saw the safeguarding service operating very differently both within the organisation and with our partners as a result of the Covid-19 virus.

My vision is to continue to ensure the Trust maintains the highest standards of quality and to provide excellence within all aspects of the Safeguarding Service.



Sally Morris
Chief Executive

Introduction

This annual report has been written to provide assurance that the Trust has robust and effective safeguarding services in place that reflect the Local Authority priorities that we work with and National Guidance, including *Working Together to Safeguard Children 2018* and *The Care Act 2014.*

The annual report provides evidence of the Trust's achievements and its continued commitment to the safety, protection and prevention of harm to its service users.

Whilst a number of achievements have been accomplished this year, we continue to challenge ourselves and others so that we develop and improve the quality of service provided. As a result of the Covid-19 virus, the year has ended with the service adapting the way it delivers its business; including offering new ways of working that enhance the service offer.

The report is divided into the following key areas;

- Safeguarding Strategic Direction and Development
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- Safeguarding Children
- Looked After Children
- Serious Case Review and Domestic Homicide Reviews
- Forward Plans

1.0 Strategic Direction

This year has seen great changes in the integration of mental health and community health services for safeguarding.

Outcomes of Annual Plan 2018/19

The objectives set in the 2018/19 plan have been achieved or are ongoing and been carried forward as demonstrated below. Additional detail on the outcomes of each objective is outlined within this report.

Table 1:

	Objectives 2019/20	Success Criteria	Actions taken for success
1	Update Strategic Framework	Framework is in place	Strategic framework was reviewed and aligned to the safeguarding business priorities
2	Ensure a successful outcome following any CQC inspections	Any recommendations are implemented	No children's safeguarding identified Action plan completed for the recommendation regarding Mental Capacity Act
3	Continue to develop and enhance the Trust Intranet section for Safeguarding	Safeguarding page on the intranet contains guidance and resources	The trust intranet page has been redesigned and updated New policies, safeguarding training materials, newsletters were added and the safeguarding team contact details were updated
4	Complete the 2019/20 Audit programme for safeguarding	Audits completed, reported and recommendations identified	Section 11 audit returns next due 2021 Audit of Safeguarding Children Child Protection referrals South Essex Audit of Safeguarding Children Supervision Survey Mental Capacity Act Audit Safeguarding Process Audit
5	Ensure a continued Safeguarding support system in place for EPUT adolescent units	Staff on EPUT Adolescent units feel fully supported by the safeguarding team	Supervisions sessions delivered Reports submitted to the relevant Senior Managers Meeting Several bespoke training sessions offered to the staff
6	Review and strengthen the arrangements in place for Exploitation and gangs	Guidance is available to staff on exploitation and gangs Staff can access training on exploitation and gangs	Corporate procedures were reviewed and updated to include new guidance and legislation Safeguarding training programmes have been reviewed and refreshed Staff have attended multi agency commissioned training EPUT Safeguarding conference on Trauma Informed Care and Exploitation

7	Raise awareness for Mental Capacity Act in light of the proposed amendments	Increased number of mental capacity assessments	Reviewed Training program Targeted areas with limited assurance with regards to carrying out capacity assessments for additional training, unfortunately some of the sessions could not be delivered due to restrictions as a result of COVID19

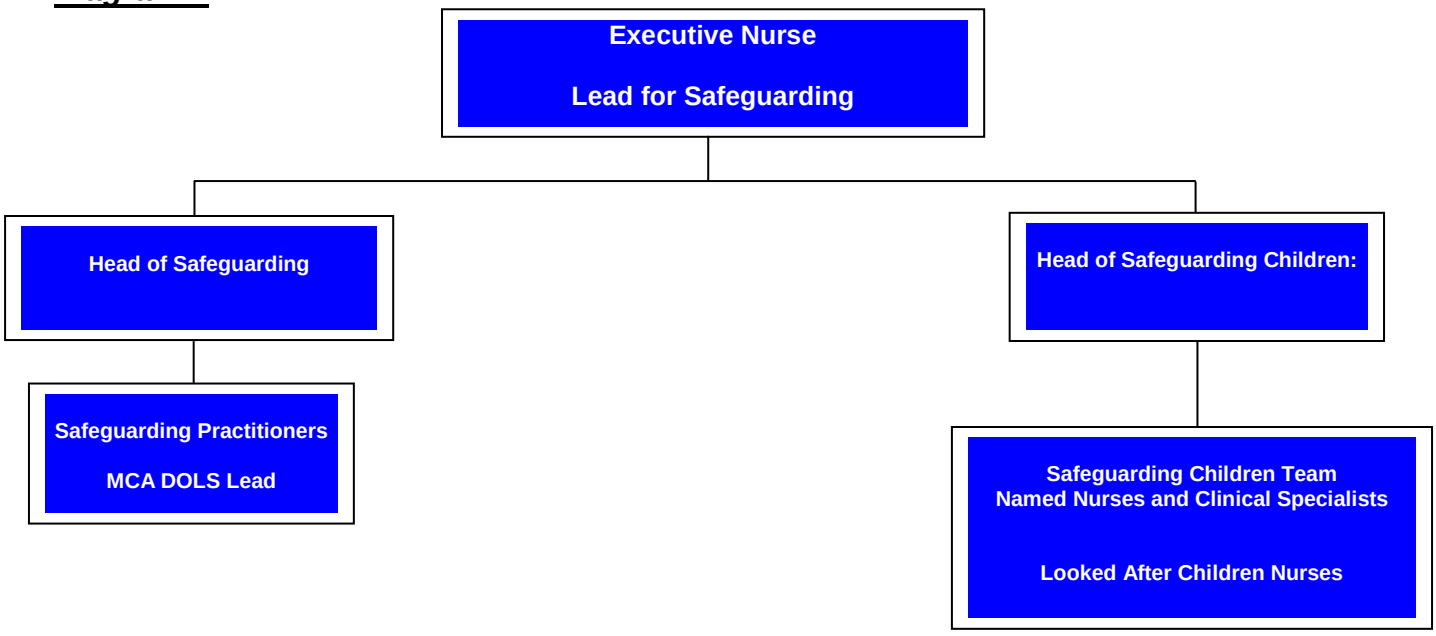
Safeguarding Structure

Within Essex Partnership University Trust (EPUT) the Executive Nurse is responsible for the delivery of the Safeguarding service, which includes the Mental Capacity & Deprivation of Liberty service and the Looked after Children service. This responsibility is outlined in the Executive Nurse's Job Description.

The Safeguarding team is led by two Heads of Safeguarding across the Trust for the provision of Mental Health and Community Health Service provision. The team additionally provide a safeguarding children service to the 0-19 service in Southend-on-Sea Borough Council (SBC). The team has adopted a "Think Family" philosophy and are providing an integrated approach to safeguarding provision which is facilitated by joint meetings and peer support. The team consists of a variety of professionals e.g. General and Mental Health Nurses, Midwives and an Occupational Therapist, all of whom bring additional expertise to the service. The safeguarding adult team operate a duty system between the hours of 9-5 Monday to Friday and aim to extend this to the children's provision.

The following chart shows the existing Safeguarding service structure.

Diagram 1



Safeguarding Group

Safeguarding within EPUT is assured via the Trust Mental Health Act and Safeguarding sub-group. The group reports to the Quality Committee which is chaired by the Executive Nurse and meets bi-monthly. The terms of reference have been agreed by the membership which

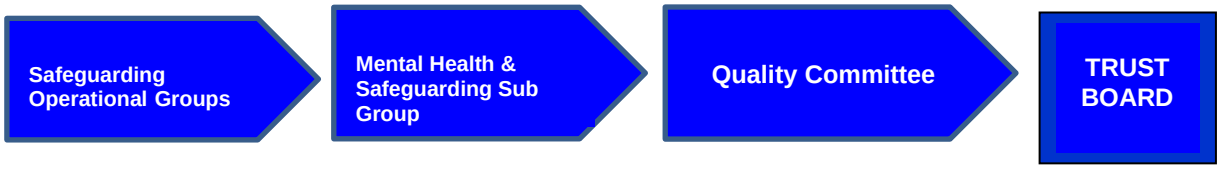
includes senior managers/clinicians from operational teams, senior members of the teams from the Mental Health Act (MHA) Office and the Heads of Safeguarding.

All Trust safeguarding and partnership reports, policies and protocols, are agreed at the sub-group before being presented to the appropriate Trust Quality Committee, Trust Executive Team or Trust Board. The sub-group is supported by operational safeguarding groups within both community and mental health services.

The Safeguarding sub-group reviews the Trust's strategic safeguarding plans and ensures alignment with the local area safeguarding partnerships.
Cases where 'lessons learnt' have been identified are presented at meetings and cascaded to clinical teams.

Safeguarding Service Reporting Pathway

Diagram 2 Demonstrates the reporting pathway for the Safeguarding service within the Trust



The Trust has robust reporting systems in place which ensures the Trust Board and associated committees are updated regularly on safeguarding performance, trend analysis and quality issues. The Trust Safeguarding team provides regular reports for the Local Authority, Clinical Commissioning Group (CCG) and NHS England.

Strategic Framework 2018-2020

The Framework establishes the vision for the Trust Safeguarding service and builds on existing achievements.

The Framework has been updated every three years to reflect changes in national and local priorities including.

- Structure & Reporting Arrangements
- Clinical Governance
- Partnership Working
- Partnership Learning Reviews and Serious Adult Reviews
- Strengthening Learning
- Equality & Diversity
- Human Resources

The Trust's strategic framework is due for renewal in 2020 for the new, three-year plan.

Safeguarding / Serious Incident/ Communications Dept. /Complaints

The Safeguarding service is represented by the Head of Safeguarding at the weekly joint meeting with the Trust's Serious Incident, Complaints, Legal Department and Communications Teams to ensure the effective interface between the services. The aim is to

ensure necessary notifications, (e.g. CCG and CQC) investigations and reports are completed appropriately and to avoid duplication of processes.

All appropriate departments are kept informed of any changes, developments and progress of Serious Incidents, Safeguarding Partnership Learning or Serious Adult Reviews and Domestic Homicide Reviews. The Trust Communications team are notified of any case that may result in media interest.

Joint reports from both the Safeguarding and Serious Incident services are presented to Local Authority Safeguarding Partnerships on request. Heads of Safeguarding attend partnership meetings when required, eg in the case of a joint serious incident or a safeguarding review. This helps to avoid duplication and supports organisational liaison.

All complaints that relate to safeguarding and the care received by service users or concerns regarding staff are sent to the team for consideration. An assessment is carried out to identify if a safeguarding enquiry or action is required.

When required, the team works in partnership with the complaints department and Human Resources team in order to achieve a resolution.

Partnership Working

Local Authority Safeguarding Partnerships

The Trust is actively represented on all the relevant Local Authority Safeguarding Children and Adult Partnerships by Executive Directors, Directors and Heads of Safeguarding. This representation is an important part of developing and influencing services for Trust service users and demonstrates the Trust's commitment to the safeguarding agenda and successful working relationships with other agencies.

Working in partnership ensures that all Safeguarding Partners are aware of the work EPUT is involved in. It also offers an opportunity for partners to seek help and expertise from the Trust when developing strategies/protocols which include aspects of mental health. Indeed, along with the CCG, one of the Local Authorities has commissioned the EPUT Safeguarding Children team to support their 0-19 services in the authority.

Regular reports and audit outcomes are presented to the Local Safeguarding Partnerships. Minutes of these Partnership meetings are routinely placed on the agenda of the Trust's Safeguarding Groups and presented by the EPUT representative.

Each Safeguarding Partnership has a number of sub-groups which include the Health Executive Forum, Training sub-group, Monitoring Audit and Compliance sub-group and Policy Development group. These are attended by members of EPUT Safeguarding team who actively participate in achieving the aims of the individual Safeguarding Partnerships.

Additional information and achievements are outlined below within the sections relating to children and adults.

Paul Hill (Southend Safeguarding Partnership Adults Business Manager):

"Essex Partnership University NHS Foundation Trust (EPUT) is a key and trusted member of the SSP. They engage in the work of SSP and actively contribute to our work. Members of SSP have also attended training events and conferences provided by EPUT which helps further develop our collaborative working. EPUT adds significant value to the Partnership"

Levi Sinden (Thurrock Safeguarding Adults Board):

"The TSAB continues to find EPUT's contribution to the board and its sub-groups, extremely valuable. Their commitment to the work of the board is demonstrated through their attendance at board and sub-group meetings, a willingness to undertake actions when required, attendance at the TSAB events, and events which are hosted by the TSAB or other agencies, which benefit the adult safeguarding agenda. We find their contribution to be responsive, flexible and timely; we will continue to develop our relationship during the forthcoming year."

Clinical Commissioning Groups (CCG)

A Safeguarding service specification for both children and adults has been agreed with Essex CCGs. Monthly and quarterly reports containing updates on the agreed specifications are presented to the respective Clinical Quality Review Group.

The EPUT Safeguarding teams meet regularly the CCG Designated Nurses and County Wide groups for Safeguarding to review current cases and joint plans with the Local Safeguarding Partnerships. These have included:

- Review of partnership services for Exploitation
- Female Genital Mutilation
- Domestic Abuse
- Looked After Children Health Reviews
- Deprivation of Liberty processes
- Mental Capacity Act
- Safeguarding Adult reviews

Care Quality Commission (CQC)

The Head of Safeguarding for mental health services has established a relationship with the CQC Inspector (Relationship Owner) appointed to cover EPUT, for the speedy review of concerns or issues raised. The purpose is to review new safeguarding cases reported to CQC and discuss the progress and outcomes of existing cases.

CQC inspectors are invited and have attended safeguarding cases where appropriate. As a consequence, a good working relationship has been established and processes have been put in place for communicating and reviewing cases that are opened with the CQC.

From 29 July to 22 August 2019, the CQC undertook an inspection of the quality of care provided by the Trust and awarded the Trust with an overall rating of Good.

The following are some of the comments made in the CQC report:

'Staff understood safeguarding legislation and described how to identify different types of abuse. Staff acted to protect vulnerable patients and worked with external agencies to increase support for patients. The trust offered all staff support with safeguarding through a centralised team that visited wards to increase awareness, offer support and to conduct investigations, where appropriate. The safeguarding team represented the trust at national events to ensure they were in touch with national developments and they communicated learning to ward teams via newsletters and visits.'

'Local leaders had appropriate oversight of issues relating to risk, safeguarding, admission and discharge and other relevant key performance indicators. Local leaders could submit items to the risk register for monitoring and action.'

'The service provided safe care. The ward environments were generally safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They aimed to minimise the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.'

'Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The trust had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.'

MAPPA – Multi-Agency Public Protection Arrangements

This is the process that enables the Police, Probation and Prison Services to work closely together, along with other relevant agencies, to manage the risks posed by violent and sexual offenders living in the community in order to protect the public. MAPPA is not a statutory body in itself but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a coordinated manner. Agencies at all times retain their full statutory responsibilities and obligations.

Safeguarding Conference March 2020

In March, a Safeguarding Conference that was due to be hosted by the Safeguarding team had to be postponed due to COVID-19. The conference was focusing on Trauma Informed Care and Exploitation within Essex, Thurrock, and Southend. This will now be reported in next year's annual report as a result of the rescheduled conference.

Work with CAMHS Adolescent Wards

Work with CAMHS Adolescent Wards includes:

- 'Introduction to Safeguarding' - a 2-hour session created and delivered to new starters and students on how we can support them and informing them about the safeguarding team's role

- 'Working with people with Learning Disabilities (LD) and/or Autism' – a short training session created for Psychiatric Assessment Unit (PAU) following several incidents with a male on the ward with a diagnosis of LD & Autism which were escalated to risk. Practice considerations, effective forms of communication and additional needs are discussed as part of this piece of work

- Local Authority Designated Officer (LADO) – Flowchart created for both adolescent wards to support them in the LADO process and ensure that all incidents are reported in a timely manner. Safeguarding Clinician met with LADO team and arranged a 'LADO training day' at St. Aubyn Centre. Unfortunately due to COVID-19 this has been postponed

'Together with Baby' Team

Links have been formed with the newly commissioned 'Together with Baby' team, with a Clinical Specialist attending team meetings to offer group advice/supervision.

Children's Services (West)

In the West there has been a recent reorganisation which has included some positive service developments, including closer links with General Practitioners (GP) consortiums and a focus on transitions for younger people who need adult mental health services. We have taken that opportunity to bring together our staff and Essex County Council (ECC) staff in a forthcoming workshop around how we can develop more effective joint working and achieve better outcomes for young people and their families.

Susanna Moorhouse (Service Manager Children in Care, Leaving and After Care and Fostering):

"In Children and Families West, we have greatly appreciated the commitment from EPUT colleagues in supporting us with those young people who are 17 years plus who have mental health difficulties. For those under 18 years the support in planning together for post 18 services during their seventeenth year is essential and beneficial in ensuring that we jointly identify the most appropriate accommodation and services to meet their complex needs once they are 18. Additionally, we have had proven success working together with a number of 18 – 19 year olds with significant mental health needs. EPUT colleagues have provided a responsive service to several young people, in close liaison with us, so that again the most appropriate way forward has been sorted as quickly as possible. We look forward over the next year, to developing working together opportunities further with families where both EPUT and Children and Families are involved where parents struggle with mental health difficulties."

Domestic Abuse (DA)

As Domestic Abuse (DA) lead we participate in the Multi-Agency Risk Assesment Conference (MARAC) steering group, the DA partnership group, and the DA health group in order to develop closer working relationships and contribute to shaping DA services in Essex.

We have also been raising staff awareness around our responsibilities to seek and share information where appropriate with our partners and our duties and responsibilities regarding data protection legislation.

DHR recommendations have repeatedly highlighted insufficient information sharing (an issue for all agencies) as a likely factor in domestic homicides. This is an area we are working hard to develop across EPUT, with support from our safeguarding admin team.

EPUT Operational Team Feedback

Simla Aldridge (Team Lead, Southend Recovery Wellbeing):

"The Safeguarding team is always accessible and available to discuss and advise on any safeguarding concerns the Southend R&W team may have on any safeguarding inquiries and we very much appreciate your help and support.

Your good self Gifty, Fiona and Sarah have been very supportive of the team in terms of attending MDTs and strategy meetings when required.

I would appreciate if our report could be updated though as there seems to be discrepancies every month, not a criticism just an observation"

Safeguarding Training

The Safeguarding Training Strategy, applicable to all Trust staff, has been updated to reflect the national requirements in the; Intercollegiate Documents (*safeguarding children 2019, adults 2018)* the Care Act 2015, the Home Office guidance on Prevent and the Mental Capacity Act 2015 (MCA) which includes the Deprivation of Liberty Safeguards (DOLS) and Intercollegiate Document 2015 (looked after children).

The strategy outlines the mandatory training programme for EPUT staff. This includes different levels of training depending on staff roles, levels of contact with children or adults and levels of responsibility within the Trust, as demonstrated below in table 2.

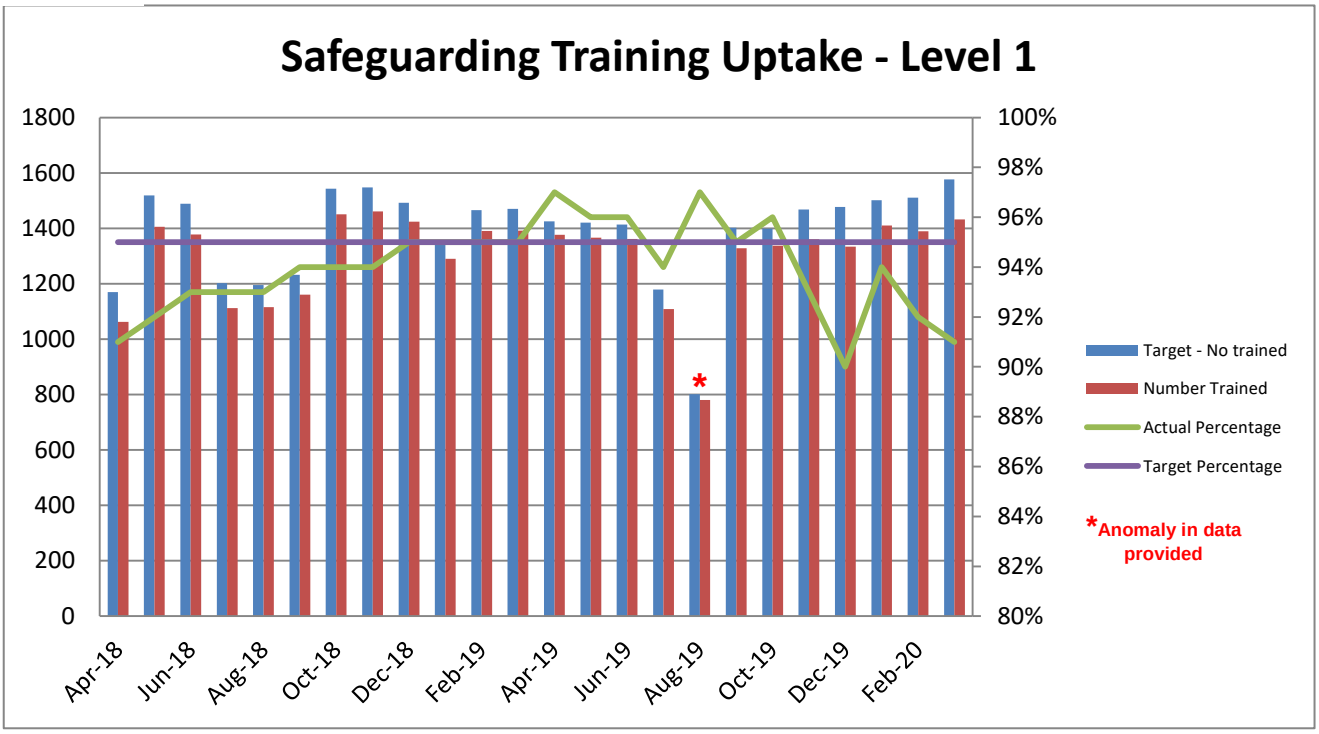
An enhanced programme on Domestic Abuse and Sexual Exploitation was added to the Level 2 training programme which is accessed by ALL clinical staff. This includes Forced Marriage, Female Genital Mutilation (FGM) and changes in the law regarding coercive control.

Table 2: Mandatory Safeguarding training levels

Statutory Mandatory Training	Staff Category	Delivery Method	Duration	Update Interval	Notes	Name of Course on OLM
Safeguarding Adults and Children Level 1 *CSTF Safeguarding Adults, CSTF Safeguarding Children*	All Staff	E-Learning	E-Learning	3 yearly	Classroom at Corporate Induction	364 Safeguarding Adult and Children Level 1 OLM (Year) 300 Safeguarding Adult and Children Level 1 OLM (Year)
Safeguarding Adults and Children Level 2 (inc. MCA, DOLS & Prevent) *CSTF Safeguarding Children Level 2, CSTF Safeguarding Adult Level 2*	All clinical staff and non clinical staff that have contact with adults, children, young people and parents/carers Update required for level 2 if staff have only completed either level 3 safeguarding children or adults. NO UPDATE REQUIRED IF STAFF HAVE COMPLETED SAFEGUARDING LEVEL 3 CHILDREN AND SAFEGUARDING LEVEL 3 ADULT.	E-Learning	E-Learning	3 yearly	Classroom at Corporate Induction	364 Safeguarding Adult and Children Level 2 OLM (Year) 300 Safeguarding Adult and Children Level 2 OLM (Year)
Safeguarding Children Level 3 *CSTF Preventing Radicalisation (Awareness of Prevent)* *CSTF Safeguarding Children Level 3*	All registered staff working within children community and inpatient services bands 5-8b All registered staff working within community mental health and learning disability services bands 5-8b All registered staff working with inpatient mental health and learning disability services bands 5-8b All registered staff working in St Albans centre, Poplar ward and Rainbow unit bands 5-8b	Classroom	1 day	3 yearly		
Safeguarding Adults Level 3 (inc. PREVENT WRAP, MCA and DoLS) *CSTF Preventing Radicalisation (awareness of Prevent)* *CSTF Safeguarding Adult Level 3*	All registered staff working within adult mental health and learning disability community inpatient services. Band 5-8b	Classroom	1 day	3 yearly		
Safeguarding Adults/Children Level 4	All registered staff working within the Safeguarding Team.	Classroom	1 day	3 yearly		

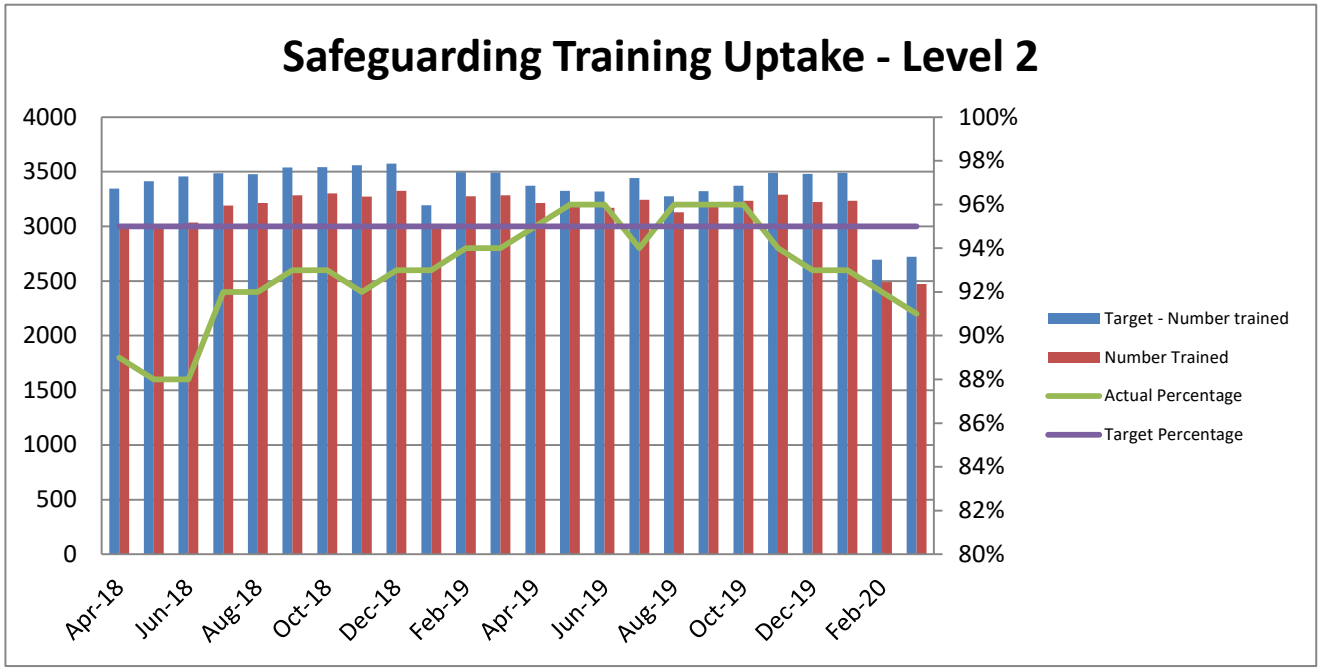
The Safeguarding training programme has been integrated into the Trust Mandatory training policy. The training compliance for 2019/20 remains a challenge, however Trust staff are able to access training across the county. This has been exacerbated by the fact that we had to cancel all face-to-face training towards the end of the year, due to COVID-19.

Chart 1



Level 1 training is for all clinical staff (Level 1 is integrated into Level 2 to avoid duplication for staff requiring both competencies). This includes basic awareness of Safeguarding, MCA DOLS, Prevent and Domestic Abuse. The competences of staff were reviewed within the organisation in October resulting in an increase in those requiring training hence the change in the compliance figures. The compliance is not meeting the compliance level set by Health Executive Board, 95%.

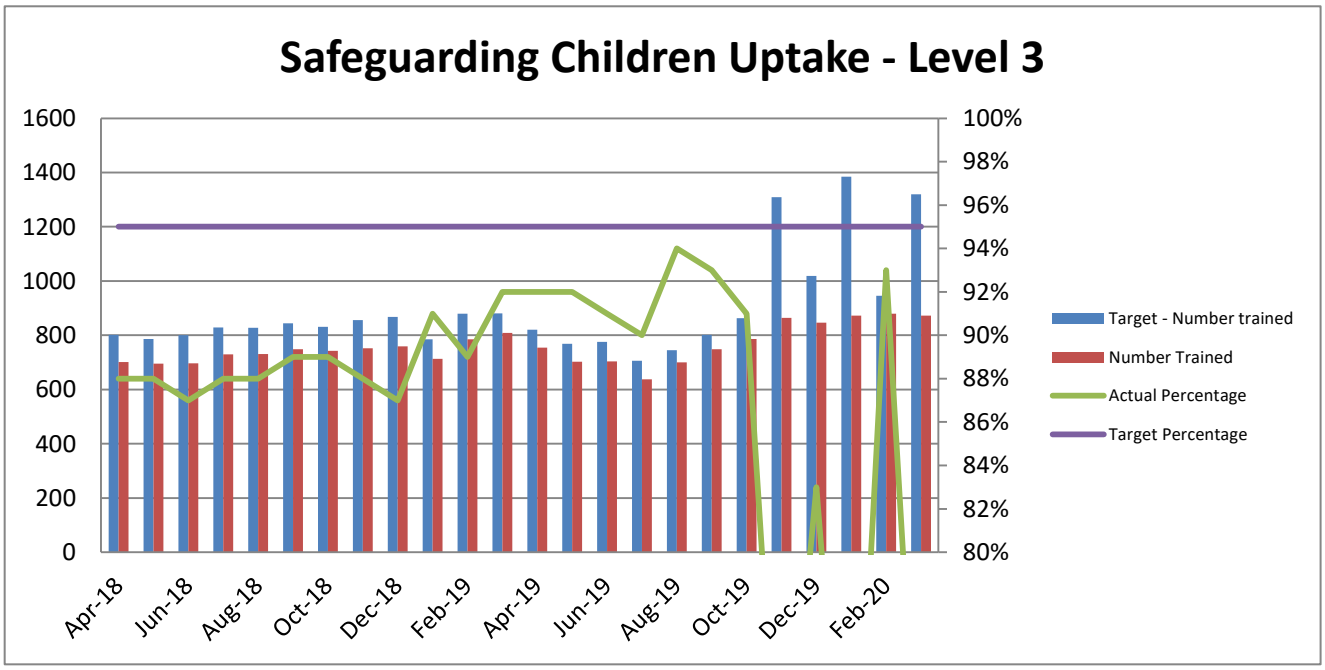
Chart 2



Staff that are required to undertake level 2 training will work with either children or adults and older people and are responsible for assessing planning, intervening and evaluating needs. This includes investigating safeguarding issues, Prevent, MCA & DOLS. The competences of all staff were reviewed in October and resulted in an increase in the number of staff required to undertake Safeguarding Level 2 training, hence the challenge with compliance.

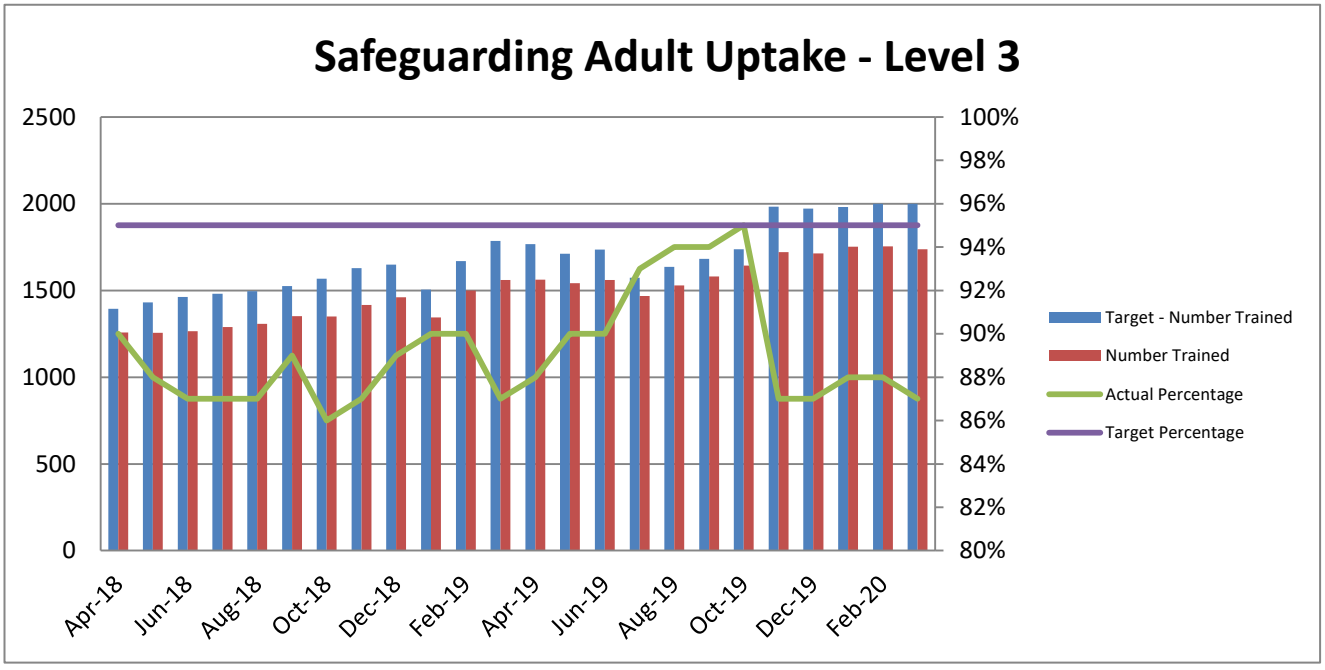
The current compliance rate is not meeting the rate set by Health Executive Board, 95%. This was largely affected by the suspension of training due to COVID-19. The compliance has generally sat above the target of 95%.

Chart 3



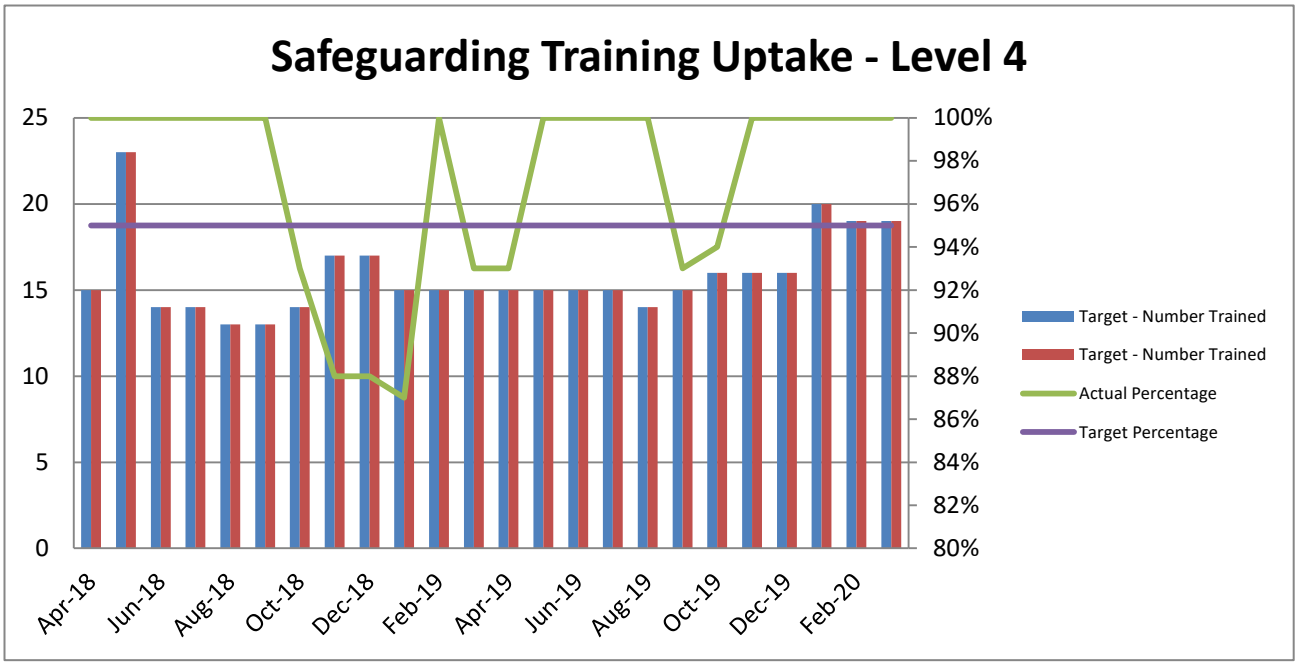
Specific staff working with children or parents and responsible for assessing planning, intervening and evaluating needs. This includes Prevent, CSE, FGM etc. The training compliance is mapped at 95% by the Health Executive Board. The competences of all staff within the organisation were reviewed in October resulting in an increase in staff required to do Safeguarding Children Level 3 training, hence the challenge in compliance. This has been further exacerbated by COVID-19, where all face to face training was suspended which impacted the progress being made.

Chart 4



Specific staff working with adults and older people and responsible for assessing planning, intervening and evaluating needs. This includes investigating safeguarding issues, Prevent, MCA & DOLS. The current compliance is not meeting the compliance set by Health Executive Board, 95%. The competences of all staff within the organisation was reviewed in October and resulted in an increase in staff required to do Safeguarding Adults Level 3 training, hence the challenge in compliance. This was further exacerbated due to COVID19, where all face to face training was suspended which impacted the progress being made. This was mainly due to the cancellation of the additional training courses planned giving more opportunities for staff to attend.

Chart 5



All registered staff working within the Safeguarding team.
The compliance for the team is generally compliant above the 95% compliance rate.
The team compliance was generally 100% for most of the months. The exceptional cases were due to long term leave (maternity leave) during the latter part of the year.

The Prevent Strategy

Prevent is one of the four elements of CONTEST, the government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism.
The Trust has a lead Prevent Officer as part of the Safeguarding team and the Trust is represented at a number of meetings with the Police and strategic groups including the CHANNEL Panel (a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorism).

Awareness of Prevent has been incorporated into all the mandatory training levels 1-3 including during Trust induction.

Mental Capacity and Deprivation of Liberty Safeguards (MCA DOLS)

The Mental Capacity Act training programme for all staff working with adults is via E-Learning and is also incorporated into face-to-face safeguarding adult training. There is an OLM for staff interested in enhancing their knowledge of MCA as well as a specialist MCA DOLS face-to-face programme for staff working in inpatient units in both mental health and Community Health settings. Additional bespoke face to face training is offered by the Safeguarding team.

Looked After Children (LAC) Training

A LAC training programme is delivered to all those involved in providing a direct service to Looked After Children, including Health Visitors, School Nurses and Family Nurses. This training outlines the legal framework and raises awareness of the health needs of those children who are Looked After.

"The training has improved my knowledge of the Strengths and Difficulties Questionnaire and how to interpret the results of these"

0-19 Practitioner

"I am now going to include more description from the voice of the child in my assessments"

0-19 Practitioner

"I am going to read and use the Initial Health Assessment to gather more information"

0-19 Practitioner

Additional Training Programmes and feedback

The Safeguarding team continue to deliver specific training programmes in addition to the mandatory programme requirements, for example:

- **An Introduction to Safeguarding** is delivered on each monthly Induction training session which is mapped at Level 1 and 2
- **Trust Board** receives an update on safeguarding on alternate years which includes any new services, requirements or changes in the law
- **Partnership Learning and Serious Adult Reviews** De-brief and learning sessions are arranged routinely for staff following a serious case review on a child or adult
- **Bespoke courses -** The team offer courses focusing on Safeguarding Awareness and the Mental Capacity Act. These are often attended by trainee doctors, student nurses, and MSc students

IMR Training

Delivered by: Althea Cribb- Independent Domestic Homicide Review Chair

(IMR) Individual Management Report training: The training outlines the types of statutory reviews that require agencies to complete Individual Management Reviews (IMRs), and why they are important. The aim of the training is for attendees to understand what an IMR is, and how to plan and complete one.

Frances Stevens (Team Manager Castlepoint, Rayleigh and Rochford Recovery and Well-being & First Response Team):

"I found it really beneficial. There was such a lot to get through I'm sure it could have filled a whole day to give it the justice it deserves, but the pace was good, challenged my thinking and developed my understanding."

DASH Training

Delivered by: Jacqueline Lovegrove - Operations manager for MARAC/MARAT team

DASH (domestic abuse stalking and harassment) is a national devised to help clients and practitioners identify risk and highlight where the risks might be greater, necessitating more intensive support, such as referral to MARAC (multi agency risk assessment conference/team) for input.

It is a very helpful clinical tool when working with clients who are experiencing domestic abuse in their lives. It can also help clients to develop insight into what they are experiencing. It is recommended that clinicians using DASH should receive the appropriate training. The operations manager of the Essex MARAT/MARAC, Jacqui Lovegrove, provides

DASH training and clinicians who participate feel more confident about using the DASH, and about domestic abuse in general.

The feedback received from delegates shows that their knowledge increased on the following subjects:

- The legislation that is relevant to safeguarding adults/DASH
- The procedure for reporting abuse
- What is and isn't good practice in DASH
- The types of abuse, signs and symptoms
- Factors that may lead to abusive situations and / or poor practice
- How to deal with disclosures, preserve evidence and record incidents according to policy requirements

How do we know training has improved clinical practice?

Those attending the training complete an evaluation form which includes being asked to make a pledge regarding what they will change in their clinical practice as a result of the training session. These 'pledges' are followed up by the Safeguarding team on a regular basis to ensure implementation.

Example of staff pledges include:

"My knowledge has greatly improved. I am more aware of legality [sic] of various . I will adopt in my practice. We discussed various difficult cases which helped me to safeguard a child/vulnerable child"
Locum Registrar (MH doctor)

"[I will] make sure I give each client the opportunity to be seen individually/alone. And to speak to the safeguarding lead in my new locality"
Assistant Psychologist

"[I will] report promptly if any safeguarding issues to the team and fill the datix form. SETSAF 2 must be completed within 5 days. And collect information and do the appropriate mental capacity assessment"
Staff Nurse, Community Hospital

"To read more about the legislation that is relevant to safeguarding. To check that the procedures for reporting abuse is followed up."
Staff Nurse, Acute MH Hospital

"Speak within my team to find out exactly how we manage a disclosure & keep the person safe following a 1 to 1 session. Find out if there is a safeguarding lead at my site & who they are. Find out the contact details for the safeguarding team & how to find this on the intranet."
Assistant Psychologist

"Asking more questions and assume no one else would if I don't. Spend more time investigating the stories told, and analyse more to get the bigger picture."
Community Mental Health Nurse

"In my clinical situation, I will try to notice any form of abuse that could raise my concerns to raise safeguarding. If in case any safeguarding is raised, I'll be able to contact the safeguarding team with the data to support my evidence."
Locum Trust Grade Doctor

"When assessing capacity in the future I will give examples of the conversation/assessment where they met criteria in demonstrating they have capacity. To book on the new Deprivation of Liberty/mental capacity course when it is available"
Clinical Lead, Substance Misuse team

"Check if safeguarding issues have been identified & raised by assessing team prior to admission"
Staff Nurse, Acute MH Hospital

"I will be more observant and informed when dealing with clients and families where children are involved. I will discuss with my manager whenever I have concerns and possibly raise a safeguarding concern. Familiarize myself with all the relevant policies"
Senior Community MH Nurse

"I will be more aware and reflect this in assessment questions – of importance of establishing family dynamics. Be able to discuss with students with more confidence now."
Staff Nurse, Older Adult MH Hospital

"Use of Health Visitor/School nurse notification [form], use this more. Find out more about online safeguarding, especially NSPCC & Stop it Now; look it up & pass information on to parents & other staff"
MH Social Worker

"Informing a patient of their rights IMCA if they do not have next of kin. More Knowledge and understanding when a patient refuses treatment, especially when they have capacity."
MH Community Nurse

"Discuss 5 principles of the Mental Capacity Act in team meetings & safeguarding discussion in partnership meeting. To share updated learning from safeguarding Level 3 training with the team and partnership agency. Actively encourage all EPUT staff to contact Safeguarding team for advice, support and guidance on all aspects of safeguarding."
Team Manager

Raising the Profile of Safeguarding

Safeguarding Links / Champions

The Safeguarding Links are an active group of staff who champion the safeguarding agenda within their respective teams by cascading information and advising colleagues.

The Links meet regularly with the Safeguarding team. Invited speakers and case studies increase awareness of current safeguarding developments and changes in legalisation.

Staff Support

The Safeguarding team provide expertise and advice to staff on a daily basis. The team have received a number of positive comments and compliments from staff:

"I would just like to say how helpful the member of the safeguarding team has been and she has been such brilliant support for staff during a recent complex safeguarding investigation."
Kerry Coker – Head of IAPT Services

Internal Safeguarding Website

The internal safeguarding website is a key resource for EPUT staff. The Safeguarding team continually develop and update the content and design. Newsletters, training materials, policies and procedures and contact posters are just a few examples of the materials updated and made available over the last year.

Learning Lessons

The Safeguarding team have contributed to identifying and presenting cases relating to children and adult services to the Learning Oversight committee. Below are examples of lessons learnt by safeguarding teams across the Trust this year which were presented to the Learning Oversight committee:

Learning Lessons: Practitioners need to challenge and escalate their concerns to improve outcomes for children

This case involved a 4-year old child who was seen by the school nurse as the school had some concerns. The result was child protection referrals for concerns of neglect. Historical concerns around neglect had meant that the child and a sibling had previously been removed previously from mother's care. The child was subsequently returned to mother but concerns continued regarding the child being visibly smaller than peers and the child returned from the 6-week break lacking in energy and without having grown. The growth centiles showed the growth was not adequate and the child looked small and underweight and had missed a follow-up appointment about the lack of growth. The child was stealing food at school, hiding food in their clothes and asking staff not to tell mother about this. The school nurse observed the child to be withdrawn and making no eye contact.

The child protection referrals were considered by Children's Social Care and the decision was made that this did not meet the threshold for intervention. The school nurse did not agree with that decision and escalated the matter through her safeguarding supervisor and Named Nurse to challenge the decision. The Named Nurse challenged whether the child had been seen by social care and whether they had considered that the child was being refused food, which would explain his faltering growth. The escalation resulted in the case being opened and the child's health and well-being is currently being monitored by a paediatrician and multi-agency professionals. The learning taken from this was that professionals must escalate their concerns when they believe a child's welfare is at risk. Referrals must contain an analysis of the situation, including history and a focus on the key risks and why the professional is concerned.

Learning Lessons: Importance of professional curiosity and responding to newly-acquired competencies

This case involved a 13-year old who had been sexually assaulted by members of their own close-knit ethnic community living in the same household. The young person disclosed the abuse to mother who contacted the Police. However, prosecutions were not progressed due to a lack of evidence. The young person received support from the local Rape Crises Service and made use of the school nurse drop-in sessions. At one of the sessions, the young person disclosed that they were receiving support from a priest, who said they should dress formally in black from head to toe, so that God could see they needed extra support. As a consequence of having completed training on Child Abuse Linked to Faith, which states that a possible sign of child abuse linked to faith or belief is a child being forced to wear

religious paraphernalia, the question was asked if in this case, there was a possibility of emotional abuse linked to humiliation and labelling.

Trust staff are not responsible for investigating child safeguarding concerns, but rather to recognise their potential. Therefore, a referral was made to Children's Social Care who opened the case and have been working with the young person to protect them from harm.

The learning taken from the review is that Child Abuse Linked to Faith and Beliefs is a hidden crime, which makes it difficult to quantify in terms of magnitude. Staff should be aware of harmful practices and the belief in concepts of witchcraft, spirit possession and the devil acting through children, leading them astray.

Professionals should consider whether these beliefs are supported by others in the family or in the community, and whether this is an isolated case or if other children from the same community are being treated in a similar manner.

Learning Lessons: Missed opportunity to prevent further abuse

This case involved a patient who had disclosed sexual activity on the ward with another patient. The safeguarding referral was only made when he reported it a second time to the Site Officer on a night shift. He had told another nurse on a previous shift but nothing had been done. He said he could have said no to the sexual activity, but he felt like he could not refuse. He said he did not like it but did not want anything done about it – he just wanted the Site Officer to know.

The other patient involved is well-known to the Trust with a risk of sexual disinhibition when he is unwell. Due to his presentation, he was detained under the Mental Health Act and transferred to another ward. Not long after his transfer, two further safeguarding referrals were received by the Safeguarding team regarding another incident of sexual inappropriateness involving him and two other patients, making it a total of three referrals in a short space of time.

The patient's risk history of sexual disinhibition was not considered and when he was transferred to the other ward, the safeguarding referral was not handed over to the receiving ward. This led to two further incidents of sexual activity which could have been prevented.

The learning taken from this case was that a patient's risk history must be taken into consideration when admitted into hospital. This is to ensure measures are put in place to protect them and others. There is a need for staff to have a better understanding of a patient's mental capacity and to be able to recognise when a vulnerable person feels coerced into doing something they are not happy to do. It calls for the need for a robust risk assessement and care plan and appropriate handover, to ensure continuity of care, minimising risks to the patiet and others. There is a need for good communication between staff to ensure all are aware of a patient's risk and plan of care. Staff must listen to patients' concerns and escalate these as appropriate. Safeguarding must be at the forefront of patient care and if there is any doubt, staff should contact the Safeguarding team for advice.

Learning Lessons: LADO Referrals

This incident relates to a female inpatient residing on Longview Generic Adolescent Psychiatric Ward, who requested to speak with her mother. The patient was unable to get through, and requested to go back to their bed space. The Staff Nurse (S/N) approached the patient and explained that items were being removed from the patient's room as they had been used for destruction of property. The patient became aggressive, making threats

towards the staff, so the S/N walked away. While the S/N was walking away, the patient threw a cup at them and punched the S/Non the side of the head from behind. The patient attempted a second punch, but the S/N defended themselves by using their arms to protect their face. Following this incident, the on-call doctor was notified as the S/N was observed to have a 'bloodied' nose. The on-call doctor notified the Site Manager upon arrival. The incident was reported as assault on the S/N, however the patient rebutted with her own allegation of assault to them by the S/N. Staff discussed the incident with the Safeguarding team, although not in detail, and the Safeguarding Lead for St Aubyn Centre was not aware of the incident until over 3 days later, whilst the LADO was not notified until 2 days later. Learning taken from this was that staff may require more training around what/whom LADO is, how to contact them, what staff member's responsibilities are, and how LADO can support them. The first training session has now been delivered to 5 new starters and the Ward Manager. St Aubyn Centre now has an appointed 'Out of Hours Site Officer' to ensure there are no gaps in procedure when incidents such as this occur.

2.0 Safeguarding Adults

The Care Act was introduced in April 2014 and set out a clear legal framework for how local authorities and other agencies e.g. the NHS and Police should protect adults at risk of abuse or neglect. The Care Act 2014 has now been fully embedded into the Trust Safeguarding service including policies, protocols and training programmes.

The responsibility for conducting an enquiry (investigating safeguarding adult issues) differs between Mental Health and Community Health Services. The Local Authority delegates the responsibility for investigating safeguarding issues to the Trust for those accessing Mental Health Services. This means that staff regularly conduct safeguarding enquiries for service users. They typically arrange meetings with police, social care and other agencies as required and invite service user family members or advocates to safeguarding meetings. The Trust Safeguarding team monitor compliance with time frames and analyse trends.

For service users accessing Community Health Services, the Local Authority is responsible for the enquiry. However, it is essential that Community Health Service staff are fully involved in investigations, representing the health needs of service users.

A reporting framework has been established to report data, trends and concerns to the Trust Senior Management team, the Local Authority Safeguarding team and the CCG's.

Brief Timeline of Adults Safeguarding Activity

April 19: Started recording safeguarding concerns/enquiries on Datix.

June 19: Safeguarding Children Policy reviewed. Annual Report completed for 2018-19, awaiting approval by the Quality Committee.

July 19: The safeguarding administration is merged, based at the C&E Centre.

August 19: Safeguarding Adults Policy and Procedures reviewed. Annual Report completed for 2018-19, and approved by the Quality Committee.The safeguarding team started a duty system.

September 19: Safeguarding Adults Policy and Procedures submitted to Mental Health Act and the Safeguarding Committee. Preparation for the Amendment of the Mental Capacity Act (moving towards Liberty Protection Safeguards)

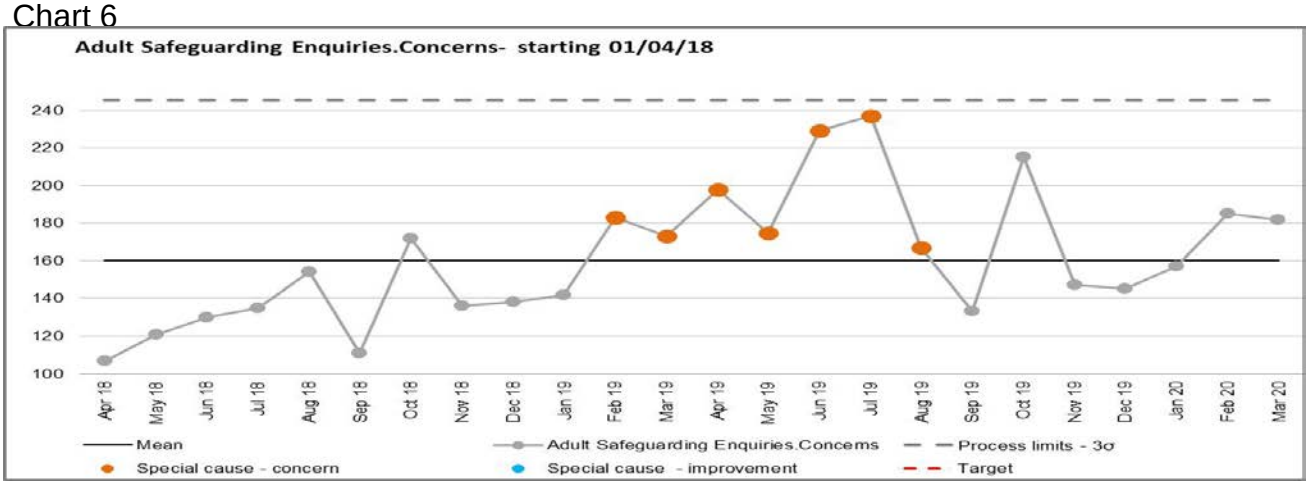
November and December 19: Safeguarding clinicians did spot checks audit regarding Mental Capacity Act.

January 20: Safeguarding Adults Policy and Procedures approved by the Quality Committee. Preparation of the safeguarding Conference, 27/03/2020 focus on Trauma informed Care and Exploitation.

February 20: Safeguarding Conference, 27/03/2020 focus on Trauma informed Care and Exploitation postponed. The preparation for the Amendment of the Mental Capacity Act (moving towards Liberty Protection Safeguards). Safeguarding team started updating the safeguarding training content.

Trends 1

Chart 6



There has been an increase in the number of concerns raised compared to 2018-19. This is mainly due to raised awareness with regards to safeguarding. The total number of safeguarding concerns raised in 2019-20 was 2170 compared to 1702 in the previous year. 36% of the concerns were raised by EPUT Staff and 64% by external agencies.

Proportion of concerns progressed to Section 42 Enquiry

Chart 7

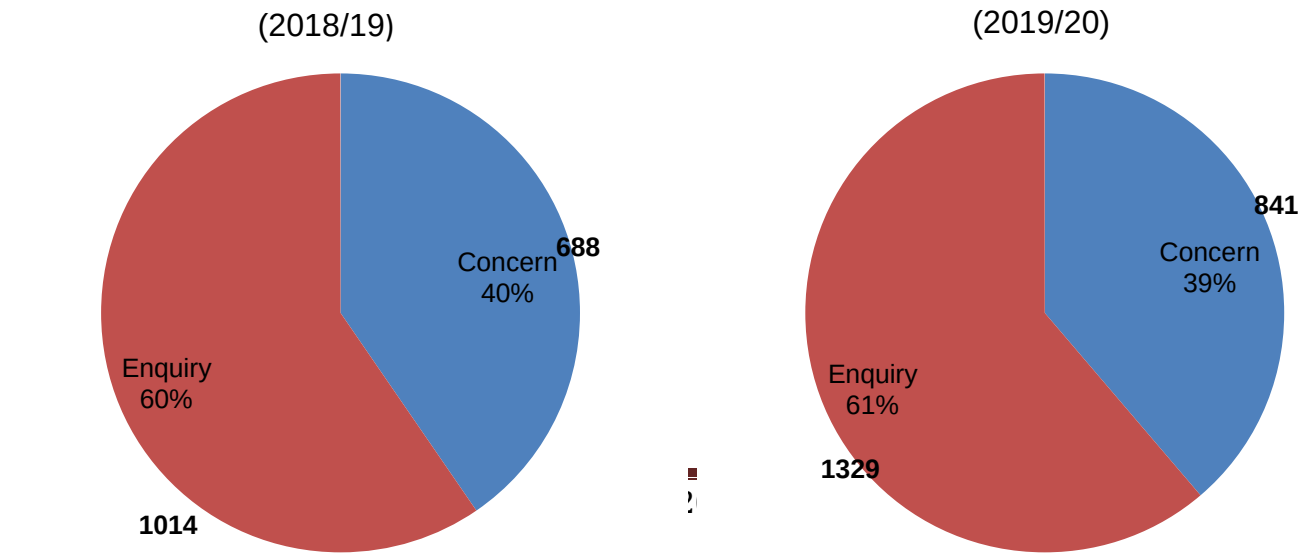
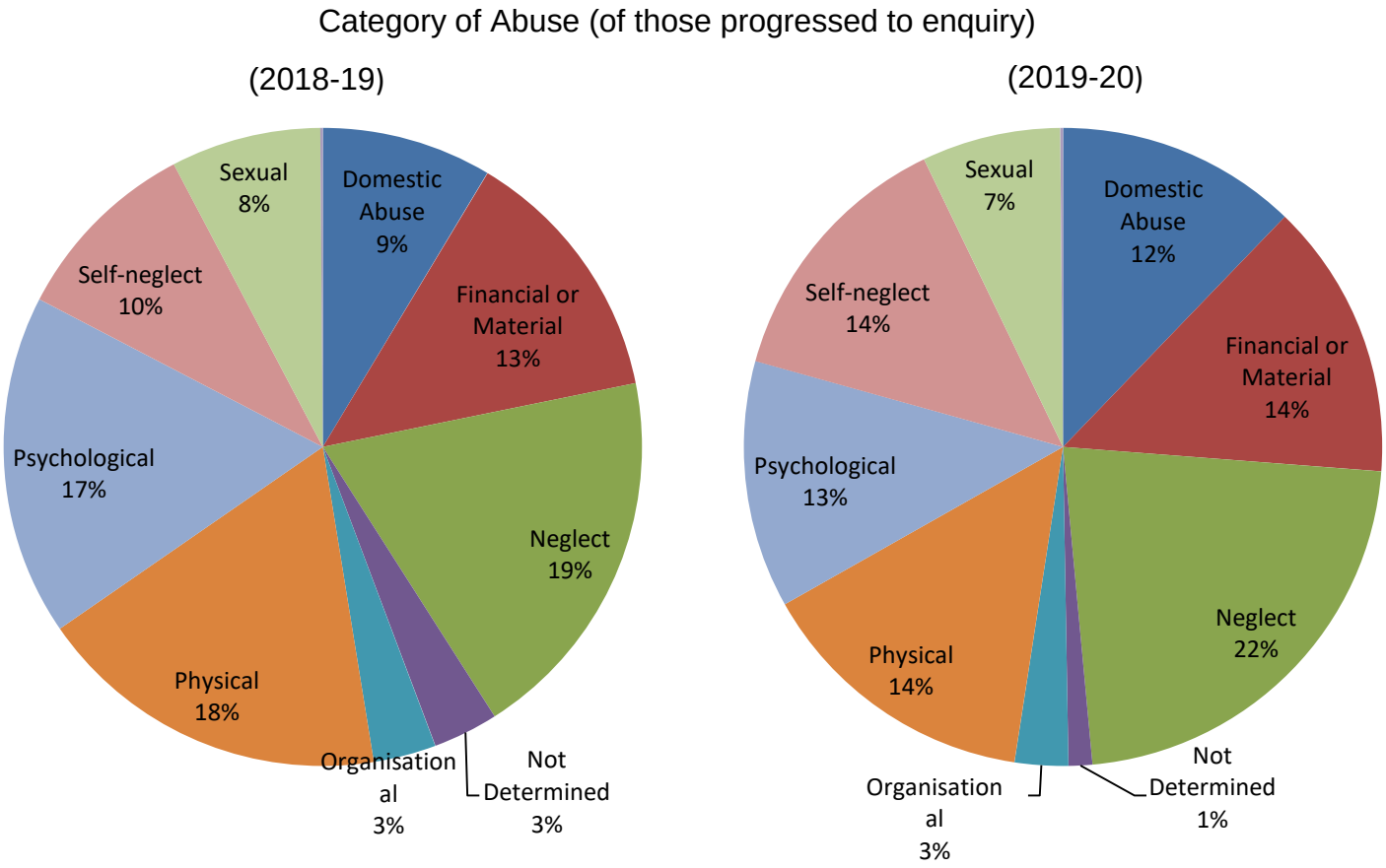
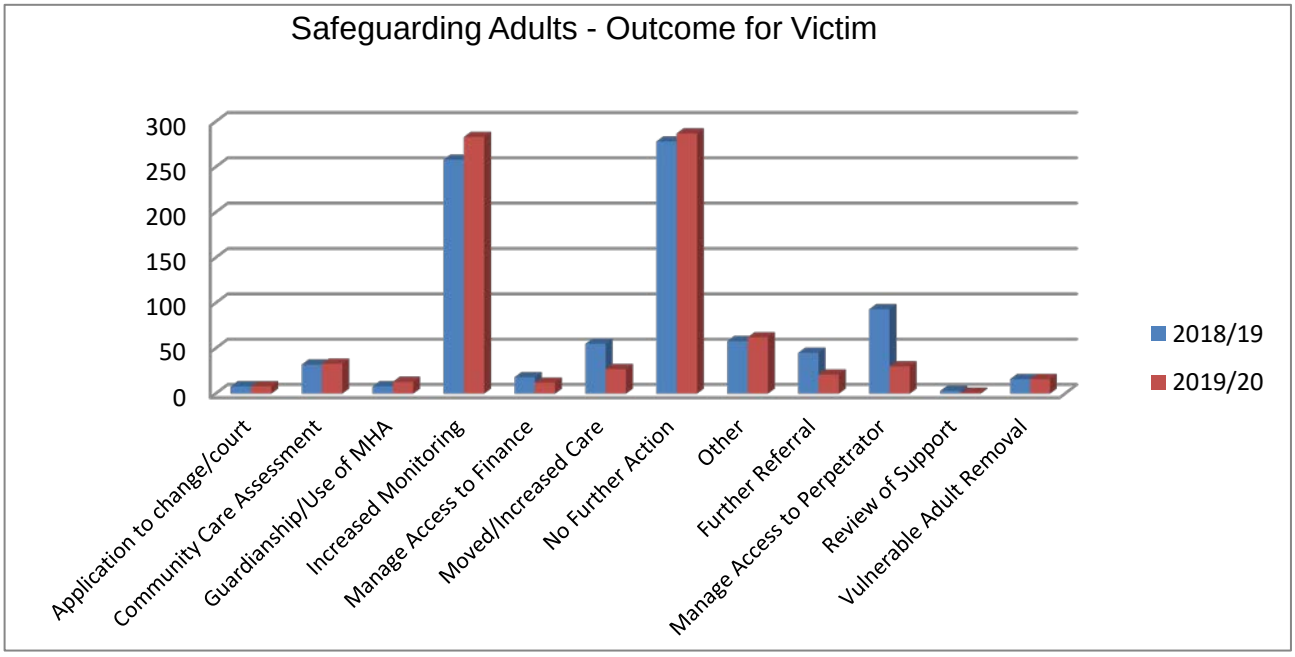


Chart 8



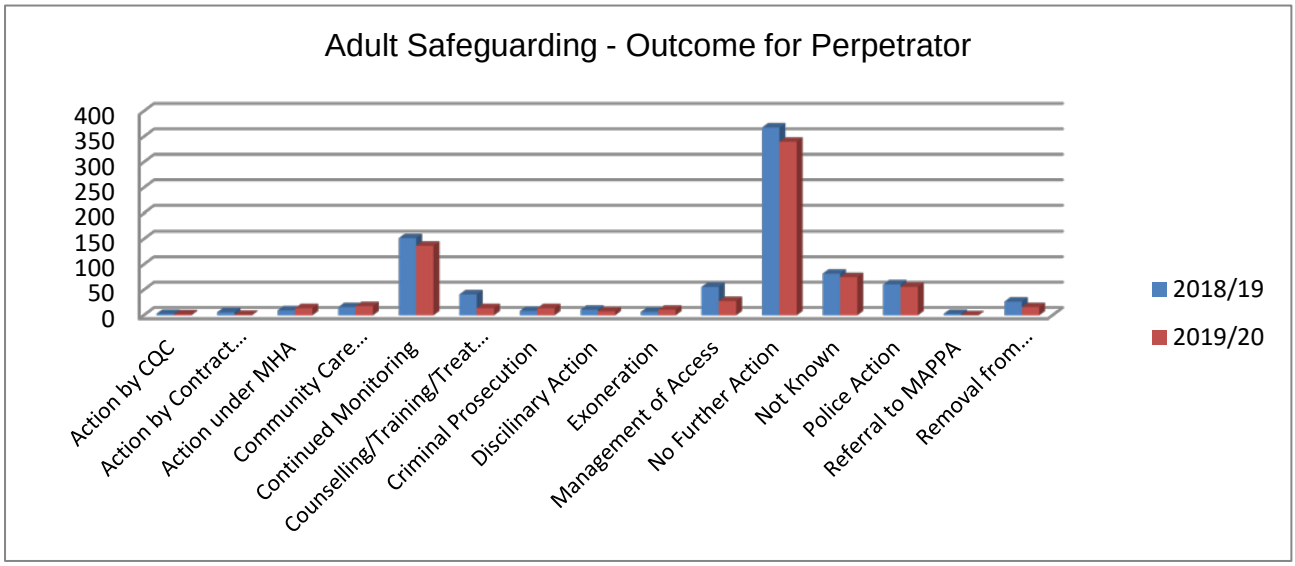
Neglect has been the most prevalent category of abuse, mainly within mental health services

Chart 9



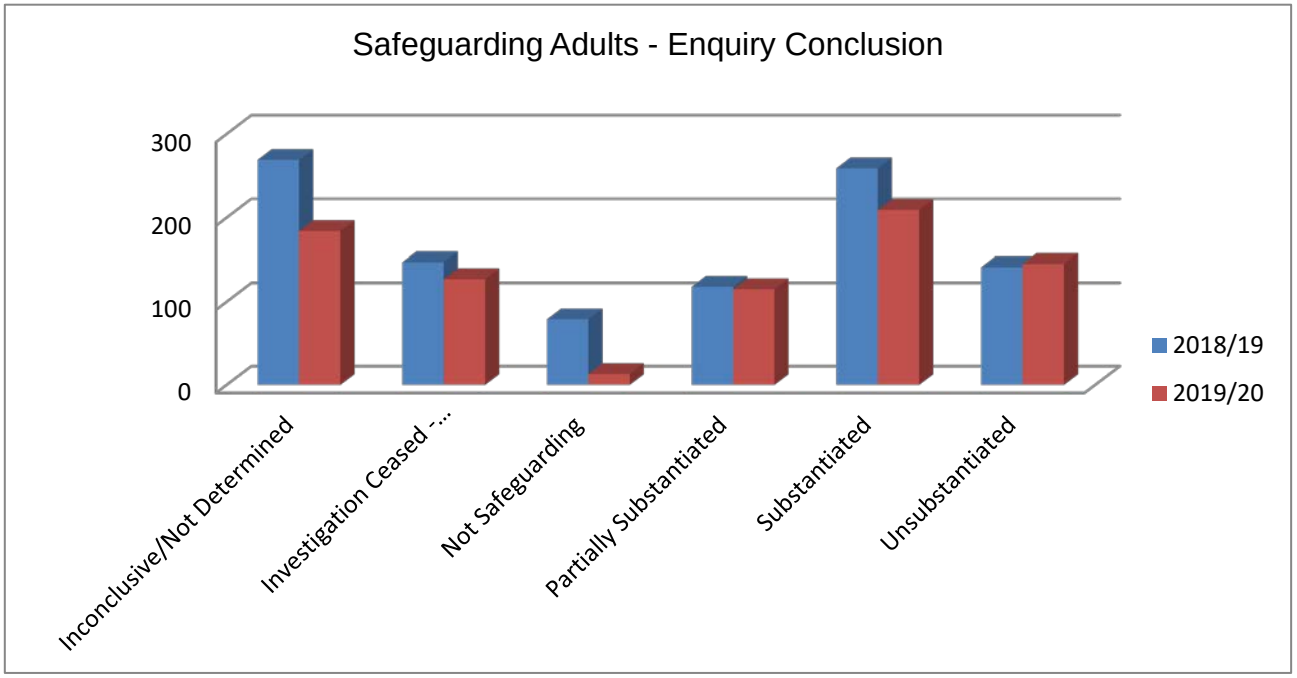
No further action and increased monitoring were the most common outcomes. No further action was mainly due to the fact that most of the concerns raised by external agencies, e.g. ambulance service or the police, could not be substantiated. The other proportion of the concerns would go for case management by respective operational teams, hence increased monitoring is another common outcome. In 2019/20 there were 285 concerns raised by Essex Police, with 33% meeting criteria for s42 enquiry. 287 concerns were raised by East of England Ambulance Service, with 36% meeting criteria for s42 enquiry.

Chart 10



A significant proportion of the concerns raised could not be substantiated or the threshold for safeguarding enquiry were not met (the concern would have been dealt with or there would already have been management plans already in place) hence the most common outcome is no further action.

Chart 11



3.0 Mental Capacity Act & Deprivation of Liberty Standards (MCA DoLS)

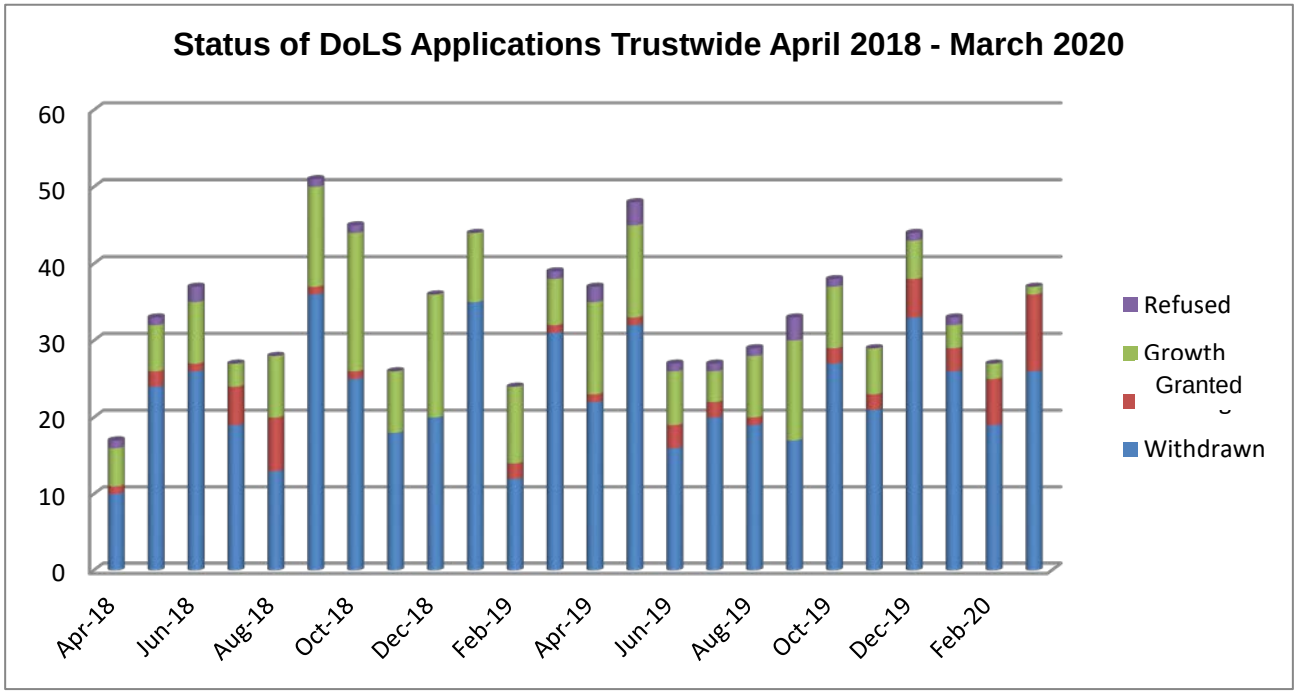
The service for Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DoLS) continues to progress well. Staff knowledge has improved and the MCA DOLS training programme has been enhanced.

Deprivation of Liberty Standards data

Deprivation of Liberty Safeguards currently apply to those persons in hospital or a Care Home who do not have the capacity to consent to their care and treatment and therefore required limitations to be placed on their liberty, in order to keep them safe.

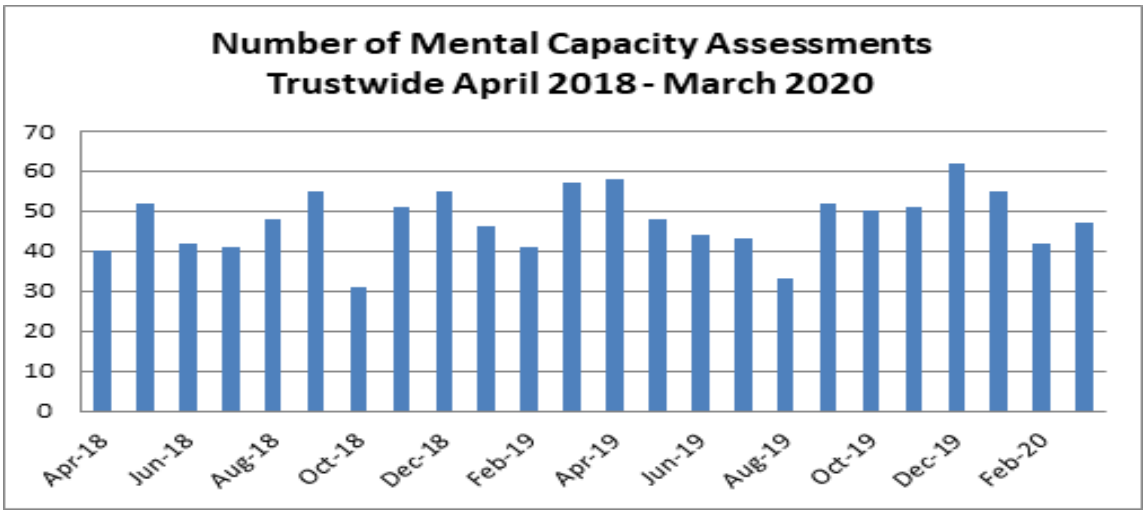
DoLS do not apply to those detained under the Mental Health Act 1983. Therefore, for EPUT, the DOLS service is focussed in Essex, Southend and Thurrock in patient and care home units.

Chart 12



A lot of DoLS requests are withdrawn due to the delay from the supervisory body (Local Authority) in carrying out the patient assessments. This concern has been escalated to the Local Authority through the Health Executive Forum.

Chart 13



There was an increase of 26 MCA's from 2018/19 to 2018/20, 559 to 585

Chart 14

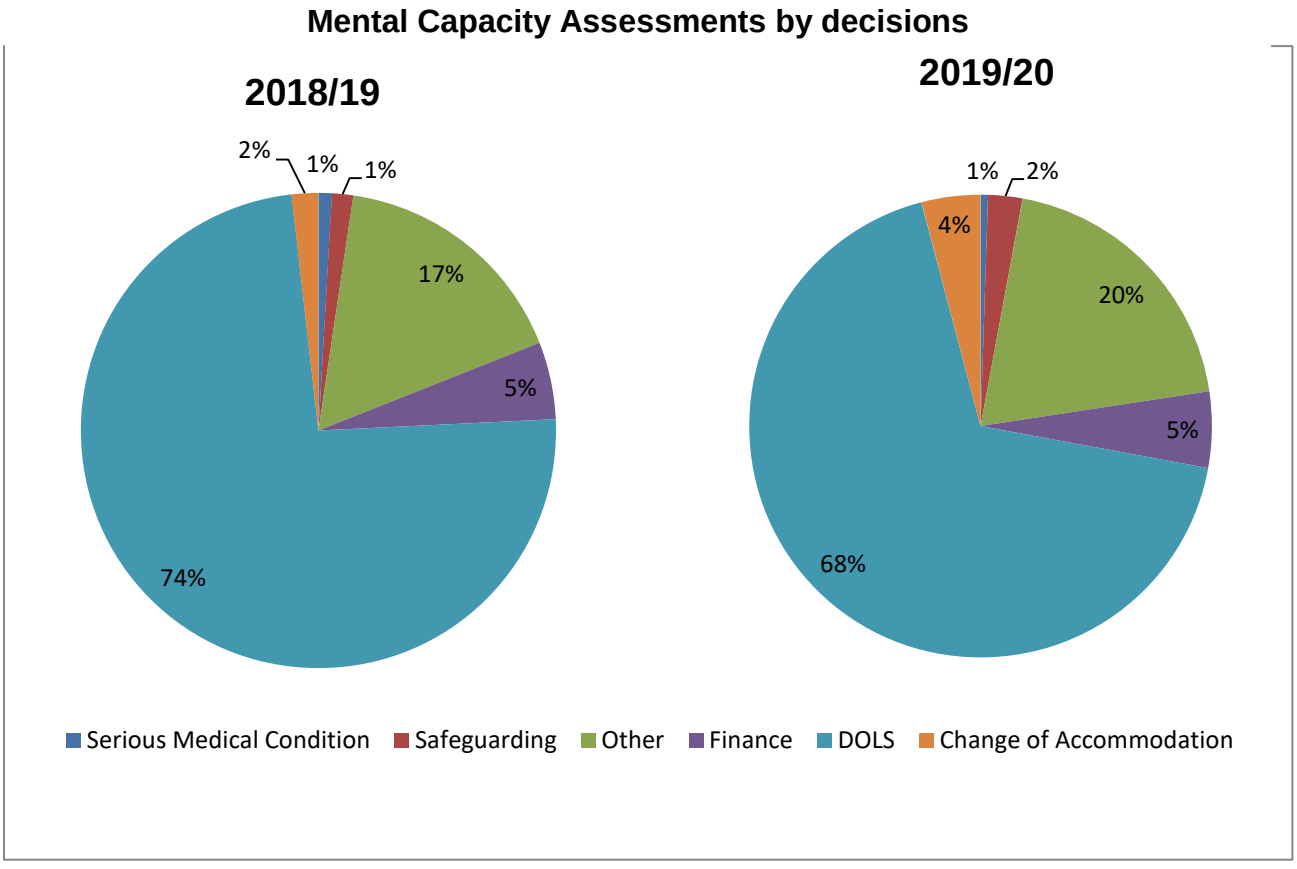
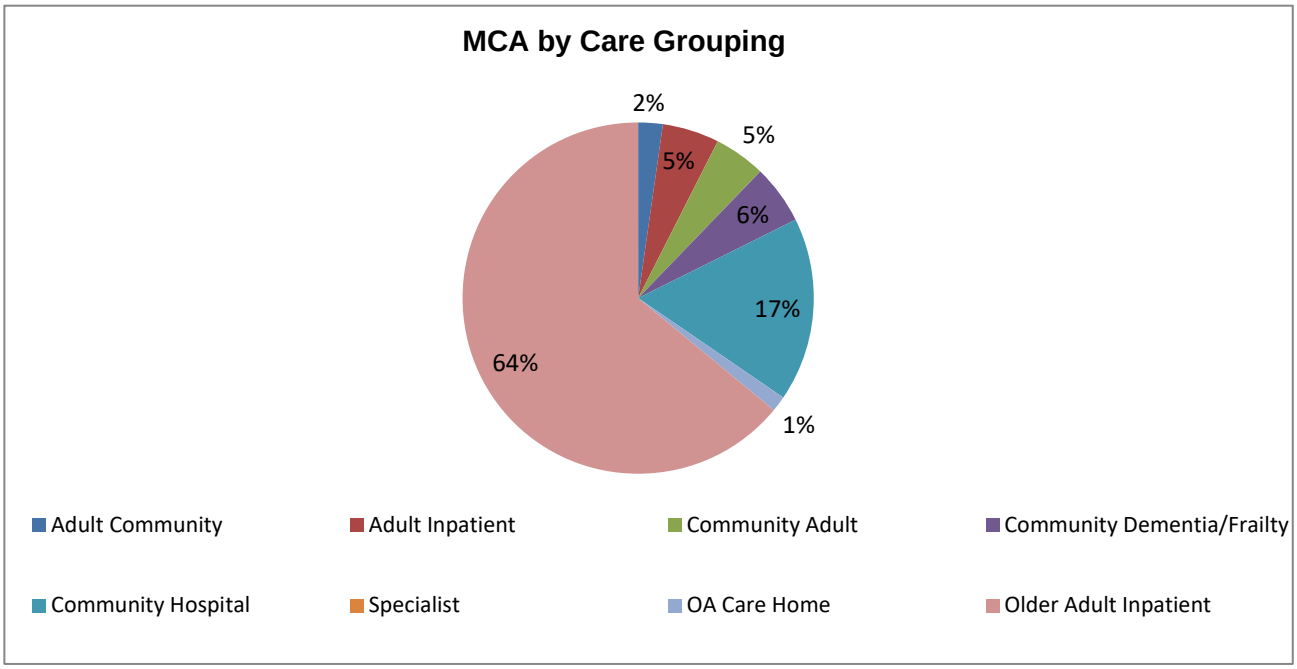


Chart 15



There are a significantly low number of assessments carried out by adult services. The expectation is that the number of assessments should be higher than we are currently recording. There are no recorded mental capacity assessments for the Tier 4 Child and Adolescence Units. The team is going to raise awareness regarding the Mental Capacity Act - this is an objective for 2020-21.

4.0 Safeguarding Children

The Trust Safeguarding teams continue to offer expert advice and support to EPUT staff and work in partnership with other agencies and Local Safeguarding Partnerships. The Trust's Safeguarding Children team also provide safeguarding support to Southend Local Authority 0-19 service as a commissioned provision.

Working Together to Safeguard Children (2018) provides the clear statutory and legal framework for safeguarding children from harm. The statutory guidance is underpinned by the Children's Act (1989) and is embedded into the Trust Safeguarding systems within its policies and procedures, local protocols, supervision and training programmes.

The responsibility for investigating whether a child requires safeguarding from harm lies with the Local Authority through Children's Social Care or the Police, but EPUT is fully involved with supporting this process by representing the health needs of the clients they provide services to. Systems and processes are in place for reporting concerns and providing data and assurance within the Trust and externally to our partners.

Safeguarding Children Referrals

EPUT staff make referrals to Children's Social Care where there is a concern that a child has been harmed and requires an immediate response. Safeguarding children referrals to social

care can also be for additional support for a family struggling to cope. Below are some extracts from staff regarding the support they have received.

"Thankful to have safeguarding support when escalating concerns about a family."

"'It can be very easy to become part of the problem with some families and this causes you to not see the full risks or what to do but the team help me do that".

"Sometimes worry that my threshold for referral has been raised to high due to regular exposure to families with complex needs."

One example of EPUT staff working in the best interests of children is the Paediatric Speech and Language service. Staff used the learning gained from working with a local family to put forward the case for a new Dysphagia service.

The family in question were obstructing the best interests of their child. They were not offering their child a range of foods following negative past experiences feeding their child.

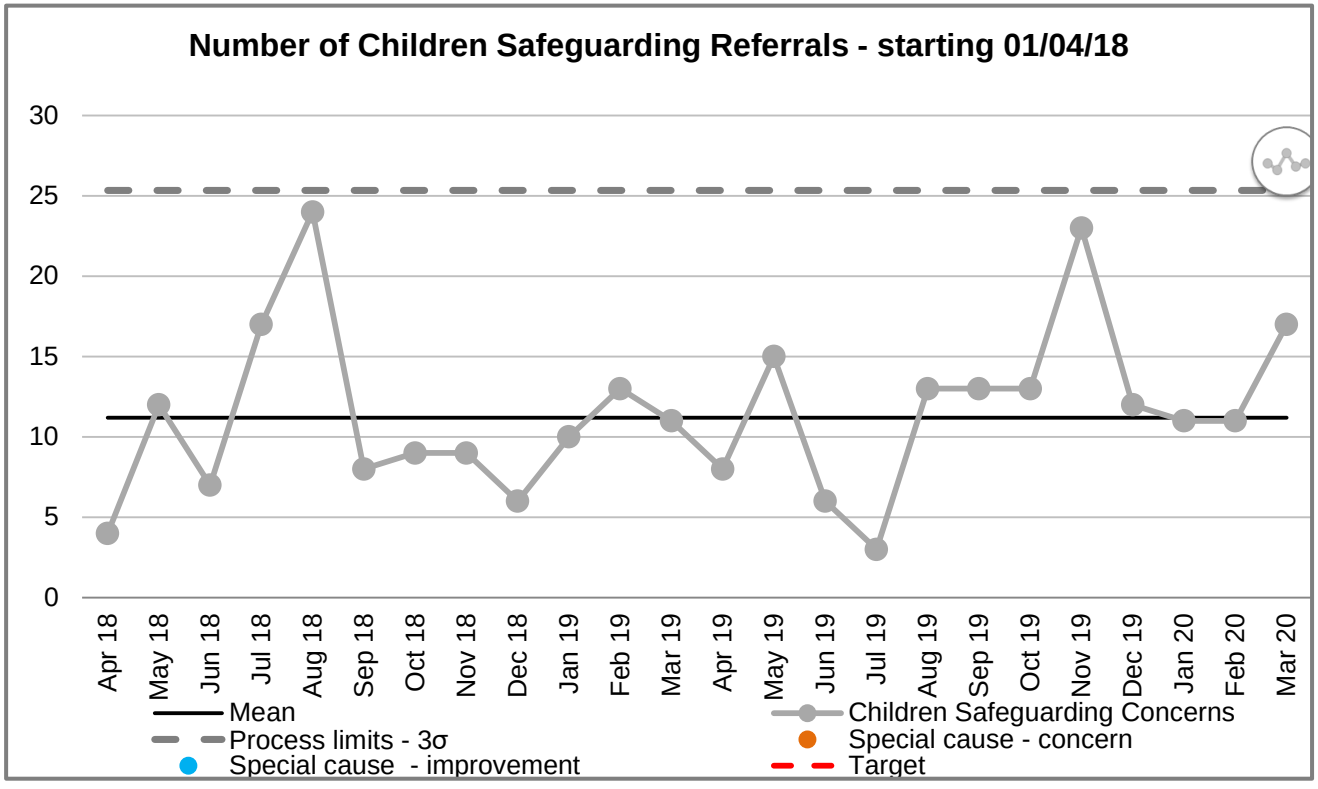
A safeguarding referral was made because they refused to consent to a referral from a tertiary medical centre for support.

The Paediatric Speech and Language service presented this as a case review to substantiate the need for a local service for families with dysphagia.

The child and the family are now receiving ongoing support for their needs.

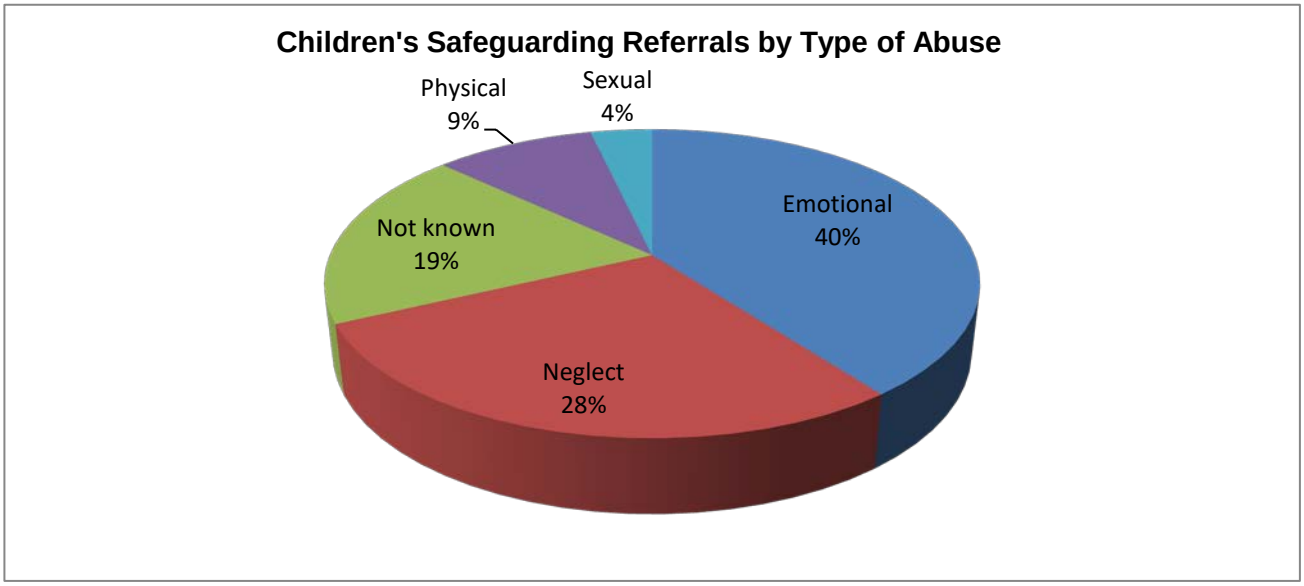
The table below demonstrates the total number of referrals to social care from EPUT staff.

Chart 14



An increase of 15 child safeguarding referrals recorded year on year, from 130 to 145. The majority of referrals are made from staff working in adult mental health services where it is felt the parents require additional support. This year's report demonstrates a change of trend of emotional abuse being the main category of abuse as opposed to neglect.

Chart 15



Referrals from EPUT staff that work with children and families are overwhelmingly as a result of emotional abuse. This is consistent across the areas that the Trust provides services to. The second area of referrals is neglect and the smallest number of referrals is sexual abuse. Domestic abuse remains to be a consistent feature for families where abuse or harm is a feature.

Developments and innovative Practice

Audit of Safeguarding Children Supervision Action Plans

An audit took place to explore the recording of safeguarding supervision by practitioners. The audit focused on reviewing the records across a number of different practitioner roles, where it was known that safeguarding children supervision had taken place in 2019. The audit was looking for recorded evidence that supervision had taken place and the action plan that resulted from that supervision. The audit then checked to see whether there was evidence that the plan had been carried out.

The audit found that the process of recording the fact that supervision has taken place and the subsequent action plan has been in place for some time but has not been fully absorbed into practice. This audit was a dip sample of 20 cases, which is a very small percentage of the cases brought to supervision throughout the year. The number of supervision documents created in 2019 was 621. The percentage audited was therefore 3%. Nonetheless, it is reasonable to infer from the data that the lack of compliance with the action plan documentation is somewhat representative of the overall picture.

As a direct consequence of the audit, in those cases where there was no evidence of action plans being followed, the child's record was checked again by the safeguarding children supervisors and relevant practitioners to ensure that no child had been left at risk by these omissions. It was found that no children were left at risk.

The results of the audit was shared with practitioners and managers via the Safeguarding Meeting and Senior Management Team meeting. An action plan was developed by the Head of Children Services to increase the use of the electronic supervision template within the

child's record. The safeguarding supervisors continue to remind practitioners at every supervision session about the recording of the action plan, where to record it and the need to show in the record that this plan has been carried out, or the reasons why not.

Exploitation and Gangs

There has been a focus on exploitation and gangs nationally as a result of criminal activity and county lines. The Trust has reviewed its processes and systems including the safeguarding training programmes being delivered to raise awareness of the issues. Within children services, alerts and data recording systems have been put in place within the electronic clinical records to assist data reporting and trend analysis. Training has been commissioned across the partnership on gangs and criminal exploitation, which EPUT staff have attended.

Safeguarding Children Supervision

Safeguarding children supervision is provided to staff working on the adolescent units, mother and baby units, perinatal mental health and community children services. EPUT staff can access advice and consultation on the telephone when cases are worrying them and they can also receive further direction on case management. In a number of cases, further intensive work is required in management oversight and providing emotional support to the frontline professional.

"I have become more confident in practice and able to approach the safeguarding team for more complex issues"

"Supervision allows you protected time to break down and discuss a case, and aids clarity around decisions for actions, that will benefit the client going forward, whilst considering all legal responsibilities'

"Supervision is often an opportunity to explore what it is that you are worried about, particularly when you are left with a 'feeling' about something but can't put your finger on it. It is a really important time of reflection and I personally find that it helps me to analyse the 'so what' and 'now what'.

An audit was carried out to obtain feedback from those practitioners in terms of their satisfaction level with the supervision they receive. Sixteen responses were received, out of an estimated caseload of 80 practitioners. The roles surveyed included health visitors, school nurses, specialist school nurses, continence nurses, paediatric diabetes nurses, perinatal mental health team, family nurses, specialist nurse for children with disabilities and paediatric community nurses.

The responses received were overwhelmingly on the positive side, with only one response indicating disagreement with the statement, and this was in regard to the one about reduction in anxiety. There were some neutral responses, most of these in regard to the process for escalation cases. Of the neutral responses one practitioner made it clear they were unable to comment on this since they had not been involved in such an escalation, but the others did not give a reason why.

"Support given to me during these sessions are able to lay these anxieties to rest"

"Useful to discuss grey area cases"

The Safeguarding team plan to re-audit in 2021, with a view to involving team leaders in improving engagement with the survey. In previous surveys, this has yielded a greater volume of responses.

The Safeguarding team have developed a Mental Capacity Assessment form with the eastern region of Essex CCG and Broomfield Hospital. They have also begun to develop a monthly newsletter which will be sent to all EPUT staff and uploaded onto the intranet. The newsletter will include 3rd party agencies (i.e. Samaritans), staff recognition, and a monthly theme.

In West Essex, the Safeguarding team are continuing to work with EPUT staff and Essex County Council to create stronger links between the organisations, supporting better information-sharing and joint working. The aim is to ensure we are better informed when working with clients, meaning we are better able to manage risks and identify and address needs. Initially, this has been within Children's Social Care, however plans are in place to develop this way of working with the adult teams too.

5.0 Looked After Children Service

The Looked after Children (LAC) team are active members of the Local Authority corporate parenting groups as well as multi-agency operational groups that work to improve the outcomes of children 'Looked After' in foster care, children's homes or during transition supporting them to living independently.

Much of the work involves ensuring the health needs of looked after children are assessed, additional needs identified and appropriate services sought. Looked after children are at increased risk of exploitation and going missing. The LAC service provides support to frontline staff working with looked after children as well as direct client care to young people who are not in education and have no universal services practitioners caring for them.

Another important part of the role is to raise awareness of the needs of looked after children through training and advice and to remind professionals of their corporate parenting responsibilities. The service additionally provides training to EPUT staff, GP's, Social Workers and Foster Carers on health related topics.

LAC Assessments: Ensuring Quality

The LAC team administrate, monitor and quality-assure health assessments that are undertaken for looked after children. In order to ensure the quality of health assessments remains at a high standard, a tool has been developed to ensure the children and young people's health needs are reviewed according to recommended guidance.

The Voice of Young People

It is sometimes difficult to obtain feedback from children and young people who are subject to safeguarding or those who are Looked After. These are examples below of feedback that young people have given.

"I am glad to be a parent and am learning like a first parent would and like its coming naturally to me but if I didn't have your help I think I wouldn't been able to understand what being a parent is fully about and all the different types of things you needed to know. When I felt low you helped me find a way to pick myself up and be strong"
Young person from FNP service

"I'm not as worried as I was at the start, I feel a lot more relaxed as I've learnt a lot of things and when I feel anxious about something I can talk about it"
Young person from FNP service

"*I want to thank you for your help, the instructions and the programme you sent me with the information. Really I want to thank you again because I watch his progress with his sleeping from your help"*
From Jigsaws service

"The LAC nurse helped me get out my feelings and problems"
Young person after their Review Health Assessment

Challenges in Looked After Children Services

A growing area of work for the EPUT LAC teams is around unaccompanied asylum seekers - young people who are exploited and those that go missing. The teams are active members of the local authority groups who focus on this group of children and young people to ensure they advocate for their health needs.

6.0 Safeguarding Learning Reviews & Domestic Homicide

Safeguarding Learning Reviews (SLR) AND Safeguarding Adults Reviews (SAR)

A Safeguarding Learning Review for a child or adult takes place when abuse or neglect is known or suspected and the person concerned has either died or been seriously harmed and there is concern about the way Local Authority Safeguarding partners worked together to safeguard that person.

Safeguarding Learning Reviews are not inquiries into how a person has died or who is culpable as this would be for the Coroners and Criminal Courts respectively to decide.

They are principally to establish whether there are lessons to be learned from a case about the way in which local professionals and agencies work together to safeguard people.

Safeguarding Learning Reviews: Children

There have been 3 new safeguarding learning referrals for children where EPUT has been directly involved and two of those have progressed to learning reviews. The majority of these reviews have occurred in Southend and the service is involved in 8 reviews in total at various parts of the process. Key themes of the reviews this year have remained to be around neglect and working with families where there are sexual harmful behaviours present along with adolescent suicide.

The EPUT Safeguarding team are members of each Local Authority safeguarding learning review panel where referrals are received and decisions made on whether the case meets the criteria for a review, and if so, which methodology should be used. The Head of Safeguarding in EPUT will additionally sit on the Serious Incident panel of any review that meets the criteria for both to align the processes.

Safeguarding Adults Reviews: Adults

"Essex Safeguarding Adult Board's Safeguarding Adult Review (SAR) Officer appreciates the positive working relationship they have with EPUT's Head of Safeguarding and members of the Safeguarding Team. This has enabled prompt information sharing, both at the point of initial SAR referral and throughout the Safeguarding Adult Review process. In addition, EPUT's Head of Safeguarding is a valued partner of the ESAB SAR Sub-committee. The Sub-Committee has met on 9 occasions in the previous year and considered 9 SAR referrals, of which it determined that 6 met the criteria to conduct a Safeguarding Adult Review."

Caroline Venables: Safeguarding Adults Review Officer, Essex Safeguarding Adults Board

There have been 5 reviews where EPUT has been directly involved. This is an increase on the previous year, with all reviews occurring in Essex.

Domestic Homicide Reviews (DHR)

A Domestic Homicide review is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship, or member of the same household as him/herself.

An intimate relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality. This may include Honour Based Violence.

There have been 3 DHRs this year.

Any learning from Serious Case Reviews or DHR are placed on the Safeguarding section of Input and also tabled at the Trust Learning Lesson Group for wider circulation. The safeguarding training (Level 3) has also been reviewed to reflect on any trends, learning or recommendations from the reviews.

7.0 FORWARD PLAN 2020-2021

The Trust Safeguarding service will continue to develop and improve services for clients. The forward plan focuses on key areas for the coming year as demonstrated in the table below:

Table 3:

	Objectives 2020-2021	Action Required	Success Criteria
1	Think Family.	To support practitioners who work with adults to understand the impact of parental issues on children and encourage appropriate information exchange and joint working across services. Establish effective collaborative processes with children-facing teams. Agree the principles of a Think Family approach with partner agencies and disseminate these to staff through supervision and training initiatives. Identify any barriers that prevent the principles being implemented in practice and take steps to mitigate their impact.	Assessments and care plans demonstrate the impact of parental issues on children in the family and promote the Think Family approach. Safeguarding referrals demonstrate that risk to all members of the family has been identified and care plans include the actions and things that need to change to reduce those risks. Learning lessons demonstrated Think Family care has been delivered by staff.
2	Integration of the two safeguarding teams.	Develop Options Appraisal for restructure of the safeguarding team.	Implementation of agreed new model of safeguarding service delivery and team.
3	The Trust will implement the new Liberty Protection Safeguards (LPS) effectively with sufficient resourcing to support said implementation.	Scoping of the potential assessments has been undertaken. Training implementation plan. LPS to be a standing agenda item on the MHA and Safeguarding Sub-Committee. Review Mental Capacity Act Policy. Engage with partner agencies regarding implementation of LPS Review existing Safeguarding Team systems to determine resources required to implement and support LPS.	Effective implementation of LPS with sufficient resourcing to support.
4	Align the Safeguarding service to the new STP and ICS systems and processes.	Integrate and merge the safeguarding service to new STP and ICS arrangements.	The safeguarding service is aligned to the new STP and ICS arrangements.
5	Review of the Trust's safeguarding Strategic Framework.	A new three-year strategic framework to be developed.	Ratification of the Trusts 2020-23 strategic framework. The Annual Report demonstrates delivery of the objectives in the strategic framework.
6	Review and submission of the Children Section 11 audit in 2020.	The Children's Section 11 audit to be reviewed and updated.	Ratification of the Children's Section 11 Audit. Submission of the Section 11 Audit to partners to demonstrate the Trust has discharged its statutory responsibilities.

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	Board Assurance Framework 2020/21 as at July 2020					
Executive/Non-Executive Lead:	Sally Morris, Chief Executive Officer					
Report Author(s):	Susan Barry, Head of Assurance					
Report discussed previously at:	Executive Operational Sub-Committee 16 June and 21 July 2020					
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, Corporate Risk Register, and Covid-19 Gold Risk Register for 2020/21 covering the two month period June (Q1) and July as at 29 July 2020	**Approval**	✓
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Review the risks identified in the BAF 2020/21 July summary and approve the risk scores (Appendix 1) taking account of actions taken by EOSC at its June meeting
2 Approve the de-escalation of BAF32 Quality Improvement to the Corporate Risk Register
3 Approve a reduction in score of BAF34 Staffing for transformation
4 Note the CRR July summary table (Appendix 2) including actions taken by EOSC at its June meeting
5 Approve the closure of CRR1 in Section 5
6 Note the proposed risks for assessment and escalation to EOSC August 2020 in Section 3
7 Identify any further risks for escalation to the BAF, CRR or risk registers

Summary of Key Issues

- This report covers two months of reporting to EOSC and the July summary includes reference to any changes made by EOSC in June 2020.
- From July the focus of risk relating only to those considered critical during the Covid-19 pandemic has been lifted and all risks are being reviewed as business as usual.
- As at July there are 18 risks on the Board Assurance Framework with one risk recommended for de-escalation (leaving 17) and 22 on the Corporate Risk Register with one risk recommended for closure (leaving 21).
- Updated corporate objectives with a Covid-19 focus have been included in the risk summaries.

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?	All
If yes, insert relevant risk	See report
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			
BAF	Board Assurance Framework	CRR	Corporate Risk Register
HSE	Health and Safety Executive	CAMHS	Child and Adolescent Mental Health Service
PICU	Psychiatric Intensive Care Unit	CQC	Care Quality Commission
DRR	Directorate Risk Register	CIPs	Cost Improvement Plans
EU	European Union	NELFT	North East London Foundation Trust
STP	System Transformation Programme	TOR	Terms of reference
QI	Quality Improvement	STARS	Specialist Treatment & Recovery Service
OD	Organisational Development	SPC	Statistical Process Control
NHSI & NHSE/I	NHS Improvement NHS England/Improvement	SEECHS	South East Essex Community Health Services
CCG	Clinical Commissioning Group	WECHS	West Essex Community Health Services
SLT	Senior Leadership Team	SMT	Service Management Team
SDIP	Service Development and Improvement Plan	QIPP	Quality, Innovation, Productivity and Prevention
CEO	Chief Executive Officer	BAU	Business as usual
ACT	Acceptance and Commitment Therapy	RAG	Red Amber Green
SI	Serious Incident	Q&S	Quality and Safety
PHSO	Parliamentary Health Service Ombudsman	HSSC	Health Safety and Security Committee
MH/LD	Mental Health/Learning Disabilities	EFA	Estates and Facilities Alert
SITREP	Situation Report	HBPOS	Health based place of safety
NEP	North Essex Partnership	TFO	Trust Fire Officer
CICC	Cumberlege Intermediate Care Centre	ITT	Information Technology and Telephony
HSCN	Health and Social Care Network	PIR	Provider Information Request

Supporting Documents and/or Further Reading

Appendix 1 – Summary of BAF July 2020
Appendix 2 – Summary of CRR July 2020

Lead

Sally Morris
Chief Executive Officer

Agenda item 7a
Board of Directors
29 July 2020

EPUT

BOARD ASSURANCE FRAMEWORK 2020/21 JULY 2020

PURPOSE OF THE REPORT

This report presents the Board of Directors with an overview of the Board Assurance Framework, Corporate Risk Register, and Covid-19 Gold Risk Register for 2020/21 covering a two month period as at 29 July 2020.

UPDATE AS AT JULY 2020

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, CRR and Covid-19 RR are available on request. The C19 RR is reviewed every two weeks currently via the Command structure.

June 2020 (Q1)
There were 17 risks on the BAF, including one for closure two new and one for escalation. During June the BAF continued to highlight Covid-19 focused risks.

July 2020
There are currently 18 risks on the BAF. With the move to reset and recovery the Covid-19 column has been removed and all risks are being reviewed monthly. Appendix 1 provides a summary of BAF risks as at July 2020 (and notes of any changes made in June 2020), including mapping of risks against the 5 x 5 scoring matrix and movement on scoring from August 2018 to July 2020. A number of risks have been removed from Table 3 as they have been closed for more than two years. The newly approved Corporate Objectives have been added.

2. Recommendations for New Risks and Risk for Closure

June 2020 (Q1)
The following new risks were considered and approved at EOSC in June and are presented for ratification to the Board:

- **BAF44** 'If EPUT does not fully capture, review and embed learning from changes to services, ways of working and governance to improve services as a result of the C19 experience then this may have an adverse impact on reset and recovery resulting in missed opportunities in transformation' **Suggested score C4 x L3 = 12**

- **BAF45** 'If EPUT does not prepare for an anticipated CQC inspection in 2020 then this may have a negative impact on the outcome of the inspection resulting in not maintaining our 'Good' rating' **Suggested score C4 x L3 = 12**

- **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' **Suggested score C4 x L4 = 16**

The following risk was considered and approved for closure at EOSC in June and is presented for ratification by the Board:

- **BAF18** 'If EPUT focusses leadership and clinical capacity on its huge transformation programme across seven CCGs and three STPs then a balance may not be achieved in managing operations resulting in a risk to safe and effective services'

July 2020
There were no new or closed BAF risks in July 2020. One risk (BAF32 Quality Improvement) is recommended for de-escalation to the Corporate Risk Register due to the refocusing of Corporate Objectives to Covid-19.

3. Assessment of new risks

The following risks have been identified since EOSC in July and will be assessed for inclusion on the BAF, CRR or Covid19 RR in August:

Modelling suggests that limiting bed occupancy to 85% on mental health inpatient wards to facilitate social distancing requirements a potential shortfall of beds which could result in delays in admissions, or an increase in out of area placements. (Finance & Performance Committee)

Insufficient capacity within Quality, Risk, Information, and Medical Teams - governance, data collation, analysis and mortality review processes may become unsustainable resulting in delays in producing mortality reports and reviews. (Mortality Review Steering Committee)

4. BAF Action Plans

Potential risks on the BAF should (in most cases) have a detailed risk mitigation action plan. Following the move to reset and recovery, from July all action plans are now being reviewed. The table below breaks these down by action plan status for June and July.

June 2020 (Q1)		**July 2020**	
Action plans approved by EOSC		**Action plans in place**	
BAF4	Fire Safety	BAF4	Fire Safety
BAF10	Ligatures	BAF10	Ligatures
BAF36	Female patients with PD	BAF36	Female patients with PD
BAF9	No force first	BAF9	No force first
BAF34	Staffing for transformation	BAF34	Staffing for transformation
No action plans required		BAF40	Resource and capacity
BAF40	Resource and capacity (linked to organisational objectives)	BAF15	HSE – linked to BAF10 Ligatures
		BAF45	CQC - reset action plan approved
BAF15	HSE	BAF41	CIPs
BAF45	CQC - reset action plan	BAF42	Financial plan
BAF41	CIPs (linked to financial plan)	BAF38	Emergency planning for Covid19 (Command structure action log covers)
BAF42	Financial plan		
Action plan reviews deferred due to C19		**Action plan reviews now business as usual and to be presented to EOSC at Q2 reporting**	
BAF20	Adult inpatient capacity (linked to organisational objectives)		
BAF31	Skills and capacity (linked to top 25% performance)	BAF20	Adult inpatient capacity
		BAF31	Skills and capacity
BAF35	Culture of fairness and learning (linked to reset and recovery)	BAF35	Culture of fairness and learning
		BAF32	Quality improvement
BAF43	Surge planning (new risk with action plan to be developed)	**Action plans to be developed**	
		BAF43	Surge planning
BAF18	Leadership and clinical capacity (linked to transformation) – Closed	BAF44	Reset and recovery
		BAF46	Young people with complex care needs
BAF32	Quality improvement		
BAF44	Reset and recovery (new risk with action plan to be developed		

5. Corporate Risk Register

June 2020 (Q1)
There were 22 risks on the Corporate Risk Register in June.

July 2020
There are currently 22 risks on the Corporate Risk Register. The summary table of CRR risks is attached as Appendix 2. Table 1 gives a summary of each risk (including notes of any changes made in June 2020), and Table 2 shows the mapping of risks against the 5 x 5 scoring matrix as an enhancement to the CRR summary. The newly approved Corporate Objectives have been added.

The following CRR risk is recommended for a reduction in score and closure:

- CRR1 medical devices – reduce to 3 x 3 = 9 target score

Following EOSC it was agreed that CRR49 Access and Assessment will be discussed in more depth with the service before the score is reduced or the risk closed. It was also agreed that CRR36 Primary Care models will be reworded to reflect the wider issue of supporting new system information requirements.

CRR48 Consultant cover in North East is to be reworded so as to cover the whole of the North inpatient service.

6. Covid-19 Risk Register

The C19 risk register is now updated two weekly and is reviewed by Silver and Gold Command leads. The Non-Executive Director responsible for emergency planning receives the risk register at the same time. A summary of Gold Command risks is appended to the CEO's report on Covid-19. The summary highlights the current risk score, target score and completion date (many of which are ongoing for the duration of the C19 crisis), and assurance thresholds.

7. Directorate Risk Registers

The Mental Health Services Directorate Risk Register was reviewed by EOSC at its meeting on 16 June, and Mental Health Specialist Services Directorate Risk Register was reviewed by EOSC at its meeting on 21 July.

6. Recommendations

The Board of Directors is asked to:

1 Review the risks identified in the BAF 2020/21 July summary and approve the risk scores (Appendix 1) taking account of actions taken by EOSC at its June meeting
2 Approve the de-escalation of BAF32 Quality Improvement to the Corporate Risk Register
3 Approve a reduction in score of BAF34 Staffing for transformation
4 Note the CRR July summary table (Appendix 2) including actions taken by EOSC at its June meeting
5 Approve the closure of CRR1 in Section 4
6 Note the proposed risks for assessment and escalation to EOSC August 2020
7 Identify any further risks for escalation to the BAF, CRR or risk registers

Report prepared by**:**

Susan Barry,
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Appendix 1

Table 1 – BAF 2020/21 Summary of Risks as at July 2020 (note: table references any changes made in June)

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 (will be reviewed against 2020/21 action plans)	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							
Corporate Objective 1: To provide safe and high quality services during Covid19 pandemic – Lead: Sally Morris supported by all Executive Directors - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score							
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 is reduced resulting in a lack of containment of the pandemic.	NL	• This risk is at threshold but remains on the BAF whilst Covid19 continues with our associated command structure in place • EPUT has implemented effective emergency planning arrangements • The Covid-19 shared drive contains all EPRR major incident folders, BCPs and anything relevant to the C19 pandemic	Risk score reduced in June 2020 Current Risk Score 5 x 2 = 10	Target Ongoing during Covid19 crisis 5 x 2 = 10	Board of Directors Covid19 Command Structure At threshold	Live Action Log maintained daily through Command Structure
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	MM	• Seven actions on BAF Action Plan • Five actions in progress • Two actions not due (one requires completion date) • Works have recommenced following lifting of C19 restrictions • A draft internal audit report has been received and further actions may be added to the BAF action plan as a result of this	Risk score unchanged June/July 20 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 June 2020

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	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 and this may impact on the safety of patients in inpatient services.	SM (FS) supported by MM	• 19 actions on BAF Action Plan • 11 actions completed • Five actions due to be completed this month • Two actions in progress to timescale • One action remains overdue (risk stratification programme including required works, start times and deadlines, present to LRRG) • Further actions have now been identified as part of a continuing dynamic review of this risk and a meeting set up to articulate these to the BAF action plan, with the Interim Ligature Co-ordinator • This risk is linked to BAF15 HSE	Risk score reduced in June 2020 Current Risk Score 5 x 3 = 15	Target March 2021 4 x 3 = 12	HSSC Quality Committee EERG LRRG Above threshold	Quality Committee June 20
BAF36	If EPUT continues to experience high numbers of female patients with personality disorders being 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.	AB supported by NH / SM (FS)	• Eight actions on BAF Action Plan • Two actions completed • Six actions in progress including three with revised dates, mainly due to Covid19	Risk score unchanged June/July 20 Current Risk Score 5 x 3 = 15	Target date change from July to-September 2020 5 x 2 = 10	Directorate SMT Mid/South Essex funding agreed Above threshold	Quality Committee June 20
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	• 19 actions on BAF Action Plan • 10 actions completed • Nine actions in progress to timescales • Action plan has been reviewed in line with draft 'reset' CQC Action Plan	Risk score reduced in June 2020 Current Risk Score 4 x 3 = 12	Target March 2021 4 x 2 = 8	Restrictive Practice Steering Group Above threshold	Quality Committee June 20

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	Assurance	Action Plan overview & scrutiny/ date
BAF40	If EPUT uses all its resources and capacity to manage the C19 pandemic then it may not achieve its organisational objectives for 2020/21 resulting in a potential stagnation of risks and an impact on our position in the wider health economy	SM (FS)	• There will be no action plan specifically on this - to be managed through regular monitoring of the BAF, CRR and other risk registers • The Board of Directors approved new Corporate Objectives at its extra-ordinary meeting in June 2020	Risk score increased in June 2020 Current Risk Score 4 x 4 = 16	Target March 2021 4 x 2 = 8	Command Structure EOSC and Board plus Standing Committees Above threshold	No Action Plan required
BAF15	If EPUT does not take actions to satisfy HSE investigations into the actions taken by former NEP in respect of patient safety then failings may be identified in the system in place prior to merger resulting in prosecutions and / or fines being imposed	SM (FS)	• No Action Plan required for 2020/21 but BAF10 Ligature action plan clearly links to this risk – additional actions have been agreed to enhance this action plan • The HSE and PHSO Steering Group continue to meet and oversee actions required to support EPUT's defence of any potential charges brought by the HSE. Lawyers have been appointed	Risk score unchanged June/July 20 Current Risk Score 5 x 4 = 20	Target date changed from June to July 2020 5 x 2 = 10	Quality Committee Above threshold	
BAF45	If EPUT does not prepare for an anticipated CQC inspection in 2020 then this may have a negative impact on the outcome of the inspection resulting in not maintaining our 'Good' rating	SM (FS)	• Previous CQC action plan contained slippage on actions and is closed • New 'Reset' CQC Action Plan approved at EOSC July 20 and will serve as BAF Action Plan • Compliance and Assurance Team liaising monthly on updates • CQC Executive Steering Group will monitor	New risk added in June 2020 and score unchanged July 2020 Initial/ Current Risk Score 4 x 3 = 12	Target March 2021 4 x 2 = 8	CQC Exec Steering Group Above threshold	Quality Committee June 2020

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	Assurance	Action Plan overview & scrutiny/ date
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: Mark Madden supported by all other Executive Directors - Impact of not achieving the Strategic Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score							
BAF20	If EPUT has insufficient adult mental health capacity then in-patient activity levels may exceed funded capacity and continued bed occupancy levels above 85% with high numbers of out of area placements, this may impact on the quality and effectiveness of services delivered as well as the Trust meeting its statutory financial duties	AB	• The action plan has been reviewed against the draft 'reset' CQC action plan. • There are six actions on BAF20 • Two actions have been completed • Four actions are in progress to timescales	Risk score unchanged June/July 2020 Current Risk Score 5 x 3 = 15	Target date changed from June to September 2020 4 x 2 = 8	Reporting to SMT CQC action plan monitored by EOSC Above threshold	
BAF41	If EPUT does not have clarity on financial plan 2020/21 the final value of CIP programme is unknown resulting in a challenge to delivering the break-even position and sustainability	MM	The Trust's Cost Improvement target for 20/21 is £11.6m, including 19/20 £5.1m recurrent shortfall brought forward • Full recurrent delivery of the 20/21 CIP target must be delivered and focus needs to be on the full year recurrent CIP for the Trust due to the current financial regime • M3 £4,156k FYE CIP schemes agreed and £876k of pipeline schemes remain deliverable • This leaves FYE unidentified balance of circa £6.7m • Finance continuing to meet and set up further meetings with directors/ service leads to discuss progressing schemes identified, and identify schemes to meet the unidentified target • Deep dive taking place at F&PC M3	Risk score unchanged in June/July 2020 Current Risk Score 4 x 4 = 16	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 (will be reviewed against 2020/21 action plans)	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	MM	• EPUT continues to operate under a National NHS Emergency Finance Regime as a result of C19. This is expected to change in M5 and a review of this risk will take place • During the first four months of 2020/21 all NHS providers reporting a deficit will receive top up payments to adjust their reported position to breakeven • In June 2020 the Trust recorded a deficit of £2,755k before top up income, including year to date Covid-19 costs of £3,994k. Cash is £29.0m above plan at M3	Risk score unchanged in June/July 2020 Current Risk Score 4 x 3 = 12	Target March 2021 4 x 2 = 8	Finance and Performance Committee Board Above threshold	No Action Plan required
BAF31	If EPUT does not have the skills, and capacity to deliver high quality services then the ability to achieve top 25% performance is reduced	SL supported by All Execs	• There are nine actions on BAF31 • Three actions are completed • Four overdue actions have been given revised target completion dates due to the impact of Covid-19 • Six actions in total are in progress to timescale	Risk score unchanged June/July 2020 Current Risk Score 5 x 3 =15	Target July 20 4 x 3 = 12	WTG Quality Committee Above threshold	
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	AB	• Work with system partners in planning for any surge in MH or CHS • Action plan to be developed through the reset and recovery group	Risk score increased June 2020 and unchanged July 2020 Current Risk Score 5 x 4 = 20	Target March 2021 5 x 2 = 10	Command Structure EOSC and Board plus Standing Committees Above threshold	PIT 1 June 20

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	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	AB	• Action plan to be developed	Current risk score 4 x 4 = 16	Risk score unchanged Target March 2021 4 x 2 = 8	SMT Above threshold	
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	NL supported by NH/SM (FS)/SL	• Action plan 2020/21 to be developed as part of the recovery plan • The 'reset' CQC action plan should be considered in relation to any review of the BAF35 Action Plan – this includes reviewing the trust wide Suicide Prevention Strategy by September 2020. A report is being compiled against the strategy, including recommendations on further plans (for end July). A campaign of awareness will be held between 10 September and 10 October. Training webinars are planned within EPUT. The 10 step toolkit has been incorporated. In addition an action on identifying learning from suicide prevention training awareness and response is due for completion August 2020.	Risk score reduced in June 2020 and unchanged in July 2020 Current Risk Score 4 x 3 = 12	Target March 21 4 x 2 = 8	Regular reporting of data in place Mortality Review Sub-Committee Learning Oversight Group Above threshold	
BAF34	If EPUT is unable to recruit new / additional staff to deliver new services and care pathways developed as part of the Transformation programme then the success of new services may be impacted or existing services may not be able to retain staff	AB / SL	• There are 13 actions on BAF action plan • 11 actions completed – EOSC recommends reducing the current risk score on the basis of progress made against this action plan • 2 actions in progress and ongoing	Risk score to reduce July 2020 Reduced Risk Score 4 x 3 = 12	Target date changed from July to October 2020 4 x 2 = 8	F&PC PIT Above threshold	PIT 1 June 2020

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans)	Assurance	Action Plan overview & scrutiny/ date
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							
BAF18	If EPUT focusses leadership and clinical capacity on its huge transformation programme across 7 CCGs and 3 STPs then a balance may not be achieved in managing operations resulting in a risk to safe and effective services	NL/ AB	• Recommended for closure by PIT June 20 • Rationale for closure of this risk – covered by risk BAF43	This risk was closed in June 2020 Risk Score at closure 4 x 3 = 12	Target March 21 4 x 2 = 8	EOSC Board PIT Above threshold	PIT 1 June 20
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							
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: Sally Morris supported by all Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score							
BAF32	If EPUT does not drive quality improvement through innovation then maintaining good and moving towards an outstanding rating is more difficult resulting in the potential stagnation of services and falling behind in whole system transformation **CLOSE ON BAF AND MOVE TO CRR**	NH supported by all Execs	• There are six actions on BAF32 • One action is completed • Five actions are in progress to timescale • EOSC recommends the de-escalation of this risk to the CRR due to the refocusing of corporate objectives on Covid-19	Risk score unchanged June/July 2020 Current Risk Score 4 x 4 = 16	Target date changed from August to September 2020 4 x 2 = 8	Learning Oversight Group PIT Above threshold	
BAF44	If EPUT does not fully capture, review and embed learning from changes to services, ways of working and governance to improve services as a result of the C19 experience then this may have an adverse impact on reset and recovery resulting in missed opportunities in transformation	NL	• Action plan to be developed through reset and recovery group	New risk June 2020 Initial/Current Risk Score 4 x 3 = 12	Target March 2021 4 x 2 = 8	Above threshold	

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

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2					BAF38
	3				~~BAF18~~ BAF35 BAF42 BAF9 BAF44 BAF45 BAF34	BAF4 BAF20 BAF31 BAF36 BAF10
	4				BAF32 BAF40 BAF41 BAF46	BAF15 BAF43
	5					

Table 3: Movement on scoring – 2 year period from August 2018 to July 2020 (rolling two year period)

Risk ID	Initial Score	Aug 18	Sep 18	Oct 18	Nov 18	Jan 19	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
BAF1	20	12↓	12↔	8 ↓		C		L		O		S		E		D		C		R		R		
BAF3	12	12↓	12↔	12↔	12↔				C		L		O		S		E		D					
BAF4	15	20↔	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔
BAF5	12	12↓	12↔	12↔	12↔	12↔	12↔	12↔	C			L			O			S			E			D
BAF6	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	Me	rg	ed	Wi	th	BAF	35
BAF9	16	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	16↑	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔
BAF10	12	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	15↓	15↔	15↔
BAF12	12	16↔	16↔	16↔	16↔	16↔	16↔	16↔	C		L		O		S		E		D					
BAF13	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	6↓	Clo	sed
BAF14	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	C	L	O	S	E	D	TO	C	R	R	
BAF15	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔
BAF16	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	C		L	O		S		E		D	
BAF18	15	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	16↓	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	Clo	sed
BAF20	12	20↑	25↑	20↓	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔
BAF21	15	8↓	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	C		R		R					
BAF22	16	12↓	16↑	16↔	16↔	16↔	9↓	9↔	9↔	9↔	9↔	9↔	9↔	9↔	C	L	O		S		E		D	
BAF23	15	New	15	15↔	15↔	20↑	20↔	12↓	8↓	CL	OS	E	D	20↑	20↔			C		R		R		
BAF24	16	New	16	16↔				C		L		O		S		E		D						
BAF25	16	New	16	16↔	16↔	12↓	12↔	8↓	C		L		O		S		E		D					
BAF26	16	New	16	16↔	12↓	8↓	8↔	C		L		O		S		E		D						
BAF27	16	New	16	16↔	16↔	16↔	12↓	12↔	C		L		O		S		E		D					
BAF28	16			New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	C	L		O		S		E		D	
BAF29	12				New	12	8↓	C		L		O		S		E		D						
BAF30	12							New	12	12↔	12↔	12↔	12↔	12↔	C	L	O		S		E		D	
BAF31	16							New	16	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔
BAF32	16							New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔ to CRR
BAF33	12												New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	6↓	Closed	
BAF34	16													New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓
BAF35	16													New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔
BAF36	15															New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔
BAF37	15																	New	15	15↔	Cl	os	ed	
BAF38	15																		New	15	15↔	15↔	15↔	15↔
BAF39	20																		New	16	Cl	os	ed	
BAF40	12																				New	12	16↑	16↔
BAF41	16																				New	16	16↔	16↔
BAF42	12																				New	12	12↔	12↔
BAF43	20																				New	15	20↑	20↔
BAF44	12																					New	12	12↔
BAF45	12																					New	12	12↔
BAF46	16																							16

Note: Risks over two years old removed from table

Appendix 2
CRR 2020/21 Summary of Risks as at July 2020 (note: table references any changes made in June)

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: Sally Morris supported by all Executive Directors - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score						
CRR51	If EPUT staff are not alert whilst on duty then high quality care will not be delivered resulting in poor patient experience	AB	• Continuing to use self-declaration forms for temporary workers prior to commencement of duty, monitoring by managers and rapid progression of cases with HR support • Update report submitted to EOSC for 2019/20 Q4	Risk score unchanged June/July 2020 3 x 3 = 9	3 x 2 = 6 July 2020	EOSC Above threshold
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	AB	• In May all targets were met • 14 wards had unfilled shifts • Continues to be monitored due to CQC profile	Risk score unchanged June/July 2020 4 x 2 = 8	4 x 2 = 8 March 2021	Sitreps Quality Dashboard/ CQC compliance Board At threshold
CRR61	If the HSE considers recent inpatient deaths as part of its case against the Trust, there is a risk that EPUT's mitigation case may be impacted, potentially resulting in the HSE taking increased regulatory or legal action against the Trust, with associated reputational damage	AB/ SM	• No contact has been made by the HSE in respect of recent inpatient deaths in relation to its existing case against EPUT	Risk score unchanged June/July 2020 5 x 2 = 10	5 x 2 = 10 July 2020	HSE Steering Group At threshold
CRR65	If the Trust is unable to achieve the ECTAS standards at The Linden Centre and The Lakes then the service becomes unsustainable resulting in a risk to the quality of services provided	MK	• MK will present a detailed options paper to EOSC post Covid-19 to include implications in terms of patient impact, finance, estate and resources, and take action as agreed • rTMS services have resumed	Risk score unchanged June/July 2020 3 x 4 = 12	3 x 2 = 6 September 2020	MMT Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR11	If EPUT fails to implement and embed its Suicide Prevention Strategy into Trust services then it may not track and monitor progress against the ten key parameters for safer mental health services resulting in not taking the correct action to minimise unexpected deaths and an increase in numbers	NH/ MK	• Reviewing Suicide Prevention Strategy by September 2020 • A report is being compiled against the strategy, including recommendations on further plans (for end July) • A campaign of awareness will be held between 10 September and 10 October • Training webinars are planned within EPUT • The 10 step toolkit has been incorporated • In addition an action on identifying learning from suicide prevention training awareness and response is due for completion August 2020	Risk score reduced June 2020 and unchanged July 4 x 3 = 12	4 x 2 = 8 March 21	Quality Committee and sub-Committees Above threshold
CRR1	If effective management of medical devices does not happen then equipment may not be available or correctly maintained or calibrated that may impact on patient safety	SM	• **Recommend this risk is closed**	Risk score unchanged in June Recommend Risk score reduced July 3 x 3 = 9	3 x 3 = 9 July 2020	Medical Devices Group At threshold
CRR16	If violence and aggression is not managed there is a risk of severe harm or death, as well as impacting on reputation and staff survey results.	SM	• Annual review of general workplace risk assessments is underway and is a statutory requirement to ensure that violence and aggression is a consideration undertaken by all services • Environmental aspects are reviewed to minimise violence and aggression • Violence and aggression task and finish group continues to meet quarterly	Risk score unchanged June/July 2020 4 x 3 = 12	4 x 2 = 8 March 21	Internal audit HSSC Staff survey Task & Finish Group Above threshold
CRR56	If blanket 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	AB NH	• 'Reset' CQC action plan covers actions related to this risk • Roll out of '10 ways to improve safety' has been completed	Risk score unchanged June/July 2020 3 x 4 = 12	3 x 2 = 6 March 21	Restrictive Practice Group Quality Committee Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR34	If there are insufficient avoidable death trainers and staff are not trained effectively in avoidable deaths then there is a risk that staff may not have the necessary skills to safely support a suicidal patient, resulting in self-harm or suicide.	MK/ NH	• Dedicated avoidable death trainer in place • Working in partnership with CCG on Suicide Prevention Programme	Risk score unchanged June/July 2020 3 x 3 = 9	3 x 2 = 6 March 21	Quality Committee Avoidable Deaths Group Above threshold
CRR40	If the Trust is not adequately prepared, or there is a lack of funding for the cyber team, it could be subject to a cyber-attack that compromises clinical or corporate IT systems, and the consequent cost pressure may result in a financial risk to EPUT	MM	• Whilst this is at threshold, during Covid-19 the NHS remains vulnerable to hacking. EPUT stopped one of these attacks during the last month.	Risk score unchanged June/July 2020 4 x 2 = 8	4 x 2 = 8 March 20	Cyber Essentials Accreditation SMOG SMT At 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: Mark Madden supported by all other Executive Directors - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 12 risk score						
CRR53	If the dormitory elimination project plan is not implemented in line with agreed timescales then there could be a delay to providing single bedroom accommodation by 2021 which could potentially impact on CQC ratings and patient experiences.	AB MM	• Phase 1 completed. Phase 1 teams have moved to Unit 8 Temple Farm • Phase 2 Langdon Unit construction works due to complete 31 July with a transfer on 14 August • Phase 2 Willow Ward construction works due to complete 14 August with a transfer on 11 September • Phase 3 Cherrydown and Kelvedon Ward refurbishments design team reviewing current floor plan to include assisted bathroom	Risk score unchanged June/July 2020 3 x 4 = 12	4 x 2 = 8 December 21	Capital Group PIT EOSC Above threshold
CRR64	If there are further 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	AB/ SM	• The occurrence of a never event in the last six months is zero • This is closely aligned to BAF10 Ligatures and remains high risk	Risk score unchanged June/July 2020 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
CRR48	If substantive consultant cover cannot be maintained in adult North ~~East~~ Essex mental health wards then there will an increase in use of locums resulting in increased costs ands potential impact on quality of care	MK	• Activity has increased and cover is being maintained by locum and agency • CQC 'reset' action plan includes recruitment of a second Consultant at Peter Bruff to improve gatekeeping with a timescale of September 2020	Risk score unchanged June/July 2020 5 x 4 = 20 risk score as per Medical DRR	3 x 2 = 6 June 20	Medical Staffing Committee Above threshold
CRR49	If access and assessment services receive high levels of referrals which do meet the threshold for secondary services then the ability to respond is reduced resulting in poor patient experience	AB	• This risk to be reviewed with Executive Director and Operational Services	Risk score unchanged June/July 2020 3 x 3 = 9	3 x 2 = 6 July 20	CCG QCPM Board CCGs Above threshold
CRR28	If mental health clinical activity is not entered into patient admin systems on a timely basis this could impact on monitoring and reporting key performance measures which could result in breaches on regulatory or contractual requirements	AB/ MK	• Reduction in routine clinical activity due to C19 crisis may improve timeliness of entry of mental health clinical activity into clinical systems • Timeliness of data entry is identified as a concern in the M3 performance report.	Risk score unchanged June/July 2020 5 x 3 = 15	4 x 2 = 8 September 20	SMT Performance reports Above threshold
CRR30	If data entry is incorrect, late or recorded on paper then managers may not have sufficient information for decision making, data from paper records cannot be reported on, impacting on contractual obligations and the risk of financial penalties	MM	• DQMI – additional national requirements introduced which has reduced compliance M3	Risk score unchanged June/July 2020 4 x 3 = 12	4 x 2 = 8 July 20	Internal Audit CCG Assurance IGSC 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 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						
CRR14	If EPUT staff morale is low then it may not be able to deliver high quality services resulting in a challenge to transformational change, patient experience and outcomes	SL	• Staff survey 2019 highlights that as a place to work or receive treatment EPUT was worse than average on 'recommending as a place to work', below average on happy for a friend/relative to receive treatment, below average on safe environment (bullying and harassment), below average on team work, below average on inclusion (acting fairly) • Staff Survey Action Plan, Organisational Development Action Plan, HR Framework Action Plan, Retention Action Plan and Revised Engagement Strategy for 2020 in place • Workforce Race Equality Standard Action Plan, Workforce Disability Action Plan also in place • New set of WRES results expected and Action Plans will be revised accordingly	Risk score unchanged June/July 2020 4 x 3 = 12	4 x 2 = 8 March 2021	Workforce Transformation Group Above threshold
CRR45	If the revised mandatory training policy requirements are not achieved this could impact on the Trust's ability to maintain a 'good' rating.	SL	• Face to face courses restarted in the middle of July with restricted numbers following Covid19 guidance • Phase 1 classes will be for new staff only, prioritised by start dates • Phase 2 will offer updates • Training includes TASID induction training, Induction moving and handling, BLS training, Grab bag training and fire	Risk score unchanged June/July 2020 4 x 3 = 12	4 x 2 = 8 March 21	Training and Development Group Above threshold

CRR57	If EPUT fails to embed equality and diversity into its culture and conversation then staff and patient experience may be negative resulting in a challenge to the CQC rating for well-led, and exposure to legal challenge for discrimination	SL supported by all Execs	• CQC 'reset' action plan includes
			  ○ re-launch and enhance communications of the BE YOU campaign – BE YOU week planned for 6 August with BE YOU launch on 1 September
			  ○ give consideration to THIS IS ME, currently in use in CAMHS, in order to roll out – September 2020
			• Equality workshop – mental health awareness and emotional aid for EPUT carers – 29 July 2020
			• Women in leadership event - 6 August 2020
				Risk score reduced in June 2020 and unchanged in July
				
				Remains a risk
				
				3 x 2 = 6
					3 x 2 = 6
					
					March 20
						Equality and Inclusion Group
						Board
						EOSC
						At threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance 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						
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: Sally Morris supported by all Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						
CRR39	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	• EPUT's research and innovation centre is paramount to providing a high quality of care and safety to patients, involving working closely with clinicians in collaboration with partner health organisations, the commercial sector and the National Institute for Health Research (NIHR) • Committed to participating and leading in research and innovation that improves local, regional and national health care outcomes including service provisions • Studies in set up include Fatigue in long term conditions and SCENE WP5 • Studies currently open to recruitment at EPUT include Cognitivity, EMPOWER, IDEAL-2, PAPT and Adult Autism Cohort Study	Risk score unchanged June/July 2020 3 x 3 = 9	3 x 2 = 6 March 2021	and Innovation MMT NIHR Clinical Trials Performance (CTP) Team Above
CRR36	If the provision of primary care services in different areas of the Trust includes a range of varying models then this presents an associated challenge to corporate services in providing performance management information and responding to data requests, resulting in a resource and capacity issue impacting on contract requirements and financial sustainability	MM	• This risk to be reviewed with Executive Director and Director of ITT as it is considered to be broader than primary care services	Risk score unchanged June/July 2020 4 x 3 = 12	4 x 2 = 8 July 20	Above threshold
Corporate Objective 5: Be a co-production focused valued system leader - 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						
CRR52	If EPUT, as the lead in the consortium, is unable to manage overruns or delays in the implementation of HSCN, then this may weaken relationships with partners resulting in a threat to reputation and a financial cost pressure	MM	• Most EPUT sites have been migrated to HSCN and there is good reason for the small number of sites that have not yet migrated • At threshold but continues to be monitored	Risk score reduced June 2020 and unchanged July 2020 4 x 2 = 8	4 x 2 = 8 June 20	C19 Command At threshold

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

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2			CRR57	CRR58 CRR40 CRR52	CRR61
	3			CRR51 CRR1 CRR34 CRR39 CRR49	CRR11 CRR16 CRR56 CRR30 CRR14 CRR45 CRR36 CRR64	CRR28
	4			CRR65 CRR53		CRR48
	5					

		Agenda Item No: 7bi
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

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

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 Approve the revised Terms of Reference for the committee.
4 Request any further information or action.

Summary of Key Issues

The Committee considered the following key issues:

Quality & Performance Report (including contractual exceptions performance)
The committee noted the following

Due to the current COVID-19 crisis full performance reporting has been suspended leaving focus on hot spots and national indicators. Indicators have been suspended during this time due to a large staff redeployment programme and the reduction of resource for validation and reporting.

Information for all suspended indicators continues to be captured and monitored by other teams and services, and where possible via live dashboards and reports. With the continued monitoring of these indicators through other means, any risks identified will continue to be highlighted to the organisation.

The Chief Operation Officer & Deputy Chief Executive reported that the Trust had identified 1 hotspots in month 2 and 1 hotspots in month 3.

Financial Performance Report

Due to the COVID-19 pandemic, for 2020/21 the Trust is operating under an Emergency Financial Regime. We will not be reporting against all five of the finance key metrics whilst the Emergency Financial Regime is in place. The Emergency Financial has been extended to month 5 and possibly month 6, however we are unclear how long this will continue.

There is a Deficit of £2.8m including all COVID related expenditure. NHS accounting rules for at least the first 4 months are that Trusts will receive a top up to bring it back to Break Even. We have therefore accrued income to match the deficit and will expect a cash top up of an equal value.

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

- 12th May 2020
- 19th May 2020
- 26th May 2020
- 2nd June 2020
- 8th June 2020
- 16th June 2020
- 23rd June 2020
- 30th June 2020

Finance & Performance Committee Workplan
Director of Compliance and Assurance/ Trust Secretary presented the Finance and Performance Committee Workplan.

The Committee approved the Workplan

Policies for Approval:
The Policies & Procedures below were approved by the Committee.

- Rostering Policy & Procedure
- Armed forces Policy & Procedure
- Recruitment & Retention Policy & Procedure

Governance Development Plan 2020/21
The Director of Compliance and Assurance/Trust Secretary asked the Committee to consider the draft Governance Development Plan for 2020/21 and recommend actions to be added (or removed) to continue to strengthen the governance arrangements in place. The draft Governance Development Plan should be viewed in the context of a live and rolling plan linked to continuous improvement within the Trust.

Four governance priorities have been identified previously and are carried forward into 2020/21:

- Being an 'outstanding' well led organisation
- Being compliant with the NHSFT Licence conditions
- Ensuring that internal governance systems are effective
- Having effective communication systems in place that support staff in undertaking their role and promote understanding of the Trust with its stakeholders

The Committee approved the plan.

Board Assurance Framework Action Plans Q1
Director of Compliance and Assurance/Trust Secretary presented the Board Assurance Framework action plans to the Finance and Performance Committee and asked them to review BAF4 Fire Safety action plan for 2020/21 and consider whether the action plan mitigates the identified risks.

Not all BAF action plans are being reviewed during the Covid-19 pandemic therefore only one is submitted for review as at the end of Q1. Draft BAF4 Fire Safety 2020/21 Action Plan was submitted to EOSC 16 June for approval and requires review by the Committee.

The Committee approved the Board Assurance Framework action plan.

EPUT Self Certification 2020/21
The Director of Compliance and Assurance/Trust Secretary presented the self-assessment of Trust compliance with Licence Condition FT4 (the Corporate Governance Statement) and note the positive statement agreed by the Council of Governors in respect of training provided to Governors.

The Committee was asked to consider compliance with the provider licence requirements prior to finalisation at Board at its extra-ordinary meeting on 24 June. A detailed self-assessment of Trust compliance against licence condition FT4 (Corporate Governance Statement) has been undertaken by the Head of Assurance.

The Council of Governors met on 12 June and considered the Trust's compliance with licence condition FT4. Views were requested. None have been received at the time of writing the report. The Council of Governors approved a statement in respect of the training provided to Governors at its meeting in May 2020 to support the Board of Directors self-certification in respect of Governor training.

The Committee agreed that it would recommend that the Board was able to meet the self-certification requirements in respect of licence condition FT4 and the training of Governors

F&P Terms of Reference
The Chair presented the revised Terms of Reference to the Finance and Performance Committee.

The Committee approved the Terms of Reference and these are presented to the Board of Directors for approval at Appendix 1.

Capital Projects Steering Group Assurance Report
Executive Director of Strategy and Transformation presented the Capital Projects Steering Groups report and revised terms of reference to provide the appropriate assurances that the key issues highlighted within the Property Management report and the Project Management Report are being addressed in line with the Trust's Policy and Procedure, and that internal governance systems are being followed.

This report will also update the Committee on the current spend of the allotted Backlog Maintenance Programme and provides an analysis of the current Capital and Revenue Position and Forecast statement.

The Committee agreed that appropriate assurance had been received and approved the revised Terms of Reference for the Capital Projects Steering Group.

Risk Management Assurance Framework 2020-2023
The Director of Compliance and Assurance/Trust Secretary presented the Risk Management Assurance Framework (RMAF) 2020-2023 to the Committee. The Committee were asked to approve the draft Risk Management and Assurance Framework 2020/23 and the draft RMAF Development Plan 2020/21. The draft RMAF covers a new three year period from 2020/2023. An RMAF development plan for 2020/21 has been drafted to continue to enhance exiting RM arrangements.

The revision has attempted to take account of the Covid-19 pandemic in its structure and

content. A broader range of risks is included at the start of the document.

The Committee approved the RMAF.

Any Risks or Issues
There were no risks or issues identified by the Committee.

Any Other Business
There was no other business

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 7bii
Board of Directors
29 July 2020

FINANCE AND PERFORMANCE COMMITTEE ASSURANCE REPORT

1.0 Purpose of Report

This report is provided by the Chair of the Finance and Performance Committee, Manny Lewis to provide assurance to Board members that the performance operational, financial and governance as at Month 2, May 2020 and Month 3 June 2020 were subject to appropriate and robust scrutiny.

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

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

The minutes of the meetings held on the 21st May 2020 and 18th June 2020 were agreed as an accurate record.

This Committee now meets Bi monthly and therefore this assurance report includes information for both May and June 2020.

2.0 Quality and Performance Report

Due to the current COVID-19 crisis full performance reporting has been suspended leaving focus on hot spots and national indicators. Indicators have been suspended during this time due to a large staff redeployment programme and the reduction of resource for validation and reporting.

Information for all suspended indicators continues to be captured and monitored by other teams and services, and where possible via live dashboards and reports. With the continued monitoring of these indicators through other means, any risks identified will continue to be highlighted to the organisation.

The Chief Executive (CEO) presented the committee with a summary of hot spots identified as at month 2 and month 3 2019/20 of the Essex Partnership NHS University Foundation Trust.

The CEO reported that the Trust had identified 1 hotspot in month 2 and 1 hotspot in month 3.

Below is a list of hotspots:-

Hotspots – Month 2

1 hotspot from last month has remained as a hotspot at the end of May. No new Hotspots have been identified in May**.**

- CPA 12 month reviews

Hotspots – Month 3

The previous hotspot for May has been removed due to an improved position. 1 hotspot has been identified as a result of reviewing performance relating to June 2020 against agreed targets.

- Timeliness of Data Entry (South Locality)

Contract Reporting

Due to the current COVID-19 crisis the Trust had agreed with commissioners a reduction to reporting requirements for 3 months. The Trust reviewed the position at the end of June and asked Commissioners to extend the period with an agreement to prepare a proposal for a phased approach to returning to full reporting. Commissioners agreed to support the Trust with this approach.

3.0 Financial Performance Report

Financial Performance Report

Due to the COVID-19 pandemic, for 2020/21 the Trust is operating under an Emergency Financial Regime. We will **not** be reporting against all five of the finance key metrics whilst the Emergency Financial Regime is in place. The Emergency Financial has been extended to month 5 and possibly month 6, however we are unclear how long this will continue.

Month 3 financial position:

Financial Position: Deficit of £2.8m including all COVID related expenditure. NHS accounting rules for at least the first 4 months are that Trusts will receive a top up to bring it back to Break Even. We have therefore accrued income to match the deficit and will expect a cash top up of an equal value.

COVID Spend: The Trust incurred further expenditure of c£1.1m in June (c£4.0m year-to-date). This is causing the deficit in Month 3 and will therefore be reimbursed through the monthly top up payments

CIP Position: £11.7m 20/21 target. For Month 3 Recurrent savings of £5.0m has been identified and £4.2m of Recurrent savings is delivered, c£2.5m of Recurrent savings has been actioned in the General Ledger. Full delivery of the 20/21 recurrent savings target must be achieved.

Agency Spend: Trust target for 20/21 is £14.1m and currently above target. The total expenditure at the end of Month 3 on Agency Staff was £3,960k against the Trust plan of £3,594k giving an adverse variance of £366k. The cumulative impact of COVID expenditure as at Month 3 was £582k.

CAPEX: Spend of £673k at the end of Month 3. New Capital regime will affect the plan. System allocation as opposed to organisational allocation is effective for 2020/21. Mid and South Essex has been given a £55.2m allocation as opposed to draft plans of £69.3m and this requires a 20% reduction in Capex plans. Against the Trust's revised CDEL for the year of £10,031k, the Trust is reporting a year to date net overspend of £179k which is purely a phasing issue where works on the Dormitory project are progressing ahead of planned spend.

Cash: £29.0m above plan. The cash balance at the end of June is £97,160k compared to an adjusted plan of £68,155k. This variance largely relates to the impact of the current cash

regime, whereby the Trust received an additional block payment in April. For the forecast cash position, the Trust has not factored in any block income during month seven in line with the latest guidance and payments reverting to monthly contract payments thereafter.

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

4.0 Sub-Committee Reports

The committee received 8 sets for months 2 and month 3 of the Executive Operational Sub Committee part one minutes for noting:

- 12th May 2020
- 19th May 2020
- 26th May 2020
- 2nd June 2020
- 8th June 2020
- 16th June 2020
- 23rd June 2020
- 30th June 2020

5.0 Finance & Performance Committee Workplan

Director of Compliance and Assurance/ Trust Secretary presented the Finance and Performance Committee Workplan**.**

The Committee approved the Workplan

6.0 Policies for Approval:

The Policies & Procedures below were approved by the Committee.

- Rostering Policy & Procedure
- Armed forces Policy & Procedure
- Recruitment & Retention Policy & Procedure

7.0 Governance Development Plan

The Director of Compliance and Assurance/Trust Secretary asked the Committee to consider the draft Governance Development Plan for 2020/21 and recommend actions to be added (or removed) to continue to strengthen the governance arrangements in place. The draft Governance Development Plan should be viewed in the context of a live and rolling plan linked to continuous improvement within the Trust.

Four governance priorities have been identified previously and are carried forward into 2020/21:

- Being an 'outstanding' well led organisation
- Being compliant with the NHSFT Licence conditions
- Ensuring that internal governance systems are effective
- Having effective communication systems in place that support staff in undertaking their role and promote understanding of the Trust with its stakeholders

Governance development actions have been collated from self-assessments carried out to support current compliance requirements (self-certification, code of governance, annual

reporting); actions identified in response to the Deloitte well led review 2019 and actions identified in 2019/20 that have not been completed.

The Committee approved the plan.

8.0 Board Assurance Framework Action Plans Q1

Director of Compliance and Assurance/Trust Secretary presented the Board Assurance Framework action plans to the Finance and Performance Committee and asked them to review BAF4 Fire Safety action plan for 2020/21 and consider whether the action plan mitigates the identified risks.

Not all BAF action plans are being reviewed during the Covid-19 pandemic therefore only one is submitted for review as at the end of Q1. Draft BAF4 Fire Safety 2020/21 Action Plan was submitted to EOSC 16 June for approval and requires review by the Committee.

Risks BAF20 inpatient capacity and bed occupancy and BAF31 skills and capacity are not currently being reviewed.

There are risks relevant to Finance and Performance Committee that are not required to have action plans:

- BAF41 Financial plan impact on CIPs – covered by performance reporting
- BAF42 Financial plan during Covid-19 – covered by performance reporting
- 6 BAF13 2019/20 CIPs has been closed.

The Committee approved the Board Assurance Framework action plan.

9.0 EPUT Self Certification 2020/21

The Director of Compliance and Assurance/Trust Secretary presented the self-assessment of Trust compliance with Licence Condition FT4 (the Corporate Governance Statement) and note the positive statement agreed by the Council of Governors in respect of training provided to Governors.

NHS Foundation Trusts are required, under normal circumstances, to make annual self-certifications to NHS Improvement under the NHS Provider Licence, Risk Assessment Framework and the Health and Social Care Act 2012, in addition to those made as part of the annual plan submission. Four self-certifications are required (one is not applicable to EPUT). It is unclear if the requirement has changed this year as a result of Covid-19 however EPUT has taken the decision to proceed as business as usual in the context of maintaining our well led and governance arrangements.

Self-certification in respect of licence condition G6 and CoS7 (not applicable to EPUT) was confirmed at the Board of Directors meeting in May 2020. Self-certification is now required in respect of licence condition FT4 (Corporate Governance Statement) and Governor Training by 30 June 2020.

The Committee was asked to consider compliance with the provider licence requirements prior to finalisation at Board at its extra-ordinary meeting on 24 June. A detailed self-assessment of Trust compliance against licence condition FT4 (Corporate Governance Statement) has been undertaken by the Head of Assurance.

The Council of Governors met on 12 June and considered the Trust's compliance with licence condition FT4. Views were requested. None have been received at the time of writing the report. The Council of Governors approved a statement in respect of the training provided to Governors at its meeting in May 2020 to support the Board of Directors self-certification in respect of Governor training.

The Committee agreed that it would recommend that the Board was able to meet the self-certification requirements in respect of licence condition FT4 and the training of Governors

10.0 Finance &Performance Committee's Terms of Reference

The Chair presented the revised Terms of Reference to the Finance and Performance Committee.

The Committee approved the Terms of Reference. These are presented to the Board of Directors at Appendix 1.

11.0 Capital Projects Steering Group Assurance Report

Executive Director of Strategy and Transformation presented the Capital Projects Steering Groups report and revised terms of reference to provide the appropriate assurances that the key issues highlighted within the Property Management report and the Project Management Report are being addressed in line with the Trust's Policy and Procedure, and that internal governance systems are being followed.

This report will also update the Committee on the current spend of the allotted Backlog Maintenance Programme and provides an analysis of the current Capital and Revenue Position and Forecast statement.

The Committee were asked to:

- Note the contents of this report.
- Ratify the reviewed Terms of Reference for the Capital Projects Programme Group Meeting
- To assure themselves that the Capital Projects Programme Group is discharging its terms of reference in respect of capital bids.

The Committee agreed that appropriate assurance had been received and noted and ratified the revised Terms of Reference for the Capital Projects Steering Group.

12.0 Risk Management Assurance Framework 2020-2023

The Director of Compliance and Assurance/Trust Secretary presented the Risk Management Assurance Framework (RMAF) 2020-2023 to the Committee. The Committee were asked to approve the draft Risk Management and Assurance Framework 2020/23 and the draft RMAF Development Plan 2020/21. The draft RMAF covers a new three year period from 2020/2023. An RMAF development plan for 2020/21 has been drafted to continue to enhance exiting RM arrangements.

This RMAF sets out a framework for EPUT's approach to risk management and assurance for the next three years. The review has been undertaken by the Head of Assurance and a further review was undertaken by a Task and Finish Group of members of the Health Safety and Security Committee and specifically the Risk Management Team and Assurance Team.

This RMAF builds on the previous three year framework and brings it up-to-date taking account of HM Government The Orange Book – Management of Risk – Principles and Concepts, published in February 2020 to assist organisations improve risk management further and to embed this as a routine part of how we operate.

The revision has attempted to take account of the Covid-19 pandemic in its structure and content. A broader range of risks is included at the start of the document.

The Committee approved the RMAF.

13.0 Any Risks or Issues

There were no risks or issues identified by the Committee.

14.0 Any Other Business

There was no other business

Report prepared by:

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

Manny Lewis
Chair of the Finance and Performance Committee

Appendix 1

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

FINANCE & PERFORMANCE COMMITTEE TERMS OF REFERENCE

1. AUTHORITY

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

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

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

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

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

2. ROLE

2.1 The Finance & Performance Committee has responsibility for the oversight and monitoring of the Trust's financial, operational (including clinical quality and workforce) and organisational performance in accordance with the relevant legislation, national guidance and current best practice. The Committee is also responsible for development and maintenance of the Trust's governance structures, systems and processes.

2.2 In line with the Trust's Investment Policy and Risk Management Framework, the Committee is responsible for ensuring the adoption and best practice in terms of decision making in line with guidance issued by NHS Improvement and the Competition & Markets Authority in relation to investments (including potential acquisitions and mergers) and the Health and Social Care Act 2012 in respect of mergers and acquisitions.

2.3 The remit of the Finance and Performance Committee, delegated limits and definition of investments is contained within the Trust's Investment Policy and Scheme of Delegation

2.4 The Committee is responsible for ensuring the appropriate investment of funds, and to oversee the amalgamation/disaggregation of funds arising from potential mergers, acquisitions or organisation reconfigurations.

3. FUNCTIONS

3.1 To consider in detail as necessary reports prepared on a monthly basis by the Executive Operational Sub-Committee detailing the performance (quality, contractual, partnership, workforce and regulatory) against identified local and national targets/ indicators that contribute to the delivery of quality services and ensuring that the Trust meets its contractual or regulatory requirements

3.2 To scrutinise the risks (hotspots) to quality and organisational performance highlighted by the Executive Operational Sub-Committee, seeking assurance that the risks are clearly articulated and mitigating action has or is being taken by Executive Directors

3.3 To identify any further risks to quality and organisational performance as a result of consideration of reports provided

3.4 To monitor progress made with implementing action to address identified risk

3.5 To agree the content of organisational performance reports to the Board of Directors including the escalation of identified or emerging risks to quality and organisational performance and/ or provision of assurance that organisational performance is being managed appropriately

3.6 To monitor operational performance and agree plans to mitigate underperformance, where necessary reporting these to the Board of Directors and NHSI where required

3.7 To ensure the Trust's compliance with the terms of its Licence, and its Constitution

3.8 To receive regular updates on compliance with governance requirements and oversee self-assessment of compliance with annual Corporate Governance Statement in order to recommend the appropriate declaration/ self-certification by the Board of Directors for submission to NHS Improvement

3.9 To scrutinise variation in financial performance and any risks highlighted by the Executive Operational Sub-Committee, seeking assurance that variation and risks are clearly articulated and mitigating action has or is being taken by Executive Directors

3.10 To identify any further risks to financial performance as a result of consideration of reports provided

3.11 To monitor progress made with implementing action to address identified variation or risk

3.12 To agree the content of financial reports to the Board of Directors including the escalation of identified or emerging risks to financial performance and/ or provision of assurance that financial performance is being managed appropriately

3.13 To receive assurance in relation to the management of the Trust's resources (including human resources, facilities, capital/revenue, assets)

3.14 To monitor implementation of the corporate and directorate objectives in the annual plan

3.15 To receive minutes and/or reports from its sub-committee and sub-groups, including (but not limited to):

- Any Productivity Plans and Reports
- Any Recovery Plan
- CIP Delivery
- Financial Performance Report
- Workforce.

Investment

3.16 To establish the overall methodology, processes and controls which govern selection of Trust investments and to review the selection process on an annual basis.

3.17 To establish a written Investment Policy that is approved by the Board of Directors and reviewed annually. The policy should also be periodically reviewed by independent professional advisors.

3.18 To monitor investments where total revenue resulting from the investment or capital value is within the delegated limits outlined in the Trust's Investment Policy for the Committee

3.19 To consider investments or marketing initiatives/opportunities:

- Where a change to the Trust's corporate structure is required (for example establishment of a subsidiary vehicle)
- To approve development of ITT that are reportable transactions to NHS Improvement
- To review all potential new transactions in the light of potential risks
- To review investment properties and vacant properties plans.

3.20 To make recommendations to the Board of Directors in relation to investment decisions.

3.21 Ensure that the underlying liquidity of the Trust is maintained where surpluses are used to finance investments.

3.22 The Committee will be exclusively responsible for determining the selection criteria; selecting, appointing, and

setting the terms of reference for any external investment consultants who advise the Committee.

3.23 Ensure safeguards are in place for security of exchequer funds by:

- Approving the list of permitted institutions
- Approving investment limits for each permitted institution
- Approving permitted investment types
- Ensuring approved bank mandates are in place for all accounts and are updated regularly for any changes in signatories and authority levels.

3.24 To monitor compliance with investment policy and procedures.

3.25 To review delegated authorities.

3.26 To approve external funding within limits delegated by the Board of Directors

3.27 To review and approve the Investment Policy and Procedure and any other policies and procedures within the scope of this terms of reference.

Workforce

3.28 To receive assurance on the implementation of the Trust's Human Resources Workforce Plan, and updates on any human resources or workforce-related issues.

Risk, Scrutiny and Action

3.29 To create a Schedule of Business setting out proposed actions, priorities and objectives and against which its performance is to be evaluated on an annual basis in accordance with paragraph 12 below

3.30 To request further data or information as necessary to support scrutiny process

3.31 To ensure appropriate links with the Audit Committee, PIT Committee and Quality Committee

3.32 To receive assurance of effective monitoring of contract performance.

3.33 To receive assurance on management of the Trust's strategic capital programme approved by the Board of Directors

3.34 To receive and approve (within the remit of these terms of reference) policies including (but not limited to):

- ITT Policies and Procedures
- Workforce Policies and Procedures
- Investment Policies and Procedures

- Any relevant Corporate Policies and Procedures (within the remit of these terms of reference)

3.35 To review and approve the Trust's risk management framework on behalf of the Board of Directors

3.36 To identify areas of significant risk to be included in the Corporate Risk Register, set priorities and actions to mitigate such risk

3.37 To escalate to the Board of Directors or refer to the relevant standing committee or sub-committee unresolved risks arising within the scope of these terms of reference that require action or that pose significant threats to the operation, resources or reputation of the Trust and, where appropriate, make recommendation to the Board of Directors in respect of including such risks in the Board Assurance Framework

3.38 To receive BAF risk action plans appropriate to the scope and role of the Committee.

4.	**SUB COMMITTEES AND SUB-GROUPS**	**Sub-Committees:** • Executive Operational Sub-Committee • Workforce Transformation Sub-Committee **Sub-Groups:** • Capital Projects Steering Group
5.	**MEMBERSHIP**	• Two (2) Non-Executive Directors (one of whom to be the Chair and another the Vice Chair) – currently Manny Lewis as Chair and Nigel Turner as Vice Chair • CEO • Executive Chief Finance Officer
6.	**IN ATTENDANCE (as required)**	• NED (Chair of Audit Committee) • Chief Operating Officer • Executive Medical Director • Executive Nurse • Director of ITT • Executive Director of People & Culture • Executive Director of Transformation & Strategy • Other Directors/Officers • Director of Compliance/Trust Secretary
7.	**SUPPORT TO COMMITTEE**	• Executive Assistant to CEO
8.	**QUORUM**	Two (2) Non-Executive Directors Two (2) Executive Directors
9.	**FREQUENCY OF MEETINGS**	The Committee shall meet monthly as required to fulfil its responsibilities, and in exceptional circumstances, as determined by the Chair or three members of the Committee
10.	**ATTENDANCE AT**	Members should attend at least 75% of meetings a year

MEETINGS

11.	**REPORTING ARRANGEMENTS AND MINUTES:**	11.1 Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval 11.2 Assurance Report to be provided to the Board bi-monthly. If requested to do so it will provide further information to the Board of Directors including the terms of any advice it has received and considered
12.	**MONITORING OF EFFECTIVENESS**	12.1 These terms of reference shall be reviewed by the Board of Directors at least annually. The Finance & Performance Committee shall undertake an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors and in achieving the Trust's objectives. This Committee shall report to the Board of Directors on the results of this review.
13.	**DATE ORIGINALLY APPROVED**	March 2019
14.	**NEXT REVIEW DATE**	July 2021

		Agenda Item No 7bii(a)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	**Board of Directors Quality Committee Assurance Report – June 2020**					
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 of Key Issues

At the meeting held on 22 June 2020, the Quality Committee:

- Received a patient story regarding a female patient, well known to mental health services that had appeared to be presenting with deterioration in her mental health. On presenting to the ward it was clear that the patient's mental health had deteriorated in a way that warranted admission. At the time the patient presented as consenting to admission and to understand the requirement to be Covid-19 swabbed and isolate pending results. However on day 2 of admission the patient refused to continue in isolation which resulted in numerous instances of leaving designated areas compromising infection control requirements in place to minimise infection rate and spread. The unprecedented situation was escalated to relevant teams for consideration of legislation and guidance. As a result of the learning on 18 June 2020 a reflective session was held virtually for EPUT clinical staff in relation to this case .The session purpose was to promote discussion and debate in relation to Covid-19, mental health, restrictive practice and legal frameworks.

Received the following reports:

- End of Life Annual Report
- Revised COVID-19 Infection Prevention & Control Board Assurance Framework
- BAF Action Plan – Quarter One
- Quality Account
- CQC Exception Report
- Mortality Data and Learning Quarterly Report
- Mental Health Act Annual Report
- Safeguarding Annual Report
- Infection Prevention & Control Annual Report

- Emergency Preparedness Resilience & Response Annual Report
- Suicide Prevention Strategy and Implementation Plan Update
- Local Security Management Specialist Annual Report

The Committee reviewed the following policy:

- PM17 Lone Worker Policy

Risks/Hotspots:

The Committee identified:

- No risks for escalation to the CRR or BAF
- 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:

- Production of the comprehensive annual reports
- Considerable amount of work undertaken by the Infection Prevention & Control Team over the last few months – they have been a credit to the organisation

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?	✓
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 7biii
Board of Directors Meeting
29 July 2020

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 28 May 2020 were approved at the meeting held on 22 June 2020.

2.2 Summary of discussions and issues identified as well as assurances provided at the meeting held on 22June 2020

2.2.1 Patient Story: Received a patient story regarding a female patient, well known to mental health services who had appeared to be presenting with deterioration in her mental health. A section 135 warrant was sought to enable entry to the patient's premises and provide an assessment of her mental health needs. Prior to the execution of the warrant the patient presented to inpatient services voluntarily. On presenting to the ward it was clear that the patient's mental health had deteriorated in a way that warranted admission. At the time the patient presented as consenting to admission and to understand the requirement to be Covid-19 swabbed and isolate pending results. However on day 2 of admission the patient refused to continue in isolation which resulted in numerous instances of leaving designated areas compromising infection control requirements in place to minimise infection rate and spread. Ward staff were quick to identify the issue and escalate their concerns. Consideration was given to the legal frameworks available, and the Mental Health Act, Mental Capacity Act (including DoLS) and Coronavirus Act. In the interim the patient's condition further deteriorated and she was detained under the Mental Health Act. On 18 June 2020 a reflective session was held virtually for EPUT clinical staff in relation to this case and a summary of the patient's circumstances and consideration given to legal frameworks was presented. The session purpose was to promote discussion and debate in relation to Covid-19, mental health, restrictive practice and legal frameworks. Further sessions are to be held to promote discussion and awareness of legal and ethical issues in the context of the pandemic. The patient remains in our care detained under the Mental Health Act.

2.2.2 End of Life Annual Report: The Committee received the annual report covering the period 2019/2020. This report provided a breakdown of the work undertaken by services providing care to those at end of life and during the last days of life. In 2019 End of Life Care received an 'Outstanding' rating by the Care Quality Commission. This was a considerable achievement and boost to services who worked very hard to improve integration and develop services following the rating in May 2018 of 'Requires Improvement'. It was noted that during the Covid - 19 pandemic services have adapted to ensure the best outcomes for people at end of life and continue to provide the very highest care irrespective of diagnosis.The organisation's success around end of life work was recognized with the committee noting that some elements of work particularly during the pandemic had been shared at a national level as examples of best practice.

2.2.3 Revised COVID-19 Infection Prevention & Control Assurance Framework: The Committee received the contents of an assurance framework that had been updated following a national update in response to emerging Covid-19 evidence and the effective infection prevention and control measures. Additional information had been added in relation to ventilation, maintaining air quality, estates and facility requirements and environmental Covid-19 secure elements. The Committee acknowledged that the work undertaken to date had been outstanding and sought assurance that any non-compliance was being addressed. The Committee was advised that through audits any non-compliance was addressed immediately and to provide support fortnightly live events are held with the IPC Team for all staff where demonstrations are given.

The Committee was advised that CQC had confirmed, following their receipt of this document that conversations were due to commence from 22 June in this respect.

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2.2.4 BAF Action Plan – Quarter One: The Committee was presented with the report that advised that 7 risks are currently allocated to the Committee for oversight and scrutiny; however at the present time, 3 of those risks are not being reviewed during Covid-19:

- BAF10 (Ligatures), BAF36 (Female Patients with Personal Disorder), and BAF9 (No Force First) – these were submitted to EOSC 16 June and approved
- BAF45 (Preparation for CQC inspection) – this is a new risk and the action plan will align to the new reset CQC action plan
- BAF15 (HSE), BAF35 (Fair Culture and Learning), and BAF32 (Quality Improvement) are not currently being reviewed

2.2.5 Quality Account: The Committee received and approved the draft updated Quality Account. It was noted that work was being undertaken to reconcile data for quarter 4which would be updated in the report.

2.2.6 CQC Exception Report: The Committee received the report and were assured that the CQC Executive Steering Group had reconvened from 2 June 2020 due to the large number of action slippages reported for the last couple of months.

As at the end of May 2020, 201 (90%) internal actions have been reported as complete which is an increase from 195 (87%) at the end of April 2020. There has been slippage reported with 17 (8%) internal actions which is a decrease from 21 (9%) reported as at the end of April 2020.

The overdue actions were reviewed in detail by the CQC Executive Steering Group to identify whether:

- the action as originally agreed should remain open or
- there is a need to change the focus of some of the actions due to other improvements and innovations that are taking place or to re-gain lost momentum.

As a result of the discussion that too place, it has been agreed that the existing action plan will be closed. A new “Reset” action plan will be developed that identifies only those (existing and new) actions that are to be taken forward from 1 July.

At the CQC engagement meeting on the 10th June; the plans for the reset approach were shared with the CQC, it was agreed to be a pragmatic approach and one which the CQC would endorse. It was noted that the CQC Executive Steering Group will reconvene at the end of June to finalise the Reset Plan.

2.2.7 Mortality Data and Learning Quarterly Report: The committee received the report which sets out data and learning for quarter four. There were **62** deaths which fell within scope for mortality review in accordance with the Trust’s Mortality Review Policy Whilst this is broadly consistent with other quarters (and with Q4 2018/19) in terms of overall numbers and remains within statistical control limits, some apparent variances in terms of deaths within particular functions were identified and explored within the attached report. Of the 62 deaths, 14 were inpatient deaths and 18 were nursing home deaths. Of these 32 deaths, 30 deaths have been confirmed as due to natural causes. Two causes of death are currently under determination; both appear to be likely to be confirmed as natural causes deaths.

It was noted that the Mortality Review Sub-Committee has now agreed a dashboard format for collating information on deaths of substance misuse service users who had had contact with the service in the preceding six months of their death.

In addition a working group reporting into the Mortality Review Sub-Committee has been established to look at the Covid-19 deaths. National guidance in this respect is still awaited.

The Committee noted that progress in terms of the completion of case note reviews and SIs has slowed during the pandemic but these are being taken forward as quickly as capacity allows. This is also the case for progressing longer term learning but is now picking up and the themes emerging were considered by the Learning Oversight Sub-Committee at their meeting earlier this month, with a view to considering how this learning can be taken forward across the Trust and actions aligned with other learning activity.

2.2.8 Mental Health Act Annual Report: The Committee received the Mental Health Act Annual Report and were invited to give feedback. It was agreed that comments would be sent to Natalie Hammond for further review at the July meeting.

2.2.9 Safeguarding Annual Report: The Committee received the Safeguarding Annual Report and was invited to give feedback. It was agreed that comments would be sent to Natalie Hammond for further review at the July meeting.

2.2.10 Infection Prevention & Control Annual Report: The Committee received the Infection Prevention & Control Annual Report and was invited to give feedback. It was agreed that comments would be sent to Natalie Hammond for further review at the July meeting. The Committee recorded their thanks on behalf of the Trust Board for the preparation of this report amidst current heavy workloads.

2.2.11 Suicide Prevention & Control Annual Report: The Committee noted that this item would be deferred and reviewed in August 2020.

2.2.12 Emergency Preparedness Resilience Annual Report and Implementation Plan Update: The Committee noted and approved the annual report and action plan.

2.2.13 Local Security Management Specialist Annual Report: The Committee noted and approved the annual report.

2.3 The Committee approved the following policy and procedure:

- RM17: Lone Worker Policy

2.4 Risks/Hotspots:

The Committee identified:

- No risks for escalation to the CRR or BAF
- 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:

- Production of the comprehensive annual reports
- Considerable amount of work undertaken by the Infection Prevention & Control Team over the last few months – they have been a credit to the organisation

Report prepared by:
Natalie Hammond
Executive Nurse

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

		Agenda Item No 7bii(b)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	**Board of Directors Quality Committee Assurance Report – July 2020**					
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 of Key Issues

At the meeting held on 24 July 2020, the Quality Committee:

- Received a patient story regarding a 34 year old female patient, who transferred to Plane ward following a road traffic accident having received treatment at Princess Alexander Hospital (PAH). The ward were proactive in sourcing equipment and further specialist care for the patient that has led to the patient being discharged from inpatients services with the ability to manage independently at home with the support of reablement services.

Received the following reports

- Quality Performance Report
- Restrictive Practice Framework Update Report
- Quality Report – Deep Dive Report HWE STP – Integration and Primary/Community Care Model
- Infection Prevention & Control Annual Report
- Mental Health Act Annual Report
- Safeguarding Annual Report
- Ligature Risks: Governance Requirements

The Committee reviewed the following policies:

- MHAPG30 Community Treatment Order Procedural Guidelines
- RM19 Water Safety Management Policy and Procedure
- CLPG17 Medical Devices

- Extension Request: Joint Working Between Mental Health & Learning Disability Services Policy
- Extension Request: Restrictive Practices Policy

Risks/Hotspots:

The Committee identified:

- No risks for escalation to the CRR or BAF
- 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:

- Restrictive practice work undertaken and analysis of data
- Work undertaken in relation to infection control
- Service transformation and the synergy/integration of mental health and community teams in supporting the holistic needs of the patient population.

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
Do you recommend a new entry to the BAF is made as a result of this report?	No

Acronyms/Terms Used in the Report			
CQC	Care Quality Committee		
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 7biii
Board of Directors Meeting
29 July 2020

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 24 July 2020 were approved.

2.2 Summary of discussions and issues identified as well as assurances provided at the meeting held on 24 July 2020:

2.2.1 Quality Performance Report: The Committee received the report and noted that due to the current Covid-19 crisis the report only included indicators which are national indicators for MH and CHS trusts set out within the Oversight Framework, Indicators needed for the Trust Annual Report and Annual Account and KPIs previously identified as hotspots.

Hotspots

One hotspot was identified as performing below target/benchmark in May 2020: CPA 12 Month Reviews (Improvement in May). It was reported that following comprehensive work undertaken the Executive Team have agreed that this is no longer a hotspot although this will continue to be monitored.

Serious Incidents

- MH Serious Incidents: In May there were eight Mental Health Serious Incidents within the Trust. This represents no change from the position in April, however overall, EPUT is continuing to see a reducing trend. It was noted that some of the incidents were related to Covid-19.
- CHS Serious Incidents: Zero Community Health Serious Incidents were reported in May and year to date, and there is no significant trend following analysis.

Safer Staffing

In May all safer staffing indicators met fill rate targets. In May there were 14 wards with unfilled shifts.

Quality Account Priorities

EPUT has set three Quality Priorities for 2020/21:

- Improvement
- Transformation
- Innovation

The Committee noted the full Quality Account action plan is currently under development and will be reported from the end of Q1.

2.2.2 Restraint Deep Dive Report: The Committee received this report that had been requested by the Quality Committee following a review of the quality performance report In May 2020; that showed there was a peak in all restraints across the Trust in April 2020. A detailed analysis had been undertaken of incidents that occurred in April 2020 in order to establish any themes, trends or learning and give assurance that appropriate actions were being taken.

Analysis of the data clearly identified that the majority of restraints occurred in a small number of areas primarily Longview, Larkwood, Cedar and Byron Court. Almost 50% of the incidents occurred in Child and Adolescent Mental Health Services the majority of which occurred on Longview. It was noted that the majority of these related to one young person who was awaiting a more appropriate placement on a low secure unit and has subsequently been more appropriately relocated. On Cedar, April 2020 saw the emergence of a small number of restrictive incidents where Covid-19 was identified as a contributory factor with violence and aggression classified as the most frequent reason for physical intervention followed by mental health disturbance. A large majority of the incidents in April 2020 related to one patient described as Covid-19 positive in isolation that was biting and spitting at staff. On Byron Court, the majority of incidents related to one patient with many of the incidents occurring at the start of lockdown with the lack of visitors and the restrictions had an impact. It was noted that the team responded by putting alternative arrangements in place to support family engagement.

The Committee supported the work undertaken to do a deep dive into the data and following discussion noted a range of factors that had impacted on service delivery and were assured that appropriate steps were being taken to minimise the use of restrictive interventions and promote patient safety. It was noted that a detailed report in relation to this agenda would be considered at the July Board.

2.2.3 Quality Report – HWE STP – Integration Primary/Community Care: The Committee received a presentation regarding transformation of Community Mental Health Services. It was noted that stakeholder engagement and co-production informed the development of the model. All elements of the pilot are now operational, inclusive of the transformation of existing Community Mental Health Services to a locality model based around PCN footprints in-line with EPUT Community Services. It was noted that this work was delivering a powerful ‘out of hospital’ strategy that was embedding the holistic needs of the population.

2.2.4 Infection, Prevention and Control Annual Report: The Committee received, discussed and approved the annual report for 2019/20**.** The importance of this agenda and the impact of Covid-19 was noted,

2.2.5 Mental Health Act Annual Report: The Committee received and approved the annual report for 2019/20 and discussed future work that was scheduled for action**.** It was noted that most aspects of work associated with the Mental Health Act had gone virtual and positive feedback had been received regarding set up and management of processes.

2.2.6 Safeguarding Annual Report: The Committee received and approved the annual report for 2019/20**.**

2.2.7 Ligature Risks – Governance Requirements: The Committee received this report which gave an update of the action that is underway and that which is planned going forward to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate. It was noted that as previously reported a CQC inspection of Trust services in July/August 2019 identified the following actions to be taken:

- Review of governance arrangements for ligature risk assessment and management (Must Do)
- Reviewing the management of ward and garden blind spots (Should Do)
- Ensuring staff fully assess the ward environment for ligature risks and blind spots (Should Do)

The Committee was assured that a detailed action plan had been developed to meet the three areas raised by the CQC. 15 internal actions had been identified and had been fully addressed.

The Committee discussed the importance of this agenda and the opportunities to align this agenda more closely with suicide prevention and the structures that support that. The format of the report and reporting arrangements were discussed and the importance of leadership, ownership and engagement in relation to this agenda. It was recognised that a learning event open to all staff would be helpful in relation to this agenda. It was agreed that a further report relating to the strategy and action plan would be brought to the September Quality Committee.

2.2.8 CQC Exception Report: The Committee considered this report that provided an update on the activities that are being undertaken within the Trust and the information available to maintain compliance with CQC standards and requirements and to support the Trust's ambition of achieving an outstanding rating by 2022. It was noted that a reset action plan had been developed to ensure that there is a clear focus on the 31 actions that are outstanding. At this point all actions are on schedule. Assurance was given that following the CQC's discussions with care homes they had confirmed that there were no items of concern.

2.2.9 Patient Story: Received a patient story regarding a 34 year old female patient, who transferred to Plane ward following a road traffic accident having received treatment at Princess Alexander Hospital (PAH). Prior to admission the ward liaised with PAH to identify and order equipment required on account of her BMI and subsequent requirements. The patient was very anxious with increased pain levels on admission. Personal care was undertaken with the patient in bed and a comprehensive rehabilitation plan was undertaken. The team quickly identified that the patient would benefit from more specialist care and agreed funding from the CCG for an 8 week intensive rehabilitation programme at Askham Rehabilitation Unit in Cambridge, after which the patient returned to Plane Ward for further support. After a further two weeks on the ward the patient was discharged home with reablement input. Following a home visit by OT the patient was reported to be managing independently at home.

2.3 The Committee approved the following policies and procedures:

- MHAPG30 Community Treatment Order Procedural Guidelines
- RM19 Water Safety Management Policy and Procedure
- CLPG17 Medical Devices

And approved extension requests for the following

- Joint Working between Mental Health & Learning Disability Services Policy
- Restrictive Practice Policy

2.4 Risks/Hotspots:

The Committee identified:

- No risks for escalation to the CRR or BAF
- 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:

- Restrictive practice work and data analysis
- Work undertaken in relation to infection control
- Service transformation that has been undertaken in West Essex and the synergy/integration of mental health and community teams in supporting the holistic needs of the patient population.

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: 7biii

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	29 July 2020

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.
4 Ratify the Terms of Reference for the People, Innovation & Transformation Committee.

Summary of Key Issues

The People, Innovation & Transformation Committee replaces the former Strategy & Planning Committee.

The Committee held its inaugural meeting on 1 June 2020, and discussed the following key issues:

- People, Innovation & Transformation Committee Terms of Reference.
- Revised Corporate Objectives Following Covid-19.
- Digital Service Change During Covid-19.
- BAF Action Plans.

The Board of Directors is asked to note the summary of discussions that took place during this meeting, and to ratify the Terms of Reference for the People, Innovation & Transformation Committee.

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			
BAF	Board Assurance Framework	Covid-19	Coronavirus Disease 2019

Supporting Documents and/or Further Reading
None

Lead

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

Part 1 Agenda Item: 7biii
Board of Directors
29 July 2020

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PEOPLE, INNOVATION & TRANSFORMATION COMMITTEE

PURPOSE OF REPORT

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

EXECUTIVE SUMMARY

People, Innovation & Transformation Committee Meeting - 1 June 2020
The People, Innovation & Transformation Committee replaces the former Strategy & Planning Committee.

The Committee's inaugural meeting was held on 1 June 2020, where Committee members had a successful and positive debate on a number of key areas. The following matters were considered:

1. People, Innovation & Transformation Committee Terms of Reference

Draft Terms of Reference for the People, Innovation & Transformation Committee were circulated and discussed. Subject to some minor amendments, Committee members approved the Terms of Reference. Their next review would be due in June 2021.

Committee members felt that there was currently some overlap with the work of other committees, therefore it was agreed that the Executive Director of Strategy & Transformation would work with the Trust Secretary's office to arrange the realignment of committees as appropriate.

The finalised Terms of Reference are attached as Appendix A. The Board of Directors is asked to ratify the Terms of Reference for the People, Innovation & Transformation Committee.

2. Revised Corporate Objectives Following Covid-19

Further to the Corporate Objectives 2020/21 being agreed by the Board of Directors in March 2020, the work of the Trust had changed significantly due to the Covid-19 pandemic. Therefore the Committee was presented with proposed revised Corporate Objectives for 2020/21.

Following discussion, it was agreed that the Executive Director of Strategy & Transformation would work with the Executive Team to finalise the revised Corporate Objectives, taking into account the feedback from People, Innovation & Transformation Committee members. The finalised revised Corporate Objectives 2020/21 would be presented to the Board of Directors for approval in July 2020.

3. Digital Service Change During Covid-19

People, Innovation & Transformation Committee members received a report providing an overview of the digital innovations put into place so far, to support the Trust's service delivery during the Covid-19 pandemic.

Following extensive discussion, Committee members agreed that now was the ideal time to set up a Task & Finish Group to identify which changes had proven to be best practice, analyse the potential cost and soft saving benefits, and develop new policies for the Trust going forward.

A report would be presented to the Board of Directors in July 2020.

4. BAF Action Plans

Committee members received a paper providing Quarter 1 Board Assurance Framework Action Plans for People, Innovation & Transformation Committee-related risks.

Three risks were currently assigned to the Committee:

1. BAF18 Transformation Leadership and Capacity.
2. BAF34 Staffing for Transformation.
3. BAF43 Surge and Recovery.

Following discussion, Committee members ratified the Quarter 1 Board Assurance Framework Action Plans for People, Innovation & Transformation Committee-related risks.

ACTION REQUIRED

The Board of Directors is asked to:

1. Note the summary of the meeting of the People, Innovation & Transformation Committee held on 1 June 2020.
2. Confirm acceptance of assurance given in respect of risk and the actions identified.
3. Request further action/information as required.
4. Ratify the Terms of Reference for the People, Innovation & Transformation Committee.

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

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

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PEOPLE, INNOVATION & TRANSFORMATION COMMITTEE
TERMS OF REFERENCE

1. AUTHORITY

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

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

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

1.4 The People, Innovation and Transformation Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

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

2. ROLE

2.1 To inform and support the Board in the development of the Trust's current and future strategic direction and Commercial Strategy making recommendations to the Board as appropriate.

2.2 To oversee and provide strategic direction, on behalf of the Board, and oversee engagement with all health and care systems in which the Trust currently operates, or may operate in the future.

2.3 To keep abreast of wider sector developments and policy direction in order to inform the Board on options for the Trust's future strategic direction.

2.4 To have oversight of the delivery of the Trust's transformation programmes.

- To have oversight of workforce strategy and planning, organisational development, talent management, mandatory training and the Just Culture.
- To promote the work of the EPUT Lab and digital developments.

3. FUNCTIONS People, Innovation and Transformation

3.1 To propose to the Board of Directors the Trust's strategic aims on an annual basis and/or as required by national guidance, taking into consideration the views of the Council of Governors, and ensuring that the necessary financial and human resources are in place or accessible for the Trust to meet its priorities and objectives.

3.2 To advise the Board of options for longer-term strategic direction.

3.3 To oversee the development of the Trust's Commercial Strategy.

3.4 To oversee the active involvement of staff, governors, service users, and carers and other stakeholders in the development of key Trust strategies and plans.

3.5 Oversee effective relationship management with key partners, stakeholders and members of the public.

3.6 To maintain oversight and critically review the Trust's transformational programmes and their alignment and impact on the future direction for the organisation.

3.7 To oversee that all projects, strategies and frameworks submitted to the Committee for consideration are supported by an appropriate Quality and Equality Impact Assessment.

3.8 To recommend to the Board the planning timetable and approach for preparing the Trust's Operating Plan, for the Board's approval.

3.9 To have oversight of the preparation of the Trust's Operational Plan.

- To monitor the Trust's progress with corporate and directorate objectives.
- To oversee the Trust's strategies and frameworks progress.

3.10 To review the potential impact on the Trust's strategic direction of significant changes in the national policy or legal framework.

Work Plan and Risk

3.11 To create an annual work plan setting out proposed actions, priorities and objectives and against which its performance is to be evaluated on an annual basis in accordance with paragraph 12 below.

3.12 To identify areas of significant risk to be included in the Corporate Risk Register, set priorities and actions to mitigate such risk.

3.13 To escalate to the Board of Directors or refer to the relevant standing committee or sub-committee unresolved risks arising within the scope of these terms of reference that require action or that pose significant threats to the operation, resources or reputation of the Trust and, where appropriate, make recommendation to the Board of Directors in respect of including such risks in the Board Assurance Framework.

4. SUB COMMITTEES AND SUB-GROUPS

Sub-Committees: None.

Sub-Groups: EPUT Lab and Workforce Transformation Group.

5. MEMBERSHIP

- Four (4) Non-Executive Directors, including the Chair of the Trust. One Non-Executive Director, other than the Chair of the Trust, shall be Chair of the Committee
- CEO
- Executive Chief Finance and Resources Officer
- Executive Director of Strategy & Transformation
- Executive Director of People and Culture

6. IN ATTENDANCE (As Required)

- Executive Director Mental Health/Deputy CEO
- Executive Medical Director
- Executive Nurse
- Other Directors and Officers of the Trust including deputies for Executive Directors

7. SUPPORT TO COMMITTEE

PA to the Executive Director of Strategy and Transformation, or as agreed by the members.

8. ATTENDANCE AT MEETINGS

Members should attend at least 75% of meetings a year.

9. QUORUM

Two (2) Non-Executive Directors
Two (2) Executive Directors

10. FREQUENCY OF MEETINGS

The Committee shall meet monthly as required to fulfil its responsibilities, and in exceptional circumstances, as determined by the Chair.

11. REPORTING AND MINUTES

11.1 Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval.

11.2 The Committee will report in writing to the Board of Directors after each meeting advising the Committee has met and the decisions it has made. If requested to do so it will provide further information to the Board of Directors including the terms of any advice it has received and considered.

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

12.	**MONITORING OF EFFECTIVENESS**	These terms of reference shall be reviewed by the Board of Directors at least annually. The People, Innovation & Transformation Committee shall undertake an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors and in achieving the Trust's objectives. The results of this review shall be reported to the Board of Directors.
13.	**DATE ORIGINALLY APPROVED**	1 June 2020
14.	**NEXT REVIEW DATE**	To be reviewed annually

		Agenda Item No: 7c(i)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	**Covid 19 Assurance Report**					
Executive/Non-Executive Lead:	Sally Morris Chief Executive					
Report Author(s):	Sally Morris Chief Executive					
Report discussed previously at:						
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 risk register and mitigations (Appendix 1).
4. Request any further information and or action.

Summary of Key Issues

The country has now been dealing with the corona virus outbreak for 5 months. The Trust's arrangements continue to be in place and are working effectively. This report provides assurance across the following areas :-

- Details on the Command structure operating within the Trust
- The impact to date on the Trust and its patients
- Communications arrangements
- Major risks and actions taken

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	✓

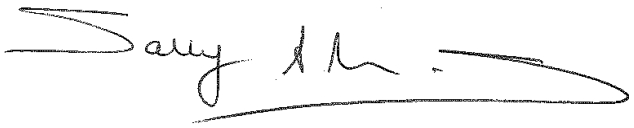
Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	✓
BAF 38 EPR arrangements for Covid 19	
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
Visit the Government website: https://www.gov.uk/coronavirus

Lead
 **Sally Morris** **Chief Executive**

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. It follows on from the report which was presented at the May 2020 meeting.

BACKGROUND

Detailed reports were presented to the March and May 2020 Board meetings explaining that a Level 4 National Incident had been declared on 30th January 2020. Despite the relaxation of many lockdown processes the NHS continues to be in a Level 4 incident. Whilst now operating in a "reset and recovery" phase it is still alert to a potential 2nd wave should that materialise.

COMMAND STRUCTURE

The Gold, Silver and Bronze Command meetings now meet every 2 days (but not at the weekend). The (virtual) Incident Control room is still operational 7 days a week, from 8am until 6pm during the week and from 9 – 5pm at weekends to receive and cascade information and guidance, manage daily sitreps required, oversee the SPOC for test and trace, identify and send staff for testing and receive and cascade swab results. Decisions made by Gold continue to communicated to all staff through the Covid Brief which is published on the days Gold Command meets.

The Covid Risk Register is regularly reviewed and updated by Gold & Silver Command. In addition, the Chairs from each of the Trusts five staff equalities networks attend the Silver Command meetings to ensure that no staff group is adversely affected by decisions made, or recommendations submitted to Gold Command.

IMPACT TO DATE

Covid 19 is still having an impact on the Trust and its patients, although this is far less than at the time of the last report. At the time of writing this report we have 14 staff off sick with Covid, and 209 self-isolating (compared to 34 sick and 259 self isolating 2 months ago). This equates to circa 4.5% of our staff. Good infection control procedures and use of PPE means that we currently do not have any Covid positive patients within our mental health inpatient or community physical health beds.

Sadly, 18 patients have passed away due to Covid in our wards since the crisis began (2 in Mental Health services and 16 in Community beds). All of these patients were elderly and had underlying health conditions.

The costs associated with Covid and their treatment are covered in the report from the Finance & Performance Committee. We understand that the finance regime we are currently under will enable Covid costs to be recovered.

COMMUNICATIONS

As the Covid pandemic has progressed the need for daily briefings has diminished, however should there be the need for an urgent message to be distributed this has taken place.

The weekly Live event which is hosted by the Chief Executive with the Executive Directors has continued with attendees regularly exceeding 500. This event allows staff to raise any questions they have directly with the Executive Directors and to receive an immediate response.

The Non Executive Directors continue to receive a weekly briefing via Microsoft Teams from the Chief Executive, as well as ad hoc briefings when necessary. The use of Microsoft Teams enables the Trust to undertake all of it's corporate meetings on a virtual basis.

The Chief Executive now sends out a fortnightly briefing (rather than weekly) to all Governors on a Friday which summarises the issues during the previous 2 weeks and the Trust's current position. The Chair includes a message of her own within this briefing.

RISKS

In the May 2020 paper a number of risks/hotspots were identified: -

i) PPE
ii) Infection & Prevention Control within the Trust
iii) Availability of Oxygen
iv) Patient & Staff testing
v) Return to work and social distancing
vi) Mental Health Surge

Since that time the risks have been updated to reflect the constantly changing environment and are detailed in the summary Covid Gold Risk Register in Appendix 1. From this it can be seen that major risks currently facing the Trust are: -

Infection & Prevention Control within the Trust
This is no longer materially impacting on the Trust, however it remains a major risk which is under constant review.

PPE
Not currently a major risk but remains on the risk register. Since the Covid pandemic began we have distributed 1,042,000 Type 2R masks, 453,050 aprons and 20,690 FFP3 Masks – this provides an indication of the scale of the task faced by staff in purchasing and distribution!

Care Home Testing
The risk here relates to Trust staff visiting Care Homes and the lack of clarity around policy and processes for testing staff as visitors to Care Homes.

Return to work and Social Distancing Covid
The Trust has continued to support a large number of staff to work from home, whilst at the same time preparing our accommodation to be "Covid Secure" wherever possible. To date there have been over 120 assessments with 14 areas already identified as secure. A large number are in the process of being signed off once full assurance has been received. This is very important as the current guidance is that staff who have been shielding can only return to Covid safe environments.

However, even if we are able to designate as many of our buildings as possible as Covid

Secure we will not be able to bring all of our workforce back as the social distancing requirements has significantly reduced our capacity. We will therefore continue to support a large number of our workforce to remain working from home.

Mental Health Surge

We are starting to see a surge in demand for mental health services, and whilst there is no reliable modelling on how big this will be and what capacity will be required we are trying to anticipate increased demand.

During the peak of the Covid crisis inpatient occupancy dropped as low as 50% in some areas. As part of our reset plans we are aiming for a maximum 85% occupancy to allow social distancing measures to be safely operated in communal areas should there be an outbreak. However, this does present a real risk and the need to balance when the number of patients requiring a bed rises above this level and the decision is to either send the patient out of area (assuming there is a bed available) with the increase the occupancy level and potentially not be able to manage an outbreak.

LEARNING

To be an outstanding Trust it is important that we are also a learning organisation. We have therefore been undertaking a wide range of activities during the Covid pandemic some of which are listed below :-

- Establishment of COVID-19 Deaths Review Working Group, reporting to mortality review sub-committee
- Data analysis of ALL deaths of patients under the care of EPUT at the date of death, including analysis of rates of increase between Jan - May 2019 and Jan - May 2020. Significant increases evident across many services.
- Rapid review of deaths in the Trust managed Nursing Homes Jan - May 2020 undertaken by Consultant in Public Health and Consultant Psychiatrist (Older People), including review of clinical records.
- Commissioned review of all Serious Incident deaths (including suicides) from March to ascertain direct / indirect impact of COVID-19 factors (eg breakdown of normal support arrangements, social isolation etc).
- Incorporation of staff support offering into reflective learning.
- Learning emerging from all activity being collated for sharing at meetings with acute trusts.

The learning we gather from the above areas will be essential if we face a 2nd wave of Covid in the coming months.

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:

Sally Morris
Chief Executive

Appendix 1

COVID19 2020/21 Summary of Risks as at July 2020 (note BAF Covid19 risks not included in this summary)

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						
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	• Robust IPC in place and fast response to interpreting national guidance into EPUT guidance • This risk is at threshold but remains a risk for the duration	4 x 2 = 8	4 x 2 = 8 ongoing for duration of crisis	At threshold
CVG 20	If EPUT has insufficient PPE available then the spread of the Covid19 virus to staff and patients cannot be fully contained resulting in EPUT not being able to deliver a service.	NH	• This risk is now at threshold but remains a risk for the duration • Trust stock levels are good and no issues reported operationally.	4 x 2 = 8	4 x 2 = 8 ongoing for duration of crisis	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	• This risk is now at threshold but remains a risk for the duration • Community staff are being fit tested with alternative masks. • Alternative FFP3 masks for those who have not been able to be "fitted" have been received (reusable and disposable) and are being trialled.	4 x 2 = 8	4 x 2 = 8 Ongoing for duration of crisis	At 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	MM	• Capital projects continuously under review • Building contractors are now returning to BAU • No significant risk to future programme identified currently • Risk is at threshold but to be monitored as pent up demand could limit availability of contractors	4 x 2 = 8	4 x 2 = 8 July 2020	At 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 Covid-19	NH	• Guidance implemented • This risk is now at threshold but remains a risk until covid secure risk assessments completed (CVG37)	4 x 2 = 8	4 x 2 = 8 ongoing for duration of crisis	At threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (Consequence x Likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 37	If EPUT is unable to ensure that premises are Covid-19 secure then community based services cannot restart resulting in further delays in service delivery	SM/ MM	• Risk assessments being carried out on premises to identify adaptations that need to be made • 120 risk assessments completed to date • 14 buildings have achieved covid secure status • Covid Secure premises are communicated and listed on InPut	4 x 3 = 12	4 x 2 = 8 August 2020	Above threshold
CVG 34	If EPUT staff are not identified as a contact of a positive patient in the community by PHE due to wearing PPE then they could infect other patients resulting in a spread of Covid19	NH	• Interim arrangement in place following regional call that organisations undertake a risk assessment to determine whether the impact on the service is greater if staff are asked to self-isolate rather than continuing to work using PPE • Staff have been risk assessed	4 x 3 = 12	4 x 1 = 4 July 2020	Above threshold
CVG 38	If the provision of self-testing kits for care home staff continues to be delayed then weekly testing cannot take place resulting in non-compliance with national requirements and increased risk of an outbreak affecting staff and patients	NH	• New risk added 23/7 from Silver/Gold Command • Issue escalated and mitigation plan being developed for the Trusts' two care homes	4 x 3 = 12	4 x 2 = 8 Ongoing for duration of crisis	Above threshold
CVG 39	If EPUT does not maintain its bed occupancy levels below the target of 85% then its ability to manage a Covid-19 or other outbreak is impacted	AB	• New risk added 23/7 from Silver/Gold Command • Executive team to discuss management of increased demand for IP beds in conjunction with managing the reduced Covid risk at this time.	4 x 3 = 12	4 x 2 = 8 Ongoing for duration of crisis	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 Covid-19	NH	• New risk added 23/7 from Silver/Gold Command • Specific issue identified regarding oral cavity suction has been escalated to NHSE/I.	4 x 3 = 12	4 x 2 = 8 Ongoing for duration of crisis	Above 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: Mark Madden supported by all other Executive Directors - Impact of not achieving the Strategic Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score						
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	• Working group in place of HR business partners and workforce development to ensure training analysis, uptake and recording takes place • C19 training data received weekly by Gold command • Increase in participation is now recorded. Action is on-going.	4 x 3 = 12	4 x 2 = 10 ongoing for duration of crisis	Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	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	• Vulnerable workers risk assessment developed and approved by GC • All staff required to be risk assessed to identify vulnerabilities linked to covid and protected characteristics. • Weekly monitoring in place of progress. • 97% of BAME staff have been risk assessed (inc bank workers who have been offered risk assessment but have not responded) • 56% of all other staff have been risk assessed • Risk is at threshold, but remains on register until end of July (national deadline)	4 x 2 = 8	4 x 2 = 8 July 2020	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	MM	• All EPUT computers are running Advanced Threat Protection under the Dx centralised solution, including the remaining Windows 7 computers • Cyber Essentials Accreditation received • NHS remains vulnerable during Covid19 – EPUT maintaining vigilance on cyber security requirements	4 x 3 = 12	4 x 2 = 10 ongoing for duration of crisis	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						

		Agenda Item No: 7cii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title	Flow & Capacity					
Executive/Non-Executive Lead:	Andy Brogan, COO & Deputy CEO					
Report Author(s):	Sarah Brazier, Flow & Capacity Lead & Lizzy Wells, Director of MH					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	

Purpose of the Report		
This report provides: Board assurance on the in-patient capacity and bed occupancy position, updating on the current flow and capacity issues, out of area placement use, highlighting challenges ahead and mitigating actions in place to address.	**Approval**	
	Discussion	
	Information	✓

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

Summary of Key Issues
The OoAP trajectory was on line for April 2021 following implementation of transformation - Crisis 24/7 Model. However, COVID -19 has now impacted and we are expecting a mental health surge of 10% demand. Due to need for social distancing we have reduced our MH inpatient occupancy to 85%. This report describes the challenges ahead and mitigating actions.

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	20
Do you recommend a new entry to the BAF is made as a result of this report?	Yes-updated

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

BAF 36

Lead

Andy Brogan
Executive Chief Operating Officer, Deputy CEO

Agenda Item: 7cii
Board of Directors
29 July 2020

ESSEX PARTNERSHIP NHS FOUNDATION TRUST

BAF20 IN-PATIENT CAPACITY AND BED OCCUPANCY 2020/21

1. Overview

This report aims to provide board assurance on the in-patient capacity and bed occupancy position, updating on the current flow and capacity issues, out of area placement use, highlighting challenges ahead and mitigating actions in place to address.

2. Out of Area Placements (OoAP) April 2020 to Date.

As preparations for wave 1 of pandemic the Trust was able to create capacity through special arrangements to discharge a number of inpatient in anticipation of additional admissions and possible C19 prevalence on our wards. This enabled capacity to be reduced and the need for OoAP. This along with a general reduction in demand during this period created lower OoAP since the commencement of the C19 period.

During the period March to May 2020 there were a number of OoAP occupied bed days (OBD) that in order to prevent Covid -19 movement/spread across treatment wards were unable to be recalled despite sufficient EPUT capacity (263 OBD). These are recorded as appropriate rather than inappropriate use of OoAP.

Apr-20	209 Appropriate OBD - unable to recall despite sufficient capacity. Integrated discharge plans implemented directly from provider site. 0 – Inappropriate OBD
May-20	54 Appropriate OBD– unable to recall despite sufficient capacity. Integrated discharge plans implemented directly from provider site. 0 – Inappropriate OBD
Jun-20	15 Inappropriate OBD (PICU Admission)

3. Projected Out of Area Private Placement (OoAP) Occupied Bed Days (OBD)

As we move to recovery we are seeing increasing demand as this heads towards 100% and the unique circumstances of the early C19 period no longer exist so holding OoAP at the current level is not sustainable.

EPUT ambition to retain 85% bed occupancy is supported by a suite of flow and capacity initiatives. Admission to wards exceeding 85% require Director authorisation. Consideration is to be given to: Ward activity/ acuity; expected discharge trajectories; need for social isolation on admission.

We are anticipating a likely increase in OoAP admission due to 15% reduction in capacity for social distancing as our forecast is that we can manage the anticipated 10% mental health surge demand.

The anticipated mental health surge demand (10%) and the EPUT ambition to retain 85% bed occupancy to allow for social distancing is our planned pressure for OoAP.

We note in our constraints to this plan that extended length of stay due to acuity and 100% pre-COVID demand will likely have impact on OoAP but we have not modelled this yet as it is too early to assess whether this early assessment will impact our current assumptions. Community transformation will provide mitigation (Phase 3 modelling assumptions expect 10%).

We anticipate demand for admission will exceed EPUT bed capacity by 15% due to the social distancing arrangement in place as described above.

	Adult 15% OBD reduction	**PICU 15%OBD reduction**	**Total Projected OOAP OBD**
July 2020	Likely breach 85% bed occupancy ambition	Likely breach 85% bed occupancy ambition	563 (7.5% reduction)
Aug 2020	1009	116	1125
Sept 2020	977	113	1110
Oct 2020	1009	116	1125
Nov 2020	977	113	1110
Dec 2020	1009	116	1125
Jan 2021	1009	116	1125

Feb 2021	911	105	1016
March 2021	1009	116	1125

4. Key Challenges and Learning.

This report seeks to set out the current flow and capacity position, highlighting challenges ahead and mitigating actions in place to address.

Key Challenges:

Challenge of the unknown impact of the COVID 19 pandemic and potential for MH surge - Anticipated to be an increased 10% demand on services.

Bed occupancy reduced to 85% to support social distancing on wards

Experiencing an increase in numbers of MHA assessment/detention

Inpatient consultants are reporting escalation in severity of clinical presentation - Potential for extended LOS

Whole system (health and social care) fatigue.

Positive learning from COVID – 19:

Positive use of available technologies – development of patient review and discharge planning meetings. (In place in West and North Essex. Implementation phase in Mid and South). To ensure:

- All admissions remain purposeful and are focused on progression towards earliest safe discharge.
- Barriers to discharge and challenges experienced in community care are shared and understood.
- All community and inpatient actions required to facilitate smooth and timely discharge are communicated and agreed.
- Clarity and agreement for post discharge follow up arrangements (within 48hrs) and discharge plans.
- Identify delayed transfer of care patients requiring escalation within wider health and social care system.

Social Care Leadership Team are engaging weekly with ECC commissioners in relation to use of the accommodation pathway and working with Discharge coordination team in EPUT to map demand. Weekly calls with ECC to plan and flex resource required are in place and

will continue to support future mapping. Action plan has been agreed with ECC and reviewed weekly.

Ongoing escalation of all Delayed transfer of care to senior health and social care commissioning teams.

Appendix COVID 19 Response - has been added to EPUT Capacity, Flow and Escalation Policy.

Report completed by:
Name: Sarah Brazier / Lizzy Wells
Title: EPUT Flow and Capacity lead / Director of Mental Health (NE & West)
Date: 15th July 2020

BAF20 In-Patient Capacity and Bed Occupancy 2020/21			
Assumption	**Potential Risk**	**Risk Score**	**Controls**
There will be sufficient adult mental health capacity, appropriate levels of bed occupancy and no out of area placements	If there is insufficient adult mental health capacity then in-patient activity levels may exceed funded capacity and continued bed occupancy levels above 85% with high numbers of out of area placements, this may impact on the quality and effectiveness of services deliver as well as the Trust meeting its statutory financial duties	**Consequence 5 x Likelihood 3 = 15**	• Whole system Flow and Capacity Policy to support the delivery of a consistent approach across services, optimising flow and consistent gatekeeping ensuring appropriate admissions to appropriate beds for the appropriate duration • COVID 19 appendix added to Capacity, flow and escalation policy • Utilisation of OPEL framework with associated escalation structure and recovery plan • Single extended seven day bed management team working and site officers out of hours • Daily Safer Staffing and Bed Occupancy SITREP providing oversight of all Inpatient admissions • Delayed transfers of care weekly teleconference calls between EPUT, CCG and LA identifying action, providing escalation and scrutiny of all delays • Mental Health safer care bundle principals embedded into practice • Trusted Assessor Model/gatekeeping to provide preferred alternative to inpatient admission and facilitating earliest safe discharge • Purposeful admission with expected date of discharge • 72 hours assessment unit model in place across EPUT • Introduction of My Care My Leave patient document • All admissions to wards exceeding 85% require AD/Director authorisation – EDD; ward activity/acuity and patient social isolation on admission to inform decision making.

Action	Action Detail	Target Completion Date	Lead	Progress	RAG
Flow and Capacity Action Plan	M5 CQC ACTION -To progress the Essex Ambitions work in relation to housing support to assist with the facilitation of timely discharge. The aim is to have an agreed joint working arrangement with Housing departments across Essex. This is to be achieved by progressing Ambition 6 of the Essex Ambitions.	~~April 2020~~ September 2020	AB / SW / LW / LP / LMc	Social Care Leadership Team are engaging weekly with ECC commissioners in relation to use of the accommodation pathway and working with Discharge coordination team in EPUT to map demand Weekly calls with ECC to plan and flex resource required are in place and will continue to support future mapping Action plan agreed with ECC 27 April 2020 and reviewed weekly The Essex Ambitions systems workshop to progress Ambition 6 is being reorganised - two shorter workshops via Teams, to be externally facilitated in September 2020	
	Complete recruitment to inpatient social worker post in West	April 2020	LPr SBr	Completed	
	Introduce locality community and inpatient review and discharge planning meetings to ensure: ○ Barriers to discharge and challenges experienced in community care are shared and understood ○ All community and inpatient actions required to facilitate smooth and timely discharge are communicated and agreed ○ Clarity and agreement for post discharge follow up arrangements (within 48hrs) and discharge plans ○ Identify delayed transfer of care patients requiring escalation within wider health	September 2020	SBr	Meetings in place in North East and West Mid and South Older adults are in place Agreement in place for Mid and South Adults and planning for implementation is underway	

Action	Action Detail	Target Completion Date	Lead	Progress	RAG
	and social care system				
CQC actions (M5)	Reflect on the Flow and Capacity Changes that took place during COVID19 to ensure the maximum occupancy level of 85% in all adult inpatient	July 2020	AB/ SW/ LW/ SBr	Identifying principles around going over 85% taking account of: ○ Compromising social distancing or patient safety ○ Numbers in isolation at any one time ○ Bed management and flow and capacity policy to be updated to reflect agreed practice	
	Undertake a review of the patients who have repeat admissions in order to understand the reasons and identify any actions to reduce these	July 2020	AB/ SW/ LW	Local high intensity user group meetings to review repeat admissions	
	Recruit second Consultant at Peter Bruff to improve gatekeeping	September 2020	AB/ LW/ MK	NHS Trust and Agency Locum currently working	

RAG rating legend
Green = completed Amber = in progress within timescale Red = overdue Grey = not due

		Agenda Item No: 7ciii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	**Female Patients with Personality Disorders**					
Executive/Non-Executive Lead:	Andy Brogan COO/ Deputy Chief Executive					
Report Author(s):	Lizzy Wells Director of Mental Health					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	

Purpose of the Report		
This report provides: Board assurance that the numbers of female patients with personality disorders admitted to inpatient services will be within manageable limits. If the Trust continues to experience high numbers of female patients with personality disorders being admitted to inpatient services then the ward environment may become more volatile and difficult to manage resulting in a risk to patient safety and length of stay.	**Approval**	
	Discussion	
	Information	✓

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

Summary of Key Issues
The Operational Inpatient leads & Professional leads have taken an holistic approach to the controls and mitigation focusing on service developments, workforce, training, therapeutic offer, environments and digital support.

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	36
Do you recommend a new entry to the BAF is made as a result of this report?	Yes-updated

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

BAF 36

Lead

Andy Brogan
Executive Chief Operating Officer, Deputy CEO

ESSEX PARTNERSHIP NHS FOUNDATION TRUST

BAF36 FEMALE PATIENTS WITH PERSONALITY DISORDERS 2020/21

This report aims to provide board assurance that the numbers of female patients with personality disorders admitted to inpatient services will be within manageable limits.

If the Trust continues to experience high numbers of female patients with personality disorders being admitted to inpatient services then the ward environment may become more volatile and difficult to manage resulting in a risk to patient safety and length of stay.

The Operational Inpatient leads & Psychology leads have taken an holistic approach to the controls and mitigation focusing on service developments, workforce, training, therapeutic offer, environments and digital support.

2. Progress and Mitigation

a) Service Development:

The following service developments will support service users with personality disorder to be treated and cared for under community services, preventing admission and providing an alternative to admission

- **Crisis 24/7** (Inc. 111, telecoaching, 4hr community crisis response, home treatment & Crisis cafes) On the 31st March 2020, the 24/7 Crisis Service was launched across EPUT, as planned even though a Level 4 incident had been declared (Covid-19). This 24/7 service is able to meet the needs of service users with personality disorder in the community, preventing Emergency Department attendance out of hours and acute inpatient admission.

- **New trauma/PD pathway to support inpatient services** is being developed across EPUT with the following progress:
  - Specialist MDT established and posts recruited to (Family Therapist interviews scheduled for late July). Service User Network Coordinating manager due to start September, following maternity leave. The Specialist MDT is starting its work, including setting up referral pathways, and oversight care coordination.

  - Locality PD&CN virtual teams being established in South East, South West and Mid, aimed at completion by October. Transitioning Psychologist posts in MSE recruited to, start dates set for September. Locality CMHT PD psych services lead established in SE and Mid, recruiting to SW.

  - Formal Consultation with Medical Psychotherapists underway, with recommendation to establish their roles in the Specialist MDT, and in the Locality Virtual teams.

  - Psychotherapy service roles identified for either establishment in Specialist PD&CN MDT, and in Adult Community Teams.

- Pilot for 15-25 year old PD intervention underway in West Essex, with co-working established with Young Concern Trust, a 3rd sector Child & Adolescent counselling organisation. Groups and psychoeducation established across the participating PCNs.

- Negotiations re PD&CN provision in secondary and HTT in WE still ongoing. - Business Case approved in NEE, waiting for Board sign-off. Implementation delayed due to COVID-19.

- Trauma Alliance in PHC established in SE, with 1wte Clinical Psychologist to treat trauma and trauma-related conditions alongside 3rd sector and charitable organisations.

- Therapy for You (SE) and Inclusion (SW< Thurrock) engaged in co-facilitation of groups, and integrated pathways for managing PD&CN across PHC and LCMHTs. Some engagement established with HPFT IAPT provider in Mid, but not in West or NEE.

- **Perinatal Services**: project underway to augment the support for parents living with personality disorder and to offer more information and access to interventions. As well as a DBT group, there is work underway to produce a comprehensive information pack as well as increased support from practitioners in the team to use videos and links to help increase skills in manage emotional dysregulation. The whole service will be trained in DBT skills in the coming year and work will continue with the PD leads as the trust PD pathway is established and bedded-in.

b) Workforce
Nursing establishment:

- In February the establishment review on female wards with a high level of PD presentations was implemented = an increase in Band 3 nursing staff over a 24hr period. A pilot period showed a reduction in ligature incidents, improved patient experience and reduced workforce stress.

Provision of psychology support:

- Assistant Psychologists available to most wards, flexibility to focus on where needed further psychology assistant posts to be advertised with roles working trust wide, once and commissioner approval signed off. Business case in progress to develop these into Clinical Associate in Psychology (CAP) posts, with enhanced MDT support, supervision, consultation and therapeutic delivery. CAP IFA approval complete and banding approved. Waiting for Ministerial sign-off (expected September). Business case to develop training is in process.

c) Training:

- All inpatient staff to have Mentalisation/ Stabilisation training. SMI training in Mentalisation, Structured Clinical Management, and CBT for PD started, delayed by COVID-19. Further training planned.

- Clinical Skills mapping completed, and SMI training including Structured Clinical Management for teams, CBT for PD, Mentalisation-Based Therapy training, and DBT training booked. KUF and SCM delivery complete in West Essex (System-wide) and being rolled out in south.

- All staff to receive monthly supervision

d) Digital/IT Support

- COVID-19 adjustments have been made, with online video treatments in both 1:1 and group format, with STEPPs and DBT groups moved online.
- Increased the use of IT support and visual display such as CCTV, trial of body worn cameras, Oxehealth Pilot.
- Oxehealth installed on Peter Bruff and Ardleigh with positive outcomes. Formal evaluation has commenced.
- Delays with installation on Chelmer and Hadleigh now being installed
- Type of bodycam has been reviewed and changed due to faults found following first pilot of bodycams (batteries running low)

e) Inpatient therapeutic offer - Increased provision of activities and therapeutic offer with a view to out of hours MDT working

- Introducing staggered shifts to include evening working across sites
- Updated protocols on activities using sensory processing and sensory integration including equipment to bring parity of availability across different sites
- Assistant Psychologists & OT assistants working evenings and weekends under supervision providing activity groups

f) Environment:

A therapeutic environment will deliver better outcomes and reduce ALOS for service users with personality disorder.

- We are introducing Sensory Rooms to all adult inpatient units which will also reduce restrictive practice, restraint and attempted ligature through the use of My Safety Plan, Advanced Statements and Advocacy Support.
- Restrictive Practice Tool being completed by all units, led by Service Managers that includes – use of sensory rooms, advanced statements and advocacy support
- Restrictive Practice Director meetings held every Friday including operations and nursing directorate
- Safety pods ordered across adult wards

In addition to the above all EUPD admissions are discussed on daily **SITREP'**s so that the risk and high activity can be shared across female treatment wards.

The trust wide roll out of **'10 ways to improve safety'** and '**Flow & Capacity'** principals will also support that admissions for females with personality disorder are within manageable limits.

3. Key Challenges and Learning.

Key Challenges:

- Commissioning of the PD/Complex case pathway = CCG's different priorities/funding allocations/timing
- Challenge of the unknown impact of the Covid 19 pandemic and potential for MH surge -Anticipated to be an increased 10% demand on services.
- Experiencing an increase in numbers of MHA assessment/detention
- Inpatient consultants are reporting escalation in severity of clinical presentation - Potential for extended LOS
- Whole system (health and social care) fatigue.

Positive learning:

- Transformation Evaluations
- Organisational serious incident learning
- Positive use of available technologies – development of patient review and discharge planning meetings. (In place in West and North Essex. Implementation phase in Mid and South).
- All admissions remain purposeful and are focused on progression towards earliest safe discharge.
- Barriers to discharge and challenges experienced in community care are shared and understood.
- All community and inpatient actions required to facilitate smooth and timely discharge are communicated and agreed.
- Clarity and agreement for post discharge follow up arrangements (within 72 hrs) and discharge plans.
- Identify delayed transfer of care patients requiring escalation within wider health and social care system.

Report completed by:
Name: Lizzy Wells
Title: Director of Mental Health (NE & West)
Date: 15th July 2020

BAF36 Female Patients with Personality Disorders 2020/21

Assumption	Potential Risk	Escalated	Controls
That numbers of female patients with personality disorders admitted to inpatient services will be within manageable limits	If the Trust continues to experience high numbers of female patients with personality disorders being admitted to inpatient services then the ward environment may become more volatile and difficult to manage resulting in a risk to patient safety and length of stay	**Consequence 5 x Likelihood 3 = 15**	Increased staffing levels following establishment review. Implementation of Crisis 24/7 Service April 2020

Action	Action Detail	Target Completion Date	Lead	Progress	RAG
Establishment review	Complete establishment review on female wards with high level of PD presentations with a view to increasing time to care, a reduction in Datix incidents, a reduction in ligature incidents, improved patient experience and reduce workforce stress.	April 2020	AB/ NH	Completed and implemented	
	As an interim measure add an additional Band 3 covering a 24 hour period	April 2020	AB/ NH	Implemented Dec 19, supported by establishment review Added to ward substantive establishment Feb 20	
Restrictive practice strategy and restraint reduction tools	Reduce restrictive practice, restraint and attempted ligature through the use of My Safety Plan, Sensory Room, Advanced Statements and Advocacy Support	~~July 2020~~ September 20	LW/ SW/ JP	Psychology have drafted My Safety Plan – still to be signed off Restrictive Practice Tool being completed by all units, led by Service Managers that includes – use of sensory rooms, advanced statements and advocacy support Restrictive Practice Director meetings held every Friday including operations and nursing directorate Safety pods ordered across adult wards Sensory room being developed	

Action	Action Detail	Target Completion Date	Lead	Progress	RAG
Provision of activities and therapeutic offer	Increase provision of activities and therapeutic offer and agree on detailed actions, with a view to out of hours MDT working	~~April 2020~~ July 2020	SR /LW	Introducing staggered shifts to include evening working across sites Updated protocols on activities using sensory processing and sensory integration including equipment to bring parity of availability across different sites Assistant Psychologists working evenings and weekends under supervision providing activity groups	
Provision of psychology support and training for staff	Introduce psychology assistant posts on all wards with high level of PD/trauma	July 2020	GW/ SW	Assistant Psychologists available to most wards, flexibility to focus on where needed Further psychology assistant posts to be advertised with roles working trust wide, once commissioner approval signed off Business case in progress to develop these into Clinical Associate in Psychology (CAP) posts, with enhanced MDT support, supervision, consultation and therapeutic delivery. CAP IFA approval complete and banding approved. Waiting for Ministerial sign-off (expected September). Business case to develop training is in process.	
	New trauma/PD pathway to support inpatient services	July 2020	GW/ SW	Specialist MDT established and posts recruited to (Family Therapist interviews scheduled for late July). Service User Network Coordinating manager due to start September, following maternity leave. The Specialist MDT is starting its work, including setting up referral pathways, and oversight care coordination. Locality PD&CN virtual teams being established in South East, South West and Mid, aimed at completion by October. Transitioning Psychologist posts in MSE recruited to, start dates set for September. Locality CMHT PD psych services lead established in SE and Mid, recruiting to SW. Clinical Skills mapping completed, and SMI training including	

Action	Action Detail	Target Completion Date	Lead	Progress	RAG
				Structured Clinical Management for teams, CBT for PD, Mentalisation-Based Therapy training, and DBT training booked. KUF and SCM delivery complete in West Essex (System-wide) and being rolled out in south. COVID-19 adjustments have been made, with online video treatments in both 1:1 and group format, with STEPPs and DBT groups moved online. Formal Consultation with Medical Psychotherapists underway, with recommendation to establish their roles in the Specialist MDT, and in the Locality Virtual teams. Psychotherapy service roles identified for either establishment in Specialist PD&CN MDT, and in Adult Community Teams. Pilot for 15-25 year old PD intervention underway in West Essex, with co-working established with Young Concern Trust, a 3rd sector Child & Adolescent counselling organisation. Groups and psychoeducation established across the participating PCNs. Negotiations re PD&CN provision in secondary and HTT in WE still ongoing. Business Case approved in NEE, waiting for Board sign-off. Implementation delayed due to COVID-19. Trauma Alliance in PHC established in SE, with 1wte Clinical Psychologist to treat trauma and trauma-related conditions alongside 3rd sector and charitable organisations. Therapy for You (SE) and Inclusion (SW< Thurrock) engaged in co-facilitation of groups, and integrated pathways for managing PD&CN across PHC and LCMHTs. Some engagement established with HPFT IAPT provider in Mid, but not in West or	

Action	Action Detail	Target Completion Date	Lead	Progress	RAG
				NEE. Perinatal Services: project underway to augment the support for parents living with personality disorder and to offer more information and access to interventions. As well as a DBT group, there is work underway to produce a comprehensive information pack as well as increased support from practitioners in the team to use videos and links to help increase skills in manage emotional dysregulation. The whole service will be trained in DBT skills in the coming year and work will continue with the PD leads as the trust PD pathway is established and bedded-in.	
	All inpatient staff to have Mentalisation/ Stabilisation training	July 2020	GW/ SW	SMI training in Mentalisation, Structured Clinical Management, CBTp, and CBT for PD started, delayed by COVID-19. Further training planned.	
IT Support	Increase the use of IT support and visual display such as CCTV, trial of body worn cameras, Oxehealth Pilot	~~March 2020~~ ~~August 20~~ September 20	JL/LW /SW	Oxehealth installed on Peter Bruff and Ardleigh with positive outcomes. Oxehealth evaluation commencing. Delays with installation on Chelmer and Hadleigh now being installed Type of bodycam has been reviewed and changed due to faults found following first pilot of bodycams (batteries running low) Oxehealth evaluation on Peter Bruff and Ardleigh has commenced	

		Agenda Item No: 7civ
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	**No Force First**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Jo Paul – Deputy Director of Quality Transformation and Gill Mordain – Strategic Advisor					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides the 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 restrictive practices across the inpatient services of EPUT.

Approval	
Discussion	✓
Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

- Discuss the contents of this report.
- Identify any further actions required.

Summary of Key Issues

The report provides a summary of:

- Assurance on current workstream activity
- Governance arrangements in place
- Enhancements to data management systems that have taken place
- Policy and procedure implementation
- Action taken to reduce risk
- Staff training

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	BAF 9 BAF 46
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			

Supporting Documents and/or Further Reading

Lead

Natalie Hammond **Executive Nurse**

ESSEX PARTNERSHIP UNIVERSITY NHS TRUST

REDUCING RESTRICTIVE PRACTICES

Introduction

This report provides the Board of Directors 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 restrictive practices in the inpatient services of EPUT.

The Trust is committed to continuously improving outcomes for patients within services and is promoting an ambition of No Force First. The standard underpinning No Force First focuses on protecting human rights and supporting the cultural change that is necessary to reduce reliance on restrictive practices so they are only used as a last resort. Where the use of restrictive practices is unavoidable they must be safe and dignified with a clear plan for continued reduction.

EPUT's ambition is that it will adopt a No Force First strategy through comprehensive and sustainable structures to monitor, deliver and integrate the approach in clinical practice. BAF9 No Force First (2020/21) action plan sets out the series of actions underway in delivering this ambition and mitigating the associated risks.

The current context of the COVID-19 pandemic is predicted to impact on the restrictive practice agenda nationally. Several factors are considered in this; lockdown measures have resulted in visiting restrictions, reduction of leave for patients, requirements to isolate and stringent patient swabbing requirements on admission prior to discharge and for suspected cases. Further to this, acuity of presenting patients may be influenced by fears and anxieties related to the pandemic as well as avoidance of therapeutic engagement in the community both by service disruption and lack of family carer support networks. The requirement to wear PPE is also considered a negative barrier for the therapeutic engagement with staff.

Further actions have been undertaken to counteract pandemic specific risk during this period and this report does confirm that the focus on mitigating risk continues to be strong and progress continues to be made, however, managing restrictive practices must be considered in the wider context of the pandemic including staffing, security, patient risk assessment, observation and care planning and preventing nosocomial transmission of COVID-19.

Independent Assurance

Care Quality Commission (CQC)

As previously reported, the CQC carried out an inspection of Trust services in July / August 2019 and the report of findings noted that there was insufficient assurance that the Trust was working with pace to reduce the use of prone restraint and to address blanket restrictions. The following issues were highlighted:

- There was no monitoring system for blanket restrictions across the organisation, information about restrictions was held at ward level
- Staff applied blanket restrictions without individual justification

- Staff continued to use prone restraint to administer intra-muscular (IM) medication to patients
- Training for alternative administration methods was not yet arranged

.

Current Progress and Activity in Reducing Restrictive Agenda

Governance Arrangements

An executive level group has been established to review EPUT's strategy and weekly meetings are scheduled with Service Directors and the Executive Lead to drive forward the agenda.

An 'on a page strategy' has been developed and circulated to inpatient areas as part of collaborative workstream setting out the ambition and key approaches to No Force First.

A further meeting with Medical, Psychology and Occupational Therapy leads was held to further develop each disciplines agenda in contributing to the collaborative work.

Psychology are leading on introduction of trauma informed care, Occupational Therapists are engaged with activities and supporting techniques to alleviate boredom, anxiety and stress all factors related to increase of challenging behaviour.

A Restrictive Practice Steering Group is in place as a forum to implement the agenda and cascade learning.

Reducing Prone Restraint

A target of 20% reduction year on year has been set. Since 15th June 2020 each Datix report of a prone restraint is recorded as a critical incident prompting a 7 Day Report by the senior staff to review the incident and ascertain the learning. Targeted support is centrally offered from these reviews. These reviews are presented with the learning to the Executive Team at their weekly meeting. At the time of writing the report there have been no breaches in receiving the reports within the 7 day timeframe.

Work is being undertaken to stop the use of prone restraint to administer intra-muscular (IM) medication to patients. Training is taking place on a ward by ward basis and there are arrangements in place to assist individuals on a one to one basis. The Medicines Management Team has reviewed the policy and guidance in relation to the use of IM injection sites. A table has been produced that clearly articulates alternative sites and dosage and this has been laminated for display in clinic rooms. The guidance has also been incorporated into medicine management training.

It has been identified that prone restraint has been used as a means to exit seclusion and work has been undertaken with the TASI Team to identify safe alternatives. A technique using a safety pod has been developed which is due to be considered by Clinical Governance and Health and Safety sub-committees. The technique, once approved, will be piloted on a small number of areas that shows high reporting in order to be evaluated prior to wider rollout.

Review of incidents using critical incident reporting is demonstrating that across the Trust the use of prone restraint to administer IM medication is reducing due to the use of alternative injection sites.

Use of New Tools and Techniques

As part of the collaborative, all wards have been issued with a toolkit comprising of a range of tools that have been found to have a positive impact on the use of restrictive interventions. In addition, learning has been taken from the Royal College of Psychiatrists collaborative in relation to restrictive practices on which two of EPUT's wards participated.

The Trust piloted the use of safety pods within a number of the wards. This has been evaluated with learning for the organisation. Ward teams received training in relation to their use and alternate injection sites. Further safety pods are now being ordered following the pilot with adult acute services keen to initiate their use. Safety pods are utilised for safe seated restraint preventing the use of prone.

Safety crosses have been implemented in some services with further areas to trial as part of the internal collaborative. Safety crosses are used to identify an 'at a glance' safety concern detailing activity of de-escalation and restraint each day so that rapid action or learning can occur by the team to respond to the increasing risk.

Implement Eight Week Collaborative across all Mental Health and Specialist Services Inpatient Areas

A new initiative engaging all wards in Mental Health and Specialist Services is a rapid eight week collaborative based on Quality Improvement Methodology which commenced in Mid-June. Each ward area is defining actions to prevent the use of restrictive practices based on a ward level scoping, data analysis and engagement with staff and patients. There has been full engagement at Ward Manager level throughout this collaborative. The actions being taken have been tailored to meet the needs of the patient profile on the ward and a range of initiatives and interventions are being implemented which include; the introduction of positive behaviour support plans, debriefing processes, implementation of a range of 'SafeWard' techniques, introduction of beverage stations, improvement to outdoor environments and sensory areas.

The collaborative is being used as the main vehicle to achieve a reduction in restrictive practice including the use of blanket restrictions. The collaborative will be supported by a Communications Strategy to share learning using live webinars, five key messages and learning events.

This collaborative is due to complete in Mid-August, at which point, outcomes will be reviewed and learning cascaded throughout the Trust to facilitate cultural change, ensuring the reduction in restrictive interventions is a long term strategy.

Ensure that Key Learning is shared across EPUT Operational Teams

Presentations have been produced as part of the collaborative and shared each week by the attendees. Two live webinars have been delivered on the impact of restrictive practice with COVID-19 and the use of the Mental Capacity Act, mental health, safeguarding and legal and ethical issues associated with restrictive practices.

Five live webinars are planned with a session looking at long term seclusion and segregation on 30 July 2020. Following the collaborative, a range of events will be scheduled to showcase improvements and learning.

Thematic Data Analysis

The Trust in 2019/20 achieved a 14% reduction of all restraints incidents. In May and June, quality and performance data indicated an increase in restraint data for both April and May. A thematic analysis of this incident data was conducted and presented to the Quality Committee. A number of restraints where indicated to be COVID-19 related as to the restrictions of isolation and lockdown measures. However 50% of restraint data related to CAMHS services and the majority relating to one individual requiring low secure provision. The delay in accessing specialist care is recorded on the Board Assurance Framework (BAF46) which states that if EPUT is unable to secure (via NHS specialist Commissioning) low secure placements for young people with complex needs than an increase in restraints and assaults may be seen.

Policy and Procedure

The Reducing Restrictive Practice Policy and Procedure was due to be reviewed in July 2020. A three month extension was requested in order that the policy could be in-line with new training standards due to be implemented in September 2020. The review is underway and scheduled to be submitted to the Quality Committee in September 2020. It will have a refreshed title of Therapeutic and Safe Intervention Policy to represent inclusion of the new training standards.

Blanket Restrictions

The Trust has developed new guidelines, 'Global Restrictive Practices Guideline on the use of Global Restrictive Practices in Inpatient Units' to ensure that no form of global/blanket restriction is implemented unless expressly authorised and subject to local accountability and governance arrangements. There is a process in place to ensure that any restrictions are accounted for through a work based risk assessment and regular review.

Trustwide global restrictions have been reviewed and where they have been considered appropriate and proportionate to the safe provision of services, they have been approved by the Executive Team. Global restrictions and the rational for their use are set out in the clinical guidance along with actions that should not form part of a global restriction.

The use of restrictions has been reviewed at ward level on a team basis and work place risk assessments have been completed to account for the rationale for the approach to be taken, which have then been reviewed and agreed through governance structures. All affected patients are made aware why the decision has been made and the impact documented in the electronic patient record.

Restrictive Practice Incident Data

Restrictive Practice Incident Dashboards on Datix have been developed and have been rolled out to all mental health, LD and specialist service Ward Managers. The dashboard identifies all restrictive incidents which gives staff a real time picture of incident activity, therefore the ability to quickly identify any emerging trends for action and/or urgent clinical review.

1. Data dashboards have been produced and are available at corporate and ward level
2. Data set has been in use since April 2019
3. Data showing a reduction in prone restraint across all areas

NHS Digital has produced a benchmark report setting out restrictive interventions across mental health trusts in England. The first report was produced in March 2020. The report indicates that EPUT has a comparably low number of restraints in relation to other trusts across the country. The report will be used internally to benchmark data and identify areas for improvement.

A recent report in the HSJ has highlighted that of 5 mental health trusts reviewed; they have all seen an increase in restraints over the course of the pandemic. Within EPUT's June data reported, there was a 25% increase in violence and aggression incidents in May. However, set against this increase in violence and aggression, the use of prone was less prevalent showing a 15% reduction in June compared to May. Deep dives into restraints have shown that there are a larger proportion of incidents that are de-escalated and managed without restraint. Analysis has found:

- An indication that there is an increased acuity of patients
- 1 CAMHS patient accounts for 39% of restraints reported. The young person is currently awaiting transfer to a low secure unit when a bed becomes available
- The increased requirement for patient isolation/swabbing due to COVID-19 is impacting on restraints

Staff Training

The new training standards from the Restraint Reduction Network and commissioned by NHS England to minimise the use of restrictive interventions were launched in 2019. These will be mandatory from 2020 in NHS commissioned services in England for people with mental health conditions, learning disabilities, autism and dementia via NHS Contracts, the Care Quality Commission Framework and Use of Force Act Statutory Guidance. The standards will support staff in health, education and social care services to understand and apply the principles of minimising use of force, with the aim of promoting the human rights and person-centred care of the people they are supporting.

EPUT's Therapeutic and Safe Intervention face to face training was suspended during the initial stages of lockdown due to the need to put infection prevention measures in place. Trainers supported any requests for information or guidance on an ad-hoc basis.

Delivery of courses is now possible with PPE as appropriate; sanitisation of equipment; mats etc., and all reasonable precautions have been put in place. The precautions have been approved by the Trust's Infection Prevention and Control leads.

The new restrictions do mean that class size is limited, but all theory has been put online, so the 5 day course has been replaced with a 2 day course to increase capacity in the training provision. The Workforce Development Team has increased training capacity to allow for three courses to run per week. An increase in TASI trainers has also been agreed to fulfil training requirements against the new standards.

An online training resource has been developed and this is due to be uploaded in July 2020.

Conclusion

The summary of information provided in this report indicates the challenge faced with reducing restrictive practices in the context of the COVID-19 pandemic. However a number of proactive actions have been implemented to ensure this agenda remains a priority and is focused on solutions to counteract the predicted challenges.

Action Required

The Board of Directors is asked to:

- Discuss the contents of this report
- Identify any further actions required

Report prepared by:
Jo Paul – Deputy Director, Quality Transformation and Gill Mordain, Strategic Advisor

On behalf of:
Natalie Hammond, Executive Nurse

		Agenda Item No: 8a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	**Mental Health & Community Health Services Transformation**					
Executive/Non-Executive Lead:	Nigel Leonard Executive Director of Strategy & Transformation					
Report Author(s):	Mark Travella Associate Director Business Development & Service Improvement Chris Dicketts Senior Contracts Manager					
Report discussed previously at:	n/a					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
To provide an update on the Mental Health and Community Health Services Transformation.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to note the content and progress of the Mental Health and Community Health Services Transformation.

Summary of Key Issues

Due to the Coronavirus outbreak, NHS England, local CCGs and the Trust operational and support services are carrying out a large number of unplanned activities. Operational services are engaged in a wide range of unplanned activities including regular deep cleaning and taking extra care and time to meet patients emotional, mental and physical health needs. Re-deployment of some staff to support safe, effective and operational resilience has taken place. Trust and system staff have paused most transformational work to support operational services concentrating on BAU. For this reason some transformational activities will slow down, stop or be adapted to meet the current needs of our patient population. All decisions being taken are with relevant stakeholder groups.

Most local systems are currently planning to adjust to a 'new normal' and the updated reports and appendices update those positions.

The Mental Health and Community Health Services Transformation Programme covers three STP areas and within them seven CCGs, two local unitary authorities and one County Council. The Programme has been reported regularly to the Board. The People, Innovation and Transformation Committee also discusses the transformation programme and the Finance and Performance Committee considers the financial implications of the programme.

The Mental Health Transformation Portfolio comprises four major programmes, and within these, 18 projects. Since the implementation of the STPs some of these schemes have remained broadly Essex wide whilst others are being developed to reflect the PLACE based care and the individual needs of each locality.

Within each STP the four major programmes are:

1. Emergency Response and Crisis Care Service
2. Personality Disorders
3. Older People & Dementia
4. Community (Primary) Care

The Trust will need to appoint to approximately 140 posts Essex wide and this excludes a number of new service development projects and the future requirements for Community (Primary) Care. A tracker is now in place alongside a number of recruitment initiatives and the Trust has recognised this challenge on the Board Assurance Framework. See appendix 1.

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?	

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

Acronyms/Terms Used in the Report			
CAT	Cognitive Analytic Therapy	PCN	Primary Care Network
CCG	Clinical Care Group	QIPP	Quality Improvement Productivity Prevention
DBT	Dialectical Behaviour Therapy	REACT	Relatives Education & Coping Toolkit
MSE	Mid & South Essex	SDIP	Service Development & Improvement Plan
PAH	Princess Alexandra Hospital	STP	Sustainability & Transformation Partnership

Supporting Documents and/or Further Reading
Main Report Appendix 1: Recruitment Update Appendix 2: South East Essex Community Services Transformation Update

Lead
 **Nigel Leonard** **Executive Director of Strategy and Transformation**

Agenda Item 8a
Board of Directors
29 July 2020

TRANSFORMATION - ASSURANCE REPORT

1 Purpose of Report

This report provides an update on the Trust's Mental Health and Community Services Transformation Programmes. Appendices are attached pertaining to each scheme for more detail where required.

2 Executive Summary

This report is written in three sections to cover the Transformational activity in:

- Mental health services across Essex
- Community transformation projects in South East Essex
- Community transformation projects in West Essex

Due to the Coronavirus outbreak, NHS England, local CCGs and the Trust operational and support services are carrying out a large number of unplanned activities. For this reason some transformational activities have slowed down or stopped, or been adapted to meet the current needs of our patient population.

In May local systems began to adapt to a new business as usual state with the following features and this may impact on the shape and delivery of of transformational programmes. :

2.1 Mental Health Services Across Essex

The mental health transformational schemes across the three STPs comprise a portfolio of four programmes Each STP will oversee the programmes of work through an SDIP. The Trust, with STPs is developing transformation programme, workforce and finance documentation to support transparent planning and assurance tracking for the 2020/21 year ahead. This planning provides clarity on the finances required and the timetable for staff recruitment to match planned operational capability.

Urgent and Emergency Care
This programme at STP level is made of three separate crisis response service projects for West Essex, MSE and NE Essex. All three projects went live successfully on or around 1 April 2020 in line with our plan and have been operational throughout Covid19.

Due to workforce challenges the services will develop across 20/21 as the full workforce is recruited. Recruitment remains a high priority. The service aligns access

points through 111 including joined up pathways with police, ambulance services and the voluntary sector.

The model for 24 hour crisis assessment and treatment services links with the current Home Treatment Teams. Crisis Cafes provided by the third sector enable an option to support people in crisis and interface with EPUT services. Crisis Cafes are located in MSE and NEE.

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

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

The three Crisis Response Services will now progress to BAU services.

Community (Primary Care)
This programme at CCG level comprises 6 projects (Southend and CPR CCGs are working together) to transform community mental health services. Mental health community services are being transformed to provide Mental Health expertise at GP surgery level, organised against the emerging PCNs. This will ensure that physical and mental health will be joined up, GPs and their patients will have rapid access to mental health expertise at surgery level, supporting the aspirations of Five Year Forward View and the NHS Long Term Plan.

Southend/CPR CCGs have been trialling new models of MH support in three GP surgeries with three seconded band 7s and are currently planning to roll out the model across all PCNs through the remainder of 20/21 and planning for full recruitment.

Thurrock has piloted MH support in one PCN and plans to roll out to two PCNs 2020/21 with the remainder 201/22. It has just recruited its first band 7 for the ASOP PCN.

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

NEE has commenced piloting in a number of PCNs and will be evaluated later in 2020. It is currently considering a new project to pull together MH community transformation and primary care transformation. Separately, EPUT staff are assisting the NEE Alliance to establish PCNs.

BB CCG is planning to commence project work Q2 2020 broadly based on the Thurrock model.

Mid Essex had commenced project work in February 2020 with work stood down to focus resources on COCID-19. It is planning to restart work in Q2 2020. Mid Essex is a large geographical area with 9 PCNs. Rollout of an approved model, based on the Thurrock model will complete across 2021/22.

The benefits to primary transformation are far reaching including much improved customer experience for patients e.g. less queuing, faster access along care pathways including testing the new 4 week standard. For local providers system interoperability and shared records are being piloted with EPUT delivering significant innovative solutions that will inform other areas of the UK.

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

SW Essex comprising Thurrock and BB CCGs are planning to work together to implement a common transformation solution across the patch based on the SE Essex model.

NEE older people's transformation is going to be a complex piece of work that incorporates the revision plans of Clacton Hospital. A local system steering group has been set up to oversee this work and its relationship with other clinical services as part of the North East Essex Health and Wellbeing Alliance.

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

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

Whilst Commissioners are supportive of the model the new Mental Health Investment Standard finance is geared towards primary care and IAPT provision rather than secondary mental health. This has delayed support for the PD programme which is an Essex wide model. The Trust is looking at other solutions to pump prime this services as we see the positive impact this can have for patients.

Risks and Issues
The significant risk relates to recruitment in all three STPs/ICSs and Appendix 1 shows the current position on the posts required and the current recruitment. Due to workforce challenges the Trust is considering examining options to improve

recruitment but is also considering alterative staffing structures with commissioners to enable service initiatives to commence in 2020/21. A major recruitment plan is in place and is showing some signs of success but this will need to be monitored closely and weekly monitoring is now in place. Preparedness plans are also being developed where required to predict any workforce shortfalls and re look at skill mix and other options for providing a safe and effective service, in the interim and long term.

Communications plan are also in place to ensure that the public, patients and carers as well as wider system health, social care and third sector staff are aware of the changes and access the new service appropriately.

2.2 Community Transformation Projects in South East Essex

A range of initiatives have been put in place to support the system during the Coronavirus outbreak across both Adult and Children's services.

Discharge to Assess: In order to support people being discharged from hospital at pace, community services have been increased to enhance 'discharge to assess' services and enable care for people in their homes.

Urgent Community Response Teams (UCRT): Services strengthen enhance 'admission avoidance' to deliver 2 hours crisis response in patients' homes. This saw the development of a Single Point of Access for UCRT across the STP hosted by the SWIFT team in EPUT. This is a three month project funded via COVID monies until end of July

Community Beds: Mountnessing Court relocated to Bayman Ward and Cumberledge Intermediate Care Centre to Gibson Ward at Brentwood Community Hospital. This was part of the STP decision to consolidate all community beds on two sites as part of the Covid-19 response. Discussions underway to secure agree optimum community bed model for STP pre-winter and there is optimism that CICC will return by 1st Oct 2020.

Community Services Models: Also within South East Essex Community services, EPUT, Provide and NELFT are working together in mid and south Essex looking at a potential joint venture led by Mutual Ventures which also engages commissioners for which James Wilson is leading. Nigel Leonard is the lead for EPUT. The work will be undertaken in the summer and the Chief Executives Officers and Chief Finance Officers of the respective organisations are involved in the work to be undertaken.

Community Contract Transformation: The Trust will also be working closely with the CCGs in South East Essex to collaboratively look at developing a robust and in-depth transformation of the contract, following a request by the CCGs. A contract with greater focus on patient outcomes and efficiency which will replace the current activity-based performance measurement, with a view to transforming service delivery around national, regional and local principles and broader 'out of hospital' modelling.

See appendix 2 for more detail on specific transformation work being undertaken in SE Essex.

2.3 Community Transformation Projects in West Essex

In order to support people being discharged from hospital, services have been supporting the safe discharge from hospital enabling residents to return home.
Poplar Ward at St Margaret's Community Hospital was designated a further respiratory ward to support the system dealing with COVID-19 patients.

Digital consultations have been undertaken by teams to ensure a continued response to meet the needs of patients. With the deployment of MS Teams, a range of services are now able to support patients with education and support group sessions including pain, diabetes and dietetics services.

As more clinical sites are designated as Covid19 secure, more face to face and group sessions will commence during July and August adhering to social distancing requirements as part of the reset and recovery of community services.

Community matrons have supported the MDT's for care homes along with GP's and other system partners with the use of video conferencing and MS Teams. The use of technology to hold MDT's will continue in the future.
Digital authorisations for injectable medicines and CD's is available to our GP practices on Systm1 and this has reduced the administrative burden for both GP's and nursing teams to support our patients especially those who are at End of Life.

WECHS will shortly be responding to the CCG's Vison and Strategy for Out of Hospital care and the innovation and service changes implemented during Covid 19 will be included in the EPUT response. This is a proposed major system wide transformation.

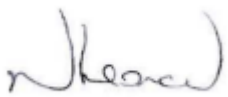
3 Action

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

Report prepared by:

Mark Travella
Associate Director Business Development & Service Improvement

On behalf of:



Nigel Leonard
Executive Director of Strategy & Transformation

APPENDIX 1 – Recruitment Update

Transformation Updates - Workforce - as at 01/07/2020

MH Emergency Response (24/7) and Urgent Care - Crisis 24/7

MSE

Go live Date -	01/04/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Psychiatrist	Consultant	1.00	-	1.00	0.00
Clinical Admin	Admin Band 4	1.00	1.00	0.00	1.00
Qualified Nurse - Team leader	Band 7	4.29	4.29	0.00	1.00
Qualified Nurses - Clinical triage	Band 6	8.59	7.64	0.95	0.89
Qualified Nurses - Asses & Emergency	Band 6	12.88	-	12.88	0.00
Unqualified Nurses - Asset & Emerg Res	Support Band 4	4.29	-	4.29	0.00
Unqualified Nurses - Asset & Emerg Res	Support Band 3	8.59	5.00	3.59	0.58
Qualified Nurse - Tele Coaches	Band 5	7.51	3.00	4.51	0.40
Crisis MSE Total		**48.15**	**20.93**	**27.22**	**0.43**

West

Go live Date -	01/03/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still**	**Rating**
Qualified nurses - Triage	Band 6	2.15	2.15	0.00	1.00
Qualified nurses - Outreach	Band 6	1.40	1.00	0.40	0.71
Qualified nurses - Telecoaches	Band 5	2.15	2.00	0.15	0.93
Unqualified nurses - Support	Support Band 4	1.40	-	1.40	0.00
Crisis West Total		**7.10**	**5.15**	**1.95**	**0.73**

North East

Go live Date -	30/03/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still**	**Rating**
Qualified nurses - Triage	Band 6	4.29	4.29	0.00	1.00
Qualified nurses - Outreach	Band 6	2.14	1.67	0.47	0.78
Qualified nurses - Telecoaches	Band 5	4.29	4.29	0.00	1.00
Unqualified nurses - Support	Support Band 4	2.15	2.15	-0.00	1.00
Crisis North East Total		**12.88**	**12.40**	**0.48**	**0.96**

Crisis Café

MSE

Staffing for the Crisis Café MSE is provided by the voluntary sector.

West

Staffing for the Crisis Café West is provided by the voluntary sector.

Crisis Café North East Alliance

Go live Date -	01/02/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still**	**Rating**
Qualified Nurses - 5pm to Midnight	Band 6	1.21	-	1.21	0.00
Crisis Café North Total		**1.21**	**-**	**1.21**	**0.00**

Core 24

MSE

Go live Date -	01/04/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Psychiatrist	Consultant	1.00	1.00	-	1.00
Medical Secretary	Admin Band 4	1.00	1.00	-	1.00
Psychologist	Sci Tech Band 8a	1.00	1.00	-	1.00
Nursing Qualified	Band 6	4.48	4.00	0.48	0.89
Admin	Admin Band 3	1.40	1.40	-	1.00
Core 24 MSE Total		**8.88**	**8.40**	**0.48**	**0.95**

West

Go live Date -	01/03/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still**	**Rating**
Psychiatrist	Consultant	1.00	1.00	0.00	1.00
Medical Secretary	Admin Band 4	1.00	1.00	0.00	1.00
Psychologist	Sci Tech Band 8a	1.00	1.00	0.00	1.00
Team Leader Nurse	Band 7	1.00	1.00	0.00	1.00
Allied Health Professional	Support Band 4	1.00	1.00	0.00	1.00
Core 24 West Total		**5.00**	**5.00**	**0.00**	**1.00**

North East

Go live Date -	01/04/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still**	**Rating**
Psychiatrist	Consultar	0.50	-	0.50	0.00
Qualified nurses	Band 7	1.00	-	1.00	0.00
Qualified nurses	Band 6	3.71	-	3.71	0.00
Admin - Medical Secretaries	Admin Band 4	1.00	-	1.00	0.00
Core 24 North East Total		**6.21**		**6.21**	**0.00**

Core 24 - For Adult and Older

MSE

Go live Date -	N/A				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Embedded within main Core 24 Model					

West

Go live Date	01/08/2019				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still**	**Rating**
Nursing Qualified	Band 6	1.59	1.00	0.59	0.63
Assoc. Pract (Nurse)	Support Band 4	1.00	1.00	0.00	1.00
Psychiatrist	Consultant	1.00	-	1.00	0.00
Core 24-Adult & Older Adult West Total		**3.59**	**2.00**	**1.59**	**0.56**

North East

Go live Date	N/A				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still**	**Rating**
Embedded within main Core 24 Model					

Personal Disorder Transformation Project - PD

MSE

Go live Date	01/04/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Principal Clinical Psychologist	Sci Tech Band 8b	1.00	1.00	-	1.00
Clinical Psychologist	Sci Tech Band 8a	3.40	2.40	1.00	0.71
Social Worker	Sci Tech	1.00	1.00	-	1.00
Occupational Therapist	AHP Band 7	1.00	-	1.00	0.00
Service User Network Cordinator	Admin Band 7	1.00	1.00	-	1.00
Assistant Psychologist	Support Band 4	1.00	1.00	-	1.00
PD MSE Total		**8.40**	**6.40**	**2.00**	**0.76**

West

Go live Date - N/A	Business case with commissioners for approva				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still**	**Rating**
Clinical Psychologist	Sci Tech Band 8a	1.70	N/A	N/A	N/A
Clinical Associate Inp & HTT	Sci Tech Band 6	1.40	N/A	N/A	N/A
PD West Total		**3.10**	-	**0.00**	

North East

Go live Date - N/A	Business case with commissioners for approval				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still**	**Rating**
Clinical Psychologist	Sci Tech Band 8a	1.70	N/A	N/A	N/A
Clinical Associate Inp & HTT	Sci Tech Band 6	1.40	N/A	N/A	N/A
PD NE Total		**3.10**	-	-	

Dementia Transformation

MSE - Mid Essex & South East

Go live Date	01/01/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Dementia Specialist Nurses	Band 6	2.03	2.03	-	1.00
Physical Healthcare Nurses	Band 6	3.00	3.00	-	1.00
Support Workers	Support Band 3	7.98	7.98	-	1.00
Dementia Specialist Nurses	Band 7	2.00	2.00	0.00	1.00
Occupational Therapist	AHP Band 7	1.00	1.00	0.00	1.00
Speech and Language Therapist	AHP Band 7	1.00	1.00	0.00	1.00
Speech and Language Therapist	AHP Band 6	1.00	1.00	0.00	1.00
Qualified Nurse	Band 5	2.00	2.00	0.00	1.00
Associate practitioners	Support Band 4	4.00	3.80	0.20	0.95
Associate practitioner (Triage)	Support Band 4	1.00	1.00	0.00	1.00
Admin	Admin Band 3	1.00	1.20	-0.20	1.20
Dementia MSE Total		**26.01**	**26.01**	**0.00**	**1.00**

West

Go live Date	01/04/2018				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still**	**Rating**
OP/Dementia nurses	Band 6	3.00	0.00	3.00	0.00
Non registered practitioner	Support Band 3	1.50	0.00	1.50	0.00
Dementia West Total		**4.50**	-	**4.50**	**0.00**

North East - This is an enabling project linked with the Clacton Hospital Redevelopment.

Business Case subject to change as to be approved by Commissioners.

Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still**	**Rating**
OP/Dementia nurses	Band 6	-	N/A		
Non registered practitioner	Support Band 3	-	N/A		
Occupational Therapist	AHP Band 5	-	N/A		
Dementia NE Total		-	-	-	-

Primary Care Wave 1 - Adult Community Mental Health Care

MSE - Mid Essex & South East

Go live Date	01/12/2019				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**

South East Essex have 3 non recurrent pilots in place with 1 band 7 seconded

in each pilot. Business cases will be developed during 2020/21 with some pilot

South West Essex has 1 band 7 seconded to post in Thurrock.

Projects commencing earlier. This was completed by the CCGs with input from EPUT.

West

Go live Date	01/02/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still**	**Rating**
Clinical Psychologist	Sci Tech Band 8a	1.00	1.00	0.00	1.00
Assistant Clinical Psychologist	Sci Tech Band 6	1.00	1.00	0.00	1.00
Pharmacist - Primary Care Lead	Sci Tech Band 7	1.00	-	1.00	0.00
Community Psychiatric Nurse	Band 6	3.00	3.00	0.00	1.00
Primary Care Wave 1 West Total		**6.00**	**5.00**	**1.00**	**0.83**

North East

Go live Date	01/04/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still**	**Rating**
Qualified Nurses	Band 7	7.00	2.00	5.00	0.29

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Primary Care Wave 2 - Freed Model/ Enhanced Comma Eating Disorder Service (EDS)																		
MSE - Freed Model not applicable in /MSE						West						North East						
EDS will be part of an Essex wide review and Business Case to follow in 2020/21						Go live Date	01/02/2020					EDS will be part of an Essex wide review & Business Case to follow in 2020/21						
Staff Description	Staff Grade	WTE Req'd	WTE Recruited	WTE Still Req'd	Rating	Staff Description	Staff Grade	WTE Req'd	WTE Recruited	WTE Still Req'd	Rating	Staff Description	Staff Grade	WTE Req'd	WTE Recruited	WTE Still	Rating	
						Psychologist/Psychological Therapist	Sci Tech Band 8a	1.00	1.00	0.00	1.00							
						FREED Champion/Coordinato	Admin Band 7	0.50	0.50	0.00	1.00							
						RMN	Band 6	1.00	-	1.00	0.00							
						Admin	Admin Band 3	0.20	0.20	0.00	1.00							
						GP with Special Interest	Consultant	0.20	-	0.20	0.00							
						Primary Care Wave 2 West Total		**2.90**	**1.70**	**1.20**	**0.59**							
Perinatal MH Transformation Funding Wave 1																		
						Cross Essex Wave 1												
						Go live Date	01/10/2019											
						Staff Description	Staff Grade	WTE Req'd	WTE Recruited	WTE Still Req'd	Rating							
						Consultant Psyciatrist	Consultant	0.60	0.60	0.00	1.00							
						Locality Clinical Lead	Band 7	2.00	2.40	-0.40	1.20							
						~~Specialist Practitioner~~ RMN/OT/Social Worker	Sci Tech Band 6	4.00	1.40	2.60	0.35							
						Psychologist	Sci Tech Band 8a	2.40	1.68	0.72	0.70							
						Psychologist	Sci Tech Band 8b	0.20	-	0.20	0.00							
						Community Nursery Nurses	Support Band 4	2.00	2.00	0.00	1.00							
						Project and Data Support	Admin Band 4	0.60	0.60	0.00	1.00							
						Project Manager	Admin Band 8a	0.60	0.60	0.00	1.00							
						Medical Secretary	Admin Band 4	1.00	-	1.00	0.00							
						Perinatal MH Total		**13.40**	**9.28**	**4.12**	**0.69**							

Perinatal MH Transformation Funding Wave 2

Cross Essex Wave 2

Go live Date	**01/04/2020**				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Consultant Psychiatrist	Consultant	1.00	-	1.00	0.00
Speciality Doctor	Medical Staff	1.00	-	1.00	0.00
Medical Secretary	Admin Band 4	2.00	-	2.00	0.00
Team Manager	Admin Band 8a	1.00	-	1.00	0.00
Clinical Team Lead	Band 7	1.00	0.40	0.60	0.40
Specialist Perinatal Practitioners (Nurse,	Sci Tech Band 6	8.00	1.40	6.60	0.18
Perinatal OT	AHP Band 7	1.00	1.00	0.00	1.00
Perinatal OT	AHP Band 6	3.00	-	3.00	0.00
Perinatal Social Worker	Sci Tech Band 7	1.00	1.00	0.00	1.00
Perinatal Social Worker	Sci Tech Band 6	2.00	-	2.00	0.00
Nursery Nurse	Support Band 4	3.00	2.00	1.00	0.67
Perinatal Support Worker	Support Band 3	5.00	-	5.00	0.00
Consultant Psychologist	Sci Tech Band 8c	1.00	-	1.00	0.00
Perinatal Psychologist Lead	Sci Tech Band 8b	1.80	-	1.80	0.00
Clinical Perinatal Psychologist	Sci Tech Band 8a	2.00	-	2.00	0.00
Pharmacist	Sci Tech Band 8a	1.00	-	1.00	0.00
Perinatal Therapist	AHP Band 7	5.00	2.20	2.80	0.44
Assistant Psychologist	Support Band 4	2.00	-	2.00	0.00
Service Manager	Admin Band 8b	0.50	0.50	0.00	1.00
Clinical Administrator	Admin Band 4	1.00	-	1.00	0.00
Clinical Administrator	Admin Band 3	2.00	-	2.00	0.00
Quality and Data Lead - to support with data reporting	Admin Band 4	0.50	-	0.50	0.00
Perinatal MH Wave 2 Total		**45.80**	**8.50**	**37.30**	**0.19**

Top Summary MSE				
Staff Categories	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Medical Staffing				
Consultant	2.00	1.00	1.00	0.50
Medical Staff	-	-	-	
Qualified Nursing staff				
Band 8b	-	-	-	
Band 8a	-	-	-	
Band 7	6.29	6.29	-	1.00
Band 6	30.98	16.67	14.31	0.54
Band 5	9.51	5.00	4.51	0.53
Total	**46.78**	**27.96**	**18.82**	**0.60**
Support to Clinical staff (Support)				
Support Band 4	10.29	5.80	4.49	0.56
Support Band 3	16.57	12.98	3.59	0.78
Total	**26.86**	**18.78**	**8.08**	**0.70**
Allied Health Professionals (AHP)				
AHP Band 8b	-	-	-	
AHP Band 8a	-	-	-	
AHP Band 7	3.00	2.00	1.00	0.67
AHP Band 6	1.00	1.00	-	1.00
AHP Band 5	-	-	-	
Total	**4.00**	**3.00**	**1.00**	**0.75**
Other Scientific, Therapeutic and Technical (Sci Tech)				
Sci Tech Band 8c	-	-	-	0.00
Sci Tech Band 8b	1.00	1.00	-	1.00
Sci Tech Band 8a	4.40	3.40	1.00	0.77
Sci Tech Band 7	1.00	1.00	-	1.00
Sci Tech Band 6	-	-	-	
Sci Tech Band 5	-	-	-	
Total	**6.40**	**5.40**	**1.00**	**0.84**
Admin & Clerical taff				
Admin Band 8b	-	-	-	
Admin Band 8a	-	-	-	
Admin Band 7	1.00	1.00	-	1.00
Admin Band 6	-	-	-	
Admin Band 5	-	-	-	
Admin Band 4	2.00	2.00	-	1.00
Admin Band 3	2.40	2.60	- 0.20	1.08
Admin Band 2	-	-	-	
Total	**5.40**	**5.60**	**- 0.20**	**1.04**
Grand Total	**91.44**	**61.74**	**29.70**	**0.68**

Top Summary West				
Staff Categories	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Medical Staffing				
Consultant	**2.20**	**1.00**	**1.20**	0.45
Medical Staff	-	-	-	
Qualified Nursing staff				
Band 8b	-	-	-	
Band 8a	-	-	-	
Band 7	**1.00**	**1.00**	-	1.00
Band 6	**12.14**	**7.15**	**4.99**	0.59
Band 5	**2.15**	**2.00**	**0.15**	0.93
Total	**15.29**	**10.15**	**5.14**	0.66
Support to Clinical staff (Support)				
Support Band 4	**3.40**	**2.00**	**1.40**	0.59
Support Band 3	**1.50**	-	**1.50**	
Total	**4.90**	**2.00**	**2.90**	0.41
Allied Health Professionals (AHP)				
AHP Band 8b	-	-	-	
AHP Band 8a	-	-	-	
AHP Band 7	-	-	-	
AHP Band 6	-	-	-	
AHP Band 5	-	-	-	
Total	-	-	-	
Other Scientific, Therapeutic and Technical (Sci Tech)				
Sci Tech Band 8c	-	-	-	
Sci Tech Band 8b	-	-	-	
Sci Tech Band 8a	**4.70**	**3.00**	-	0.64
Sci Tech Band 7	**1.00**	-	**1.00**	0.00
Sci Tech Band 6	**2.40**	**1.00**	-	0.42
Sci Tech Band 5	-	-	-	
Total	**8.10**	**4.00**	**1.00**	0.49
Admin & Clerical taff				
Admin Band 8b	-	-	-	
Admin Band 8a	-	-	-	
Admin Band 7	**0.50**	**0.50**	-	1.00
Admin Band 6	-	-	-	
Admin Band 5	-	-	-	
Admin Band 4	**1.00**	**1.00**	-	1.00
Admin Band 3	**0.20**	**0.20**	-	1.00
Admin Band 2	-	-	-	
Total	**1.70**	**1.70**	-	1.00
Grand Total	**32.19**	**18.85**	**10.24**	**0.59**

Top Summary North East				
Staff Categories	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Medical Staffing				
Consultant	**0.50**	-	**0.50**	
Medical Staff	-	-	-	
Qualified Nursing staff				
Band 8b	-	-	-	
Band 8a	-	-	-	
Band 7	8.00	**2.00**	**6.00**	
Band 6	11.36	5.96	5.40	0.52
Band 5	4.29	4.29	0.00	1.00
Total	**23.65**	**12.25**	**11.40**	**0.52**
Support to Clinical staff (Support)				
Support Band 4	**2.15**	**2.15**	- **0.00**	1.00
Support Band 3	-	-	-	
Total	**2.15**	**2.15**	- **0.00**	1.00
Allied Health Professionals (AHP)				
AHP Band 8b	-	-	-	
AHP Band 8a	-	-	-	
AHP Band 7	-	-	-	
AHP Band 6	-	-	-	
AHP Band 5	-	-	-	
Total	-	-	-	
Other Scientific, Therapeutic and Technical (Sci Tech)				
Sci Tech Band 8c	-	-	-	
Sci Tech Band 8b	-	-	-	
Sci Tech Band 8a	**1.70**	-	-	0.00
Sci Tech Band 7	-	-	-	
Sci Tech Band 6	**1.40**	-	-	0.00
Sci Tech Band 5	-	-	-	
Total	**3.10**	-	-	0.00
Admin & Clerical staff				
Admin Band 8b	-	-	-	
Admin Band 8a	-	-	-	
Admin Band 7	-	-	-	
Admin Band 6	-	-	-	
Admin Band 5	-	-	-	
Admin Band 4	**1.00**	-	**1.00**	0.00
Admin Band 3	-	-	-	
Admin Band 2	-	-	-	
Total	**1.00**	-	**1.00**	0.00
Grand Total	**30.40**	**14.40**	**12.90**	**0.47**

Top Summary Cross Essex				
Staff Categories	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Medical Staffing				
Consultant	**1.60**	**0.60**	**-**	0.38
Medical Staff	**1.00**	**-**	**1.00**	0.00
Qualified Nursing staff				
Band 8b	-	-	-	
Band 8a	-	-	-	
Band 7	3.00	2.80	0.20	0.93
Band 6	-	-	-	
Band 5	-	-	-	
Total	**3.00**	**2.80**	**0.20**	**0.93**
Support to Clinical staff (Support)				
Support Band 4	7.00	4.00	3.00	0.57
Support Band 3	5.00	-	5.00	0.00
Total	**12.00**	**4.00**	**8.00**	0.33
Allied Health Professionals (AHP)				
AHP Band 8b	-	-	-	
AHP Band 8a	-	-	-	
AHP Band 7	6.00	3.20	2.80	
AHP Band 6	3.00	-	3.00	
AHP Band 5	-	-	-	
Total	**9.00**	**3.20**	**5.80**	
Other Scientific, Therapeutic and Technical (Sci Tech)				
Sci Tech Band 8c	1.00	-	1.00	0.00
Sci Tech Band 8b	2.00	-	2.00	0.00
Sci Tech Band 8a	5.40	1.68	3.72	0.31
Sci Tech Band 7	1.00	1.00	-	
Sci Tech Band 6	14.00	2.80	11.20	0.20
Sci Tech Band 5	-	-	-	
Total	**23.40**	**5.48**	**17.92**	0.23
Admin & Clerical staff				
Admin Band 8b	0.50	0.50	-	1.00
Admin Band 8a	1.60	0.60	1.00	0.38
Admin Band 7	-	-	-	
Admin Band 6	-	-	-	
Admin Band 5	-	-	-	
Admin Band 4	5.10	0.60	4.50	0.12
Admin Band 3	2.00	-	2.00	
Admin Band 2	-	-	-	
Total	**9.20**	**1.70**	**7.50**	0.18
Grand Total	**59.20**	**17.78**	**40.42**	**0.30**

Top Summary Overall				
Staff Categories	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Medical Staffing				
Consultant	**6.30**	**2.60**	**2.70**	0.41
Medical Staff	**1.00**	**-**	**1.00**	0.00
Qualified Nursing staff				
Band 8b	-	-	-	
Band 8a	-	-	-	
Band 7	18.29	12.09	6.20	0.66
Band 6	54.48	29.78	24.70	0.55
Band 5	15.95	11.29	4.66	0.71
Total	**88.72**	**53.16**	**35.56**	**0.60**
Support to Clinical staff (Support)				
Support Band 4	22.84	13.95	8.89	0.61
Support Band 3	23.07	12.98	10.09	0.56
Total	**45.91**	**26.93**	**18.98**	**0.59**
Allied Health Professionals (AHP)				
AHP Band 8b	**-**	**-**	**-**	
AHP Band 8a	**-**	**-**	**-**	
AHP Band 7	9.00	5.20	3.80	0.58
AHP Band 6	4.00	1.00	3.00	0.25
AHP Band 5	-	-	-	
Total	**13.00**	**6.20**	**6.80**	**0.48**
Other Scientific, Therapeutic and Technical (Sci Tech)				
Sci Tech Band 8c	1.00	-	1.00	0.00
Sci Tech Band 8b	3.00	1.00	2.00	0.33
Sci Tech Band 8a	16.20	8.08	4.72	0.50
Sci Tech Band 7	3.00	2.00	1.00	0.67
Sci Tech Band 6	17.80	3.80	11.20	0.21
Sci Tech Band 5	-	-	-	
Total	**41.00**	**14.88**	**19.92**	**0.36**
Admin & Clerical taff				
Admin Band 8b	**0.50**	**0.50**	**-**	
Admin Band 8a	1.60	0.60	**-**	
Admin Band 7	1.50	1.50	-	1.00
Admin Band 6	-	-	-	
Admin Band 5	-	-	-	
Admin Band 4	9.10	3.60	5.50	0.40
Admin Band 3	4.60	2.80	1.80	0.61
Admin Band 2	-	-	-	
Total	**17.30**	**9.00**	**7.30**	0.52
Grand Total	**213.23**	**112.77**	**92.26**	**0.53**

Rating Key			
Range	1.00	>/= 0.70	< 0.70 - 0.00
Colour Code			
Position	Totally recruited.	On track	Not on track
Action	No action required.	Minimal monitoring	Active monitoring

APPENDIX 2

South East Essex Community Services - Transformation Projects

Update July 2020

	COVID Transformation Projects			
		Project	***Update***	***Due Date***
1	**Relocated Mountnessing to Brentwood Hospital**	In response to STP decision to consolidate all community beds on two sites Mountnessing Court relocated to Bayman Ward, Brentwood Community Hospital on Friday 10 April 2020	The future of community Beds provision will be in the recover/reset planning, no decision as yet. July 2020 Awaiting STP decision on future of Mountnessing Court.	Complete
2	**CICC relocated to Brentwood Hospital**	In response to STP decision to consolidate all community beds on two sites. CICC relocated from Rochford to Gibson Ward, Brentwood Community Hospital on 1 May 2020	The future of community Beds provision will be in the recover/reset planning, no decision as yet. July 2020 Awaiting STP decision on future of CICC. Remain optimistic that CICC will return to Rochford Hospital on 1 October 2020. Project Group established to oversee repatriation. Full Action Plan available.	Complete
3	**Standardised UCRT** (Urgent Community Response Team) **Model across the STP**	Phase One EPUT Led project to establish SPA for UCRT across the STP. Successfully completed and mobilised 30 April. EPUT hosting the SPA on a 3 month project funded by COVID Phase 2 – will see development of business case for the model to be rolled out across the STP. EPUT project managing the Business Case Development. The next phase – Phase 3 Mobilisation of standardised model for UCRT.	July 2020 Phase One complete 30/4/20 Single Point of Access for UCRT fully operational, hosted by EPUT. Phase Two complete 17/7/20 Outline Business Case and Investment Plan for standardised UCRT model across STP has been agreed; Now been submitted to STP Finance Group for consideration.	
4	**Community Integrated Team (Discharge to Assess Model)**	Establish Integrated Community Discharge Team to deliver 'Discharge to Assess' model with EPUT providing overall lead and responsibility.	May 2020 EPUT hosting Project group making good progress focusing on a) Establishing CIT and interface with the Acute discharge Team. b) Reinvigorating SPOR c) Creating MDT huddles to track and management patient post discharge d) Contractualise new specification for CIT July 2020 Progress continues as above. Specification with CCG for consideration.	
5	**Care Home**	National requirement to deliver Providing dedicated on Infection	May 2020 Dedicated care homes training team within	

	Training (Super Training)	control and PPE to care homes	EPUT tasked to provide for 131 South East Essex Care Homes. Training programme already under way. July 2020 Excellent progress virtually every care home in SEE now trained by EPUT Care Home Training Team.	
6	**CICC Reset/Recovery**	Review service specification for CICC and including criteria for agreement by local placed commissioners as part of reset work.	May 2020 Draft specification developed with a proposed broader remit for CICC which includes Step up and Step Down, with a focus on frailty. July 2020 As above Draft Specification with CCG for consideration as part of overall project to repatriate CICC 1 October 2020.	
7	**Future Service Delivery Models**	To review the wide range of work changes that have taken place within community services under the principle of adopt, adapt or abandon.	May 2020 Changes in delivery to be considered to include: • Remote working • Clinical prioritisation • Reduced face to face contacts • Caseload cleansing • Use of digital tools July 2020 Work progressing, services identified across three community providers to be reviewed at scale. Project Group being established. Locally, work to align services to PCNs progresses at pace and will be the focus of forthcoming workshops.	

	Transformation Projects aligned to Corporate Objectives, Service Development Plans and System-wide priorities			
		Project	***Update***	***Due Date***
1.	**Urgent Community Response Team (UCRT) known locally as SWIFT**	Establish and test **comprehensive community response team SWIFT** (that includes Falls OT response provision) that impacts on reducing acute hospital activity.	Service having demonstrable impact and now working with commissioners to mainstream into SEECHS contract. Specification and KPIs agreed with CCG with plans to mainstream in the forthcoming contracting round. The Falls response service now fully operational.	**March 2020**
		In 2020/21 we will project manage: *a) Enhancing the SWIFT Crisis response impact by looking specifically at proving sub-cut hydration, neutropenic sepsis and step up beds in community, and;* *b) Aligned our Crisis Response to our comprehensive*	***Jan 2020 Update*** Project group in place with Project Plan to steer development of enhancements into next year. Progress already made on Neutropenic Sepsis and Falls response.	***2020/21***

		Intermediate Care (IC) Transformation program to improved integration and collaboration across all of IC services.	Work plan for IC (including Crisis Response now agreed through project board) ***Feb 2020*** • *Service continues to provide significant admission avoidance activity* • *Working in partnership with NELFT and PROVIDE to deliver on CTT project with SWIFT team member attending EEAST hub to delivery Cat 3/4/5 calls direct to community services* • *SWIFT now providing Falls lifting service using Razer Chair* *May 2020* *Established a single of point access UCRT /SWIFT hosted by EPUT and servicing the entire Mid & SE STP. This is available to paramedics.* *July 2020 In response to COVID 19 all UCRT focus has been reviewed across the STP and project managed by EPUT.* *See Section 3 COVID Transformation Projects above*	
2.	**Comprehensive Community Palliative Care Offer in South East Essex**	Establish a comprehensive population-health management model for **Community Palliative Care / EOL Services** that includes management of EOL register (finding those in last 12 month of life) and delivering of high quality front line EOL care	Services now fully operational as a consolidating single offer and deliver demonstrable system impact and demonstrated in recent CQC achievement of 'outstanding, recognises the high quality 'caring' front line service We are now working with commissioners to mainstream into SEECHS contract. Specification and KPIs agreed with CCG with plans to mainstream in the forthcoming contracting round.	**March 2020**
		In 2020/21 *we will:* *a) Ensure consolidated service focus delivers on achieving 1% of population target for End of Life Register and meet all new challenging contractual KPIs.* *b) Work with CCG and local hospice to develop pathways that maximise access to the new hospice beds (to be opened March 2020)*	*Monthly steering Group meeting to drive transformation and improve performance.* ***Feb 2020*** • *Teams now fully aligned to PCN localities* • *Planning underway to establish weekly palliative care consultant chaired MDT facilitated by community team to commence in first week April* *May 2020* *Activity remains high during COVID.* *July 2020 Team has experienced high death numbers during April and May.*	***2020/21 Complete***
3.	**'Anticipatory Care' (population health)**	Establish an effective **population health model** of anticipatory care for those who are frail in South East Essex entitled '**Care**	Services now fully operational with project plan to streamline under one operational model	**March 2020**

	model for frailty **Care Coordination Services**	**Coordination'** services. These services were originally commissioned separately across the two CCGs in South East Essex. We are now working to streamline under a single South East Essex	We are now working with commissioners to mainstream into SEECHS contract. Specification and KPIs agreed with CCG with plans to mainstream in the forthcoming contracting round.	
		In 2020/21 we will: *a) Be working with CCG and PCNs to deliver new 'Primary Care Network' national specification for 'anticipatory care' by aligning to our Care Coordination service.*	***Jan 2020*** *The PCN specification for Anticipatory Care now published (in draft), and it is clear that Community services will have a 'contracted' dedicated role requiring focussed project methodology to deliver.* ***Feb 2020*** • *Project Group established (05/03/20) to oversee the streamlining of Care Co services across South East Essex* • *Full project plan drafted covering comprehensive range of work streams* *May 2020* *Teams focussed on cleansing caseload registers to ensure high risk vulnerable patients remain safe during COVID* *July 2020 Project Group reconvened with continued focus on strengthening the Frailty focus for Care Coordination.*	***2020/21***
4.	**Respiratory Care - Build single comprehensive community service model for respiratory care**	**Establish Integrated Community Respiratory Nursing Service.** A redefined sustainable service able to deliver a quality service against updated service specification with dedicated medial leadership, closer Integration between Respiratory Nursing, Hospital Oxygen Team, Pulmonary Rehabilitation and Spirometry services	Draft specification has been developed and dedicated steering group overseeing transition to new model	**Sept 2020**
		In 2020/21 will: *Continue to deliver on this priority project next year to transform our respiratory services and embed in contract. Priorities remain as above.*	***Jan 2020*** *Dedicated project group in place with the accountability to STP work programme.* *Feb 2020* • *Project group finalising key priorities for 2020/21* • *Plans advanced to recruit lead GP for respiratory to work alongside EPUT Community Team* • *Aim to be mobilised by April 2020.* *May 2020* *EPUT to employ GP with extended role with respiratory. Team heavily focussed on managing COVID.* *July 2020 GP now employed by EPUT for Respiratory. The workstream is now being reviewed at STP level. Draft*	***2020/21***

			Business Case for optimum service being drafted.	
5.	**Develop single streamlined 24/7 community nursing offer**	With movement of palliative care and respiratory out of Integrated Nursing specification, opportunity exists to re-visit and refocus the core community nursing offer. Establish core activity and develop unique specification KPIs and outcome measures. Mainstream 2018/19 CCG investment to enhance 24/7 DN cover into core emerging specification.	Work plan in place informed by workshop and new specification in draft	**March 2020**
		2020/21 Project continues as above.	***Jan 2020*** *Dedicated workgroup to finalise specification and contratualise.* *Feb 2020* • *Draft specification for Community Nursing and subject to ongoing revision in partnership with CCG.* *May 2020* *Team heavily focussed on managing COVID.* *July 2020 Progress delayed by COVID but remains a priority for 2021.*	***2020/21***
6.	**Heart Failure Service**	Key system QIPP scheme that sees additional investment and expansion of the team which includes the increased provision of IV diuretic is the community	Final review of Service Specification and agreement of baseline activity and cost in order to close the project and CV into contract to be actioned imminently Implementation of the IV Diuretic Service fully mobilised Implementation of the enhanced CHFS.	**Jan 2020**
		2020/21 As above.	***Jan 2020*** *Envisaged project complete March 2020.* *Feb 2020* • *Enhanced services fully operational.* • *Working with CCG to consider project closure.* July 2020 as previously reported enhanced services are fully operational. During Covid -19 working arrangements have been adapted and implemented to response accordingly.	***March 2020 Completed Closed***
6.	**Care Home Training (inc Sepsis management)**	To review and refocus our EPUT Sepsis and care home education service in line with local authority offer (and other partners) to maximise the reduction in A&E and NEL admissions and improve patient outcomes	Plans and developments for the future: 1. Care Home Education Workshop (Dec 2019) 2. Agree timely information sharing and regular monitoring arrangements (Dec 2019) 3. Implement care home survey for training feedback (Dec 2019) Analysis of ongoing impact on A&E attendance and	**March 2020**

			admission reductions (Dec 2019) Obtain assurances over staffing levels (Dec 2019) Redesign and reinvigoration of training marketing (Jan 2020) 4. Care Home attendance planner to be developed (Jan 2020) Review current running costs (Jan 2020) Review service specification (Feb 2020) Update and agree KPIs (Feb 2020) Consider mainstreaming into core service contract (Mar 2020)	
		2020/21 Renewed focus which includes: 1. *To work with commissioners to secure Long Term support for Care Homes Training.* 2. *Align EPUT care home services to emerging Primary Care Network specification for Enhanced Care in care homes.* 3. *Care Homes training team now part of unique project in partnership with UCL to test technology and pathways for 'Managing the Deteriorating Patient'.*	***Jan 2020*** 1. *Working with CCG to secure decision on long term funding.* 2. *The PCN specification for Care Homes now published, now it is clear that Community services will have a dedicated role requiring focussed project methodology.* 3. *Project now live and subject to full evaluation in March 2020.* ***Feb 2020*** • *Care Home team have fully mobilised the UCL partnership project that sees team providing training and technology to better identify and manage the deteriorating patient – data being submitted for formal evaluation at end of March.* • *Team continue to demonstrate significant impact in reduction of sepsis presentations to acute services with South East Essex* *May 2020* *A key priority workstream for COVID and now providing Super Training Model to SEE Care Homes.* July 2020 See section 5 COVID Transformation Projects	***2020/21***
7.	**Aligning EPUT services to emerging SEE Intermediate Care Strategy**	We will work with community provider partners in the STP to build our respective Intermediate Care Strategy and associated service offer including: • Improved Single Point of Access (SPA); • Aligning crisis response (using SWIFT) to SPA; • Acute based Pathway coordinators • Streamlined Access intermediate care beds;	Key actions in train include: • EPUT Steering Group • Develop / review service specification (consider in unique spec or refreshed SPOR to SPA spec) • Identify and agree KPIs • Agree monthly reporting • Quality team assurance	**Sept 2010**

		• Collaboration and Partnership with Reablement provider • Enhanced domiciliary rehab services, and • Aligning Care Coordination services.	• Key stakeholder engagement for effective use of the role	
		2020/21 *To undertake a comprehensive transformation of our Intermediate Care service offer to improve services and deliver in line with NICE Guidance (2019) and emerging South East Essex IC Strategy.* *Project has 10 dedicated work streams including above.*	***Jan 2020*** *Full transformation project programme now being mobilised.* ***Feb 2020*** • *Senior Project Group established alongside key work stream sub-projects.* • *Patient Pathway workshop completed* • *Priority focus on developing Single Point of Access model aligned SPOR and DN Liaison contact centre* • *Commitment from JL to support the implementation of dedicated telephony system post April 2020* *May 2020* *Focus on supporting hospital discharge as part of COVID management which includes the creation of a dedicated community integrated team for discharge see above.* *July 2020 Project recently reconvened. Transformation in line with NICE guidance remains a priority. Project plan to be refreshed.*	***2020/21***
8.	**Integrated Community Wound Care Service**	Consolidate Tissue Viability and Leg Ulcer services under unique specification that improves and enhances service offer to population of South East Essex.	Key Actions in train: 1. Agreed SDIP with CCG that formalises shared commitment to these service transformations 2. Established Project Group for each workstream with representation from CCG 3. Agreed work plan for project with key milestones 4. Delivering as per work plan 5. Reporting progress through SDOG 6. Close to varying new specifications into contract"	**March 2020**
		2020/21 As above.	***Jan 2020*** *Envisaged project complete March 2020.* ***Feb 2020*** • *Services aligned under single budget* • *Successful bid for additional specialist wound care TNP equipment now being mobilised* ***May 2020*** *Project nearing completion waiting CCG to CV the agreed specification into contract.* *July 2020 Project complete and closed, now operating as*	***March 2020 Complete***

			business as usual.	
9.	**Occupational Therapy Offer**	Develop new specification and mobilise health community OT offer that covers all elements under one service umbrella (including inpatient, falls crisis response, Care Co) and aligns with Social Care OT under comprehensive Intermediate Care Offer (See also project 7).	Key actions underway include: • Reviewing Specification and consider redraft that move to comprehensive offer • Considering single OT clinical leadership for all elements • Meeting with social care OT services to consider integrated / collaborative opportunities and models	**Sept 2020**
		2020/21 Commitment now to CCG support to continue as above and will be included in SDIP priority next year.	***Jan 2020*** *Project Group to be established to deliver as above.* ***Feb 2020*** *Initial scoping of CHS services employing OTs configuration underway, service review work plan being developed with associated time lines.* *May 2020* *Currently on hold pending single specification which is working progress.* *July 2020 Delayed due to COVID, progress as per May 2020.*	***2020/21***
10.	**Continence Service**	Addressing long standing non-compliant KPIs by undertaking detailed service review that will deliver new service model in line with national guidance and deliver on KPI the ensure annual reviews are completed.	Key actions underway: • Develop specification in line with national guidance • Developing work plan that deliver new operational arrangements that sees full compliance with all KPIs inc annual reviews	**March 2020**
		2020/21 *As above.*	***Jan 2020*** *Envisaged project complete September 2020.* *Feb 2020* • *Enhanced services fully operational.* • *Working with CCG to consider project closure.*	***March 2020 Complete***
11.	**Primary Care Networks inc Mobilising new joint PCN specifications for 'Anticipatory Care' and ' Enhanced Care in Care Homes'**	Align community services offer to emerging PCNs and build relationship and alliances with PCN Clinical Directors.	Key Actions to date: • Aligned core teams to PCNs • Early engagement with PCN clinical directors • Ensure all specifications reference PCN commitment • Develop monitoring arrangements for activity/population health management data within each PCN • Develop Alliance agreement document that can be used to formalise community offer for each	**March 2021**

			emerging PCN	
		2020/21 *Draft PCN specifications now published that identify roles for community service to support delivery. Dedicated project methodology required to implement.*	***Jan 2020*** *Emerging national framework for delivery of specifications will be adopted locally for implementation. It is likely to priority within SDIP as impacts contracted service delivery* *The Actions listed above still remain priority in next financial year.* ***Feb 2020*** • *Also see Project 3 above* • *Awaiting national publication of 'anticipatory care' spec for PCNs* • *Contacting PCN Clinical Directors to start building contacts and our service offer* *May 2020* *Senior team developing a unique service offer for PCNs. The proposed presentation to be available early June for presentation to PCN this will include key aims and deliverables.* July 2020 Locally, work to align services to PCNs progresses at pace and will be the focus of forthcoming workshops.	***2020/21***
12.	**Giving frontline staff ability to capture QI proposals**	We would introduce and support a quality improvement methodology that ensures front-line staff are able to suggest QI ideas/suggestions and these are processed.	Currently reviewing App technology i.e. Improve Well that uses App to capture and process QI proposals form frontline staff	**March 2020**
		2020/21 *Remains priority and is being looked at by the Trust's Organisational Development Team.*	***Jan 2020*** *Project ongoing.* ***Feb 2020*** • *Working with Gill Mordain to establish SEE Quality Hub* • *Staff being identified for QSIR training and becoming QI Champions* • *'ImproveWell' QI app presented at technology meeting* *May 2020* *Work continues to establish QI hub in SEE Community services.* *Keen to avail technological solutions that support QI to capture in the frontline.* *July 2020 delayed due to COVID. However, the development of a QI hub for SEECHS remains a priority for Q3.*	***2020/21***

13.	**Speech & Language (Adults)**	***2020/21*** *Once CCG commissioning support secured for the investment mobile arrangements to roll out service in line with specification*	***Jan 2020*** *Business Case with CCG for consideration* ***Feb 2020*** • *Confirmation from CCG that fund SLT expansion.* • *Plans mobilised to recruit* *May 2020* *In view of CCG funding project closed and new appointments will be recruited.*	**2020/21**
14.	**Children Strategy and Associated work streams**	***2020/21*** ***STRATEGY:*** *Development of Children Strategy for South East Essex with delivery plan that will require project methodology to implement.*	***Jan 2020*** *Will require renewed focus to ensure delivery next financial year.* *Feb 2020* • *CCG led workstream* • *Awaiting confirmation on agreed approach for Strategy development* *May 2020* *Number of task & Finish groups established* *Some good progress made.* *Delayed due to COVID* *July 2020 Limited task and finish groups have recommenced eg Asthma and work to develop business case is underway.* *Further delay due to the interdependencies with partner organisations and capacity issues at SUFHT*	**2020/21**
		NEURO-DEVELOPMENT: *Immediate First 6 Months Implement Neurodevelopment Pathway across South East Essex. Locally Commissioned Full Pathway by 1st April 2020 as part of consolidated offer.*	*Feb 2020* • *CCG led workstream* • *EPUT fully engaged in emerging pathway development* *May 2020* *New MDT assessment process implemented* *This has demonstrated good outcomes with more parent and child friendly process, however all referrals in to the Lighthouse Centre have been suspended since COVID.* *July 2020 Further delay due to the interdependencies with partner organisations and capacity issues at SUFHT*	**2020/21**
		SCHOOL NURSING: *Following successful business case submission progress the mobilisation of service expansion.*	*Feb 2020* • *Planning underway to mobilise expansion.* *May 2020* *Undertaken interviews and offers made to successful candidates. Completing recruitment process.*	**2020/21**

			July 2020 – recruitment processes have been completed and start dates set for all new posts. Epilepsy pathway is being drafted and work has commenced with SUFHT and other associated teams to contribute to the pathway development. *Negotiations underway with SBC School Nursing service to transfer associated caseloads to EPUT for the schools now to be managed by the Specialist School Nursing team.*	
		IMMUNISATION PROGRAMME: Maintain delivery of challenging Imms targets.	***Jan 2020*** *Awaiting decision on Bedfordshire and Essex contract award* *Feb 2020* • *Now confirmed that EPUT were successful in securing new contract worth £6m* • *Mobilisation project to be established to mobilise by mid-2020/21* *May 2020* *Contract award successful by remains an outstanding challenge to award. This has been put on hold due to COVID. Contract extension has been offered for 1 year.* *July 2020 Confirmation from NHSE that the contract award has been finalised. EPUT successful in three lots – BLMK, Essex and Herts. Contract variation for the BLMK and Essex have been agreed to Aug 2021. Herts contract will commence 1st September 2021 to allow for Covid – 19 recovery and reset of immunisation programmes.*	**2020/21**
15.	**Frailty**	***2020/21*** *Work with partners to develop a strategy for frailty for South East Essex alongside delivery plan. SEECH will be involved in all work streams including:* • *Population segmentation and risk stratification* • *Managing mild frailty and 'Age Well' programme* • *Supporting people living with 'moderate' frailty* • *Supporting people living with 'severe frailty'* • *Reducing hospital length of stay* • *Falls and Fragility Fractures management* • *Delirium, dementia and cognitive disorders* • *Personalised Care* • *Patient Experience*	***Jan 2020*** *Strategy in draft* *Emerging Proposal sees EPUT developing locality in CPR to become vanguard for frailty* ***Feb 2020*** • *Steering Group refreshing work plan and priorities for 2020/21* • *Joint Dementia / community teams workshop established for end of March to build integration across mental and physical services* *May 2020* *Workstream on hold in view of COVID, strategy will reconvene on 21 May.* *July 2020 Mental Health & Physical Health services in SEE*	**2020/21**

			and are committed to joint Frailty Project. Project brief being drafted.	
16.	**Locality Development**	**2020/21** With a renewed focus within CCGs to build comprehensive locality neighbourhood teams and alliances in line with emerging PCNs…….EPUT will be play a crucial role to aligning Teams to the emerging PCN localities and the development of multi-disciplinary localities teams.	***Jan 2020*** Community Services being mapped to PCNs CCG led Workshops planned for Feb 2020 ***Feb 2020*** • *CCG led locality develop 'week' focused on Canvey undertaken in Feb with great success* • *Planning underway for similar event in Rochford locality in April 2020* May 2020 CCG keen to refocus this workstream and develop locality models. July 2020 Locally, work to align services to PCNs progresses at pace and will be the focus of forthcoming workshops.	**2020/21**

		Agenda Item No: 9a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	**CQC Update**					
Executive/Non-Executive Lead:	Sally Morris, Chief Executive					
Report Author(s):	Amanda Webb, Compliance Officer					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

Purpose of the Report		
This report provides an update on progress with implementing actions arising from the CQC Well Led Inspection of the Trust in July – August 2019.	**Approval**	✓
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report.
2 Agree the closure of the original CQC action plan with actions being transferred to the Reset Action Plan.
3 Approve the Reset Action Plan.
4 Identify any further action that is required to be taken.

Summary of Key Issues

This report provides:

- **Ownership and Leadership:** Details are provided of the proposal for the next stage of the CQC compliance Programme. The restart of the working group 'Toward Outstanding' will initially focus on 4 key themes that are believed could make the difference to the quality of our services and lead to improved ratings. These are learning lessons, equalities, data quality and restrictive practice.

- **Preparing for Annual Inspection:** The CQC confirmed on 16th March 2020 immediate cessation of routine CQC Inspections. The CQC have not yet announced when they will be returning to routine inspections. Details are also provided of the roll out of the Emergency Support Framework in Mental Health Trusts.

- **Progress with Existing Action Plans:** The current position against the CQC unannounced inspection (July-August 2019) and the introduction of the 'reset' action plan

- **Internal Compliance Regime:** Due to Covid-19, internal CQC inspection visits to services are to remain on hold however details are provided around current tasks the compliance team will be undertaking.

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 'Reset' Action Plan

Lead
Sally Morris, **Chief Executive**

Agenda Item 9a
Board of Directors
29th July 2020

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.

2.0 Ownership and Leadership

2.1 'Towards Outstanding'

As previously reported it was agreed that the trust would take forward the next stage of our compliance programme through a new ambitious working group '*Towards Outstanding'* to focus on 4 key themes (learning lessons; equalities; data quality and restrictive practice) that we believe could make the difference to the quality of our services and lead to improved ratings.

Due to Covid-19, the Towards Outstanding meetings were suspended. It should however be recognised that tremendous learning and innovation has occurred as part of responding to the crisis that will contribute to the Trust's outstanding ambition.

It was agreed at the Executive CQC Steering Group on the 26 June that the 'Towards Outstanding' working group will re-convene. The first meeting is due to take place 24 July 2020.

3.0. Preparing for Annual Inspection

3.1. CQC Update

The CQC confirmed on 16th March 2020 immediate cessation of routine CQC Inspections however it may be necessary to still use some of its inspection powers in a very small number of cases where risks are identified and as such focused inspections at short notice may take place. The CQC has not yet announced when it will be returning to routine inspections.

3.2. Emergency Support Framework

From Monday 22 June, the CQC started to roll out a new part of its approach to regulation during COVID-19, the Emergency Support Framework (ESF), with NHS acute, combined and mental health trusts.

The interim approach has a number of elements:

- using and sharing information to target support where it's needed most
- having open and honest conversations
- taking action to keep people safe and to protect people's human rights
- capturing and sharing what the CQC do.

The CQC will use this emergency approach in all health and social care settings registered with CQC during the pandemic, and for a period afterwards. The **emergency support framework is not an inspection, and the CQC will not rate the organisation as a result.**

Both EPUT nursing homes have participated in an ESF information collection and interview process. The feedback reports received did not identify any issues.

Having effective infection prevention and control (IPC) measures in place remains of vital importance in providing all patients with safe care and when re-establishing non-COVID services. In April, NHS England and NHS Improvement issued guidance on IPC, including a board assurance framework. EPUT IPC team carried out a self assessment of compliance with the assurance framework and presented the outcome to the Board of Directors in May 2020.

As part of the Emergency Support Framework, the CQC discussed the Trust's IPC assurance arrangements with the Executive Nurse on 16 July 2020. A feedback report has been received that confirmed:

The trust has undertaken a thorough assessment of infection prevention and control, across all services, since the pandemic of Covid 19 was declared. There were appropriate systems in place which included having prompt identification of people within the organisation who have, or are at risk of developing an infection. Appropriate isolation facilities have been established for patients across the trust and IPC isolation and cohorting guidance is in place. Staff have received, and continue to receive necessary training, in line with national guidance and are updated accordingly. The trust continues to provide information for carers and the wider public through their website and by posters throughout the hospital. The trust continues to ensure that the health needs of staff are met. This is a supportive and holistic approach which considers both the physical and psychological needs of staff. All care workers, to include volunteers and external contractors, are given sufficient information to ensure that they are aware of, and discharge their responsibilities in preventing and controlling infection. The trust has a system of escalation in relation to PPE should difficulties arise, which staff can access throughout the 24-hour period, across seven days a week.

4.0 Progress with Existing Action Plans

4.1. CQC Unannounced Inspection (July – August 2019)

At the Executive CQC Steering Group on 2nd June the Trust CQC action plan was discussed in detail and it was agreed this needed to be revised to ensure it was fully reflective of the current position. Following this discussion and review, the Trust has developed a reset of the original action plan, which aims to resolve the remaining issues identified by the CQC from the inspection and to ensure actions have been fully embedded in practice and facilitates change. The action plan has been developed with consideration of all previous actions taken and those that remained open to ensure these continued to be taken forward to address the original issues identified.

At the Trust CQC engagement meeting on the 10th June; the plans for the reset approach were shared with the CQC, it was agreed to be a pragmatic approach and one which the CQC would endorse.

As at the end of June 2020, all 223 internal actions on the original action plan were closed. 13 internal actions were considered still relevant therefore transferred onto the reset action plan, some with some minor adjustments in order to fully meet the CQC issues identified. 3 internal actions were previously closed, however following review, were re-opened due to the current measures not being sufficient to cover the issue originally highlighted by the CQC. 4 internal actions were closed as it was identified that the actions would not be progressed and new actions developed; within the reset action plan, to address the final areas remaining

from the original issues identified. Where actions have been closed and transferred to the Reset Action Plan this has been identified to provide a clear audit trail.

The Reset Action plan presented at Appendix 1 consists of 31 Internal Actions to ensure the remaining 14 CQC Requirement Actions are fully met. Actions transferred to the Reset Action Plan have the same closure reference as detailed in the original action plan.

The Quality Committee reviewed the original and Reset Action Plans when it met 24 July 2020 and was satisfied with the transition arrangements.

The Quality Committee recommended the Reset Action Plan for approval.

As at the end of June 2020 all actions are progressing in line with the revised timescales.

5.0 Internal Compliance Regime

5.1. Internal CQC Inspections

Due to Covid-19, internal CQC inspection visits to services are to remain on hold until 1 September. The Compliance Team is currently developing a calendar of visits for when inspections can recommence. In the meantime the team will be carry out some 'dip testing' visits to a selection of areas. Testing of previously closed actions will be undertaken to ensure practice has been embedded and sustained.

6.0 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
Compliance Officer

On behalf of:

Sally Morris
Chief Executive

DRAFT
CQC 'Reset' Action Plan
Version 5 (Update 17th July 2020)

Key
Green – actions complete
Grey – action not started / not due
Amber – actions in progress
Red – actions passed timescale / risk identified

Introduction – Background information

Following the CQC Well Led and unannounced inspection of the Trust (July – August 2019) a detailed action plan was developed, which aimed to resolve the issues identified by the CQC and to ensure actions taken had been fully embedded in practice and facilitated change. The action plan progressed well and as at the end of May 2020, 201 (90%) internal actions were reported as completed. However there had been slippage reported with 17 (8%) internal actions.

It was acknowledged that progress with the remaining actions for completion had been impacted by the necessity to focus on responding to the COVID19 pandemic. Therefore an agreement was made at the Executive CQC Steering Group on the 2nd June 2020 that the action plan should be fully reviewed and refreshed to identify the actions that can be closed off, those that can be carried forward and new actions developed to address the final areas remaining from the original issues identified.

What are we doing?

The Trust has developed a reset of the original action plan, set-out below, which aims to resolve the issues identified by the CQC from the inspection and to ensure action has been fully embedded in practice and facilitates change. The action plan has been developed with consideration of all previous actions taken and those that remained open to ensure these continued to be taken forward to address the original issues identified.

At the CQC engagement meeting on the 10th June; the plans for the reset approach were shared with the CQC, it was agreed to be a pragmatic approach and one which the CQC would endorse.

The draft action plan was developed by the Exec CQC Steering Group. The Quality Committee considered the action plan 24 July 2020 and recommended it to the Board of Directors 29 July 2020 for approval.

Delivering Sustainable Improvement

The Trust aims to ensure that the action taken following the implementation of this newly reset action plan continues to deliver the identified improvement and that this is sustained across the Trust.

The monitoring of the reset action plan will follow the same scrutiny where possible, as the original action plan to ensure the action plan is developed, delivered and sustained in terms of governance and testing. However due to the current restrictions in place (as a result of Covid-19) visits to services may not be possible and as such testing may need to be undertaken via various methods, e.g. remote / virtual checking.

The Trust will also continue to complete testing that action has been reported as completed during the implementation of the action plan, rather than waiting until the action plan has been fully completed to request evidence. This is to ensure that if action has not been fully completed as reported, the action can be re-opened or urgent action taken to ensure it is completed at the time, rather than trying to rectify issues a number of months after the event.

Resources / Investment Required To Deliver Our Plan

There are a number of actions identified where reviews / investigation needs to be undertaken to identify the solution to fully address the concern raised by the CQC. The outcome of the reviews / investigations may identify solutions where additional resource would be required to fully resolve the issue. The following CQC requirement actions have been identified as potentially requiring additional resources dependent on the outcome of a review / investigation:

- M7. The trust must ensure that they eliminate mixed-sex accommodation on Henneage ward to uphold patients' privacy and dignity.
- M14. The trust must ensure that wards for patients with organic diagnoses are dementia friendly.
- S10. The trust should review their systems to keep patients' possessions safe and secure on the wards.

Previous Actions Remaining Open

The CQC requirement notice actions which remain open from the previous action plan due to not all individual actions being completed are:

M2. The trust must review their risk management systems to prevent overly restrictive ward rules (Acute Adult & PICU)
M3. The trust must ensure that blanket restrictions like locking patients' bedroom doors are reduced and regularly reviewed. (Wards for Older People)
S3. The trust should review its system for monitoring and learning from incidents involving the use of prone restraint.
M5. The trust must review their bed management systems to achieve recommended bed occupancy rates of 85%
M6. The trust must review their governance arrangements to ensure actions identified from incident investigations are applied consistently across wards. (Acute Adult & PICU)
S5. The trust should consider the effectiveness of the systems in place to share learning from incidents. (Trustwide)
S6. The trust should ensure staff are aware of all safety incidents and lessons learned. (Long Stay Rehabilitation)
M7. The trust must ensure that they eliminate mixed-sex accommodation on Henneage ward to uphold patients' privacy and dignity.

Previous Actions Remaining Open

M14. The trust must ensure that wards for patients with organic diagnoses are dementia friendly.
S8. The trust should review the efficiency of its data systems
S10. The trust should review their systems to keep patients' possessions safe and secure on wards.
S11. The trust should improve the way they get feedback from patients and carers and involve them in the development of the ward service.
S12. The trust should review their systems for ensuring staff complete regular checks of patients' physical health.
S14. The trust should ensure care planning includes the needs of patients with protected characteristics.

The focus remains on the 4 key themes that we believe could make the difference to the quality of our services and lead to improved ratings;

- Restrictive Practice
- Equalities
- Learning Lessons
- Data Quality

All other actions for the action plan developed following the CQC inspection in July - August have been reported as completed and are detailed in the body of the action plan.

Monitoring of Reset Action Plan Progress

	Action Type	Must Do / Should Do Actions				Specific Actions That Address Must Do/Should Do Actions			
		Total Actions	Actions Complete	Actions Within Timescale	Actions Past Timescale	Total Actions	Actions Complete	Actions Within Timescale	Actions Past Timescale
Requirement Notices	Combined Must and Should Do	6	0	6	0	10	4	6	0
	Must Do	3	0	3	0	11	1	10	0
	Should Do	5	0	5	0	10	0	10	0
TOTAL		**14**	**0 (0%)**	**14**	**0**	**31**	**5 (16%)**	**26**	**0**

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
Regulation 12: Safe Care and Treatment **M2. The trust must review their risk management systems to prevent overly restrictive ward rules (Acute Adult & PICU)** **M3. The trust must ensure that blanket restrictions like locking patients' bedroom doors are reduced and regularly reviewed. (Wards for Older People)**							
S3. The trust should review its system for monitoring and learning from incidents involving the use of prone restraint.							
As at the end of May 2020, 7 actions remained open for the requirement notices M2 and S3. Following the review at the Executive CQC Steering Group on the 2nd June 2020, it was identified that the 1 action would be re-opened and carried forward (Ref 4) due to the current measures not being sufficient to cover the issue originally highlighted by the CQC, 2 actions would be closed as the action has been completed (Ref 23 and 24), 1 action would not be progressed any further therefore closed (Ref 1), the remaining 3 carried forward (Ref 2, 3 and 5) and new actions developed to address the final areas remaining from the original issues identified. Summary of progress made prior to 'Reset' Action Plan: • Governance process for Restrictive Practice reviewed and agreed • The collaborative working for the Royal College of Psychiatrists on reducing restrictive practices for the two wards selected has been initiated • Restrictive Practice Conference with key speakers to understand the national approach to restrictive practice was undertaken • Support and coaching visits to Trust inpatient areas to understand the current culture and approach to restrictive practices was undertaken which influenced the implementation plan in relation to restrictive practice • System in place across all wards to ensure compliance with the requirements of the new restrictive practice data set • Wards are using Safety Crosses to monitor any incidents and the type of restrictive practice that has occurred • Debriefing protocol after incidents for both service users and staff to ensure individual and organisational learning takes place following incidents put in place • Core strategies from the Reducing Restrictive Practice Guide implemented across all inpatient areas • Pilot project in the use of Safety-Pods to determine if these will help reduce prone restraints undertaken • Ongoing training is in place for use of safety pods and alternative injection sites for patients • Datix reporting updated to ensure there is a distinction between planned prone restraint for injection (patient determined) and resisted restraint • Datix restraint dashboard developed to allow individual ward managers to review live restraint / prone restraint data							
• The CQC were not assured that the Trust was working with pace to address blanket restrictions. **(Summary – Page 5)** • Staff applied blanket restrictions without individual justification. This included restricting patients access to outside space, bedrooms and hot drinks. The trust did not monitor the	New Action identified in order to progress the final areas remaining from the original issues identified.	Initiate and implement a process to manage and review prone incidents as 'critical' incidents (BAF9)	NH / JP	Jul - 2020	**Update 23/06/2020** BAF9 confirms process has been agreed and full system to be rolled out from 15 June **Update 16.07.2020** Confirmation		

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
application of blanket restrictions through its reducing restrictive interventions work, this information was held locally at ward level. Staff continued to restrain patients in the prone position to administer intramuscular medication, despite policy supporting staff to administer in other sites. Training for alternative administration methods was not yet arranged. **(Summary – Pg6, 21)**					received that this has been rolled out and is complete		
	The action has been carried across from the previous action plan and has been adapted to reflect the work that has been identified previously and moving forward in order to implement the Core Strategies from the Reducing Restrictive Practice Guide. (Ref 2)	Implement 8 week rapid collaborative with Acute Adult inpatient and Specialist Services; whereby each ward will focus on one area of improvement that will cover the six core strategies in order that the Restrictive Practice group can measure the impact and cascade where necessary (BAF9)	NH / JP	Aug - 2020	**Update 23/06/2020** BAF9 confirms schedule in place for all inpatient areas and initial sessions have taken place Hotspots have been identified with follow up actions to be agreed **Update 16.07.2020** Sessions have taken place with all wards and supporting material circulated. All wards have identified one area for action (some areas have introduced more). Outcomes will be reviewed using qualitative and quantitative data with ward meetings taking place second week in August. Senior leadership group is in place incorporating multi-professional		

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
					representation that meets bi-weekly to discuss progress and address issues raised.		
	The action has been carried across from the previous action plan and will be followed through via this action plan as action remains relevant. (Ref 3)	Implement National Training Standards for Restrictive Practice (BAF9)	NH / AS / AH	Sep - 2020	**Update 23/06/2020** Accreditation applied for and visit required. Due to Covid-19 this was delayed. **Update 16.07.2020** Recruitment taking place to a band 6 post to work closely with JP in relation to wider RP agenda. Face to face TASI training recommences in August with the support of an additional two temporary trainers Training standard theory information to be incorporated into 5 key messages.		
	New Action identified following the CQC Executive Steering Group Meeting in order to progress the final areas remaining from the original issues identified.	Undertake the roll out, across Acute Adults and PICU, the '10 ways to improve safety' work stream which is the strategic approach to improving safety. (BAF9)	AB / SW / LW	Jul - 2020	**Update 15/07/2020** It was confirmed at the CQC 2 Outstanding meeting that the strategic approach has been rolled		✓

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
					out. Posters have been made available to all the teams and services. Evidence held in local drives and will be continually updated.		
	Action re-opened from the previous action plan due to the current measures not being sufficient to cover the issue originally highlighted by the CQC. (Ref 4)	Undertake option appraisal to determine the solution to allow patients access to their bedrooms on older people's inpatient wards.	MM / RC / JC / AW	Aug – 2020	**Update 17.07.2020** Audit being undertaken by Compliance to identify with each ward whether a solution needs to be identified.		
• The CQC were not assured the trust was working with pace to reduce the use of prone restraint and to address blanket restrictions. There was no monitoring system for blanket restrictions across the organisation, information about restrictions was held at ward level only. Staff continued to use prone restraint to administer intra-muscular (IM) medication to patients, despite being policy supporting staff to inject in other sites. From March 2019 to August 2019 staff recorded 183 incidents involving prone restraint. Eighty five percent (156) of those incidents occurred to administer IM medication. **(Summary – Pg5, 6, 21)** • From March 2019 to August 2019 staff recorded 183 incidents involving prone restraint. Eighty five percent (156) of those incidents occurred to administer IM medication. We were not assured that the trust worked to reduce prone	The action has been carried across from the previous action plan and will be followed through via this action plan as action remains relevant. (Ref 5)	Following the pilot project in the use of the Safety-Pods, develop an implementation plan and undertake the roll-out.	NH / JP / SH	Sep - 2020	**Update 27.05.2020** Deputy Director Quality Transformation (JP) confirms SH is reviewing their use in specialist services and is reporting back to the RP group in June **Update 16.07.2020** Feedback considered at committee meeting and plan in place to address issues raised supported by senior leadership team.		

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
restraint at pace. Many leaders discussed the use of prone being attributed to the administration of intramuscular injection. Staff continued to use prone restraint to administer intra-muscular (IM) medication to patients, despite being policy supporting staff to inject in other sites. Leaders described staff culture as a challenge in this area due to many years of this practise. The trust described quality issues with the raw data relating to restraint and stated it did not describe the level of restraint or if the patient resisted. The trust had a quality priority to review data and recording methods, however this issue contributed to our concerns regarding data quality, which is reflected later in this report. **(Appendix – Pg19)**					Further safety pods are in the process of being procured to be distributed across a wider range of inpatient areas. Wards currently receiving training in relation to use.		
Action Status:				Actions open			
Test 1: Evidence of Action Completion							
					Safety Strategy		

Regulation 17 Good Governance
M5. The trust must review their bed management systems to achieve recommended bed occupancy rates of 85%

As at the end of May 2020, 3 actions remained open for the requirement notice M5. Following the review at the Executive CQC Steering Group on the 2nd June 2020, it was identified that 1 action would be closed as the action has been completed (Ref 7), 1 action would not be progressed any further therefore closed (Ref 8), the remaining 1 carried forward (Ref 6) and new actions developed to address the final areas remaining from the original issues identified.

Summary of progress made prior to 'Reset' Action Plan:

- Options for electronic support system for discharge being explored
- Process for admitting a patient to a health-based place of safety where beds are not available confirmed
- Process implemented for bed management to chase ward staff for accurate dashboard updates on a daily basis
- Confirmation received that staff are made aware of all the work underway to improve the bed management system, such as high intensity user group, assessment unit model and emotionally unstable personality disorder work

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
• Bed occupancy provided challenge, particularly on acute mental health wards, where occupancy was over 100%. Patients remained on wards when they were ready for discharge. **(Summary – Pg8)** • Ardleigh, Cedar, Chelmer, Galleywood, Gosfield and Stort ward staff explained that occasionally the trust offered a patient a bed temporarily in a section 136 suite if they needed an inpatient admission and there was no bed available. This placed a further pressure on staffing and the rooms are only designed for short term use and do not promote recovery. However, trust information showed there was one incident between May and July 2019 of an "inappropriate admission" whereby a patient had been nursed in the Section 136 suite due to a lack of bed availability and out of area placement. Staff gave other examples of how they managed bed occupancy such as extending patients community leave (Galleywood), looking at alternative wards to admit patients' to if a bed was not available on their ward (Gosfield). **(Appendix – Pg102)** • Staff had reported one incident relating to lack of bed availability on Ardleigh and there were four complaints made about bed availability (in the last two months) from patients or carers from Ardleigh, Peter Bruff and Grangewater wards. Ten of 69 staff (14%) also raised concerns about patients frequently being readmitted and bed pressures. Staff gave examples of where some patients were regularly 'revolving' in and out of the wards and	New Action identified in order to progress the final areas remaining from the original issues identified.	Reflect on the Flow and Capacity Changes that took place during Covid19 to ensure the maximum occupancy level of 85% in all adult inpatient wards is maintained (BAF20)	AB / SW / LW / SB	Jul – 2020	**Update 01.07.2020** Confirmed at CQC 2 Outstanding meeting that they will Identify principles around going over 85% Things to consider: • Compromise social distancing or patient safety? • Consider number in isolation at one time **Update 15/07/2020** It was confirmed at the CQC 2 Outstanding meeting that the Phase 3 return that was submitted and the out of area stock take paper reflects the plan for bed management. Its been agreed that the AD/Director locally authorise reviewing activity, Social Distancing and Isolating. Bed management and Flow and Capacity Policy to be		

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
community. These included patients with a diagnosis of emotionally unstable personality disorder; patients who had been under child and adolescent mental health wards and struggled with the transition to adult services; patients with dual mental health and drug and alcohol issues or patients' with 'socio economic' problems. Staff said there could be seasonal impacts such as an increase during winter. **(Appendix – Pg103)**					updated to reflect agreed practice.		
	The action has been carried across from the previous action plan and will be followed through via this action plan as action remains relevant (Ref 6)	To progress Ambition 6 of the Essex Ambitions work in relation to housing support to assist with the facilitation of timely discharge. The aim is to have an agreed joint working arrangement with Housing departments across Essex. (BAF20)	AB / SW / LW / LP/ LMc /	Sept - 2020	**Update 01.07.2020** Confirmation received from AD Social Care (LP) that they are arranging a 2 system wide workshops via teams, scheduled for September, externally facilitated		
	New Action identified in order to progress the final areas remaining from the original issues identified.	Undertake a review of the patients who have repeat admissions in order to understand the reasons and identify any actions to reduce these (BAF20)	AB / SW / LW	Jul – 2020	**Update 01.07.2020** Confirmed at the CQC 2 Outstanding meeting that they undertake Locality/System high intensity user group meetings which review repeat admissions.		✓
	New Action identified in order to progress the final areas remaining from the original issues identified.	Recruit a 2nd Consultant at Peter Bruff in order to improve gatekeeping (BAF20)	AB / LW / MK	Sept - 2020			
Action Status:				Action open			
Test 1: Evidence of Action Completion							
					Patient Review and Discharge Planning Meeting		✓
					HIUG recording - master		✓

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
					Master HIUG Agenda template		✓
Regulation 17 Good Governance **M6. The trust must review their governance arrangements to ensure actions identified from incident investigations are applied consistently across wards. (Acute Adult & PICU)**							
S5. The trust should consider the effectiveness of the systems in place to share learning from incidents. (Trustwide) **S6. The trust should ensure staff are aware of all safety incidents and lessons learned. (Long Stay Rehabilitation)**							
As at the end of May 2020, 2 actions remained open for the requirement notices M6, S5 and S6. Following the review at the Executive CQC Steering Group on the 2nd June 2020, it was identified that both action would not be progressed any further therefore closed (Ref 9 and 10) and new actions developed to address the final areas remaining from the original issues identified. Summary of progress made prior to 'Reset' Action Plan: • Quarterly Serious Incident themed reports introduced • Learning lessons masterclass held at the Trust Leadership Event							
• The trust did not ensure staff learned lessons from previous incidents and worked in a different way to reduce reoccurrence. Despite a variety of ways in which lessons could be shared, there continued to be repetitive themes identified as recommendations and learning. Examples included: communication with external agencies, record keeping and the administration of emergency treatment. There had been recent difficulties within specific teams tasked with monitoring the implementation of action plans following incidents, which the trust was in the process of addressing. **(Summary – Pg5, 21)**	New Action identified in order to progress the final areas remaining from the original issues identified.	Implement Fortnightly Trust wide reflective learning sessions	MK	Jul - 2020	**Update 26.06.2020** 1st session scheduled for 01.07.2020 **Update 09.07.2020** 2 sessions currently held and a schedule in place. Sessions have had a good uptake with over 200 at the first one. **Update 16.07.2020** Agreed that a summary sheet will be sent out with the Certificate of Attendance so		✓

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
					individuals have notes that can be shared and reflected upon.		
	New Action identified in order to progress the final areas remaining from the original issues identified.	To implement the suicide prevention inpatient plan based on the National Confidential Inquiry '10 ways to improve safety' (NCISH)	AB / SW / LW	Jul - 2020	**Update 15/07/2020** It was confirmed at the CQC 2 Outstanding meeting that the strategic approach has been rolled out. Posters have been made available to all the teams and services. Evidence held in local drives and will be continually updated.		
	New Action identified in order to progress the final areas remaining from the original issues identified.	Review the Trust wide Suicide Prevention Strategy	MK / NH	Sep - 2020	**Update 16.07.2020** We are in the process of compiling a report reviewing progress made against the Trusts Suicide Prevention Strategy including recommendations on further plans. First draft will be ready by the end of July. There is also a campaign to raise awareness of suicide prevention		

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
					training. Plan to run from 10/09 – 10/10. Major focus will be w/c 10 September - Training, webinars etc. both within EPUT and available to external partners Suicide Prevention Group is in situ, with subgroups focusing on carers, clinical and learning culture NCISH Suicide Prevention Toolkit completed. Posters have been produced to support raising awareness as there is a push to create a 'mantra' on this within ops staff that LW is leading on.		
	New Action identified in order to progress the final areas remaining from the original issues identified.	To identify the learning from the suicide prevention training 'Awareness and Response' (BAF35)	RZ	Aug - 2020			
Action Status:				Action open			
Test 1: Evidence of Action Completion							
					Learning Lessons Webinar Schedule		
Regulation 12: Safe Care and Treatment **M7. The trust must ensure that they eliminate mixed-sex accommodation on Henneage ward to uphold patients' privacy and dignity.**							

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
As at the end of May 2020, 6 actions remained open for the requirement notice M7. Following the review at the Executive CQC Steering Group on the 2nd June 2020, it was identified that the 6 actions would be carried forward (Ref 11, 12, 13, 14, 15 and 16). Summary of progress made prior to 'Reset' Action Plan: • A high-level mixed-sex accommodation working group met and agreed the approach to understanding of CQC guidance, policy development, safety plans, meeting transgender requirements and review of signage.							
• Henneage ward did not comply with guidance on eliminating mixed-sex accommodation. Male patients walked past bedrooms occupied by patients of the opposite gender to access shower facilities. This potentially impacted on patient safety, privacy and dignity. **(Summary – Pg53)**	The action has been carried across from the previous action plan with a slight change to the wording and will be followed through via this action plan. (Ref 16)	Implement the room changes from the review (including signage, clustering, protocols etc.) to ensure patient safety, privacy and dignity.	MM / RC	Sept - 2020	**Update 24.06.2020** Confirmed at EERG that the approval has been agreed. **Update 09.07.2020** EERG Action Log confirms Contractor appointed and works due to commence on 20th July with practical completion scheduled for the 28th August 2020.		
• The layout and management of some bedrooms did not support the elimination of mixed sex accommodation or enhance the privacy and dignity of patients **(Summary – Pg33)**	The action has been carried across from the previous action plan and will be followed through via this action plan as action remains relevant (Ref 11)	Review CQC guidance and develop a guide for staff setting-out the Trust approach to mixed-sex accommodation	AB / SW / AW / FS	Sept - 2020	**Update** Trust approach agreed.		
	The action has been carried across from the previous action plan and will be followed through via this action plan as action remains relevant	Undertake a scoping exercise using the new guide to confirm staff understanding of mixed-sex accommodation to identify	AB / SW / AW / FS	Sept - 2020			

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
	(Ref 12)						
	The action has been carried across from the previous action plan and will be followed through via this action plan as action remains relevant (Ref 13)	Undertake training for wards where understanding is limited to ensure staff are applying the guidance correctly	AB / SW / AW / FS	Sept - 2020			
	The action has been carried across from the previous action plan and will be followed through via this action plan as action remains relevant (Ref 14)	Review wards with mixed-sex accommodation and identify any potential breaches and / or privacy and dignity concerns to identify solutions	AB / SW / AW / FS	Sept - 2020			
	The action has been carried across from the previous action plan and will be followed through via this action plan as action remains relevant (Ref 15)	Implement identified solutions from the review (including signage, clustering, protocols etc.).	AB / SW / AW / FS	Sept - 2020			
Action Status:				Action open			
Test 1: Evidence of Action Completion							

Regulation 9: Person centred care
M14. The trust must ensure that wards for patients with organic diagnoses are dementia friendly.

As at the end of May 2020, 1 action remained open for the requirement notice M14. Following the review at the Executive CQC Steering Group on the 2nd June 2020, it was identified that the 1 action would be carried forward (Ref 21).

Summary of progress made prior to 'Reset' Action Plan:

- Operational protocols for Wards for Older People with Mental Health Problems include key requirements for dementia patients (i.e ensuring newspapers are in date etc.)

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
• Two dementia wards did not provide patients with an environment that supported their needs. There were issues with flooring and a lack of dementia friendly signage. There was minimal access to items that provide sensory stimulation and clocks and newspapers were out of date. Older people could not personalise their bedrooms on wards and the rationale given was a breach of infection control policies. **(Summary – Pg8, 56)**	The action has been carried across from the previous action plan and will be followed through via this action plan as action remains relevant. Due to the time delay with the previous action, the action has been slightly amended to ensure the correct measures are being taken forward to cover the CQC's concerns. (Ref 21)	Identify what is still required following the Dementia Friendly Review of the Dementia Wards; in order to ensure the CQC concerns are met and then action.	MM / RC	Aug - 2020	**Update 01.07.2020** Audits received from Head Occupational Therapist and PLACE order obtained in order to identify what is still required. **Update 14.07.2020** Analysis undertaken by Head of Risk and Compliance (JC) which identified the top 10 that would have an impact. JC to liaise with AF and TA.		
Action Status:				Action open			
Test 1: Evidence of Action Completion							
					M14. Audits Folder		
					PLACE Results 2019		

S8. The trust should review the efficiency of its data systems

As at the end of May 2020, 1 action remained open for the requirement notice S8. Following the review at the Executive CQC Steering Group on the 2nd June 2020, it was identified that the 1 action would be carried forward (Ref 18) and a new action developed to address the final areas remaining from the original issues identified.

Summary of progress made prior to 'Reset' Action Plan:

- Review undertaken for 1 CHS Community and 1 Mental Health inpatient ward to review the process for appraisals, supervision and mandatory training to ensure data remains correct.
- Review undertaken with software supplier to develop further/gain a greater understanding in order to ensure it works going forward

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
• 'Smart Ward' programme trialled on 2 Inpatient Wards • The HIE system has been improved to ensure data is merged between the North and South Patient Electronic System in order for staff to see summary data for those patients who have accessed services in both areas.							
• The trust had challenges with the quality of its data. Staff described difficulties with the electronic record keeping system, the training data and data produced in performance reports. Senior leaders described data as incorrect and the need to provide extra narrative to performance reports to accurately reflect the performance of the service. (Summary – Pg5)	The action has been carried across from the previous action plan with a slight change to wording and will be followed through via this action plan (Ref 18)	Report and agree the recommendations from the Smart Ward Programme and roll out	MM / JL	Sept - 2020			
	New Action identified in order to progress the final areas remaining from the original issues identified.	Undertake a webinar on data quality in order to listen to the staff and identify what issues they are encountering.	MM / JL	Jul - 2020	**Update 26.06.2020** Live webinar scheduled for July-2020		
Action Status:				Action open			
Test 1: Evidence of Action Completion							
S10. The trust should review their systems to keep patients' possessions safe and secure on wards.							
As at the end of May 2020, all actions were closed for the requirement notice S10. Following the review at the Executive CQC Steering Group on the 2nd June 2020, it was identified that the 1 action would be re-opened and carried forward (Ref 22) due to the current measures not being sufficient to cover the issue originally highlighted by the CQC. Summary of progress made prior to 'Reset' Action Plan: • Review of current ACT access card processes confirm that the service users allocated card only works on their bedroom door • Safes have been made available for service users valuable possessions							
• Staff did not provide facilities for patients to store their possessions securely. **(Summary – Pg12, 46)**	Action re-opened and wording amended from previous action plan due to the current	Carry out options appraisal to identify whether the issue identified can be addressed by	MM / RC	Sept-2020	**Update 26.06.2020** Safes for valuables have been		

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
• Whilst wards had items for patients to have a secure locker this was not in their bedroom. The Trust had not ensure that all patients could lock their bedrooms (or dormitories) and keep items secure from others for example Cedar, Thorpe, Grangewaters, Assessment Unit and Kelvedon Ward.	measures not being sufficient to cover the issue originally highlighted by the CQC. (Ref 22)	additional banks of lockers in communal spaces or via ACT.			provided. Individual units for storage in bedrooms have been reviewed however discounted as they increased the ligature risks within the bedrooms. Banks of lockers in communal areas – no one would use them however a trial being undertaken in Gloucester Ward. Some Acute Adults already have in place. ACT conversation would cover this as lockable bedroom, locked possessions South issue as doors are open **Update 16.07.2020** Audit undertaken by Compliance to identify what each ward currently have in regards to Possession storage and door		

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
					access. Audit to be reviewed and compliance to liaise with Estates to discuss findings.		
Action Status:				Action open			
Test 1: Evidence of Action Completion							
S11. The trust should improve the way they get feedback from patients and carers and involve them in the development of the ward service.							
As at the end of May 2020, 1 action remained open for the requirement notice S11. Following the review at the Executive CQC Steering Group on the 2nd June 2020, it was identified that the 1 action would be carried forward (Ref 19) and new actions developed to address the final areas remaining from the original issues identified. Summary of progress made prior to 'Reset' Action Plan: • Community meetings form part of the patients therapeutic programme to encourage attendance/ involvement for all wards. • Community meetings protocol developed to ensure feedback is used to inform 'You said, We did'. • Regular carers engagement events being held							
• From a sample of community meeting minutes checked the minutes varied in quality and detail. Not all showed how staff had involved patients in the meeting and if staff had responded to actions from the previous meeting. **(Appendix – Pg110)**	New Action identified in order to progress the final areas remaining from the original issues identified.	Identify the plan to improve carer involvement in Acute Adult and PICU wards and implement	AB / SW	Jul - 2020			
	The action has been carried across from the previous action plan with a slight change to wording and will be followed through via this action plan (Ref 19)	Carers engagement Framework and strategy to be reviewed in order to ensure consistent approach and ensure it applies Trustwide – Mental Health and Community	AB / LW / LP / AJ	Sept - 2020	**Update 09/06/2020** Carer Engagement Framework in place and on Input. Framework timeframe is 2018-2020. Consultant Social Worker (AJ) confirmed the review is currently being undertaken		✓

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
					and expected to be completed within the next couple of weeks. **Update 19/06/2020** Associate Director Social Care (LP) developed presentation identifying the Carers strategy and current position.		
Action Status:				Action open			
Test 1: Evidence of Action Completion							
					Carers Presentation		
S12. The trust should review their systems for ensuring staff complete regular checks of patients' physical health.							
As at the end of May 2020, 1 action remained open for the requirement notice S12. Following the review at the Executive CQC Steering Group on the 2nd June 2020, it was identified that the action would be closed as the action has been completed (Ref 20) and new actions developed to address the final areas remaining from the original issues identified. Summary of progress made prior to 'Reset' Action Plan: • Weekly physical health check clinic rolled out across the Trust • Evidence record when physical health check is declined by a patient along with a minimum timeframe set for a repeat attempt. • Regular reminders sent from performance for ward to re-attempt the physical health check when it had previously been refused.							
• There were gaps in physical health records. **(Summary – Pg6, 12, 46)** • Most patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The trust monitored patients who had been on wards for over a	New Action identified in order to progress the final areas remaining from the original issues identified.	Undertake an initial deep dive review of recording of physical health information	MM / JL	Jul – 2020			
	New Action identified in order to progress the final areas	Identify what action is required to standardised the way it is	MM / JL	Jul - 2020			

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
year. Four wards had not met the trust threshold as Cedar and Finchingfield had 50% compliance, Grangewater and Thorpe had 0%. Other wards did not have patients on their ward for over a year. Five of 49 patients records (10%) held minimal information (Cedar and Kelvedon). For example, two Cedar patients had refused a check, but it was unclear if staff had asked them again. **(Appendix – Pg90)**	remaining from the original issues identified.	recorded on the patients electronic record to ensure consistency					
	New Action identified in order to progress the final areas remaining from the original issues identified.	Explore any potential electronic bed side app/system for data collection which uploads to the electronic patient record	MM / JL	Sept - 2020			
Action Status:				Action open			
Test 1: Evidence of Action Completion							
					Physical Health Clinic Monitoring Form		
S14. The trust should ensure care planning includes the needs of patients with protected characteristics.							
As at the end of May 2020, all actions were closed for the requirement notice S14. Following the review at the Executive CQC Steering Group on the 2nd June 2020, it was identified that the 1 action would be re-opened and carried forward (Ref 17) due to the current measures not being sufficient to cover the issue originally highlighted by the CQC and a new action developed to address the final areas remaining from the original issues identified. Summary of progress made prior to 'Reset' Action Plan: • Protected characteristics poster developed to raise awareness of the different protected characteristics. • Guidance for staff on recognising protected characteristics and how to approach care once this is recognised has been developed • Care Plan audit developed to check patients protected characteristics have been identified and incorporated. • Role of ward Equality Champions has been expanded.							
• Staff had not always identified the needs of all patients with a protected characteristic in care plans. **(Summary – Pg47)** • The trust collated data about patients in relation to protected characteristics under the Equality Act. However, only	Action re-opened and wording amended from previous action plan due to the current measures not being sufficient to cover the issue originally highlighted by the CQC.	Re-launch and enhance communication of the BE YOU campaign	SL / JD / GB	Sept - 2020	**Update 26.06.2020** SL confirmed the following events: BE You launch - 1st week September BE YOU week - 6th August		

Details from the Report	Source	Action Detail	Lead	Time scale	Progress		Evidence
six of 49 patients (12%) of care records showed evidence of staff referencing this in their care plan. The trust was developing the role of ward equalities champions to give support to staff and patients and promote equality and diversity.	(Ref 17)						
	New Action identified in order to progress the final areas remaining from the original issues identified.	Give consideration to 'THIS IS ME'; which is currently in use in CAMHS, in order to roll out	SL / JD / GB	Sept - 2020			
Action Status:				Action open			
Test 1: Evidence of Action Completion							

K**ey Leads:**

AB	Andy Brogan	**AH**	Anthea Hockly	**AS**	Amanda Secular
DC	Denise Cook	**FS**	Faye Swanson	**GB**	Gary Brisco
IC	Ian Carr	**JC**	Jane Cheeseman	**JD**	Jo Debenham
JL	Jan Leonard	**JP**	Jo Paul	**LMc**	Lynn McGhee
LP	Lynn Prendergast	**LW**	Lizzie Wells	**MK**	Dr Milind Karale
MM	Mark Madden	**NH**	Natalie Hammond	**RC**	Ricard Chilcott
RZ	Rebecca Zicari	**SB**	Sarah Brazier	**SH**	Scott Huckle
SL	Sean Leahy	**SW**	Sue Waterhouse		

END

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 9b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	**PHSO and HSE Steering Group Assurance Report**					
Executive/Non-Executive Lead:	Alison Davis, Non-Executive Director / Chair of the PHSO Steering Group					
Report Author(s):	Gill Brice, Associate Director of Planning					
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 PHSO and HSE Steering Group. This is a Task and Finish Group established by the Board to oversee the work relating to the PHSO and HSE requests for information.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the summary of the meetings held on 25 June 2020.
2. Confirm acceptance of assurance given in respect of the actions identified.

Summary of Key Issues

The PHSO & HSE Steering Group met on 25 June 2020. The following items were discussed:

- Action Log
- PHSO Action Plan
- HSE Investigation

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	BAF 15
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			
PHSO	Parliamentary and Health Service Ombudsman	HSE	Health and Safety Executive

Supporting Documents and/or Further Reading

Lead
Alison Davis **Non-Executive Director / Chair of the PHSO & HSE Steering Group**

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Part 1 Agenda Item: 9b
Board of Directors
29 July 2020

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PHSO and HSE STEERING GROUP

PURPOSE OF REPORT

This report is provided to the Board of Directors by the Chair of PHSO and HSE Steering Group. It is designed to provide assurance to the Board of Directors that risks that may affect the achievement of the organisations objectives are being managed effectively.

EXECUTIVE SUMMARY

PHSO and HSE Steering Group meeting of 25 June 2020
The PHSO and HSE Steering Group met on 25 June 2020. The Steering Group had a robust and thorough discussion on a number of key areas. The following matters were considered:

1. **Steering Group Action Log**
   Updates were received and slippage was identified due to Covid-19. All incomplete actions have a revised completion date of July 2020.

2. **Final PHSO Action Plan**
   The Group approved a revised target date for one action in relation to the new National SI Framework. Assurance was requested on all outstanding items that interim action is being taken on matters within the Trust's control.

3. **HSE Investigation**
   The Group approved revised target dates for two actions relating to alerts and one action in relation to window replacements.

4. **Risks**
   No risks were identified.

ACTION REQUIRED

The Board of Directors is asked to:

1. Note the summary of the meeting held on 25 June 2020.
2. Confirm acceptance of assurance given in respect of the actions identified.

Report produced by:
Gill Brice
Associate Director of Planning

On behalf of:
Alison Davis
Non-Executive Director / Chair of the PHSO and HSE Steering Group

		Agenda Item No: 9c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 July 2020**

Report Title:	**EPUT (Interim) Quality Account 2019/20**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Susan Barry, Head of Assurance					
Report discussed previously at:	Extra-ordinary Board 24 June 2020					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides the Board of Directors (in public) with the final (interim) EPUT Quality Account 2019/20 as approved at the Extra-Ordinary Board of Directors meeting 24 June 2020 for publication to EPUT public website as an interim document.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the EPUT (interim) Quality Account 2019/20 formally approved at Extra-Ordinary Board (not held in public) on 24 June 2020 for publication on the public website

Summary of Key Issues

1 Normally the Quality Account is due for publication formally by the end of June each year, however, due to Covid-19, this has been delayed and submission is advised by NHSE / I by 15 December 20.
2 The Board is asked to note a minor change to the statement produced by the Council of Governors which was required as a result of final Q4 data. The change was agreed with the Lead Governor and did not materially affect the views of the Council.
3 EPUT has worked to its normal timetable in producing this Quality Account and will publish an interim version in July with a Council of Governors statement but without partner statements.
4 The CEO has written to partners with the revised timetable for final publication, no replies have been received at the time of writing.
5 Partner statements will be added in November prior to final approval by the Board of Directors.
6 Some Q4 nationally published data remains unavailable due to the suspension of submission and its publication due to Covid-19 to release capacity across the NHS to support the response.
7 Following publication of the interim Quality Account on the EPUT website a copy will be sent to partners for information, ahead of requesting statements in the autumn.

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	BAF 9 No Force First BAF35 Culture of Fairness and Learning Lessons BAF32 Quality Improvement through Innovation BAF34 Staffing for Transformation
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 £**			x
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	x

Acronyms/Terms Used in the Report			
EPUT	Essex Partnership NHSFT	NHSE	NHS England
CCG	Clinical Commissioning Group	NHSI	NHS Improvement
QC	Quality Committee	NHSI/E	NHS England / Improvement
Q4	Quarter Four	BAF	Board Assurance Framework

Supporting Documents and/or Further Reading
Final EPUT Quality Account 2019/20

Lead
Natalie Hammond **Executive Nurse**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

FINAL INTERIM EPUT QUALITY ACCOUNT 2019/20

1.0 Purpose of report

This report provides the Board of Directors in public with the final draft EPUT Quality Account 2019/20 for noting for publication to EPUT public website as an interim document and circulation to partners for information ahead of requesting formal statements in the autumn.

2.0 Background

On 1 May 2020 regulations making revisions to Quality Account deadlines for 2019/20 came into force. While primary legislation continues to require providers of NHS services to prepare a Quality Account for each financial year, the amended regulations mean there is no fixed deadline by which providers must publish their 2019/20 Quality Account. NHS England and NHS Improvement recommended for NHS providers that a revised deadline of 15 December 2020 would be appropriate, in light of pressures caused by Covid-19. Draft Quality Accounts should be provided to stakeholders (for 'document assurance' as required by the Quality Accounts regulations) in good time to allow scrutiny and comment. For finalising Quality Accounts by 15 December, a date of 15 October would be reasonable for this. In this respect the CEO has written to partners outlining the new timetable for final publication and seeking their agreement. At the time of writing this report no replies have been received.

As reported to the Board of Directors in May EPUT agreed to continue with its original timetable except for the partner consultation and submission to the Secretary of State for Health and Social Care. In this way we have discharged our responsibility to our public in terms of reporting on quality and the final version approved at this meeting will be published on our website. A revised Quality Account will then be published at the end of the year in line with the revised regulation.

This final draft version was approved at the Extra-Ordinary meeting held on the Board of Directors on 24 June. Since then amendments have been made to the Council of Governors statement and Q4 data has been added to the Data Quality section.

3.0 Final Interim EPUT Quality Account 2019/20

The final interim EPUT Quality Account 2019/20 is attached to this report for noting in public. This version will be published on the EPUT public website. EPUT will then follow the timetable outlined to the BOD at its meeting in May with final publication by 15 December 2020. Partner statements will be added in November prior to final approval by the Board of Directors.

Some Q4 nationally published data remains unavailable due to the suspension of submission and its publication as a result of Covid-19 to release capacity across the NHS to support the response. It is expected that this data will be included in the final version of the Quality Account.

4.0 Recommendations

The Board of Directors is asked to:

1 Note the final interim EPUT Quality Account 2019/20 formally approved at the Extra-Ordinary Board (not held in public) on 24 June 2020 for publication on the public website

Report prepared by: Susan Barry, Head of Assurance
On behalf of: Natalie Hammond, Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

Quality Account 2019/20

"Working to improve lives"

Contents

Part 1: Statement on quality

"I am taking this opportunity to record how extraordinarily proud I am of our staff for their outstanding delivery of care and services during the Covid-19 pandemic. We will never be able to thank them enough. Even in an unprecedented global health emergency, they worked together brilliantly, pulling out all the stops to deliver care for our patients and in wider local communities. This Quality Account was prepared in the midst of the pandemic. My heart goes out to all those across the world who have lost loved ones during this time."

This Quality Account for 2019/20 shows how Essex Partnership University NHS Foundation Trust (EPUT) met our quality commitments for 2019/20, our third as a newly-merged organisation, and it outlines our quality priorities for 2020/21.

Each year, we set ourselves different quality priorities to help us to achieve our long-term quality goals. We base these annual priorities on the feedback about our services we've received during the previous year from our service users, carers, staff and stakeholders. We also use findings from our Trust-wide learning from incidents, complaints and Care Quality Commission (CQC) inspections. Finally, as EPUT's senior leadership team, we bring our own knowledge of our services to bear.

During this year, the CQC rated our services as 'Outstanding' overall for Caring. As CEO, I've visited many Trust services at all times of the day and night. This is one of the most rewarding parts of my job. I've always been welcomed and made to feel at home on the frontline of our care provision, even when I've startled staff by popping into their ward unexpectedly in the early hours! I'm delighted their care of the people using our services has been recognised and, as ever, I am extremely proud of them.

We set ourselves eight quality priorities for 2019/20. In line with NHS England/ Improvement guidance, we ensured these priorities covered indicators from the three areas of service user quality – safety, effectiveness and patient / carer experience. To ensure quality is core to running EPUT, we align our quality priorities with our corporate objectives.

We check in throughout the year on how we're doing in meeting our quality priorities. We have a range of forums and events which promote and maintain engagement between our service users, carers, staff, Board of Directors, Council of Governors, NHS Foundation Trust membership and stakeholders. At these, we have monitored progress against our current quality priorities and sought views on proposed quality priorities for 2020/21.

Most of our priorities for 2019/20 related directly to improving the care we provide in our services. Our top quality priority was to provide harm-free care. This reflects our determination that our services will improve sufficiently to be rated as 'Good' overall for Safety at our next Trust-wide CQC inspection. A number of sub-priorities were set here, covering areas such as reducing pressure ulcers and falls, patients missing fewer doses of their medication, improving the physical

health of our mental health patients and introducing new ways to support our staff in picking up early warning signs that a patient's condition may be deteriorating.

In addition to this harm-free care top priority, we also set ourselves direct patient care priorities on: reducing restrictive practices in mental health services; rolling out comprehensive suicide prevention training to our community mental health teams and improving the care we provide for people at the end of their lives.

I am pleased to report that all these quality priorities were achieved, sometimes by exceeding our ambitious achievement targets. For instance, I am particularly pleased that our End of Life services are now rated as 'Outstanding' overall by the CQC.

Our remaining four quality priorities supported our determination to improve patient safety and our ambition to enable our staff to develop their innovative skills for their patients' benefit. Developing collective leadership means EPUT is not 'top-down' but we work together as leaders to enhance performance and improve practices. Continuous improvement means we never rest on our laurels, but are always on the lookout for ways to make our best even better. Effectively using modern technology is central to transforming outcomes for our patients. It enables us to find, use and share more and better data quickly, safely and widely across EPUT. Embedding a just and learning culture at EPUT means individuals, teams and the organisation as a whole learns more widely and deeply from mistakes, which leads to us being able to make real life improvements to the safety of our patients.

I'm pleased to report we achieved these quality priorities too. I'm particularly pleased with our growing cohort of home-grown Quality Champions; they've risen wonderfully to those challenges often faced by trailblazers and are a significant influence on our quality improvement programme.

This report details many more achievements of which EPUT is justifiably proud. It also details our improvement plans for this year. I hope it gives a clear understanding of how seriously we take our responsibilities and how determined we are to provide safe, effective, caring, responsive and well-led NHS services.

Statement of Accuracy

I confirm that to the best of my knowledge, the information in this document is accurate.

Sally Morris
Chief Executive
Essex Partnership University NHS Foundation Trust

Part 2: Our Quality Priorities for improvement during 2020/21 and Statements of Assurance from the Board

What services did EPUT provide in 2019/20?

During 2019/20, we provided hospital and community-based mental health and learning disability services across Essex as well as a small number of specialist mental health and/or learning disability secure services in Essex, Bedfordshire and Luton. We also provided community health services in South East Essex and West Essex as well as some specialist children's services Essex-wide.

How have we prepared this Quality Account?

The Quality Account has been prepared in accordance with the national legislation and guidance relating to the preparation of Quality Accounts in the NHS. The legislation and national guidance on Quality Accounts specifies mandatory information that must be reported within the Quality Account and local information that EPUT can choose to include; as well as the process that Trusts must follow in terms of seeking comments from partner organisations (Clinical Commissioning Groups, Healthwatch organisations, and Local Authority Health Overview and Scrutiny Committees) and the Council of Governors on their draft Quality Account as well as independent assurance from an external auditor.

This Quality Account has been collated from various sources and contains all the mandated information that is required nationally, as well as a significant amount of additional local information. It is set out in three sections in accordance with the national legislation and guidance. The report was considered in draft form by the EPUT Quality Committee and Board of Directors. The draft report was also sent to Clinical Commissioning Groups, Healthwatch organisations, and Local Authority Health Overview and Scrutiny Committees and they were given 30 days in which to consider the content and provide commentary for publication in the final version. Clinical Commissioning Groups are required to provide a statement whereas the other partners are given the opportunity to provide a statement for inclusion should they wish to do so. The resulting statements are included at Annexe A of this Quality Account. The draft document was also sent to Local Authority Health and Wellbeing Boards for consideration and comment should they wish. The Lead Governor for EPUT also provided a statement, on behalf of the EPUT Council of Governors, which is included in Annexe A.

This Quality Account would normally align itself to the Quality Report section of our Annual Report. Due to the Covid-19 pandemic a decision was made not to include a Quality Report in the EPUT Annual Report, thus there is no external audit of the Quality Account this year.

2.1 Key actions to maintain and/or improve the quality of services delivered in 2020/21

How have we developed our priorities for the coming year?

Each year we set annual Quality Priorities to help us to achieve our long term quality goals. They are identified through feedback from service users, carers, staff and partners, as well as information gained from incidents, complaints and learning from Care Quality Commission findings.

Our Quality Priorities represent the greatest pressures that EPUT is currently facing. Following the unprecedented period of Covid-19 it is anticipated there will be changes to the healthcare system on a macro and micro scale that will impact on quality priorities moving forward. The Covid-19 pandemic had brought with it potentially disruptive transformation of services. However, together with system partners EPUT has implemented many transformation initiatives at pace and made significant adaptions and improvements to services.

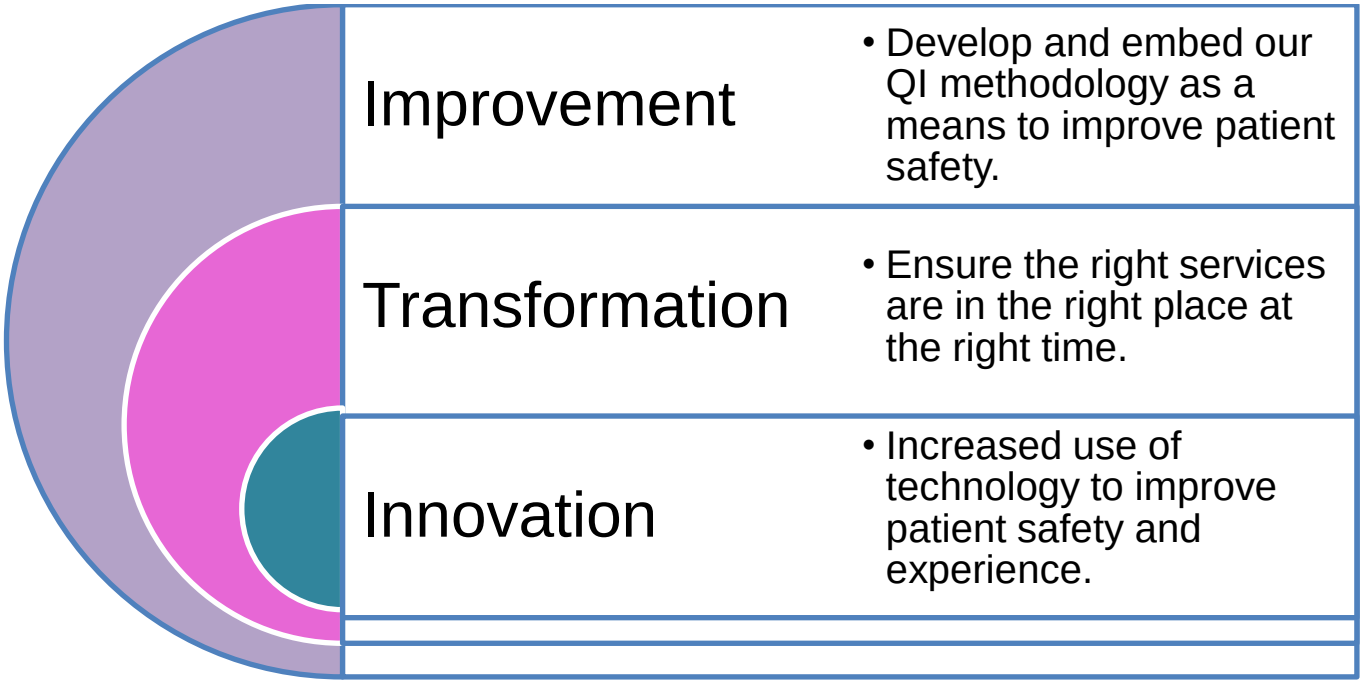
As an organisation moving forward through the recovery from the first wave of the Covid-19 pandemic EPUT is seeking to use this phase as an opportunity to transform and reform services while learning from the improvements, innovations and adaptions that were introduced at speed to protect both our communities and our workforce. As a mental health and community service Foundation Trust we are aware that this pandemic will have an unprecedented impact on our communities moving forward.

We will build on the changes brought about by the pandemic to enhance patient care and lock in operational improvements, whilst also identifying the longer term challenges to protect and improve the wellbeing of our communities. As a result it is considered that our strategic quality priorities relating to innovation, improvement and transformation are the best fit for EPUT at the present time. Due to the unprecedented changes required, we acknowledge that the content of our quality priorities may be challenged, adapted and reformed over the next year as we respond to the needs of our communities and our workforce; EPUT will ensure processes are in place to adapt to the challenges we face.

We have provided an in year update of progress against our quality priorities. Through a range of forums and engagement events incorporating EPUT Board, governors, service users, carers and staff we have monitored the progress against the 2019/20 quality priorities and sought views on proposals for new quality priorities driving progress into 2020/21.

In line with NHS Improvement/ England guidance our priorities cover indicators from each of the three areas of service user quality – safety, effectiveness and experience which are aligned with EPUT corporate objectives.

The quality priorities for 2020/21 agreed by the EPUT Board of Directors are as follows:



2.1.1 Priority 1 – Develop and embed QI methodology as a means to improve patient safety

EPUT sees quality improvement as a key enabler to transform services and bring about changes to deliver person centered care that is better, safer, more effective and efficient. The goal is to standardise best practice, ensuring that the workforce have the skills, resources and capabilities to implement proven and better ways of delivering care. The impact of Covid-19 has seen the introduction of quality improvements across all services in extremely accelerated timeframes due to the need to build improvements and solve problems at pace.

During this year we will evaluate and learn from improvements made during this unprecedented time, leveraging our connectivity to identify new solutions to providing healthcare. We will build on our current approach to improving quality and patient safety, delivering a mixture of centrally commissioned projects in line with EPUT priorities and service/individual level initiatives delivered through Directorate QI Hubs. We will test, refine and continue the journey of embedding a quality improvement methodology based on well-established continuous improvement techniques. This will support the delivery of sustainable improvements at scale and pace.

- **Directorate Improvement Hubs**
- Identify, and delivery of, a minimum of three quality improvement projects
- Identification of 20 Quality Champions per hub to undertake QSIR
- Engagement of service users and carers in QI initiatives

- **Development of QI Training Directory**
- Delivery of four cohorts of QSIR training
- Delivery of one day QI training across all improvement Hubs (120) people
- Embed QI in leadership and induction programmes

- **Sharing best practice and learning lessons**
- Ensure all QI initiatives have clear outcomes and data measures
- Use data and learning from incidents to identify QI projects
- Develop systems for sharing and celebrating best practice

- **Accreditation Programme**
- Develop accreditation programme across inpatient services
- Embed principles of Just Culture and Human Factors
- Develop internal recognition system to support levels of accreditation

2.1.1 Priority 2 – Transformation: Ensure the right services are in the right place at the right time

Covid-19 has brought about the need for a redesigned healthcare system with system partners identifying new solutions at unprecedented speed to address operational challenges. It is a situation that is likely to lead to a fundamentally different healthcare system. The pandemic has indicated where systems are defective and shown how technological innovation can be used to move away from institutionally based healthcare and that along with the rapid education and role adaptation within the workforce has enhanced our ability to provide care in different ways. It is a challenge that requires input from all, co-producing healthcare to meet personal and individual needs within our population, therefore EPUT will continue to work with system partners to ensure seamless integration of recent and future developments. The current situation has demonstrated the importance of flexibility within our programme plans to align with ongoing national and local priorities.
Currently, the Mental Health and Community Health Services Transformation Programme (STP) covers three STP areas and within them seven CCGs, two local Unitary Authorities and one County Council.

The Mental Health and Community Transformation Portfolio comprise four major programmes in mental health transformation and within these, 18 projects and over 20 programmes in community services. Since the implementation of the STPs some of these programmes have remained broadly Essex wide whilst others are being developed to reflect the ‘PLACE’ based care and the individual needs of each locality.

Within each STP the four major programmes for mental health transformation are:

Emergency Response and Crisis Care Service:

People facing a mental health crisis should have access to care 7 days a week and 24 hours a day in the same way that they are able to get access to urgent physical health care. Getting the right care in the right place at the right time is vital. Analysis of RAID and occupied bed days data indicates an increasing system pressure for acutely unwell mental health patients. The ambition for implementing the MH5YFV is that by 2020/21:

- All areas will provide crisis resolution and home treatment teams (CRHTTs) that are resourced to operate in line with recognised best practice – delivering 24/7 community-based crisis response and intensive home treatment as an alternative to acute inpatient admissions
- Out of area placements will essentially be eliminated for acute mental health care for adults
- All acute hospitals will have 'all-age' mental health liaison teams in place, and at least 50% of these will meet the 'Core 24' service standard as a minimum

Personality Disorders:

The Business Case for this programme of work proposes a Personality Disorder and Complex Needs pathway which is integrated with wider primary care services and provides evidence-based interventions and enhanced self-care. It emphasises prevention of crisis episodes through linking with both urgent care and primary care pathways, delivering multiple benefits for patients and the system.

Key actions are as follows:

- Development and delivery of a bespoke training programme to improve awareness and ensure the diagnosis of Personality Disorder is provided
- Remodeling of current psychotherapy and Personality Disorder services into an Essex-wide specialist MDT
- Expansion of Personality Disorder treatment interventions
- Enhanced clinical skills training
- Enhance integration with system partners

The outputs expected are an improvement in service user feedback, clinical improvements, positive attainment of specific individual goals using GAS goals, reduction in hospital stays (reduction in admissions, and length of stay) and improved movement through services in the system, and reduction in waits for treatment.

Older People and Dementia:

This programme was first introduced in Mid and South Essex STP. It is a model of dementia care that ensures early diagnosis and good post diagnostic support. It is a community model that is optimally provided with system partners in primary care, and is able to respond proactively to those with dementia or suspected dementia and their carers in their own homes and community settings. This is supported by a dementia inpatient model that provides for those with the most complex needs.

To embed and expand the following actions will be taken:

- Implementation of new ways of integrated working
- Increased use of telemedicine
- Introduction of collaborative assessment, review, treatment and care interventions
- Embed inpatient service model
- Develop systems to enhance carer support

The outputs expected are an increase in dementia diagnosis rates, a reduction in inpatient admissions, and reduced length of stay in inpatient settings and improved service user experience and outcomes.

Community (Primary) Care:

This programme is currently under development. It will be delivered on a locality basic ensuring services meet the needs of local populations.

Across **Community Health Services** in both South East Essex and West Essex a range of transformations have been developed and will be delivered in partnership. EPUT alongside system partners has developed a road map with clear milestones for all transformation projects.

Key programmes - EPUT is developing 'system' programme documentation to support transparent and shared control documents for the future ensuring implementation is in line with agreed timescales and success measures which incorporate the following:

- **Community Crisis Response:** Enhance the SWIFT Crisis response team established in 2019/20 to align with the Intermediate Care Transformation programme to improve integration and collaboration across all Intermediate Care services

To enhance the current service provision work will be undertaken with NELFT and PROVIDE with SWIFT team member attending EEAST hub to deliver Category 3/4/5 calls direct to community services.

The outputs expected are significant admission avoidance activity, reduction in falls and neutropenic sepsis response.

- **Comprehensive Community Palliative Care Offer in South East Essex:** Establish a comprehensive population-health management model for Community Palliative Care/EOL Services that includes management of an EOL register and delivery of high quality front line EOL care**.**

This will require a consolidated service focus delivering on achieving a 1% population target for End of Life Register meeting all challenging contractual KPIs and work with community care and local hospices to develop pathways that maximise access to new hospice beds scheduled to open during 2020.

- **Case Management of Frail and Complex Patients:** in West Essex a programme is being developed to standardise the system offer/ specification for case management that links directly with services across the system. Work will be undertaken with system partners to reduce A&E attendance and non-elective admissions.

- **Development of West Essex Intermediate Care:** A business case is currently being developed inclusive of a full options appraisal to develop systems that reflect the needs of local populations.

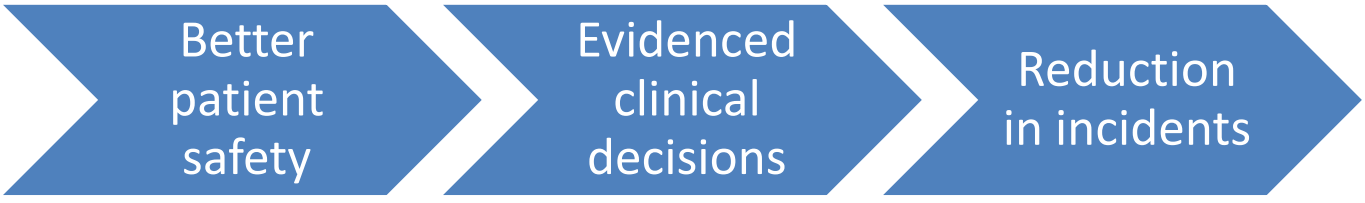
EPUT is working with system partners to build a transformation model that meets the needs of local populations. It is recognised at this stage that some of the transformations set out may develop or transform into different specifications through engagement with system partners and stakeholders.

2.1.1 Priority 3 – Innovation: Increased use of technology to improve patient safety and experience

EPUT has been extremely innovative at developing and using technology to improve services. Through EPUT Lab clinicians have been empowered to identify technology that improves clinical decision making, supports individuals to manage their own health and frees up clinical time to allow smarter working across services. The pandemic has brought the use of technology to the forefront of the organisation supporting new ways of working and providing care.

EPUT Lab is in place as one forum in which innovative treatment solutions are presented and evaluated and staff given the opportunity to be credited for their solutions and sponsor any projects that emerge.

EPUT has an ambition to engage with the Model Hospital in order to provide the best patient care in the most efficient way. EPUT will review, access and implement a range of digital tools that will compare productivity and identify opportunities to make improvements to clinical services. During 2020/21 EPUT Lab will identify a range of technological innovations that will be evaluated in respect of the following areas:



2.2 Statements of Assurance from the Board for 2019/20

2.2.1 Review of services

During 2019/20, EPUT provided and/or sub-contracted 141 relevant health services.

EPUT has reviewed all the data available to them on the quality of care in 141 of these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 represents 94% of the total income generated from the provision of relevant health services by EPUT for 2019/20.

The data reviewed aimed to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. During 2019/20 monthly data quality reports were produced in a consistent format across all services. These reports monitored timeliness of data entry and data completeness. There has been excellent clinical engagement with a clear understanding of the importance of good data quality across the clinical areas. Further information about data quality is included in the data quality section 2.2.7.

2.2.2 Participation in clinical audits and national confidential inquiries

Clinical audit is a quality improvement process undertaken by clinicians, doctors, nurses, therapists and support staff that seek to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change (NICE 2005). Clinical audit is a tool to assist in improving services; robust programmes of national and local clinical audit result in clear actions being implemented to improve services are a key method of ensuring high quality. EPUT participates in all relevant National Clinical Audit Patient Outcome Programme (NCAPOP) audit processes and additional national and locally defined clinical audits identified as being important for the people who use our services.

During 2019/20 11 national clinical audits and two national confidential inquiries covered relevant health services that EPUT provides

During that period EPUT participated in 100% national clinical audits and 100% national confidential inquiries of the national clinical audits and national confidential inquiries which it was eligible to participate in

The national Clinical Audits and national confidential inquiries that EPUT was eligible to participate in during 2019/20 are as follows:

National Audit of Care at the End of Life Round 2(NACEL)
National Sentinel Stroke National Audit Programme Round 6 (SSNAP) 2019/20
UK Parkinson's Audit 2019

National Audit of Cardiac Rehabilitation (NACR) National Asthma and COPD Audit Programme (NACAP) National Audit of Inpatient Falls (NAIF) - National Falls and Fragility Audit Programme (FFFAP) National Diabetes Foot Care Audit Round 5 (NDFA) 2019/20 POMH-UK Topic 19a: Prescribing for depression in adult mental health services POMH-UK Topic 17b: Use of Depot/LA antipsychotic injections for relapse preventions POMH-UK Topic 9d: Antipsychotic prescribing in people with learning disability National Clinical Audit of Psychosis 2019/20 (EIP)

National Confidential Inquiries:

- CAMHS
- National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)

The national clinical audits and national confidential inquiries that EPUT participated in during 2019/20 are as above.

The national clinical audits and national confidential inquiries that EPUT participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of that audit or inquiry:	
National Clinical Audits **POMH - Prescribing Observatory for Mental Health*	No. of cases submitted as a % of the number of registered cases required by the terms of the audit/ inquiry
National Audit of Care at the End of Life Round 2 (NACEL)	100% of required cases had information provided to national organisers
National Sentinel Stroke National Audit Programme Round 6 (SSNAP) 2019/20	Data collection is on-going and continuous
UK Parkinson's Audit 2019	100%
National Audit of Cardiac Rehabilitation (NACR)	Data collection is on-going and continuous
National Asthma and COPD Audit Programme (NACAP)	Data collection is on-going and continuous
National Audit of Inpatient Falls (NAIF) - National Falls and Fragility Audit Programme (FFFAP)	100% of required cases had information provided to national organisers
National Diabetes Foot Care Audit Round 5 (NDFA) 2019/20	Data collection is on-going and continuous
POMH-UK Topic 19a : Prescribing for depression in adult mental health services	100% of required cases had information provided to national organisers
POMH-UK Topic 17b : Use of Depot/LA antipsychotic injections for relapse preventions	100% of required cases had information provided to national organisers
POMH-UK Topic 9d : Antipsychotic prescribing in people with learning disability	100% of required cases had information provided to national organisers.
National Clinical Audit of Psychosis 2019/20 (EIP)	100% of required cases had information provided to national organisers

The reports of nine national clinical audits were reviewed by EPUT in 2019/20 and we intend to take the following actions to improve the quality of healthcare provided (examples listed)

NACEL 1

- Complaints related to EoLC to be quarterly reported to EPUT wide EoLC Group
- Care of the Deceased Patient Guideline revised to include domiciliary teams. Information included in the leaflet relating to Last Days of Life
- Tools/prompts to recognise and provide palliative care for patients whose recovery is uncertain (e.g. AMBER Care Bundle)
- Processes to create personalised recommendations for a person's clinical care in a future emergency (e.g. ReSPECT)
- Opportunities for staff to reflect on emotional aspects of their work (e.g. Schwartz rounds)
- Guidelines for referral to 'Pastoral care/Chaplaincy team'
- Guidelines to promote dignity evidenced within the EoL Care Guideline around holistic individualised care with dignity and compassion
- End of Life Care Clinical Lead developed a leaflet to be included in EPUT wide Induction
- Department of Work and Pensions (DWP) leaflet 1027, 'What to Do After a Death in England and Wales' included in EoL and Bereavement leaflets
- Carers are provided with information on bereavement services

SSNAP Round 5

- Working relationship between CICC and Essex ESD Team to be robust
- Team to ensure timely submission of complete data set to SSNAP
- Close working relationship with Beech Ward (St Margaret's Hospital) and West Essex ESD Team and timely submission of complete data set sent to SSNAP
- Project Group to contact SSNAP regarding incorrect patient data allocation

NAIC 2018

- IT issues at CICC to be resolved; relocation from CICC to Rochford site and training will solve the access problems to SystmOne
- More feedback to be collected from service users; PREM to be completed in CICC, MNC, SWIFT service and ESD teams
- Review the Caseload for Home based teams; Review of the therapy caseload in June

NDFA Round 4

- Provide faster expert first assessment in SE and SW Essex Team
- Work with CCG to increase accuracy and appropriateness of referral from General Practice
- Discuss findings at the Diabetes network meetings
- Promote timely electronic referrals
- Implementation of the Hot Foot tool (System wide stratification tool for referral of urgent foot problems)

POMH Topic 18a

- Clinicians to ensure all necessary documentation including discussion with the patient and/or carers completed for off label prescription and to discuss in the annual review
- Clinicians to make sure all patients on Clozapine have annual general physical examination with BP, body weight, glycemic control and plasma documented on notes
- Physical Health forms in Mobius and Paris to be updated/modified to record annual checks
- Pharmacy to ask CCG's to remind GP's to add Clozapine information to Summary Care Record (SCR)

POMH Topic 6d

- Inpatient service ward managers to review existing processes to ensure reviews take place
- Community Deputy/Associate Directors with responsibility for community services to initiate with Team Managers/Leads a review of processes in depot clinics/ administration to enable regular monitoring of physical health to take place
- Inpatient service ward managers to review use of checklists or side effect rating scales (physical health monitoring tool for patients on psychotropic medication)
- Community Deputy Directors/ Team Managers to work with community team managers /leads to ensure Lunsers checklists or other rating scales as part of depot clinic/ depot administration processes incorporated into clinical reviews.

POMH Topic 7f

- Community team managers/leads review of processes and availability of equipment to enable regular monitoring of physical health
- Patients are reviewed with checks undertaken and recorded
- Use of checklists or rating scales as part of physical health clinic administration processes
- Feedback to NPSA re current information packs to patients to be reviewed
- NPSA packs to be re issued to all community clinics and re-order packs when low

POMH Topic19a

- Comprehensive treatment histories to be undertaken and clearly documented for all patients referred into EPUT services, to include any comorbid conditions, alcohol and substance use, physical and psychiatric disorders
- Crisis/care plans for patients with depressive illness to have potential triggers/ stressors identified with strategies identified incorporated within the patient's management plan
- Annual reviews undertaken and recorded for patients managed long term by the CMHT; including assessment of symptoms, severity and frequency of their depressive episodes, responses, adherence and side effects to medication

NCAP EIP Spotlight Audit

- All service users allocated to care co-ordinator within 48 hours of referral acceptance
- Care co-ordinator to make contact within 12 days and agree a plan for further engagement
- Conduct gap analysis and discuss results with commissioners to agree an approach to address any shortfall in family interventions
- Obtain feedback from service users/ families on hesitance to receive family interventions

- Look at adaptations that can be made to interventions to accommodate the feedback
- Revisit the option of family interventions with each service user and their family
- Ensure that teams have sufficient staff trained to deliver family interventions
- All service users to have a full physical health assessment based on the Lester Tool
- Service users to receive annual physical health check if in the service for >1 year
- Physical health data to be shared with service user's GP
- Team now has 2 x Wellbeing Clinics which will increase compliance
- Team to have sufficient equipment to undertake physical health checks
- Systems and processes in place ensuring that clinical staff identify triggers for physical health screening and provide interventions appropriately
- Electronic tools available for staff to collect outcome measures for HoNOS, DIALOG, QPR
- Operational managers to ensure that care coordinators carry out a baseline and subsequent score every six months for at least two of the EIP outcome measures

(Note: All national clinical audit reports are presented to relevant Quality and Safety Groups at a local level for consideration of local action to be taken in response to the national findings.)

The reports of 28 local clinical audits were reviewed by the provider in 2019/20, and EPUT intend to take the following actions to improve the quality of healthcare provided (examples only are listed)

- Achieve 100% compliance in notifying relative / carer / NOK on each episode of seclusion
- Medical and multidisciplinary reviews to take place in line with policy requirements
- Relevant paper work to be completed by staff with scanning ability
- Care plans to include specific care requirements during each episode of seclusion
- Task and Finish Group convened to support Longview in achieving overall compliance
- MH Inpatient Safety and Quality Group to work with individual Teams
- Monthly data submission to Clinical Audit Department from all adult MH to be consistent
- Restrictive Practice Grp members to advise on terminology and consider raising awareness of BSP's and potential use across wider practice areas
- Staff competencies and training in end of life care
- SystmOne review of end of life care data recording, templates and care plans
- Redesign of last days of life care plan to include robust training and implementation plan
- Seek assurance from our partners and learn from system approaches to care
- Ensure staff record information given to patients
- Provide process for staff to ensure patient handheld records of administration of medications scanned into SystmOne following their death for future audit/review
- Audit/review of patient's medication charts and symptom management post death
- Project lead/ audit team liaise with business analysis / performance team re finance data
- ECG's carried out and recorded as routine on admission and repeated quarterly
- Debrief arranged, followed through and document following each episode of RT
- Ensure physical observations documented; document refusal on Datix/ Nursing shift noted
- Standardisation of EoL care across services to update systems to record DNACPR status
- Ensure DNACPR is included in End of life training
- Clinical supervision to ensure all EOL patients on caseloads have a DNACPR in place

- Ensure DNACPR reviewed for all patients admitted to community hospital for both step down and step up beds
- Raise awareness in medical teams to complete the delirium screening tool on admission
- The medical team on Roding/ Kitwood wards to use inpatient admission assessment form
- Delirium screening tool to be added to SystmOne electronic records
- Staff to screen all patients on admission for continence problems using EPUT screening tool and if applicable, complete full continence assessment form, and record on SystmOne
- Clear documentation that a medication review for falls risk has been carried out
- Nursing and therapy staff to be reminded to do lying and standing BP
- CHS Nursing staff to document falls advice given to patients, relatives/ carers
- Ensure relevant records completed and updated as required by the Record Keeping Policy
- Rainbow Ward manager to address lack of carer involvement / crisis planning in care plans
- Team Managers to address issues relating to involvement of carers and Crisis planning through supervision with their staff teams
- MH Inpatient Safety and Quality Group to work with individual Teams (Gosfield, Grangewaters, Ipswich Road, Kelvedon, Peter Bruff, Stort and Hadleigh)
- Ward level Audit findings to be shared with respective team at Team Meetings for discussion and team level consideration on how to improve their performance
- Monthly dashboard discussed as standing agenda item at monthly Community Services Safety and Quality Group meeting

2.2.3 Clinical Research and Innovation

We offer opportunities for patients and staff to take part in research studies relevant to them, enabling us to support the NHS to improve the current and future health of the population together with providing an evidence base for ongoing better healthcare. EPUT is committed to being a research active organisation providing a balanced portfolio of interventional, observational, large scale surveys, commercial and non-commercial studies across Essex.

The total number of patients receiving and staff delivering relevant health services provided or sub-contracted by EPUT in 2019/20 that were recruited during that period to participate in research approved by a Research Ethics Committee and the Health Research Authority (HRA) was 669. This number of recruits was from participation in 33 research studies opened to participation at EPUT in 2019/20.

Our research portfolio 2019/20 included the National Confidentiality Inquiry into Suicide and Safety in Mental Health (NCISH), recruiting 42 participants, and suicide by middle-aged men study, recruiting 6 participants.

EPUT is aligned with the National Institute for Health Research (NIHR) Clinical Research Network (CRN) North Thames (NT), which provides regional support for researchers and funds a number of EPUT research delivery staff to run studies on the NIHR CRN portfolio, a database of high quality peer reviewed clinical research studies meeting CRN eligibility criteria and expected to lead to significant changes in the NHS within five years.

EPUT continues to collaborate locally with Anglia Ruskin University (ARU), University of Essex (UoE), University of Hertfordshire, University of East Anglia (UEA), University of Bedfordshire and acute Trusts through University College London Partners (UCLP), the Eastern Academic Health Science Network (EAHSN) and the NIHR North Thames Applied Research Collaborative (ARC).

In 2019/20 we have submitted 2 NIHR Research for Patient Benefit (RfPB) grants as follows:

- The development of a patient and public involvement framework for acute mental health inpatient settings – collaborating with UoE
- Implementing a new specialist community mental health team for preconception advice for women with severe mental illness (SMI) - collaborating with RAND Europe

EPUT is working on a partnership research proposal with NIHR to fund the commissioning of a joint project between adult health and social care organisations in Camden, Essex and Edinburgh to promote and evaluate Family Group Conferencing. EPUT is supported by Professor Martin Webber at the University of York with whom we have developed a close alliance following successful completion of the evidence-informed social intervention research study based in the psychosis service pathways known as 'connecting people'.

In February 2020 EPUT commenced the one year ODESSI research trial of the newly delivered treatment in Thurrock known as Peer Open Dialogue (POD); the trial is being conducted in close association with UCL and will consider how POD compares to 'Treatment as usual'. Research in Finland, where it originated, has shown that patients who were under POD needed significantly fewer admissions and in some cases came off their medication and remained stable, for example patients with psychosis.

2.2.4 Goals agreed with Commissioners for 2019/20 (CQUINs)

The CQUIN (Commissioning for Quality and Innovation) payment framework aims to support a cultural shift towards making quality the organising principle of NHS services, by embedding quality at the heart of commissioner-provider discussions. It continues to be an important lever, supplementing Quality Accounts, to ensure that local quality improvement priorities are discussed and agreed at Board level within and between organisations. It makes a proportion of the provider's income dependent on locally agreed quality and innovation goals.

A proportion of EPUT's income (1.25% of contract value) in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between EPUT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. ***In light of the Covid-19 pandemic the Commissioners have stated that they will be making payments for all the 2019/20 CQUINs.***

Our CQUIN programme for 2019/20 included schemes negotiated with commissioners across the areas in which we were commissioned to operate services. The CQUIN programme consisted of mainly national schemes and valued at just under £3 million which represents 1.25% of contract

value for EPUT. This compares to the 2018/19 CQUIN programme which represented 2.5% of contract value equating to just under £6 million. Although these CQUINs were nationally mandated, the quarterly milestones Trusts are expected to meet on the journey to achieving the final CQUIN requirement were agreed locally. This supported the need for different Trusts to work in different ways over the duration of the CQUIN, while working towards a common goal.

Our CQUIN programme included:

- staff flu vaccinations
- alcohol and tobacco screening
- alcohol and tobacco - tobacco brief advice
- alcohol and tobacco - alcohol brief advice
- 72hr follow up post discharge
- mental health data quality - quality maturity index
- mental health data quality – interventions
- use of anxiety disorder specific measure IAPT
- three high impact actions to prevent hospital falls
- six month review for stroke survivors
- healthy weight in adult secure mental health services
- tier four CAMHS staff training
- provision of a catheter care passport (local CQUIN agreed with South Essex Community CCG)

Our dedication to continually improving services endures; and teams have proven to be committed to and adept at managing resources to meet the stretching goals for quality improvement within the national CQUINs that have been set by commissioners in previous years as well as locally negotiated schemes.

2.2.5 Stretching goals for quality improvement – 2020/21 CQUIN programme for EPUT

Commissioners have incentivised us to undertake 15 CQUIN projects in 2020/21. The value of our 2020/21 CQUIN scheme will equate to 1.25% of Actual Annual Contract Value, as defined in the 2020/21 NHS Standard Contract.

The schemes agreed for 2020/21:

- CCG2: Cirrhosis and fibrosis tests for alcohol dependent patients
- CCG3: Malnutrition screening
- CCG4: Oral health assessments
- CCG5: Staff flu vaccinations
- CCG6: Use of anxiety disorder specific measures in IAPT
- CCG7a: Routine outcome monitoring in CYP and community perinatal MH services
- CCG7b: Routine outcome monitoring in community MH services
- CCG8: Biopsychosocial assessments by MH liaison services
- CCG11: Assessment, diagnosis and treatment of lower leg wounds
- CCG12: Assessment and documentation of pressure ulcer risk

- CCG17a: Data security protection toolkit compliance
- CCG17b: Reported access to NHS mail
- PSS2: Adult Secure healthy weight
- PSS3: CAMHS Tier 4 Needs Formulations
- PSS5: Outcome reporting in Perinatal services (Mother and Baby Unit)

All national CQUINs have now moved over to using denominator and numerator figures to calculate percentages of achievement, measured against a minimum and maximum achievement threshold.

Note on the impact of Covid-19:
Commissioners have confirmed that they are standing down 2020/21 CQUINs until July 2020 as a result of the Covid-19 pandemic. EPUT will receive the value of the 2019/20 CQUIN scheme in full.

2.2.6 What others say about EPUT

Care Quality Commission

Essex Partnership University NHS Foundation Trust (EPUT) is required to register with the Care Quality Commission and its current registration status is registered with conditions. EPUT has the following conditions on registration in relation to Clifton Lodge and Rawreth Court (Nursing Homes):

- A requirement to have Registered Managers
- A limitation on the number of beds provided by the services

Essex Partnership University NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2019/2020.

The Care Quality Commission completed two inspections during 2019/2020:

CQC Focused Inspection (April 2019)

The CQC completed an unannounced inspection of Adult Acute Inpatient services on 3 and 11 April 2019. The CQC completed the inspection following a number of concerns raised by various sources to the CQC about care and treatment of individuals on acute wards. The concerns included how staff managed patient risk and how staff supported patients when they were ready to be discharged from hospital.

The inspection was undertaken on seven wards across three sites:

Basildon Mental Health Unit (Basildon Assessment Unit, Grangewaters Ward, Thorpe Ward)
The Derwent Centre (Chelmer Ward, Stort Ward)
The Linden Centre (Finchingfield Ward, Galleywood Ward)

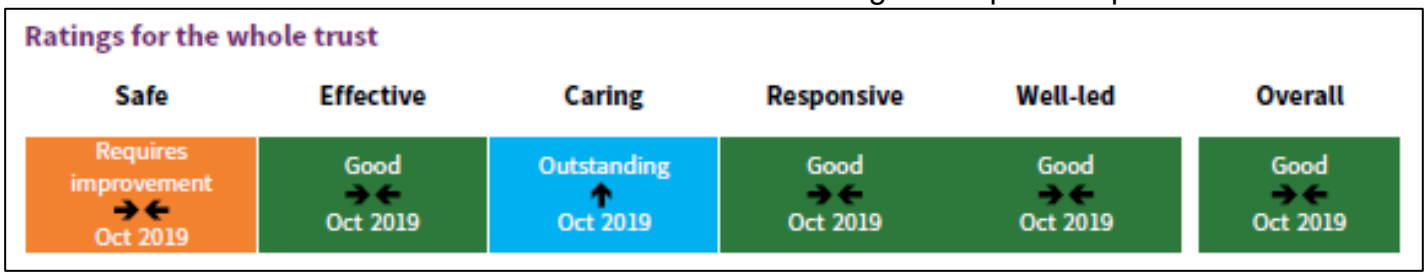
The report confirmed that the inspection was not rated and did not impact the overall rating of EPUT. The report provided positive assurance in relation to the reasons why the inspection was completed, including:

- Staff worked in collaboration with patients to plan their discharge and started discharge planning at the right time. The CQC saw examples of robust and detailed discharge plans.
- EPUT employed staff specifically to support patients moving on from hospital and the CQC saw evidence of staff supporting patients with visits to the community in relation to their housing.
- Staff completed detailed and individualised risk assessments and care plans with patients and patients were involved in creating 'my care, my recovery' plans to manage their own risks.
- All staff spoken with, including agency staff, took time to make themselves aware of patient risks and needs by looking at care notes and receiving thorough handovers.

However, the report identified five 'Must Do' and 2 'Should Do' actions that EPUT needed to address. An action plan was developed and identified 69 individual internal actions. As at the end of December 2019, all actions were addressed and therefore closed.

CQC Well Led Inspection (July-August 2019)

The CQC completed an unannounced inspection of six core services within EPUT over a three day period commencing 29 July 2019 and carried out the planned 'Well Led' inspection 19 – 22 August 2019. The report confirmed that EPUT had upheld the overall rating of 'Good' and had achieved a rating of 'Outstanding' for the Caring domain and 'Good' in the Effective, Responsive and Well-Led domain. The 'Safe' domain has received a rating of 'Requires Improvement':



This is an improvement from the previous rated inspection in April – May 2018 with one domain (Caring) moving from 'Good' to 'Outstanding'. The ratings for the other four domains have remained the same.

During this inspection the CQC visited the following core services:

- End of life care
- Child and adolescent mental health wards
- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems
- Specialist mental health services – substance misuse

Out of the six core services inspected, three (50%) have improved, two (33%) have remained the same and one (17%) has declined. CAMHS and End of Life Service have improved to an overall 'Outstanding' rating, with End of Life moving from 'Requires Improvement' to 'Outstanding'

overall.

The CQC report confirmed that inspectors found a number of examples of outstanding practice across EPUT:

- They identified that staff respected and valued patients as individuals and empowered them to be partners in their care.
- Staff promoted people's dignity and offered care that was compassionate, supportive and person centred and staff went the extra mile to care for patients and feedback from families and carers indicated that the care exceeded their expectations.
- It was identified that staff were committed to working in partnership with patients, and their carers to achieve positive outcomes, they made this a reality for each person and staff consistently displayed EPUT values in the care they delivered.
- Staff valued the emotional and social needs of their patients and embedded them in care and treatment. For example in end of life services, staff had gone food shopping for the relative of a person who had lost weight because they would not leave home in case their relative died whilst they were out. Staff made such offers effortlessly and did so with the sole aim of ensuring the people they looked after, and those important to them, were cared for.
- The CQC identified that staff recognised that patients need to have access to, and links with, their advocacy and support networks in the community, and they supported patients to have easy access to independent advocates.
- Staff involved patients and carers in risk assessment and care planning to ensure treatment addressed patient need, in a way that was preferable to them.
- Staff demonstrated a strong person-centred culture and inspired to offer care that was kind and promoted dignity.
- Leaders valued the strong, caring and supportive relationships formed between staff, patients and relatives.
- On the children and adolescents' wards staff identified areas on the ward where patients could express their feelings including via blackboards and white boards. Staff issued patients with a resource box on admission whereby the patients could personalise the content of their resource box and use the chosen items when upset or anxious. Patients had led the redesign of an area of the ward and Staff and patients now use this area for de-escalation and patients refer to this area as 'the snug'. Patients had completed 'patient reported outcome measures', which led to meaningful involvement and co-production. The areas covered in the patient reported outcome measure were: 'having hope', 'having an equal say in my care', 'being a part of improving the service', 'understanding my mental health and how to manage it' and 'feeling good about myself'
- EPUT valued feedback on the services they received from patients and carers. Staff monitored responses and took steps to change services based on feedback provided, to overcome obstacles to delivering care. Staff empowered people who used the services to have a voice and to realise their potential.

Community Health Services (CHS):

Community end of life care	Good → ← Oct 2019	Good ↑ Oct 2019	Outstanding ↑↑ Oct 2019	Outstanding ↑ Oct 2019	Good ↑ Oct 2019	Outstanding ↑↑ Oct 2019
Overall*	Good → ← Oct 2019	Good → ← Oct 2019	Outstanding ↑ Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019

Mental Health:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Requires improvement → ← Oct 2019	Requires improvement ↓ Oct 2019	Requires improvement → ← Oct 2019
Long-stay or rehabilitation mental health wards for working age adults	Good ↑ Oct 2019	Requires improvement ↓ Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
Wards for older people with mental health problems	Requires improvement ↓ Oct 2019	Good ↑ Oct 2019	Good → ← Oct 2019	Requires improvement ↓ Oct 2019	Good → ← Oct 2019	Requires improvement ↓ Oct 2019
Child and adolescent mental health wards	Good ↑ Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑ Oct 2019
Substance misuse services	Requires improvement → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement → ← Oct 2019
Overall	Requires improvement → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019

The report also contained a number of positive themes throughout the inspection, including where EPUT:

- Addressed many of the issues identified at the last inspection in May 2018
- Increased the oversight, monitoring and recruited leaders in service such as end of life care and substance misuse
- Staff confidently described knowledge of risk areas in services such as acute mental health wards, they described areas of risk and how they mitigated it to increase patient safety
- Made improvements to medicines management processes and resolved issues with stock rotation
- Staff ensured that they applied for deprivation of liberty safeguard applications in good time and assessed patient's mental capacity where appropriate
- Leadership was strong and had a clear sense of direction. The leadership and governance of EPUT promoted the delivery of high quality, person centred care
- Took opportunities to improve services and provide better care and outcomes for people using services
- Had a clear and robust governance structure to oversee performance, quality and risk.
- Used a variety of tools to monitor and assess risk
- Staff assessed the needs of patients in a timely way and used information to develop holistic, person centred care plans
- Staff cared for patients in line with national guidance and best practice
- Staff had access to regular supervision and specialist training
- Staff respected and valued patients as individuals and empowered them to be partners in their care.
- Valued feedback on the services they received from patients and carers

The CQC inspection report identified 4 key areas which EPUT must improve in:

- Learning lessons
- Equalities
- Data quality
- Restrictive practice

The report identified 18 'Must Do' and 29 'Should Do' actions that EPUT needed to address. An action plan was developed and identified 223 individual internal actions.

As at the end of March 2020, a total of 193 internal actions have been reported as completed (87%) which confirms that progress continues to be made with the actions agreed to address the findings of the inspection.

2.2.7 Data quality

Our ability to have timely and effective monitoring reports, using complete data, is recognised as a fundamental requirement in order for us to deliver safe, high quality care. The Board of Directors strongly believes that all decisions, whether clinical, managerial or financial, need to be based on information which is accurate, timely, complete and consistent. A high level of data quality also allows us to undertake meaningful planning and enables services to be alerted to any deviation from expected trends.

Internal audit carried out a data quality audit on randomly selected KPIs across EPUT during October 2019 and advised there was 'moderate assurance' on the controls that were in place.

EPUT achieved an average Data Quality Maturity Index score of 90.1% for Q1, 93.8% for Q2, 96.5% for Q3, and 93.7%* for Q4 compared to the NHSI Oversight Framework target of 95%. The final Q4 figure is yet to be published. *Q4 figure below target due to introduction of seven new indicators in March 2020.

EPUT's Information Governance Data Security and Protection Toolkit (DSPT) overall score for 2019/20 was compliant across all assertions.

Essex Partnership University NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission.

Essex Partnership University NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number was:

- 99.8% for admitted patient care (Apr 19 – Mar 20)
- 100% for outpatient care (Apr 19 – Mar 20)
- N/A for accident and emergency care

The percentage of records in published data, which included the patient's valid General Medical Practice Code was:

- 96.0% for admitted patient care (Apr 19 – Mar 20)
- 99.12% for outpatient care (Apr 19 – Mar 20)
- N/A for accident and emergency care

We will be taking the following actions to improve data quality:

- Awareness raising throughout EPUT of importance and impacts of data quality

2.2.8 Learning from deaths

1. Background and context

The effective review of mortality is an important element of our approach to learning and ensuring the quality of our services continually improves. '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' was published by the NHS National Quality Board in March 2017 and set out extensive guidance for Trusts in terms of approaches to reviewing mortality, learning from deaths and reporting information. Its aim was to help initiate a standardised approach that would evolve as national and local learning in respect of mortality review approaches increases.

During 2019/20 we continued to strengthen our approaches to mortality review in line with national guidance. We take every death of a person in our care very seriously. We expect our staff to be compassionate and caring at all times. The aim of reviewing the care provided to people who have died is to help improve care for all our patients by identifying whether there were any problems, understanding how and why these occurred and taking meaningful action to implement any learning. The reporting of mortality data is part of this review process and continues to be an evolving, challenging, process across the whole NHS both nationally and locally, to gather and analyse the data. The review of mortality and reporting of data will, therefore, continue to evolve over time to become more meaningful as we learn from our own experiences and those of other NHS Trusts.

As Trusts have been able to determine local approaches to undertaking mortality reviews and defining deaths which should be in scope for review, mortality data is not comparable between Trusts. As such, we use data locally to monitor the review of mortality and to assist in the ultimate aim of learning from deaths and improving the quality of services. Due to the nature of the services we provide, there will be a number of deaths that will be 'expected'. Nevertheless, we are always mindful that even if the person's death was 'expected', their family and friends will feel deeply bereaved by their loss, and we strengthened our processes to support those people. We undertook a review of a sample of 'expected' deaths to identify any learning on the quality of the care we provide to people at the end of their lives.

2. Explanatory notes

* Please note, all figures stated in the section below relate to deaths 'in scope' for mortality review. Deaths 'in scope' are defined in EPUT's Mortality Review Policy as all deaths:

- That have occurred within our inpatient services (this includes mental health, community health and learning disability inpatient facilities and within the prison)
- In a community setting of patients with recorded learning disabilities
- Meeting the criteria for a serious incident, either within our inpatient services or in a community setting

and

- Any other deaths of patients in receipt of our services not covered by the above that meet the Grade 2 case note review criteria. These are identified on a case-by-case basis and include:
- Any patient deaths in a community setting which have been the subject of a formal complaint

and/or claim by bereaved families and carers

- Any patient deaths in a community setting for which staff have raised a significant concern about the quality of care provision
- Any deaths of patients deemed to have a severe mental illness in a community setting. For the purposes of this policy, this is any patient with a psychotic diagnosis (schizophrenia or delusional disorder) recorded on electronic clinical record systems that are recorded as having been under the care of EPUT for over two years
- Any deaths identified for thematic review by the Mortality Review Sub-Committee (including a random sample of 20 expected inpatient deaths per annum). Please note, information relating to these deaths is reported separately in section 9 below

Figures are only stated for Q1 – Q3 of 2019/20. Information in relation to Q4 will not be reported to the Board of Directors until June 2020. Q4 2019/20 information will, therefore, be reported in EPUT's Quality Account for 2020/21. The reporting schedule was the same last year; and, therefore, information relating to Q4 2018/19 is reported in this Quality Account.

At the time of preparing this Quality Account, the thematic reviews and expected inpatient death review sample for 2019/20 are in the process of being defined and commissioned and figures are therefore not included within the data below. Information in relation to thematic reviews of 2019/20 deaths will therefore be reported in EPUT's Quality Account for 2020/21. Information relating to the thematic reviews of 2018/19 deaths (which have been undertaken during 2019/20) is included in this Quality Account.

The figures contained in this section of the Quality Account are consistent with the agreed approach for reporting quarterly information to the Board of Directors and are reported as at 4 March 2020.

3. National Guidance Ref 27.1 - Number of deaths in scope for mortality review

2018/19 Q4: The number of deaths within scope for mortality review in Q4 2018/19 was 65.

2019/20 Q1 – Q3: During 2019/20 (Q1 – Q3*), 162 EPUT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Q1	53	Q2	56	Q3	53

4. National Guidance Ref 27.2 - Number of these deaths subjected to case record review/investigation

2018/19 Q4:
By 4 March 2020, three Grade 2 case note reviews and 16 Grade 4 Serious Incident investigations have been carried out in relation to 19 of the Q4 2018/19 deaths. Note: in addition one case record review and zero Serious Incident investigations are in progress.

For the full year 2018/19, by 4 March 2020 12 Grade 2 case note reviews and 69 Grade 4 Serious Incident investigations have been carried out in relation to 81 of the total of 235 2018/19 deaths. Note: in addition seven Grade 2 case record reviews and zero Grade 4 Serious Incident investigations are in progress.

2019/20 Q1 – Q3:
By 4 March 2020, two Grade 2 case record reviews and 41 Grade 4 Serious Incident investigations have been carried out in relation to 43 of the Q1 – Q3 2019/20 deaths included above.

Note: in addition to the above, three Grade 2 case record reviews, one Grade 3 Critical Incident review and 13 Grade 4 Serious Incident investigations are in progress.

The number of deaths in each quarter 2019/20 for which a case record review or an investigation was carried out (including those in progress) was:

Q1	18	Q2	27	Q3	15

The grade of review for 41 of the 162 deaths is under determination.

Explanatory note:
- 61 closed reviews at Grade 1 (do not fall within the category of case note reviews/ investigations)
- 43 closed reviews at Grade 2 - 4 (case note review/investigation)
- 17 reviews in progress at Grade 2 - 4 (case note review/investigation)
- 41 final grade of review still under determination

Total = 162 deaths

5. National Guidance Ref 27.3 - Deaths judged more likely than not to have been due to problems in care

2018/19 Q4:
- One, representing 1.5%, of the patient deaths during Q4 2018/19 are judged more likely than not to have been due to problems in the care provided to the patient.
- Please note, three reviews are still in progress / a judgement in terms of problems in care is still to be made at the date of preparing this information.
- For the full year 2018/19, by 4 March 2020, six (representing 2.5%) of the patient deaths during the reporting period are judged more likely than not to have been due to problems in the care provided to the patient.

Please note, for the full year 2018/19, a total of 21 reviews are still in progress / a judgement in terms of problems in care is still to be made at the date of preparing this information.

2019/20 Q1 – Q3:
Three, representing 1.8%, of the patient deaths during the reporting period are judged more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:
- zero - representing 0% for the first quarter
- three - representing 5.3% for the second quarter
- zero - representing 0% for the third quarter

Please note, 63 reviews are still in progress or a judgement in terms of problems in care is still to be made at the date of preparing this information.

The above judgements have been estimated using a tool designed locally by EPUT, based initially on the Royal College of Physicians Structured Judgement Review tool/methodology and revised to take account of the tool/methodology published by the Royal College of Psychiatrists in November 2018.

6. National Guidance Ref 27.4 - Examples of learning derived from the review/investigation of deaths judged more likely than not to have been due to problems in care

The following are examples of learning derived from the investigation of deaths judged more likely than not to have been due to problems in care provided to the patient:

- A communication plan, including contact with next of kin, should be agreed prior to a patient's discharge
- Clinical teams must ensure follow up with patients 48 hours after discharge; and undertake a further risk assessment if contact is not achieved
- The Glasgow Coma Scale (GCS) Observations competency should be added to the induction of bank and agency registered nursing staff
- Guidance on the use of high/low and floor line beds should be added to EPUT's Falls Guideline
- A revised bedrail risk assessment form should be uploaded onto the clinical system, including mental capacity questions
- Guidance should be provided to staff completing care plans for patients at risk of ligature. This should explain key elements and minimum standards for consideration within these plans to aid in their formulation and recording
- The Basic Life Support training programme should be reviewed to include identification of all equipment contained in the emergency grab bag to ensure that all staff are familiar with the equipment and how to identify it.

7. National Guidance ref 27.5 - action taken in consequence of the learning above

We have taken the following actions as a result of the examples of learning detailed above:

- Reviewed the processes used for follow up of patients after discharge and introduced new enhanced protocols. These include the community teams undertaking follow up to ensure this occurs on a timely basis as well as actions to take if contact attempts have been unsuccessful. Compliance with the new protocols is monitored to ensure achievement.
- The induction for bank and agency registered nursing staff has been updated to include competence in Glasgow Coma Scale (GCS) Observations.
- Guidance on the use of high/low and floor line beds added to EPUT's Falls Guidelines.
- The bedrail risk assessment form has been revised, including the addition of mental capacity questions, and uploaded onto the clinical system.
- At the time of writing this report, enhanced guidance in terms of care plans for patients at risk of ligature is under development.
- EPUT's Basic Life Support training has been revised to include information in terms of EPUT's emergency grab bags and their contents.

8. National Guidance Ref 27.6 – Impact of the actions described above:

The impact of the example actions described above is as follows:

- The process for following up patients discharged from inpatient units after 48 hours has been

strengthened, including actions to be taken if contact has been unsuccessful. It is anticipated that this will assist the effective discharge of patients successfully into the community with appropriate support

- All bank and agency registered nursing staff are required to be competent in Glasgow Coma Scale (GCS) observations if working within EPUT
- There is clear written guidance for staff enabling them to act appropriately in terms of high/low and floor line beds
- Comprehensive bed rail risk assessments can be undertaken utilising the form available electronically for all clinical staff
- On completion, there will be detailed guidance available for staff in terms of care plans for patients at risk of ligature to ensure care plans are of a high standard
- Via completion of EPUT's Basic Life Support training, all EPUT staff will be familiar with the contents of EPUT's emergency grab bags and thus be able to identify contents and take appropriate action in the event of any emergency

9. Learning from other deaths subjected to mortality review/investigation

We identify any appropriate learning from all mortality reviews undertaken and agree actions irrespective of whether the death has been judged as being more likely than not to have been due to problems in care provided to the patient. Examples of such learning include issues relating to:

- Risk assessment
- Documentation/record keeping
- Communication
- Discharge and assertive follow up
- Disengagement
- Family and carer involvement
- End of life care / physical healthcare

In addition to the individual mortality reviews outlined in the sections above, during 2019/20 we undertook the following thematic reviews of deaths occurring in 2018/19:

- A sample of expected inpatient deaths
- A sample of EPUT's nursing homes patient deaths (Clifton Lodge and Rawreth Court)
- A sample of deaths classified as serious incidents

A review of a sample of deaths of patients diagnosed with a Severe Mental Illness which were not classified as serious incidents occurring in 2018/19 was also underway at the time of writing this report.

The above reviews have resulted in a total of 45 deaths being subjected to overarching thematic review. We have also undertaken an audit of a random sample of 7 deaths closed at Grade 1 review (desktop review).

We have shared the learning from these reviews with teams and our Mortality Review Sub-Committee is overseeing its implementation. Examples of learning and actions being taken as a result include:

- Inclusion of a separate specific end of life care plan on patient's records accessible by all staff involved in decision making for the patient

- Review of record systems to ensure all records are easily accessible on electronic systems
- Ensuring that the discussion and agreement of Do Not Attempt resuscitation (DNACPR) with patient / family is appropriately documented in clinical records as per EPUT guidance
- Exploring further the reasons for transfer of patients from EPUT inpatient units to the acute Trusts in the final phases of their lives to identify whether there is any learning for EPUT in terms of being able to meet the patient's preferred place of death request
- Strengthening communication between the acute Trust and EPUT inpatient units when deaths occur within the acute Trust following discharge from EPUT to ensure timely notification of deaths, thus improving the support that EPUT can offer to bereaved families / carers

10. National Guidance ref 27.7 – 27.9 - Mandated information that will be reported in 2020/21 Quality Account

We are unable to report on the following mandated information in the Quality Account 2019/20 and will report on this in the Quality Account 2020/21:

- The number of case record reviews or investigations finished in 2020/21 which related to deaths during 2019/20 but were not included in the Quality Account for that previous reporting period (Q4 information)
- An estimate of the number of deaths included above which we judge as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this (Q4 information)
- A revised estimate of the number of deaths during the previous reporting period taking account of the deaths referred to in the point above (Q4 information)

Larkwood Ward

A huge thank you to you all for looking after my daughter and being the people to ignite her recovery.

She was a very poorly, sad girl when she came to you and I am now seeing my girl again, trying so hard and taking responsibility, which is all down to you.

Please give my thanks also to the OTs and school and Danielle. What you are able to do is a wonderful and life-affirming change to kids who can't see the light at the end of that tunnel.

My gratitude also for how supportive you have been to me and other family and friends.

2.2.9 National mandated indicators of quality

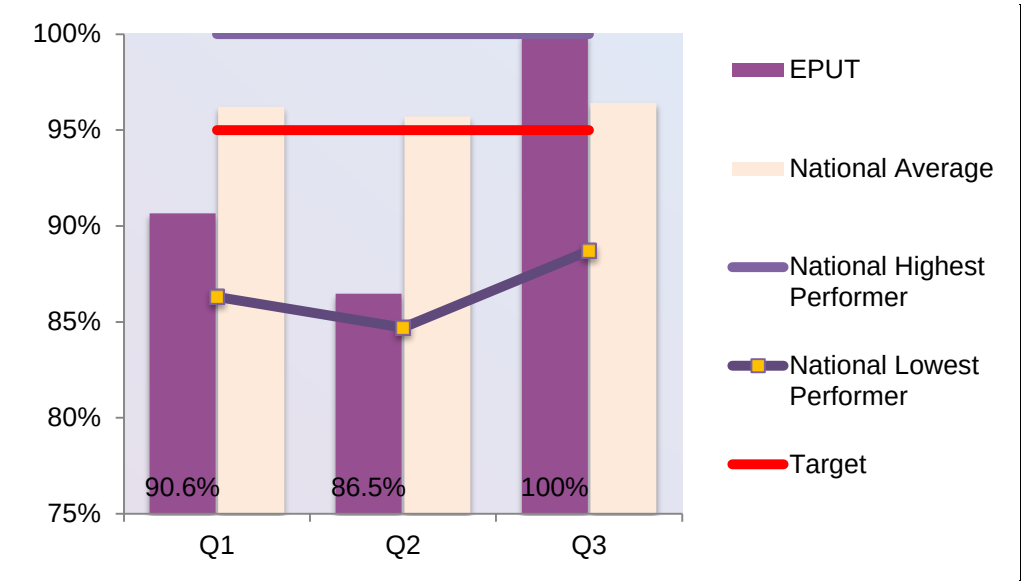
Since 2012/13 NHS Foundation Trusts have been required to report performance against a core set of indicators using data made available to EPUT by NHS Digital. This section outlines these indicators and how we have performed as a Trust along with data for the highest and lowest performing Trusts and the National average, where available.

The information presented has been extracted from nationally specified datasets and as a result can only be reported at an EPUT-wide level.

1. Patients on Care Programme Approach (CPA) followed up within seven days of discharge from psychiatric inpatient stay

This indicator measures the percentage of patients that were followed up (either face to face or by telephone) within seven days of their discharge from a psychiatric inpatient unit.

Data source: NHSD Strategic Data Collection Service (SDCS) – MHPrvCom via NHS Digital
National Definition Applied: Yes



2019/20	Q1	Q2	Q3
EPUT	90.6%	86.5%	100%
National Average	96.2%	95.7%	96.4%
National Highest Performer	100%	100%	100%
National Lowest Performer	86.3%	84.7%	88.7%

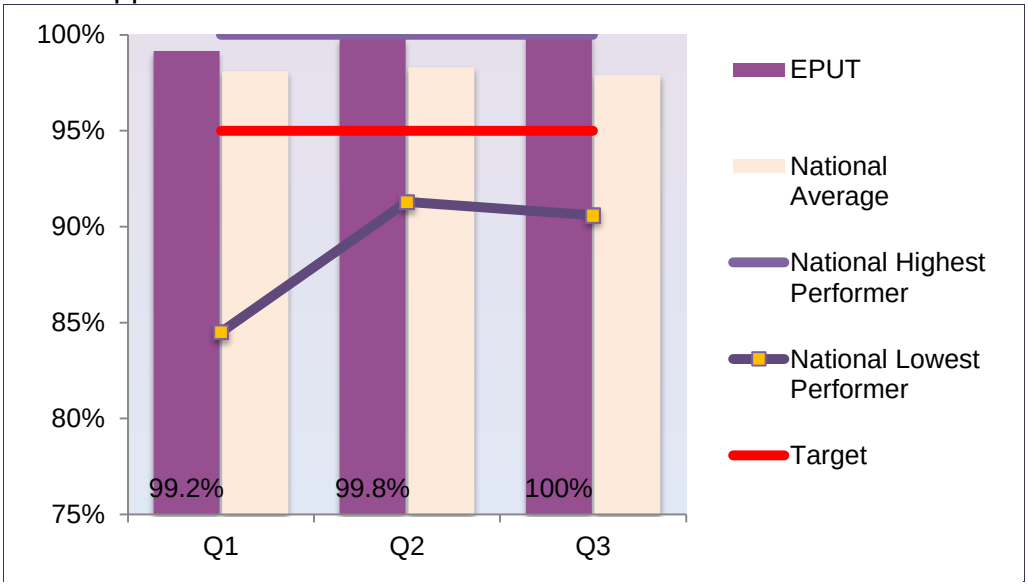
EPUT has achieved this target in Quarter 3 however EPUT failed to achieve the target in Quarters 1 and 2 and performed below the National average for the same period. This was due to a change in internal monitoring to bring indicator construct in line with national constructs. A Rapid Response Action plan was initiated and compliance has been achieved consistently throughout Quarter 3. In Quarter 4 the submission and publication of this National data was suspended due to Covid-19 to release capacity across the NHS to support the response.

We have taken a number of actions to further improve service quality for this indicator including provision of a live dashboard for operational services to self-monitor and enhanced data quality checking with routine reporting. Learning is also disseminated across all appropriate services.

2. Admissions to acute wards gate kept by Crisis Resolution Home Treatment Team

This indicator measures the percentage of adult admissions which are gate kept by a crisis resolution and home treatment team.

Data source: NHSD Strategic Data Collection Service (SDCS) – MHPrvCom via NHS Digital
National Definition Applied: Yes



2019/20	Q1	Q2	Q3
EPUT	99.2%	99.8%	100%
National Average	98.1%	98.3%	97.9%
National Highest Performer	100%	100%	100%
National Lowest Performer	84.5%	91.3%	90.6%

In 2019/20 EPUT consistently surpassed the target of 95% and performs above the National average for each quarter. Performance on this indicator is routinely monitored and reported as part of our Quality and Performance reporting.

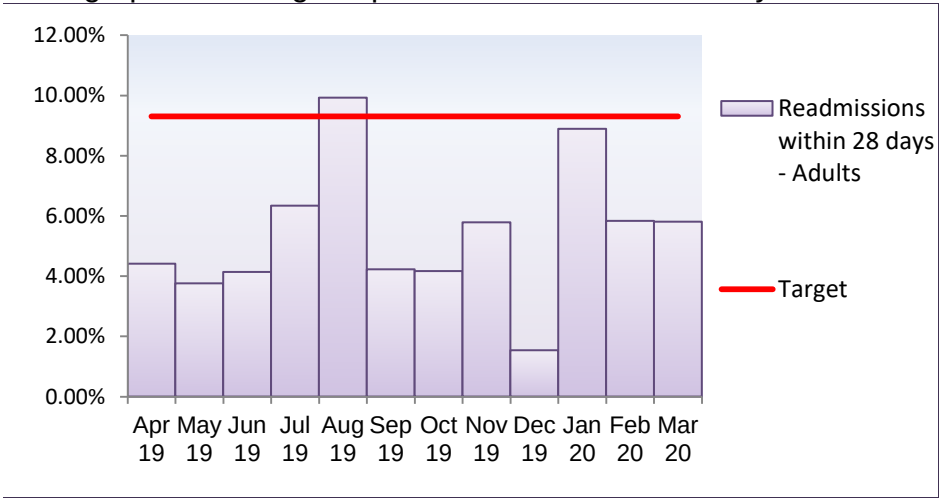
Quarter 4 data is unavailable due to the suspension of this submission and its publications; this submission was paused due to Covid-19 to release capacity across the NHS to support the response.

3. Readmissions

This indicator measures the percentage of adults and older adults who are readmitted to EPUT within 28 days. There is no set national target for readmission rates; therefore the MH benchmarking average has been used by EPUT to set appropriate targets.

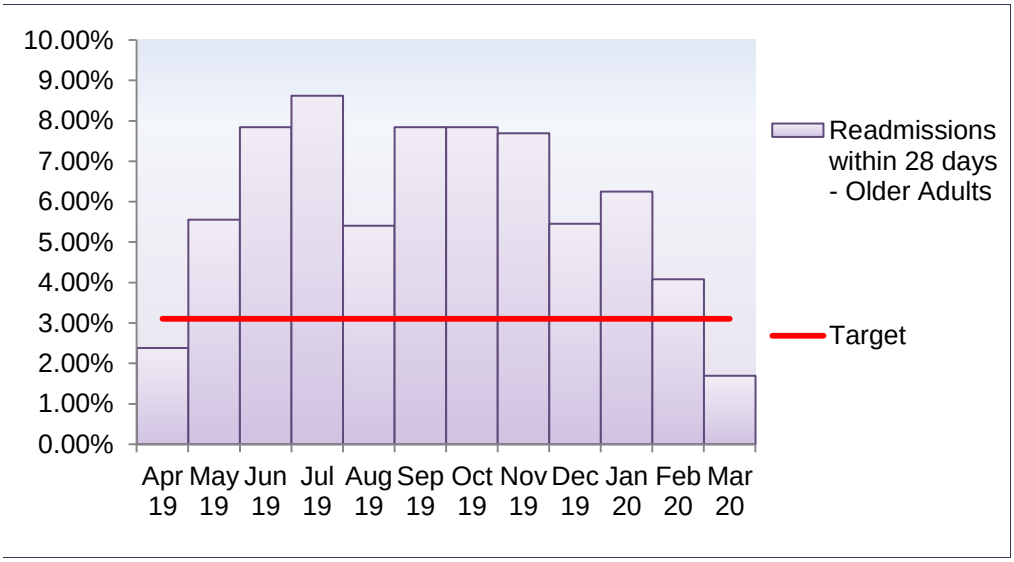
Data Source: EPUT systems (Mobius and Paris)
National Definition applied: Yes

In the graphs below, good performance is illustrated by levels of activity below the target line.



The percentage of adults readmitted within 28 days has performed below the target of less than 9.3% for all months with the exception of a surge in August 2019. In August 2019 performance rose to just above target at 9.9%.

The percentage of older adults readmitted within 28 days has breached the target of less than 3.1% for all months with the exception of April 2019 and March 2020.



In 2019/20 EPUT was consistently below national target of 9.3% for Adults with the exception of one month in August 2019.

In 2019/20 EPUT was almost consistently above the national target of 3.1% for Older Adults.

Analysis has been undertaken to look at why Older Adult readmission rates are above national average and a high proportion of the discharges and readmissions were found to be for acute hospital care.

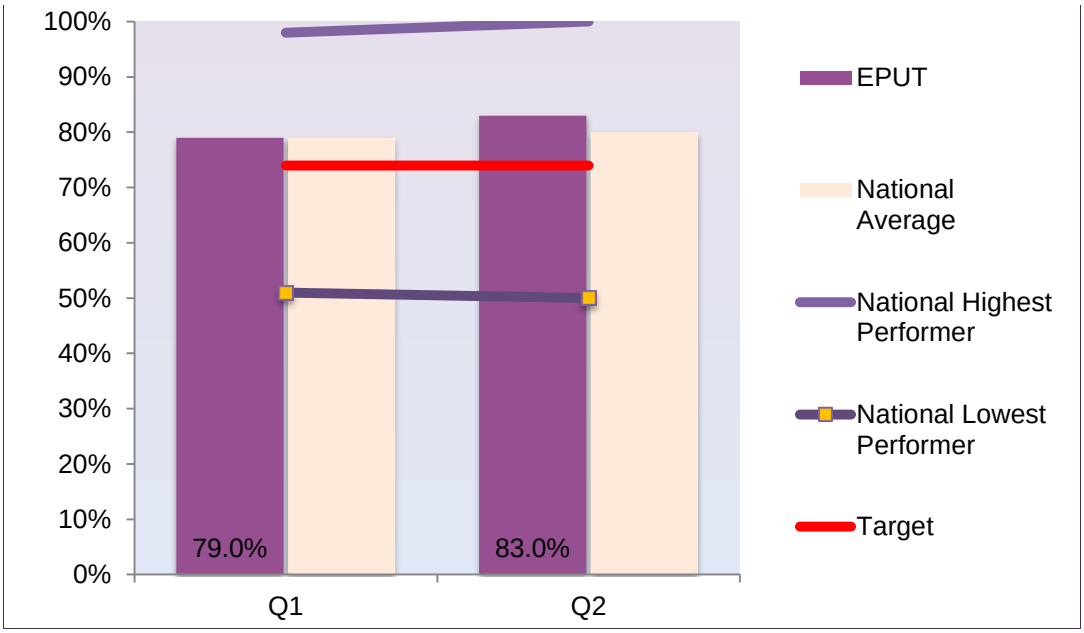
Performance on this indicator is routinely monitored and reported as part of our Quality and Performance reporting.

4. Staff recommended score of EPUT as a place to receive treatment

The Friends and Family Test is available to staff to anonymously record whether they would recommend EPUT to their family or friends, either as a place to work or as a place to receive care. This section details what percentage of staff would recommend EPUT as a place to receive treatment.
The aim of the Staff Friends and Family Test is for all staff to have the opportunity to feed back their views on their organisation at least once per year.

Our staff were able to record their views from 1 April 2019 to 31 March 2020, however please note that responses are not reported for Q3 as this coincides with the National NHS Staff Survey. Due to the Covid-19 outbreak this submission was suspended to release capacity from March 2020 and we therefore do not have Quarter 4 information.

Data source: Staff Friends and Family Test (FFT) survey **National definition applied: Yes**



2019/20	Q1	Q2
EPUT	79%	83%
National Average	79%	80%
National Highest Performer	98%	100%
National Lowest Performer	51%	50%

The above information outlines that EPUT has performed in line and above average in Quarters 1 and 2. The Staff Friends and Family Test (SFFT) is helping to promote a big cultural shift in the NHS, where staff have both the opportunity and confidence to speak up, and where the views of staff are increasingly heard and are acted upon. EPUT produces regular reports following each publication of the survey results and works to introduce measures for improving our scoring.

5. Patient experience of community mental health services

The Care Quality Commission (CQC) conducts an annual survey for clients who have received care from community mental health services in England. In this section you will find the results of the 2019 EPUT survey.

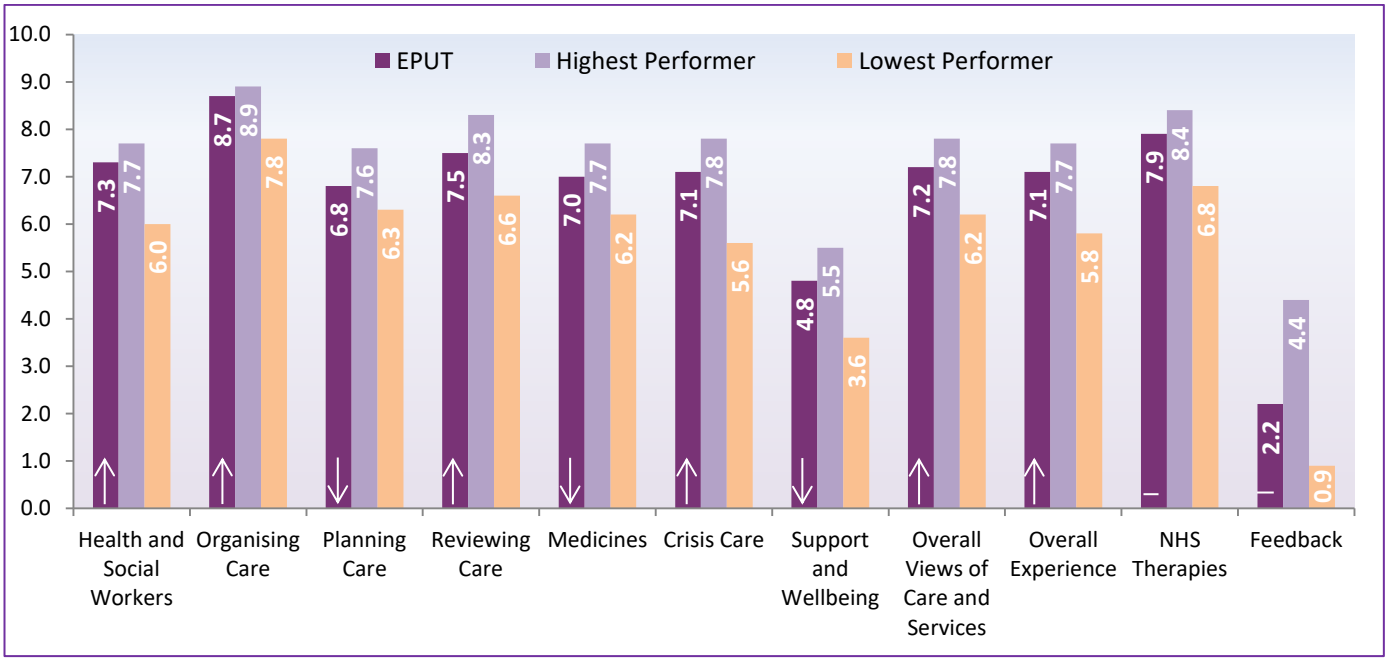
EPUT is continuously working to improve our service and a large part of that work is driven by client feedback, so that we can understand what clients think about their care and treatment.

The survey is commissioned by the CQC and received responses from 12,551 people, a response rate of 27%.

Our 2019 report shows how we scored for each evaluative question in the survey, compared with the lowest and highest Trusts. Scores are shown on a scale of 0 to 10.

Data source: CQC Community Mental Health Services Survey
National Definition Applied: Yes

The questions are split into different domains and a summary of results is provided in the graph below:



Arrows in the above graph have been added to highlight which domains have improved or declined from the 2018 survey results. Comparing the 2018 and 2019 scores, EPUT improved in six domains and declined in three. Two new domains have been added for 2019 and comparison

analysis therefore cannot be undertaken.

A full action plan has been developed to make improvements in all areas below national average and all areas where a decline has been noted.

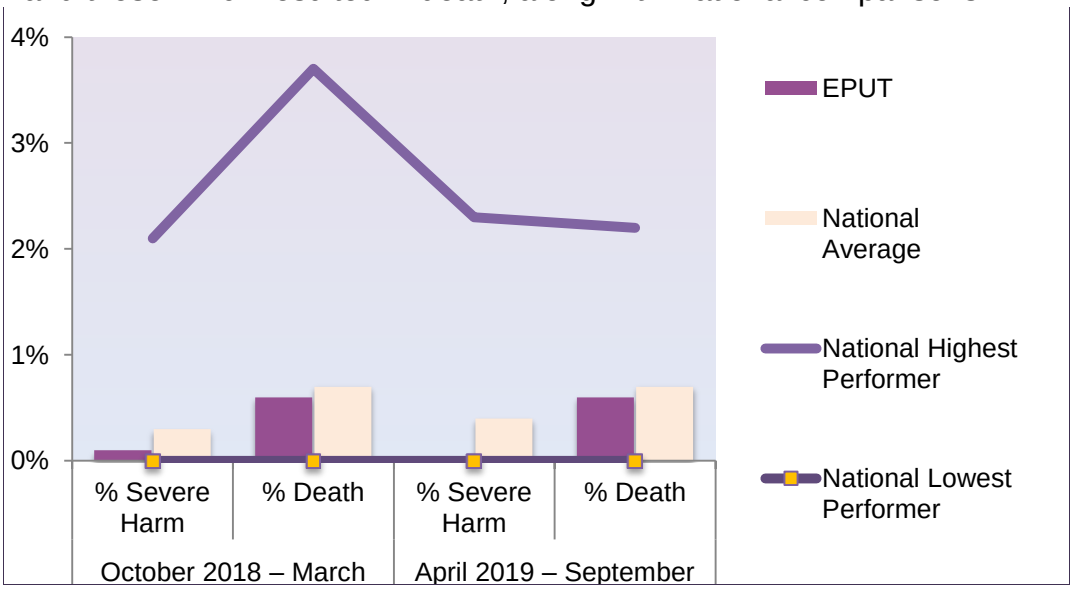
6. Patient safety incidents and the percentage that resulted in severe harm or death

This indicator measures the number of incidents to occur in EPUT and the percentage of those that result in severe harm or death.

Data source: NRLS NPSA Submissions *National definition applied: Yes*

Reporting Dates	1st October 2018 - 31st March 2019 (Published September 2019)			1st April 2019 - 30th September 2019 (Published March 2020)		
	All incidents	Severe harm	Deaths	All incidents	Severe harm	Deaths
EPUT	7,603	5	43	8,170	3	48

The graph below shows the percentage of all incidents we reported to the NRLS that resulted in severe harm and those which resulted in death, along with National comparisons.



2019/20	October 2018 – March 2019			April 2019 – September 2019		
	Incident Rate	% Severe	% Death	Incident Rate	% Severe	% Death
EPUT	70.6	0.10%	0.60%	64.2	0.04%	0.60%
National Average	57.3	0.30%	0.70%	62.9	0.40%	0.70%
National Highest Performer	118.9	2.1%	3.7%	130.8	2.3%	2.2%
National Lowest Performer	14.9	0%	0%	17.2	0%	0%

The above graph and table highlights that EPUT has consistently performed below the national average for patient harm resulting in severe harm or death. EPUT has however performed above

the National average in overall incident rates per 1,000 bed days.

There is robust governance within EPUT to ensure no harm/ low harm rates including benchmarking ourselves against national averages and other Trusts within our cluster group.

We are taking the following actions to improve our incident reporting rates by:

- Training ward managers in the running of their own incident reports for monitoring purposes of their respective area
- Routine reporting of incident rates and patient harm through a number of internal reports
- Undertaking six monthly auditing of incident reporting to ensure all Patient Safety incidents have been recorded as such on the incident recording system.

Incident system training is ongoing, and work is planned (once the Covid-19 threat has passed) to work with Service Managers to improve the quality of lessons learned from incidents. Quality Priorities for the coming year have been set to improve patient safety.

2.2.10 Doctors' Rota Gaps

Annual Report on Safe Working of Junior Doctors 2019/2020

This section provides assurance that doctors in training are safely rostered and that their working hours are compliant with the terms and conditions of their contract.

Doctors in Training Data:

Number of doctors in training (total inclusive of GP and Foundation)	122
Number of doctors in psychiatry training on 2016 Terms and Conditions (average)	50
Total number of vacancies (average over reporting period)	31
Total vacancies covered by LAS and MTI (average over reporting period)	21

Annual data summary:

Trainees within EPUT

Specialty	Grade	Q1	Q2	Q3	Q4	Total gaps (average WTE)
Psychiatry	CT1-3	32	31	31	29	13.25
Psychiatry	ST4-6	22	18	18	19	17.75
Total		54	49	49	48	31

Trainees outside EPUT overseen by the LET guardian

Specialty	Grade	Q1	Q2	Q3	Q4	Total gaps (average WTE)
GP trainees	ST1	13	13	13	15	1.75
Foundation	FY1	12	12	12	12	0
Foundation	FY2	12	12	14	14	2

Agency Usage:

EPUT does not use agency workers and relies on the medical workforce to cover out of hours i.e. 5pm to 8:30am at internal locum rates. There are varied reasons for covering out of hours

ranging from sickness, the additional out of hours that less than full time trainees cannot contractually cover, and vacant posts.

The total number of shifts covered in reporting period:

Locum bookings (internal bank) by reason					
Reason	No. of shifts requested	No. of shifts worked	No. of agency shifts	No. of hours requested	No. of hours worked
Vacancies/ Maternity Leave/ Sickness/ LTFT cover	471.5	471.5	0	5054.5	5054.5
Total	471.5	471.5	0	5054.5	5054.5

Exception Reports:

A total of 15 exception reports were raised by trainees via the Allocate reporting system from April 2019 to March 2020.

Issues Arising

- Gaps in rota from April 2019 – March 2020
    - Core Trainee (CT) Grade – total of 30 WTE
    - Specialty Trainee (ST) Grade – total of 89 WTE
- The gaps at CT level are filled with internal doctors who are paid an internal locum rate. The gaps at ST level are unfilled; on occasions Consultants, especially in the North of EPUT, had to step down to cover the gap. Agency locums have been generally avoided. There are no particular reasons or patterns observed for these gaps and national recruitment seems to be the issue.
- Junior doctors expressed concern at lack of facilities in on call rooms especially at Colchester, Epping and Gloucester Ward.
- Junior Doctors requested an updated ‘Stepping Down Policy’.
- Health Education England has granted £30,000 to our Junior Doctors.

Actions taken to resolve issues

- Rolling adverts on NHS jobs are in place and EPUT has recruited a number of MTI and LAS doctors who are covering the gaps in the rota.
- GPs and FY2s are given the opportunity to express an interest in joining the bank to participate in on-call when they leave EPUT.
- Facilities in on calls rooms at various sites have improved after escalating the issues to the relevant Managers.
- The HEE funding amount has now been finalised and signed off at the Junior Doctors Forum; Junior Doctors have decided on how they are going to utilise the money to improve the facilities at their work site.

Key issues from host organisations and actions taken

- There are no specific key issues within EPUT with regard to vacancy rates. There is a National recruitment issue.

At the Junior Doctors Forum, Doctors have raised the following issues:

- Facilities in on call rooms and doctor's room
- Lack of rooms and facilities to carry out their daily tasks at Gloucester ward at Thurrock
- Doctors requested access to blood results from pathology labs
- Senior Doctors requested laptops

All the above issues have been addressed:

- Facilities in their on call and doctors' room have improved
- Gloucester Ward Doctors have been identified a room to carry out their tasks
- Laptops have been distributed to the Senior Doctors
- More improvements to their working environment are in progress via the HEE funding, which Doctors had autonomy to decide on how to use the money. This has been finalised and signed off at the last Junior Doctors Forum.

It can be highlighted that EPUT had a very good pass rate in the last MRCPsych examination and is hoped that these Doctors will be recruited as Senior Trainees in the near future.

2.2.11 Staffing in adult and older adult community mental health services

The long-term implementation plan for the NHS 2019/20 to 2023/24 set out a proposal to transform mental health services. A ring-fenced local investment fund worth at least £2.3 billion a year in real terms by 2020/24 aims to ensure the NHS provides high quality, evidence-based mental health services to an additional two million people. For EPUT this is translated into five primary strands

Perinatal Services

EPUT perinatal services have received additional funding that has increased staffing. This is progressing well ahead of an agreed business case. Better quality services have resulted from system working with midwifery and integrated physical and mental health pathways

Perinatal Mental Health

By 2023/24:

- At least 66,000 women with moderate to severe perinatal mental health difficulties will have access to specialist community care from pre-conception to 24 months after birth with increased availability of evidence-based psychological therapies. Their partners will be able to access an assessment for their mental health and signposting to support as required;
- Maternity Outreach Clinics will be available across the country, combining maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience.

Community (Primary) Care

There are a small number of Trusts acting as early implementers and West Essex is one of these. An evaluation of this model should result in a roll out between 2021 and 2024. EPUT is a leader in delivery and other pilots will take place in Southend, Castle Point and Thurrock, operated by senior clinical staff. Again this is whole system working between physical and mental

health, including GPs. Mid/South Essex and Brentwood/Basildon will come on line in Quarter four with a full roll out the following year. There are exceptional calls on this funding.

Personality Disorders

For people with a diagnosis of personality disorder a business case has been agreed for an Essex system wide model funded by three System Transformation Partnerships (STPs). However, it should be noted that only Mid/South Essex have agreed funding at present, with West Essex withdrawn for 2020/21 and North Essex still negotiating. This has resulted in the need to review the start and rollout of this major model. Training, consultation and a special case holding team aims to reduce out of area bed number. The model will reduce admissions and provide more effective care locally rather than out of area.

Adult Severe Mental Illnesses (SMI) Community Care

By 2023/24:

- All STPs/ICSs will have received funding to develop and begin delivering new models of integrated primary and community care for adults and older adults with severe mental illnesses, incorporating care for people with eating disorders, mental health rehabilitation needs and complex mental health difficulties associated with a diagnosis of a 'personality disorder', among other groups. These new models of care will span both core community provision and also dedicated services, where the evidence supports them, and they will be built around Primary Care Networks. By the end of 2023/24 every STP/ICS will have at least one new model in place, with care provided to at least 370,000 adults and older adults per year nationally, giving them greater choice and control over their care, and supporting them to live well in their communities.
- A total of 390,000 people with SMI will receive a physical health check.
- A total of 55,000 people a year will have access to Individual Placement and Support services.
- The 60% Early Intervention in Psychosis (EIP) access standard will be maintained and 95% of services will achieve Level 3 NICE concordance.

Urgent and Emergency Care

Three services have been launched in North Essex, West Essex and Mid/South Essex. A 24-hour public facing crisis helpline is now in place, enabling mental health assessment and safe tele coaching. This has involved an additional 50 staff across Essex and recruitment continues.

Mental Health Crisis Care and Liaison

By 2023/24:

- There will be 100% coverage of 24/7 age-appropriate crisis care, via NHS 111, including:
  - 24/7 Crisis Resolution Home Treatment (CRHT) functions for adults, operating in line with best practice by 2020/21 and maintaining coverage to 2023/24;
  - 24/7 provision for children and young people that combines crisis assessment, brief response and intensive home treatment functions [see also *Children and Young People's Mental Health*];
  - A range of complementary and alternative crisis services to A&E and admission (including in VCSE/local authority-provided services) within all local mental health crisis pathways;
  - A programme for mental health and ambulances, including mental health transport vehicles, training for ambulance staff and the introduction of nurses and other mental health professionals in Integrated Urgent Care Clinical Assessment Services.
- All general hospitals will have mental health liaison services, with 70% meeting the 'core 24' standard for adults and older adults.

Additionally, appropriate access and waiting time standards for urgent and emergency mental health care will be field tested during 2019/20, with trajectories for introduction over the course of the LTP to be confirmed thereafter.

Older People and Dementia/Frailty

New, fully integrated health and social care and frailty models are in place in Mid and South Essex and are having a positive impact on admission rates. Two wards have been closed as a direct result of this integration. Agreement with Clinical Commissioning Groups through business cases will improve and roll this out in due course.

Older People's Mental Health

The implementation of the Long Term Plan provides a unique opportunity to ensure consistent access to 'functional' mental health support for older adults and address the mental health needs of older adults wherever they may arise or present[1]. Older people's mental health (OPMH) is embedded as a 'silver thread' across all of the adult mental health ambitions, including IAPT, community-based services for people with severe mental illnesses (SMI) and crisis and liaison mental health care.

Note on the impact of Covid-19:

Although the current Covid-19 pandemic may divert attention away from these transformation projects they will continue and the impact may be a slight pause or slowing down rather than any cessation.

2.2.12 Whistleblowing

At EPUT we are creating an environment where our staff are able to speak up and raise concerns about poor practice without fear of victimisation. We want to encourage staff to express any concerns in a constructive way and to put forward suggestions in order to contribute towards the delivery of care and services to patients, service users and carers.

A 'standard' integrated policy was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS aimed at improving the experience of whistleblowing. It was expected that the policy (produced by NHS Improvement and NHS England) is adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients and service users. EPUT took this recommendation forward in 2017, and our approach and local process has therefore been integrated into EPUT's Raising Concerns (Whistleblowing) policy and procedure, which provides more detail about how we will look into a concern.

The policy and procedure does not replace existing policies and procedures regarding grievance or complaints, or dealing with patient events as described in the 'Being Open and Duty of Candour policy', nor is it intended to replace the normal lines of communication between staff and their managers. Matters of concern should still be dealt with through normal management and/or clinical advisory channels

If an individual raises a genuine concern under this policy, they will not be at risk of losing their job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully an individual into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action. Provided an individual is acting honestly, it does not matter if they are mistaken or if there is an innocent

explanation for their concerns.

We are committed to the principles of the 'Freedom to Speak up' review and its vision for raising concerns, and will respond in line with them.

We are committed to listening to our staff, learning lessons and improving patient care. On receipt the concern will be recorded and the individual will receive an acknowledgement within two working days. We will tell the individual who will be handling the matter, how to contact them, and what further assistance required. If required, we will write summarising the concern and setting out how we propose to handle it and provide a timeframe for feedback.

Individuals can raise concerns about risk, malpractice or wrongdoing in connection to any harm to the service we deliver. Just a few examples of this might include, but are by no means restricted to:

- unsafe patient care
- unsafe working conditions
- inadequate induction or training to staff
- lack of, or poor, response to reported patient safety incident
- suspicions of fraud (which can also be reported to our local counter fraud team)
- a bullying culture (across a team or organisation rather than individual instances of bullying)

How does the Freedom to Speak Up agenda support staff?

Freedom to Speak Up is a national agenda and an elected Principal Guardian is in place for EPUT. We have a number of mechanisms in place to enable staff to raise issues, for example a designated facility on the intranet and the 'Raising Concerns' policy and procedure. The idea of the Freedom to Speak Up Principal Guardian is that they facilitate discussions between staff and management. Local Guardians are also in place to support the Principal Guardian.

Roding Ward

To all the nursing staff on Roding ward, a very big thank you!

You all were so very kind to me, especially Jenny - so very patient! I miss having you all around, although it is lovely to be home again.

I'd also like to thank all the staff in the kitchen, who were never impatient with me.

Part 3: Review of quality performance 2019/20

3.1 Progress against the quality priorities we set for 2019/20

Quality priority 1: EPUT will aim to achieve a minimum 95% harm free care through the national Safety Thermometer data collection with the aim to drive continuous improvement to move towards zero:

- Pressure ulcers
- Avoidable falls
- Medication omission
- Physical health of mental health patients and
- Early warning systems for deteriorating patients

AREA	PRESSURE ULCERS
Why did we set this priority?	• Pressure ulcers represent a major burden of sickness and reduced quality of life for people and their carers with the most vulnerable people being aged 75 • The presence of a pressure ulcer creates a number of significant difficulties psychologically, physically and clinically to patients, their families and their carers. They have a profound impact on a person's overall wellbeing and can be both painful and debilitating • Pressure ulcers can be serious and lead to life-threatening complications
What were our aims?	• Develop a trajectory for a reduction in category 2 pressure ulcers (2018/19 outturn 669) • Zero category 3 and 4 pressure ulcers acquired as a result of omissions in care with a 50% reduction in year against current performance (2018/19 outturn 6)
What actions did we take?	• Developed trajectory for reduction in category 2 pressure ulcers • Developed and embedded RCA Pressure Ulcer Guidelines across all clinical services • Rolled out NHSI recommendations in relation to the revised definition and measurement of pressure ulcers • Reviewed incident reporting system to ensure consistency in reporting • Reviewed and revised guidelines on prevention and management of pressure ulcers to ensure consistency and standardisation of practice across EPUT • Revised training programmes and information packs cascaded to all teams with face to face training to support implementation of NHSI recommendations
Future actions	• Further update of PU guidelines required to clarify and simplify some key areas (reporting process and frequency of risk assessments) • Develop quick reference and FAQ guide for the PU reporting process • Develop minimum data set guide for frequency of risk assessments as a resource for EPUT teams • Undertake 'deep dive' of all pressure ulcer incidents to identify themes, trends and lessons learned

AREA	FALLS
Why did we set this priority?	• Across England and Wales, over 36,000 falls are reported from mental health units and 28,000 from community hospitals • They are the most commonly reported type of incident in community hospitals and the third most commonly reported type of incident in mental health hospitals • Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged over 75 in the UK
What were our aims?	• 15% reduction in all falls against 2018/19 outturn 1620 (2017/18 1552) • 10% reduction in the number of falls resulting in a serious incident against 2018/19 outturn 7 • 50% reduction in the number of falls as a result of omissions in care against 2018/19 outturn 6
What actions did we take?	• Reviewed Falls Guidance and provided clarification regarding the requirement to complete a Falls Risk Assessment in people under the age of 65 • Introduced Falls: Supportive and Safe Observation Guidelines and output measures in relation to a reduction in the number of falls • Implemented a procedural guideline for Delirium • Continued participation in the National Audit of Inpatient Falls • Undertook learning events with falls champions • Reviewed guidance in relation to safe use of bedrails
Future actions	• Continued participation in the National Audit of Inpatient Falls to include mental health wards • Implement the Delirium Guideline to include a Delirium Pathway • Undertake a local audit to examine post-falls management

Byron Court

I would like to take the opportunity to extend my appreciation to the entire staff Team at Byron Court for all their hard work and dedication in supporting JR through his treatment while an inpatient. The time and diligence demonstrated through their collaborative partnership working instilled the processes to establish effective transition and discharge planning thus ensuring the successful outcome that JR presently enjoys within the community to date.

AREA	Omitted Doses
Why did we set this priority?	• Over the last 12 months omitted doses have featured within the top three subcategories of medication incidents, both for mental health and community health services • A review of medication incidents by the National Patient Safety Agency (NPSA) identified that omitted and delayed medicines was the second largest cause of medication incidents reported to the National Reporting and Learning System (NRLS) • Omitted doses impact patients by reducing chances of successful treatment and also tend to increase length of stay which impacts financially on EPUT.
What were our aims?	• To reduce the incidence of omitted doses by 50% where no reason code is annotated • To provide assurances that medicines are being used safely and effectively across EPUT
What actions did we take?	• Recruitment of a Trust Medication Safety Officer (MSO) in Q1 of 2019/20 • Thematic analysis of incidents relating to omitted doses and identification of high risk medications • Omitted doses captured on inpatient units as part of a weekly pharmacy checklist and auditor is required to report this using the DATIX incident reporting system • An annual omitted doses audit is undertaken as part of the pharmacy audit programme • The MSO works with the risk management colleagues to improve usability of the DATIX system for staff when submitting medication-related incidents • Reinvigoration of EPUT Medication Safety Group in quarter two 2019/20 at which omitted doses is a standing item on the agenda • Funding for EPMA secured with a plan to roll out to start in 2020/21
Future actions	• Development of an algorithm for staff on the actions to be taken if a dose is missed • The Medication Safety Group will update guidance on time critical medicines to improve the understanding of staff on the impact of omitted doses • The MSO will continue to follow up DATIX reports of medication incidents involving a delayed or omitted dose to ensuring appropriate action has taken place

Holly Wheelchair Team

I'm writing to thank you so much for your efforts on my behalf with the wheelchair, which are much appreciated.

It is so much more manageable than the previous one, besides giving me more control.

AREA	PHYSICAL HEALTH OF MENTAL HEALTH PATIENTS
Why did we set this priority?	• It has been shown that the most successful systems for improving physical health care of patients with serious mental illness are those where physical and mental health care is integrated
What were our aims?	• To support nursing and support staff in the development and maintenance of physical health competencies • To implement the competency framework
What actions did we take?	• Put in place physical health training programme based on competency framework incorporating management of diabetes and Coronary Vascular Disease • Reviewed and implemented physical health audit incorporating a qualitative outcome baseline
Future actions	• Continued delivery of physical health training to nursing and support staff

Robin Pinto Unit

To all the wonderful staff at Robin Pinto

Thank you so much for the exceptional care and support you have given to Adam over the last two years.

We are truly grateful from the bottom of our hearts.

AREA	EARLY WARNING SYSTEMS FOR DETERIORATING PATIENTS
Why did we set this priority?	• The Modified Early Warning System has been implemented within EPUT inpatient services to support staff in the detection of physical deterioration
What were our aims?	• To ensure that patients physical health is monitored and deterioration is recognized and treated promptly
What actions did we take?	• Audit of MEWS charts and review of findings
How well did we do?	• The audit findings indicate that MEWS recording is being used accurately across the inpatient setting. Improvement from previous audit is evident
Future actions	• Action plan to be developed to improve escalation/recording of raised MEWS scores • Delivery of face-to-face training on vital signs monitoring across inpatient areas where areas for improvement have been identified • Review early warning scoring systems to ensure compliance with most appropriate model

Quality priority 2: No Force First. We will seek to embed the principles of No Force First in order to reduce restrictive interventions

AREA	NO FORCE FIRST
Why did we set this priority?	• 'No Force First' was originally an initiative within mental health inpatient units in the United States to dramatically reduce the number of, and ultimately eliminate dangerous restraint and seclusion events • It has a proven record of success in transforming healthcare environments and enhancing safety for service users and staff
What were our aims?	• EPUT has agreed to adopt No Force First as its restrictive practice reduction programme following significant success as a strategy in other mental health inpatient environments • The impact of No Force First on wards had shown to reduce conflict and restraint and associated work related sickness with significant benefits for service users and staff • In addition, two wards were selected to take part in a two year collaborative working with Royal College of Psychiatrists on restrictive practices • Through the Restrictive Practice Steering Group comprehensive and sustainable structures will be established to monitor, deliver and integrate the approach in clinical practice
What actions did we take?	• Introduced ward level system ensuring compliance with new national data set • Active participation by two wards in RCP reducing restrictive interventions collaborative • Implemented a range of tools and techniques e.g. safety crosses and safety pods across a range of inpatient areas • Implemented a debriefing protocol at ward level and developed a psychological debriefing support system for staff • Held a reducing restrictive practice conference • Scoping exercise led by Executive Nurse across inpatient areas informing further actions • Reviewed in-house training programmes and undertook BILD accreditation • Developed dashboards from ward to board • Change in practice in relation to pharmaceutical management of restraint supported by training programmes
Future Actions	• Appointment of QI Facilitators working with front line teams to cascade implementation of a range of tools and techniques to change practice • Roll out learning from RCP collaborative • Roll out of OLM and BILD new training criteria

Access and Assessment Team
I want to tell you how very much I have appreciated what you have done for me over the last several months. More than anything, though, I have so valued your warmth and sincerity. Since we first met I have felt I had a friend on my side, which is something I have not been accustomed to.

Priority 3: Suicide/Unexpected Deaths: Following the publication of the NHS Zero Suicide Alliance EPUT has revised its Suicide Prevention Strategy taking recommendations from working groups to identify priorities for action

AREA	SUICIDE/UNEXPECTED DEATHS
Why did we set this priority?	• Suicide is a significant public health problem and reduction and prevention is a major part of our role • The number of unexpected patient deaths (including deaths by suicide, neglect and misadventure has increased across mental health Trusts

What were our aims?	• As a result of the publication of EPUT's Suicide Prevention Strategy and recommendations from working groups the following priorities have been identified to ensure successful implementation and embedding of the strategy into EPUT services:
	  • Suicide Prevention Safety Tools and communication
	  • Suicide Prevention Learning Culture
	  • Suicide Prevention Family and Carer Involvement

What actions did we take?	• Appointed a dedicated suicide prevention trainer and are in the process of rolling out a comprehensive training programme • Revised Suicide Prevention Group underpinned by 3 work streams: clinical, Family and Carer Engagement and Learning Lessons Culture • Development of a dashboard to drive performance • Work streams have been established for Family and Carer Engagement and Learning Lessons Culture • Review of suicide and self-harm policy • Work undertaken with system partners to develop an integrated suicide plan • Membership of Zero Alliance • Partnership with Samaritans • Introduction of Staying Alive Suicide Prevention app on all EPUT mobiles • Three audits undertaken linked to Suicide Prevention Strategy – DNA, Meds on discharge and risk assessment prior or inpatient leave
Future actions	• Workshop to cascade learning for development of a learning culture • QI approach to be taken to reduction of self-harm • Audit and dashboard to inform future actions.

Priority 4: Collective Leadership

AREA	COLLECTIVE LEADERSHIP
Why did we set this priority?	• It is recognised that in order to operate as an outstanding organisation it is essential that EPUT works collectively with its staff, service users and system partners to plan, deliver and evaluate the quality of care and associated outcomes that is provided
What were our aims?	• To develop and embed systems of collective leadership to enhance EPUT performance and improve practices for staff and patients
What actions did we take?	• System involvement in NHSI Transforming Change through System Leadership • Collective working to identify key transformation projects • Staff involvement in transformation and QI programmes

	• Collective leadership embedded in OD Frameworks • Review of leadership forums supporting wider engagement
Future Actions	• Further work will be undertaken to develop and embed EPUT Organisational Development programme

Priority 5: Continuous Improvement

AREA	CONTINUOUS IMPROVEMENT
Why did we set this priority?	• Nationally and internationally a case has been made to change the way patient safety is approached in the NHS • QI provides a methodology to drive continuous and sustainable improvements in relation to patient safety
What were our aims?	• Our aim is to embed continuous improvement within the culture of the organisation and empower all staff, service users and carers to work together to enhance the reliability of service provision
What actions did we take?	• EPUT board completed NHSI's Leadership in Improvement programme • Directorate QI Hubs introduced • Gained accreditation to deliver QSIR and implemented first cohort alongside other training programmes • Developed Gold level Quality Champions to provide coaching/mentorship • Develop dashboards against quality priorities
Next Steps	• Further development of QI Hubs • Development of training strategy • Ward accreditation schemes • Closer integration with research and innovation

Priority 6: Effective Use of Technology

AREA	Effective use of technology
Why did we set this priority?	• As set out in national guidance and strategy published by National Information Board data and technology are central to transforming outcomes for patients and local populations
What were our aims?	• Through the effective use of technology EPUT will implement improved mechanisms of acquiring, reviewing, understanding, analysing and exchanging patient safety data and knowledge.
What actions did we take?	• Through EPUT Lab developed and reviewed and implemented a number of technological systems • Development of a dashboard against quality priorities • Strengthening of ward to board use of data to inform decision making • Introduction of Perfect Ward app to strengthen audit and systems of assurance • Implementation of SafeCare to improve Safer staffing
Next Steps	• Technological innovations driven through EPUT Lab to deliver against the Model Hospital

Priority 7: A Just and Learning Culture

AREA	A JUST AND LEARNING CULTURE
Why did we set this priority?	• Patient Safety is of primary concern • Delivery is dependent on the development of a Just, and Learning Culture where individuals and organisations can learn from mistakes improving systems and processes to enhance patient safety
What were our aims?	• A just and learning culture will be developed to embed EPUT's agreed approach in response to incidents and errors to protect both staff and people that use our services.
What actions did we take?	• Principles of just and learning culture and human factors embedded into induction, leadership and quality champion training • Process reviewed and enhanced to share 72 hour review of serious incidents within one week to relevant teams • Key messages and lessons learnt distributed monthly • Developing Learning Culture Group established to develop work plans and cascade learning. • Datix training and risk training updated to enhance focus on learning lessons.

Priority 8: End of Life Care

AREA	END OF LIFE CARE
Why did we set this priority?	• Supportive End of Life care is critical for people in the last months or years of their life • Following a CQC inspection it was reported that some improvements could be made to Trust services
What were our aims?	• EPUT is committed to the provision of the very highest quality of care for people with advanced life threatening illnesses • They and their families should expect good end of life care, whatever the cause of their condition and all those identified as end of life should have the opportunity to discuss, plan and identify their preferences for their care at end of life and their preferred place of death
What actions did we take?	• Implemented 'national ambitions' through EPUT End of Life Care framework • Developed and implemented competency framework to enhance knowledge, develop skills and promote positive attitudes and behaviour in the delivery of care to patients at the end of life • Participated in National Audit for Care and End of Life for inpatient services • Undertook local audits relating to care at end of life and Do Not Attempt Cardiopulmonary Resuscitation • Developed dashboard to develop a set of measureable, person centred outcomes to ensure EPUT has a greater understanding of the impact of the care being delivered by teams and to monitor quality and performance • Developed information leaflets for Life Limiting and End of Life conditions, and Care in the Last Days of Life to supplement information for patients and carers • Participated in the national Dying Matters Campaign • Implemented the role of End of Life Champion across all teams

Future actions	• Undertake an analysis of audit findings to determine actions and implement recommendations • Strengthen feedback from carers by the development of a questionnaire • Explore options for a forum for carers • Continued working with system partners to develop a standardised approach to EoL care and frailty

Beech Ward (Essex)

Thank you for all the help you give
Thank you for being there
Thank you for all the things you do
Thank you for all your care
Thank you for standing by my side
Thank you for staying true
Thank you for giving me the strength
Thank you for being you!

Has the priority been achieved?

The Board of Directors considered the strategic context, their knowledge of EPUT and the feedback from staff and stakeholders during the planning cycle and identified eight Quality Priorities for 2019/20.

RAG (Red Amber Green) ratings have been applied to provide an accessible method of understanding the levels of performance. RAG ratings should be used in conjunction with the actual levels of performance which are also quantified in the charts that follow.

RAG rated RED to indicate that performance has not met the target by a significant margin.

RAG rated AMBER to indicate that performance is close to target.

RAG rated GREEN to indicate that performance has met or exceeded the target %.

AMBITION		YEAR END POSITION	
1	Achieve 95% harm free care through the national Safety Thermometer data collection	• March 2020 Performance 95.7%	
1a	Reduce the number of avoidable category three and four pressure ulcers acquired in our care	• At year end there have been 6 Cat 3 / 4 pressure ulcers as a result of omissions in care (18/19 OT = 6)	
1b	Reduce the number of avoidable falls that result in moderate or severe harm and a 15% overall reduction in falls	• Not in performance report. The reduction in all falls is 8% at year end and reduction in avoidable falls was 60% with 4 at year end compared to 10 18/19 OT)	
1c	Reduce the number of omitted doses of medication across our services	• MH/LD - During the audit period 5% of prescribed doses were omitted. However, if those doses which were omitted for a valid clinical reason are excluded the omission rate falls to 1%. Therefore, 99% of doses were administered as intended • CHS - During the audit period 2.3% of prescribed doses were omitted. However, if those doses omitted for a valid clinical reason are excluded the omission rate falls to 0.5%. Therefore, 99.5% of doses were administered as intended	
1d	To improve the physical health of mental health patients	• 85.9% of SMI inpatients had a physical health assessment • 91.8% of EIP patients had a physical health assessment • 39.1% of SMI community patients (in care + 1 year) had a physical health assessment in last 12 months • 45.7% of SMI community patients (in care <1 year) have had a physical health assessment • Please note physical health assessment does not include all requirements of a Cardio Metabolic Assessment	
1e	Ensure early warning systems for deteriorating patients are in place	• The audit findings indicate that MEWS recording is being used accurately across the inpatient setting. Improvement from previous audit is evident	
2	Implement 'No Force First' to reduce the number of restrictive practices including restraints	• 20% reduction in use of seclusion • 12% reduction in restraints and 7% reduction in prone restraints	
3	Roll out suicide prevention training to community mental health teams	• 587 contact with Samaritans • Dashboard developed	

AMBITION		YEAR END POSITION	
4	To develop and embed systems of collective leadership	• Completion of NHSI leadership programmes • System transformation partnerships in place • Improvement in staff survey results	
5	To embed continuous improvement	• Directorate Improvement Hubs in place • QSIR training in place with further cohorts planned • 120 Quality Champions trained, bronze level • 30 Quality Champions Coach/Mentors in place	
6	Effective use of technology	• EPUT Lab review and implementation of a number of technological advances • Implementation of Perfect Ward to provide increased assurance of practice • Roll out of SafeCare to increase accuracy of staffing levels in relation to patient acuity	
7	To embed a just and learning culture	• Staff survey results demonstrated improvement in patient safety, reduction in discrimination and respect at work	
8	To improve End of Life Care	• EPUT received CQC 'outstanding' rating in relation to End of Life Care in the Well Led Review 2019	

3.2 Overview of the quality of care offered in 2019/20 against selected local indicators

As well as progress with implementing the quality priorities identified in our Quality Account last year, EPUT is required to provide an overview of the quality of care provided during 2019/20 based on performance against selected quality indicators. EPUT has selected the following indicators as they have been regularly monitored by the organisation. There is some degree of consistency of implementation across our range of services. They cover a range of different services and there is a balance between good and under-performance.

Data for two indicators, Readmissions and IAPT Recovery Rates have been reported in the National Mandated and Key National Indicator section of this report.

PATIENT SAFETY

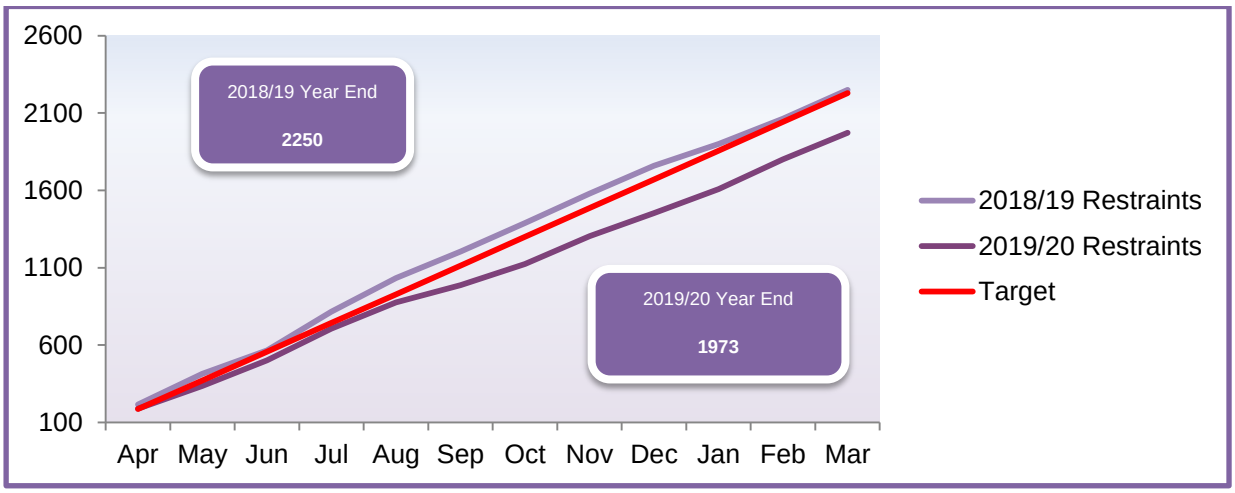
3.2.1 Restraints

Restraints

EPUT monitors the use of restraints by inpatient ward on a monthly basis, including the reason for restraint and the type of restraint. The most common reasons for restraint are self-harm, physical assault, anti-social behaviour and clinical care. The most common types of restraint are patient standing and in a supine position. The use of prone position restraints are monitored in greater detail.

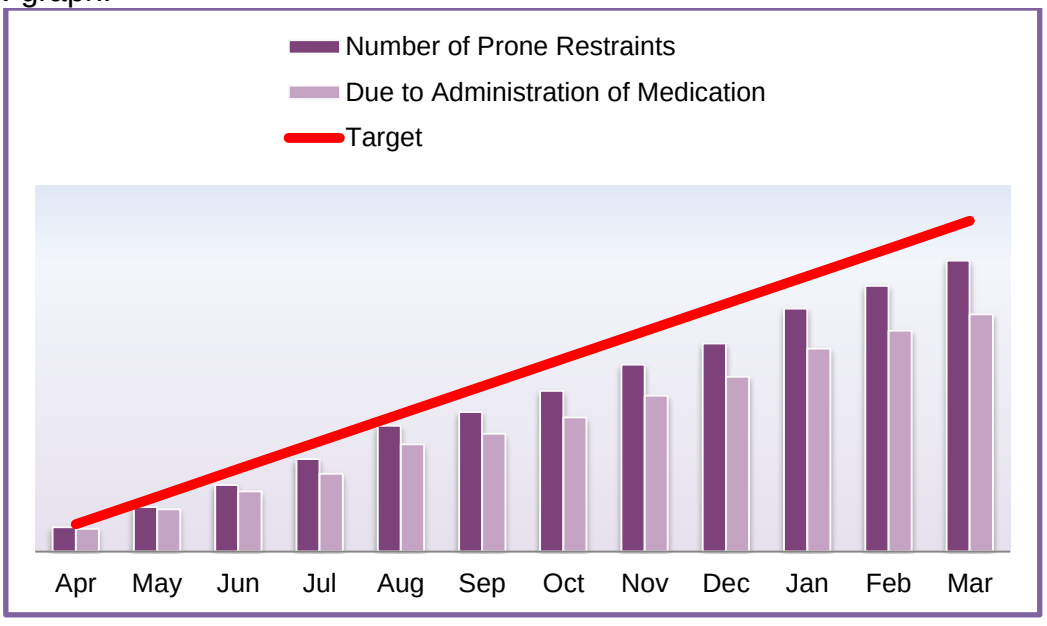
The total number of restraints in 2019/20 was 1973; this is a positive reduction on year end position for 2018/19 which was 2256 (please note 2251 restraints were reported in the 2018-19 report however a further 5 incidents were identified after publication date). EPUT is also pleased to report that the rate of restraints per 10,000 beds is lower than the national benchmark.

The graph below demonstrates the reduction target set by EPUT against 2018/19 out turn and the 2019/20 performance against this target. Reduction started in July 2019 and has been sustained across the year.



Prone Restraints

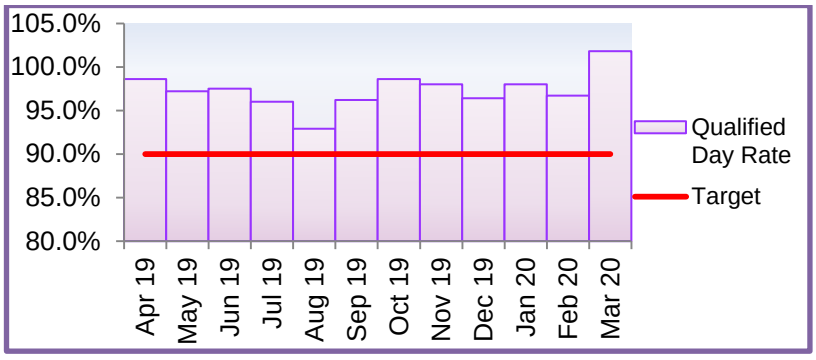
In 2019/20 EPUT achieved a reduction in the number of prone restraints with the largest portion of being undertaken to facilitate the administration of intra-muscular medication. This is presented in the below graph.



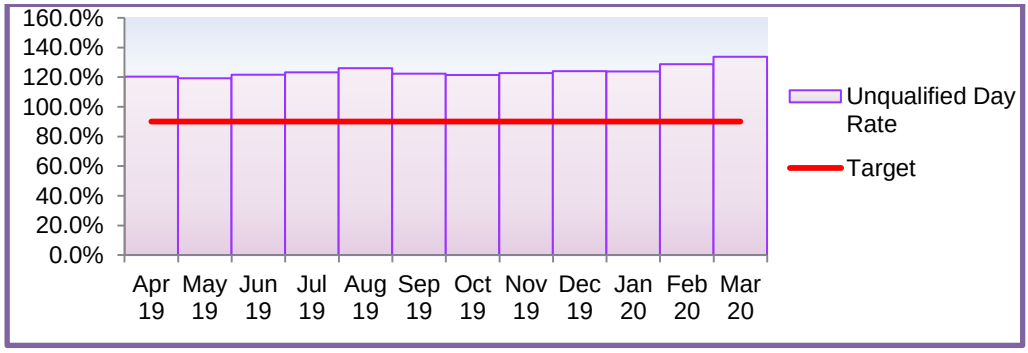
Reducing restrictive practices forms one of EPUT'S Quality Priorities and is described in more detail in section 2.1.2.

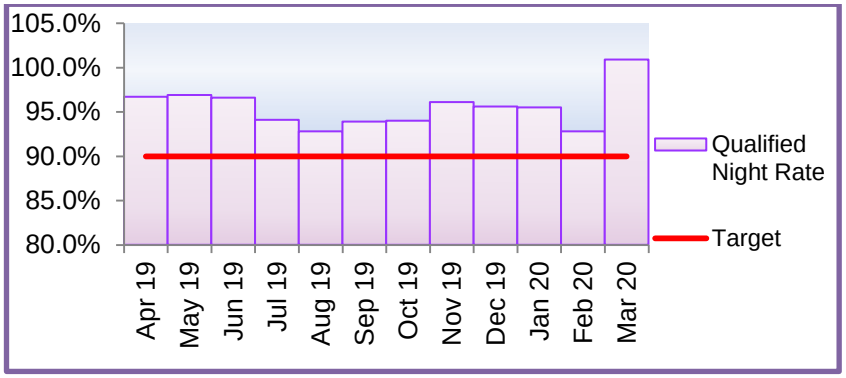
3.2.2 Safer Staffing

All Trusts are required to publish information on nursing staffing levels in ward based clinical areas, along with the percentage of shifts filled that meet safe staffing guidelines. EPUT monitors the actual levels of staffing compared to the established levels on a shift by shift basis.

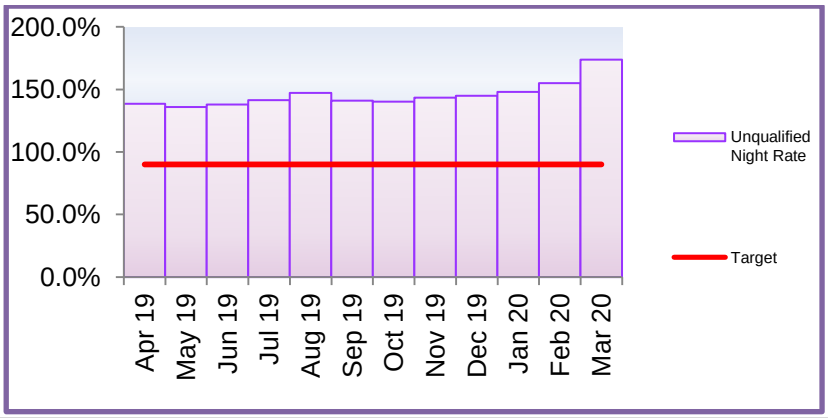


In 2019/20 EPUT consistently surpassed our 90% target for four indicators EPUT measures itself against.





Daily sit rep calls are undertaken with all wards to review current staffing levels and risks.



3.2.3 Serious Incidents

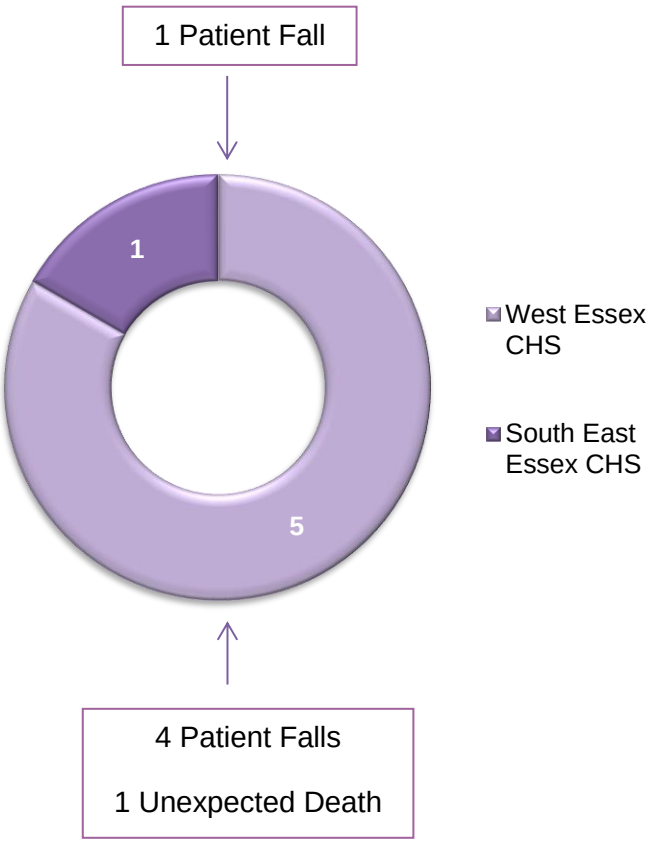
Data Source: Datix

National Definition applied: East of England and Midland's definition applied

A key part of EPUT's patient safety systems is the monitoring we undertake on all serious incidents, including the lessons we learn and share following each incident to ensure learning is embedded into clinical practice.

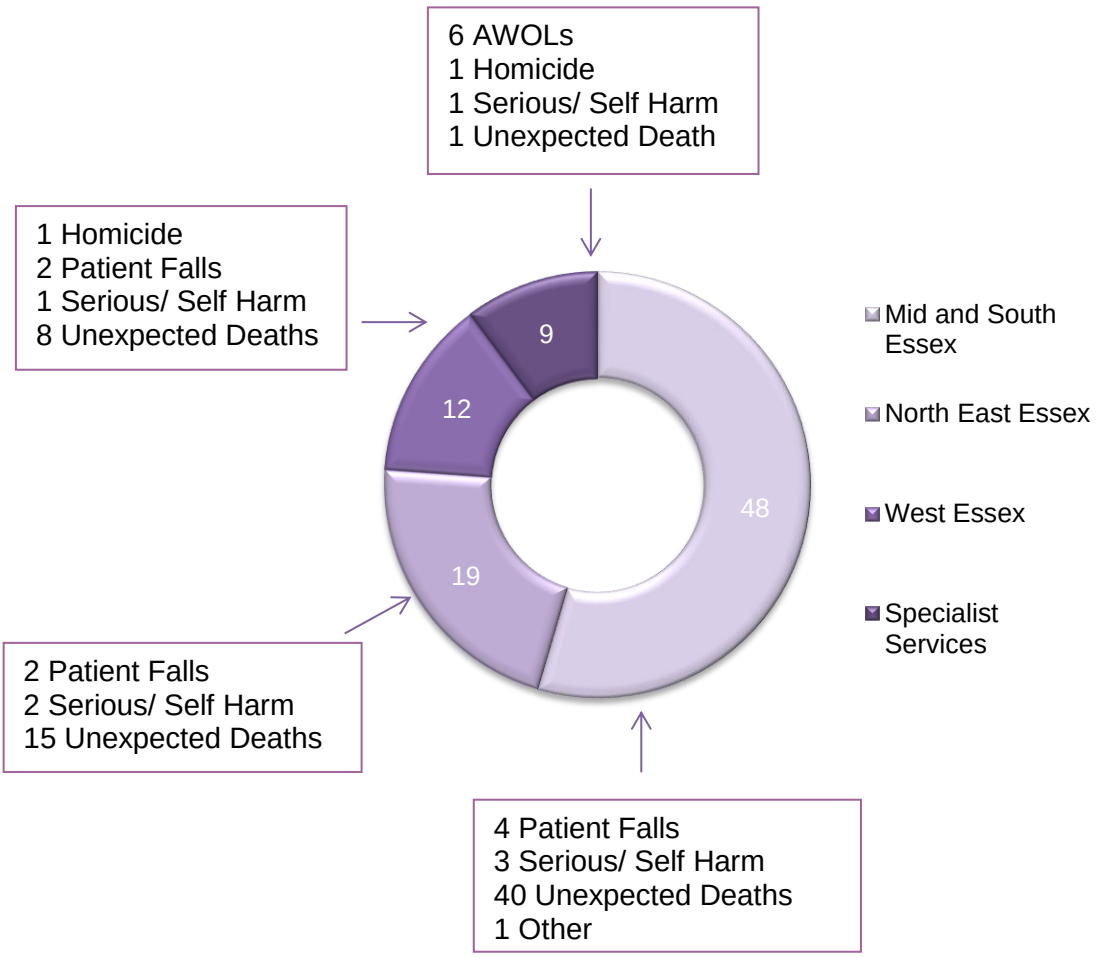
EPUT reported six serious incidents in Community Health Services in 2019/20 which represents no change from the six reported in 2018/19.

The diagram below details the number of serious incidents by area and the type of incident for Community Health Services.



In Mental Health services EPUT reported 88 serious incidents (SIs) in 2019/20 which is a positive reduction on the 109 reported in 2018/19 (please note that 113 SIs were reported in 2018/19 but 6 were downgraded following investigation after publication date).

The next diagram details the number of serious incidents by area and the type of incident for Mental Health services:



There were six avoidable pressure ulcers reported in 2019/20 and four avoidable patient falls.

The most common type of serious incident is an unexpected death. EPUT had 65 unexpected deaths in 2019/20. EPUT has committed to reducing this number through its Suicide Prevention Strategy and this is also set as a Quality Priority ambition, more details of which can be found in the Quality Priorities section of this report.

3.2.4 Complaints

Data source: Datix

National definition applied: only to K041-A submissions to the Department of Health

Complaints referred to the Parliamentary and Health Service Ombudsman

During 2019/20 a total of 19 complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO). Of these 19 referrals, the PHSO decided not to investigate in 10 cases. Two cases have been closed with financial redress of £500 and £100 respectively, one is awaiting a final report and the remaining six are ongoing at either assessment stage or under investigation.

In addition to the 19 cases received this year there were five cases from 2018/19 that remained

open at the start of this year and carried over. Of these, three have now been closed with one of them receiving financial redress. Provisional reports have been received for the remaining two and EPUT is awaiting final reports. One case referred from the previous North Essex Trust prior to the formation of EPUT was upheld with recommendations.

Complaints closed within timescales

The percentage of complaints resolved within agreed timescales' indicator is a measure of how well the complaints-handling process is operating. The agreement of a timescale for the resolution of a complaint is identified in the NHS Complaints Regulations; however these do not stipulate a percentage target to be achieved. EPUT believes that commitments to complainants should be adhered to and aims for 100% resolution of all complaints within the agreed timescale with the complainant.

This year EPUT has achieved 93.1% for complaints closed within agreed timescale.

Non-Executive Director Reviews

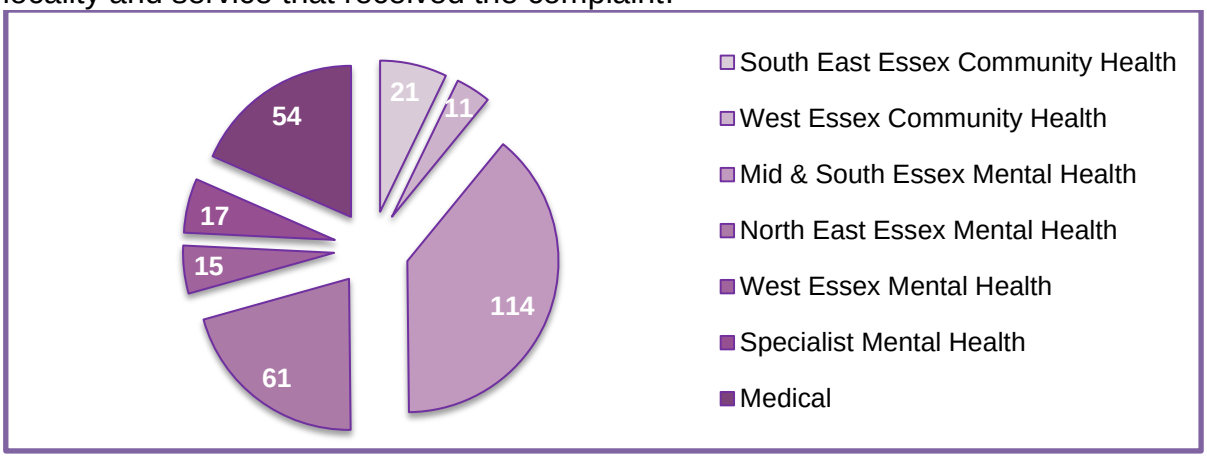
An important part of the complaints process is the independent review of closed complaints by the Non-Executive Directors (NEDs). Complaints are selected at random each month. The reviewer will take into consideration the content and presentation of the response, whether they feel EPUT has done all it can to resolve the complaint and if they think anything else could have been done to achieve an appropriate outcome. During 2019/20, the NEDs reviewed 27 complaint responses. The majority received a good or very good rating for how the investigation was handled and the quality of the response.

Formal complaints received

Please note: The figures stated in this section of the report (and those reported in EPUT's Annual Complaints Report) do not correspond with the figures submitted by EPUT to the Health and Social Care Information Centre on our national return (K041A). This is because EPUT's internal reporting (and thus the Quality Account and Annual Complaints Report) is based on the complaints closed within the period whereas the figures reported to the Health and Social Care Information Centre for national reporting purposes have to be based on the complaints received within the period.

Complaints Received by Locality

In 2019/20 EPUT received a total of 293 complaints against numerous services across EPUT, eight of which were withdrawn. At year end, the number of active complaints was 49. The next diagram represents the number of complaints received by EPUT. The complaints have been split by the locality and service that received the complaint.



Number of complaints upheld/ partially upheld:

A total of 288 complaints were closed during the year.

Upheld	Partially Upheld	Not Upheld	Not Investigated	Withdrawn
24	177	69	10	8

Patient Advice and Liaison Service queries and locally resolved concerns:

EPUT received a total of 959 Patient Advice and Liaison Service queries and 110 locally resolved concerns in 2019/20.

Nature of complaints received:

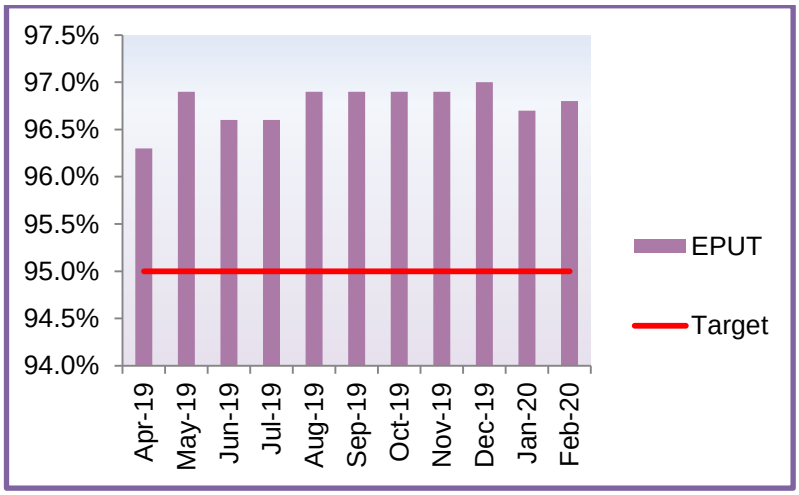
The top three themes for complaints for both mental health and community during 2019/2020 were Staff Attitude, Unhappy with Treatment, and Communication. The table below shows the outcomes of the closed complaints for each of these three themes:

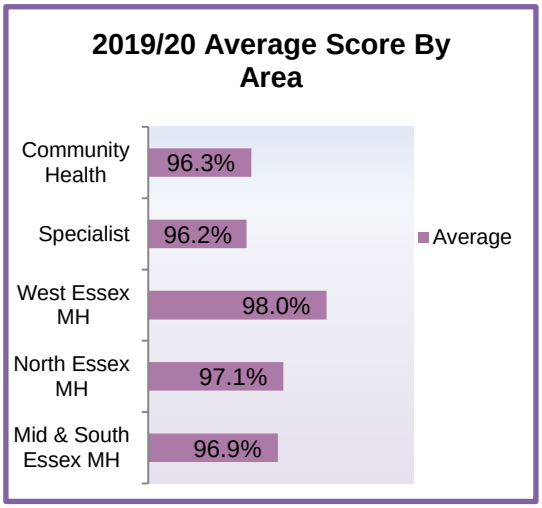
2019/20	Staff Attitude	Unhappy with Treatment	Communication
Complaints Closed	85	24	28
Upheld	5	1	6
Partially Upheld	56	17	18
Not Upheld	16	5	3
Not Investigated	2	1	1
Withdrawn	6	0	0

3.2.5 Patient Environment

EPUT measures the environment of each inpatient ward and assigns monthly scores following these audits. In 2019/20 EPUT achieved the target of 95% for each month in the year, and no individual area fell below this target. A review was undertaken of all EPUT cleaning schedules in accordance with the National Standard of Cleanliness 2019, concluding that EPUT met all National standards. The below graphs details EPUT's overall scores throughout the year as well as the average score for each individual area.

Please note that due to the Covid-19 pandemic, audits were not able to be carried out in March 2020.



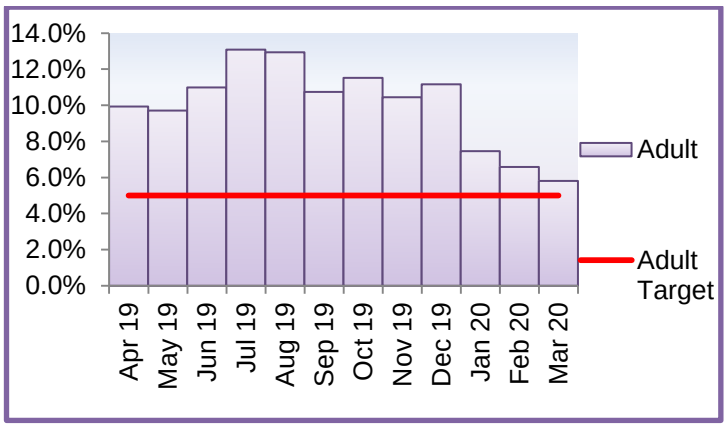


CLINICAL EFFECTIVENESS

3.2.6 Delayed transfers of care

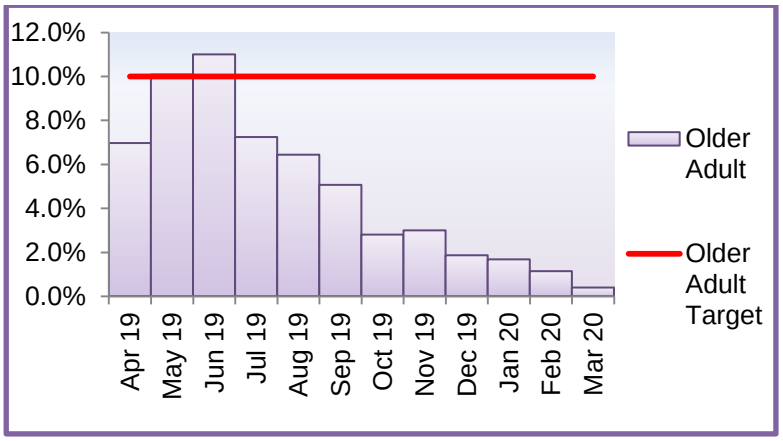
Data Source: EPUT systems (Mobius and Paris) *National Definition applied: Yes*

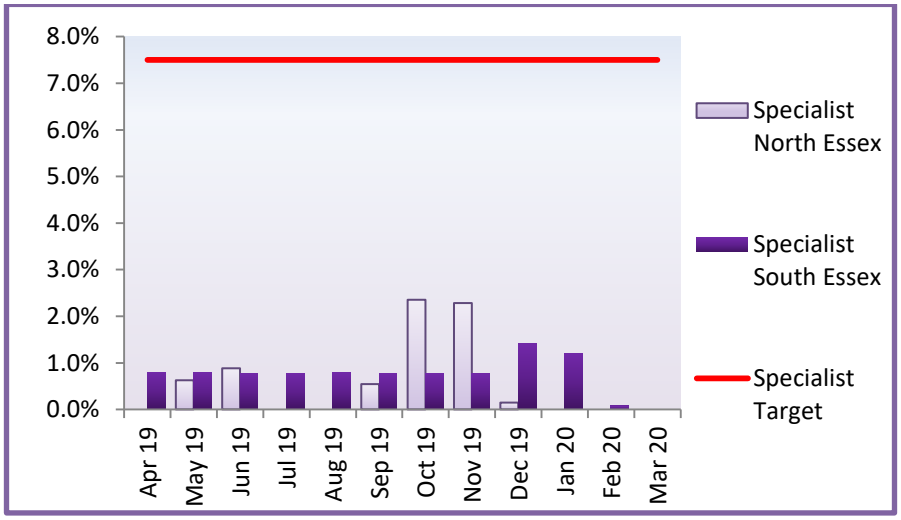
EPUT undertakes monitoring of delayed transfers of care in weekly and monthly reporting as well as in daily sit rep calls. EPUT continues to take improvement measures to reduce the delay rate.



EPUT's adult delayed transfers of care have consistently been above the target of less than 5%, however, work remains ongoing to reduce this and an improvement in performance is emerging.

EPUT has also been working to improve older adult delayed transfers of care and achieved this since July 2019 with performance below the target of less than 10%.





Specialist delayed transfers of care remain low and EPUT can consistently been below the target of less than 7.5% throughout 2019/20.

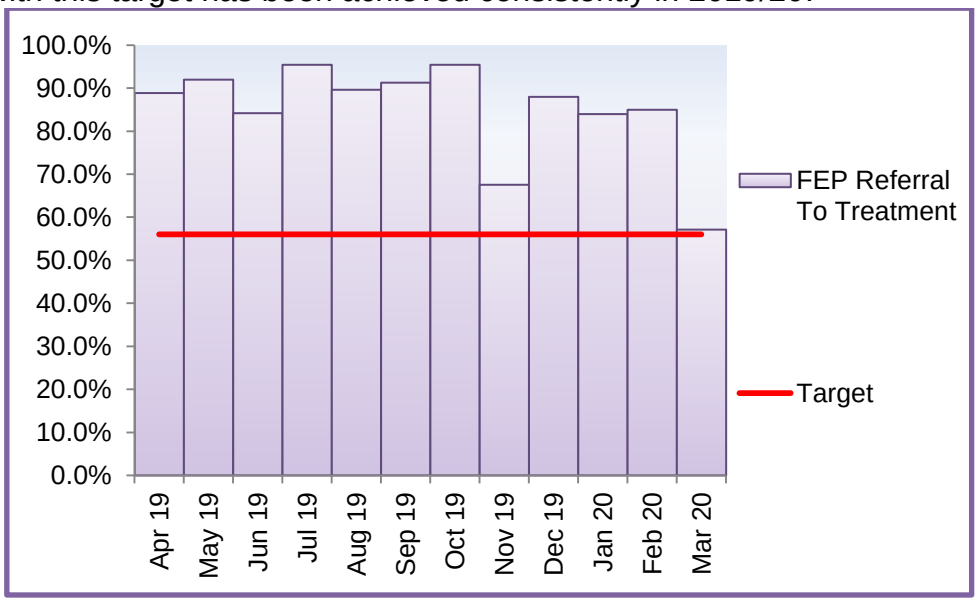
3.3 Performance against key national priorities (NHS oversight framework)

This section provides an overview of performance in 2019/20 against key national targets relevant to EPUT's services, contained in NHS Improvement's (NHSI) Oversight Framework in accordance with the national guidance issued by NHSI for Quality Accounts.

Data for one indicator, 'Patients on Care Programme Approach (CPA) followed up within seven days of discharge from psychiatric inpatient stay' has been reported in the mandatory indicator section of this report.

3.3.1 First Episode Psychosis: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral

This indicator measures the percentage of referrals for people with a first episode of psychosis treated within two weeks. The current target measured against is performance above 56%. Compliance with this target has been achieved consistently in 2019/20.

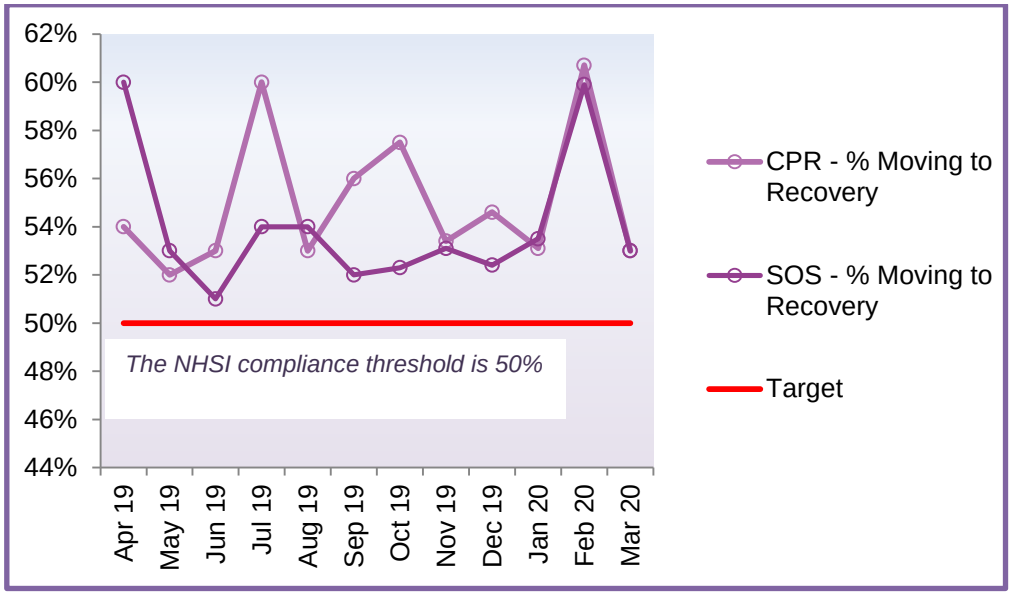


3.3.2 Improving Access to Psychological Therapy Services: Recovery Rates above 50% and Access Targets

Recovery Rates:

This indicator measures the percentage of patients discharged from IAPT services who have moved to recovery. IAPT services are commissioned from EPUT by two CCG's, namely Castle Point and Rochford CCG, and Southend on Sea CCG.

Both of these CCG's have consistently surpassed the 50% threshold in 2019/20:

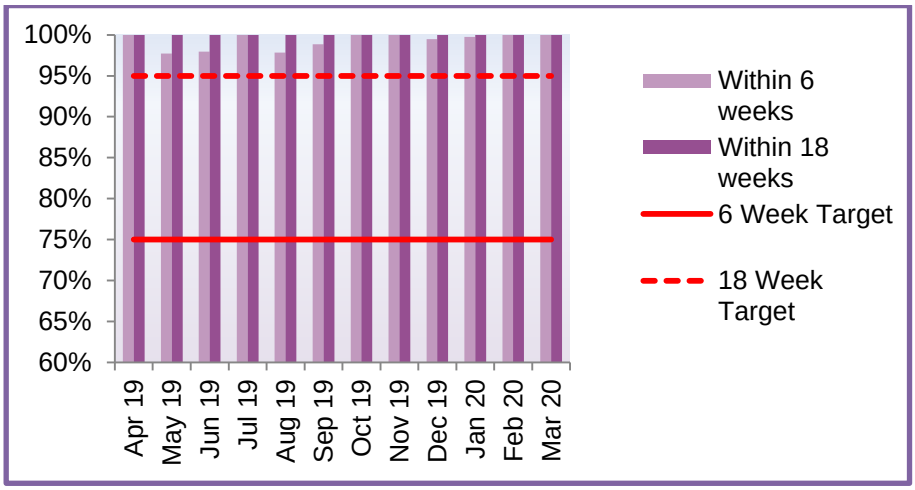


Access Rates:

This indicator measures the percentage of referrals to IAPT services where treatment commences within: 6 weeks (Target 75%) 18 weeks (Target 95%). Compliance with both of these targets has been consistently achieved throughout 2019/20.

EPUT achieved an average of 99% for those starting treatment within 6 weeks

EPUT achieved an average of 100% for those starting treatment within 18 weeks

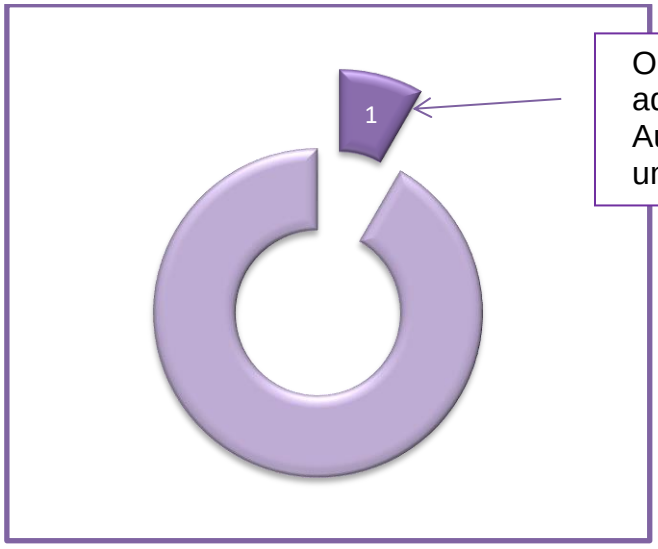


3.3.3 Under 16 Admissions to Adult Wards

This indicator measures the number of admissions to Adult Mental Health Wards where the client is aged less than 16 years old.

In 2019/20 EPUT witnessed one under 16 year old admitted to one of its Adult Wards:

No further child or adolescent clients were admitted to an adult ward in 2019/20.

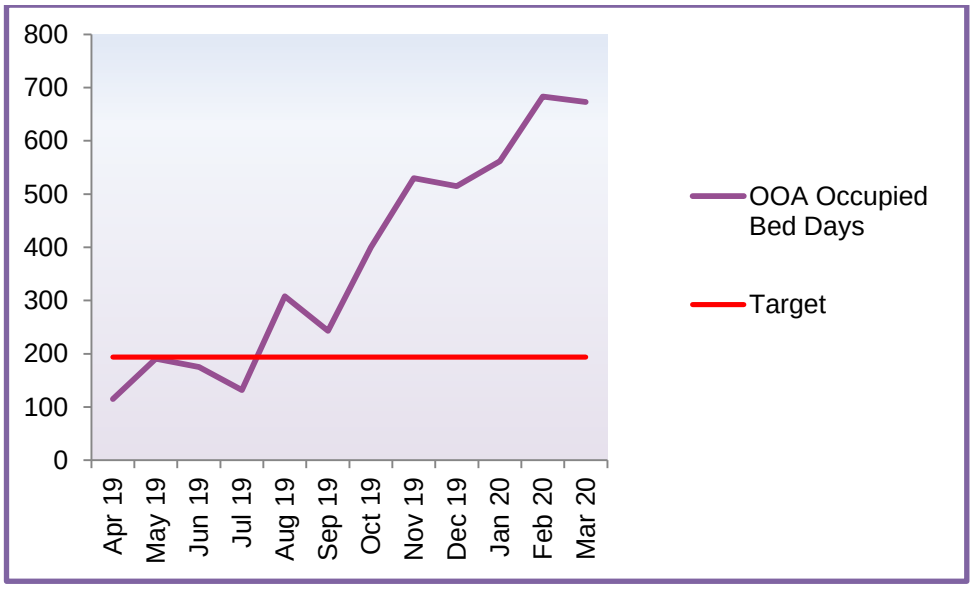


One under 16 year old admitted for one day in August 2019 due to unavailability of a bed.

3.3.4 Out of Area Placements

This indicator has formed part of the NHS Oversight Framework since November 2017. The indicator measures the number of days that patients have spent in in-patient facilities that are out of area and therefore not part of our Trust.

EPUT has seen an increase from its 2018/19 position and a gradual increase month on month in 2019/20 resulting in failure to achieve the reduction target. Significant work has been undertaken to improve OOA rates and a new Capacity and Flow work stream has been established.



The average number of days EPUT clients spent in an out of area bed each month for 2019/20 was 377 days

2019/20 Year End

3.4 Listening to our patients and service users

We believe that receiving and acting on feedback from our service users is crucial to maintaining the high quality standards we set ourselves and work continues to increase the feedback received. This section of our Quality Account outlines some of the ways in which we capture feedback from people who use our services together with some examples of changes we have

made and outcomes resulting from that feedback. Information in terms of the results of the Friends and Family Test (FFT) is included in the local quality indicators of this report.

Patient Survey Feedback

EPUT has in place a unified patient survey. This draws together the national NHS Friends and Family Test (FFT) and a further series of local questions around key areas we identified together with people who use our services. Surveys are sent to all patients who have recently been discharged, either from inpatient services or community caseloads as well as some patients who have chronic long term conditions to ensure they continue to receive a good service. Carers are also asked to complete the survey for those unable to fill it in themselves.

In 2019/20 EPUT introduced online dashboards for Managers to access their service FFT results. They are then able to discuss feedback with their team or individuals, where appropriate, using it as an opportunity to reflect on practice and look for improvements. Managers are encouraged to use positive feedback to share and reinforce good practice, as well as encourage further participation in the survey.

Question	EPUT Scores 2019/20
To what extent did you feel you were listened to?	9.3
To what extent did you feel you understood what was said?	9.3
To what extent were staff kind and caring?	9.6
To what extent did you have confidence in staff?	9.4
To what extent were you treated with dignity and respect?	9.5
To what extent did you feel you were given enough information?	9.2
How happy were you with the timing of your appointments?	9.2
How would you rate the food?	7.7
To what extent would you say the ward/clinic was comfortable?	8.8
To what extent would you say the ward/clinic was clean?	9.3

A total of 5,447 responses were received to the Survey in 2019/20. The results of the answers to the local questions are detailed in the table above (figures denote average score out of 10).

The lowest scoring area with an average of 7.7 was food. The Patient Experience Team attends Open Inpatient Meetings in order to listen to concerns from service users, and an item that does feature in some meetings is food. The Team contacts the Facilities Department to discuss any issues brought forward. This has led to menu changes in some areas. In addition, the Facilities Department undertakes their own surveys and audits in relation to food to try and improve the patient experience.

EPUT also participates in the National Community Mental Health Survey. The Community Mental Health Patient Survey 2019 was sent to patients who received treatment from EPUT from September to November 2018 to complete and return.

Other Key Patient Experience Engagement Activities

'Your Voice': The aim of these events is to give service users, carers, members of EPUT and Governors as well as the public a chance to speak directly to the Chief Executive about the services provided by EPUT. They are held across all localities and include different presentations

from teams relevant to the locality. The events also provide an opportunity to update everyone on EPUT's planning process. Feedback from these events is generally positive, although attendance does vary considerably from locality to locality.

Community Mental Health Forums: These are public forums, their purpose to provide the opportunity for service users, carers and staff to discuss services in their area and share feedback with EPUT. Forums are chaired by a locality lead for EPUT who is supported by operational staff. These Forums are now in place across EPUT and have been well received by members of the public whose attendance continues to grow. Some smaller forums are also held more as discussion groups, which include patients, carers and local voluntary organisations.

Stakeholder Reference Group: One of EPUT's strategic objectives is to involve service users and carers more to play a meaningful role not only in current services but also the future of EPUT services. The Stakeholder Reference Group was initially set up to discuss the merger and engage on Mental Health transformation work. This group remains in place and members receive updates on developments from operational leads. Many attendees continue in smaller working groups looking at specific service areas of transformation. The Stakeholder Reference Group offers the opportunity for attendees to feedback to others on the discussion topics in the smaller working groups.

Training: EPUT continues to involve both carers and service users at corporate induction. They are invited to present with a member of the Patient Experience Team to share their lived experiences. This session is positively received by both attendees and volunteers. In addition, service users give talks at the mental health first aid training, and service users and carers take part in some clinical staff interview panels. Service users also share their lived experiences with EPUT Health and Social Care Apprentices in the form of a workshop.

Co-production: The Patient Experience Team is responsible for driving EPUT's work to support co-produced projects. These include supporting operational services to set up Service User Groups and collaborate on projects such as 'Always Events'.

Open Inpatient Meetings: These are now in place across all mental health wards and work is ongoing to implement these in our Community Health wards. These meetings allow managers the opportunity to gather feedback from patients and relatives to improve services. Good practice is also recorded in order that it can be cascaded as learning throughout EPUT. As much as possible we encourage patients/service users to lead the meetings.

Buddy Scheme: The scheme seeks to empower both service users and our future healthcare workers by increasing understanding of mental health through true partnership-based work and education. It gives mental health nursing students an opportunity to engage with an identified service user who acts as a 'Buddy' in a series of structured meetings and provides an opportunity to learn from carers, gaining insight into their experience. The scheme encourages students to enquire with sensitivity and respect about service user and carer experiences of living with mental illness within the context of family, work and the wider community.

Outpatient Surveying: This is conducted in order to increase FFT returns by service users who

attend community based outpatient clinics and appointments. A member of the Patient Experience Team together with a volunteer, where appropriate, will proactively hand out FFT surveys for service users to complete on arrival or on leaving the outpatient centres. The presence of a volunteer assists this as they can often engage with service users who may not wish to engage with someone from EPUT and are more comfortable talking to a person with lived experience.

Patient Experience Framework: During 2019/20 the Patient Experience Team undertook a project to engage with people who have lived experience in order to co-produce the new Patient Experience Framework for 2020-2023. Workshops were held across EPUT's footprint with people who have lived experience invited and a working group set up to draw this up. This project is currently ongoing.

Valuing people who have lived experience: During 2019/20 EPUT made a commitment to reach best practice guidelines on valuing the contribution made by people who have lived experience by recompensing them for their time. A working group was set up including operational staff, support services and people with lived experience to draw up this policy. This project is currently ongoing.

Targeted engagement: The Patient Experience Team has traditionally held events that allow people who have used services to attend and feedback. It was recognised in 2019/20 that this approach may miss people who would not normally attend these types of events. To alleviate this, the Team proactively seeks feedback from services by visiting places where people who use services attend, such as community centres and events.

Examples of actions we have taken/ outcomes from service user feedback we have received

The table below details some examples of the 'You Said, We Did' feedback gathered by the services. These are actions we have taken and outcomes that have been achieved as a result of listening to feedback from our patients, service users and carers over the past year. The Patient Experience Team collects this information on a monthly basis.

You Said	We Did
You asked for subtitles on TV as you were hard of hearing	We are putting up a notice advising that patients can ask for the subtitles to be used on the TV
You asked for a relaxation room for when you are stressed	We have changed the purpose of the Quiet room to a Relaxation room which can be used. It has bubble lights, relaxing chairs, soft floor, and relaxing music can be played
You would like to do some more cooking sessions	We provided some baking sessions with support staff
Improve choice of sandwiches, desserts and availability of squash and fruit juice	We are organising regular three monthly reviews of the menu choice with Facilities Team
Patients asked for more access to their bedrooms	Bedrooms are now open 24/7 with access throughout the day

Closing statement from Chief Executive

Thank you for your time and interest in reading EPUT's third Quality Account and my last one before I retire from EPUT at the end of November. I hope you have found it a clear, straightforward and informative report.

I have always valued highly the opportunities to meet with you directly but, of course, under current national Coronavirus pandemic restrictions we cannot hold our public meetings. We hope to resume a schedule of engagement events in due course but, meanwhile, please share any quality improvement suggestions with us by contacting our Trust Secretary. These will be taken forward as EPUT returns to 'business as usual'.

Thank you for supporting EPUT and other local NHS services while we are continuing to deal with this unprecedented global health emergency. On my retirement, EPUT's new Chief Executive will inherit a thriving Trust, with exemplary staff of whom I could not be more proud. Their services will remain essential as we help local people and communities to recover from the effects of this pandemic. Please continue to support them as we could not do it without you.

Keep safe and keep looking out for one another. I send my very best wishes to you, your families and friends for the future.

[Sally's signature]

Sally Morris
Chief Executive
Essex Partnership University NHS Foundation Trust (EPUT)

This is a final draft of the Quality Account 2019/20 and we have chosen to publish it ahead of the date in the revised regulations issued on 1 May 2020 in order to fulfill our obligations to you in relation to how we deliver quality services in EPUT. A final version will be published by mid-December 2020.

Please send any questions or comments about this Quality Account to:
Faye Swanson
Trust Secretary

Email: epunft.trust.secretary@nhs.net
Post: Essex Partnership University NHS Foundation Trust
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Annexe 1:
Comments on the Quality Account

EPUT Council of Governors' Statement on the Quality Account 2019/20

We have been invited to review the draft Quality Account for 2019/20. This has been undertaken by the Lead Governor co-ordinating thoughts and ideas from colleagues. This provides Governors with an opportunity to assure members of our Trust, via the Annual Report to Members that quality is at the heart of what EPUT does and will not be compromised. We have to ensure that the priorities which were set for 2019/20 have been met and are continuing to be taken forward.

We are pleased to note that the independent inspection by CQC has rated the in-patient CAMHS and End of Life services as 'Outstanding', and that for the whole Trust Care was 'Outstanding'. This is very heartening and reflects the efforts put in by all the staff involved.

We continue to be concerned that Safety is still rated as Requires Improvement. We notice that there has been a reduction in Serious Incidents from 109 in 2018/19 to 88 during this year, and that prone restraints continue to fall (anticipated at 6%) and, although it is not clear from the graph as to the actual numbers, there is still some way to go before the Board's target of zero prone restraints is achieved. We are aware of the introduction of some 'pods' to assist in the administration of medication for those patients who are reluctant to co-operate and this has a significant effect on the prone restraints required, as the majority are for this purpose. We have been able to monitor these during our regular 'Quality Visits' to EPUT's facilities.

We do note that the other safety concerns of Omitted Doses are down, as are Avoidable Falls (down from 10 to four during the year to date), with All Falls showing an 8% reduction. Grade 3/4 Pressure Ulcers total six, which is the same as last year, against an ambition to reduce year on year.

We are pleased to see the mention in Priority 2 Transformation of 'co-producing healthcare to meet personal and individual needs of our populations.' We expect this increased focus on co-production to produce an increase in the quality of care.

We also note that out-of-area placements, which were at a high level of nearly 700 occupied bed days in March 2020 (average for the year was 377), have been reduced to zero since, following the request to reduce occupancy during the Covid-19 pandemic. It is now (as at April 2020) at 65%. This is a major factor in a patient's recovery journey and the staff are to be congratulated on this remarkable achievement. This issue of capacity for in-patient MH adults, which the Governors have raised during the year, appears to have been addressed as a result of the pandemic pressure on beds and we look forward to EPUT maintaining this position. Cardio-metabolic assessment targets, which have been a hotspot for some time, also appear towards the end of the year to have been resolved.

We look forward to the other hotspots mentioned being addressed in the coming months, including timeliness of data entry and Care Programme Approach, and these improvements in quality and particularly in patient safety being maintained.

We are aware that patients regularly bring up the issue of food quality and that steps have been taken to try to address these. The Governors have been active in undertaking PLACE visits during the year when food is sampled and I can report that Governors were generally impressed with the quality offered.

The Governors hold the view that EPUT's Board engages in the processes relating to quality in EPUT, and treats 'Quality' as a top priority. We have attended EPUT stakeholder events, alongside service users and their carers, members of staff and senior staff from Local Authorities and Clinical Commissioning Groups, when time was spent considering the priorities for the coming year.

We appreciate the good working relationship which exists between the Board (both Executive and Non-Executive Directors) and the Council and the regular attendance and input that we have received from Directors, whose standard of reporting continues to be generally very high. We are also pleased that the Chief Executive, Sally Morris, uses the occasion of each of the Council meetings to address the Governors on an issue of interest. Her close involvement with the Council is much appreciated.

We have been pleased to continue, on your behalf, to undertake 'Quality Visits' to a wide range of Trust facilities. These have enabled us to talk to staff as well as patients and to listen to any concerns there may be about quality. We can report that when these have been raised they have been immediately considered.

A basic tenet for any hospital trust is that a service user's physical condition should not be worsened by being in its care. We can give an assurance that the Quality Account is an honest commentary on the last year which shows a Trust which continues to be high performing, and the Board of EPUT have agreed a set of priorities which will continue to support the essential requirement that safety and quality comes first.

John Jones
Lead Governor

June 2020

GLOSSARY

A&E	Accident and Emergency
ARC	Applied Research Collaborate (NIHR)
ARU	Anglia Ruskin University
AWOL	Absent Without Leave
BILD	Bild Association of Certified Training
BP	Blood Pressure
BSP	Behaviour Support Plan
CAMHS	Child and Adolescent Mental Health Services
CC	Community care
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CHS	Community Health Services
CICC	Cumberlege Intermediate Care Centre
CMHT	Community Mental Health Trust
CPA	Care Programme Approach
CRHT	Crisis Resolution Home Treatment
CRHTT	Crisis Resolution & Home Treatment Team
CRN NT	Clinical Research Network – North Thames (NIHR)
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Core Trainee
CYP	Children and Young People
DNA	Did Not Attend
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DSPT	Data Security and Protection Toolkit
DWP	Department of Work and Pensions
EAHSN	Eastern Academic Health Science Network
ECG	Electrocardiogram
EEAST	East of England Ambulance Service Trust
EIP	Early Intervention in Psychosis
EOL	End of Life
EOLC	End of Life Care
EPMA	Electronic Prescribing and Medicines Administration
EPUT	Essex Partnership University NHS Foundation Trust
ESD	Early Supported Discharge
FFT	Friends and Family Test
FFFAP	National Falls and Fragility Audit Programme
FY	Foundation Year (doctor)
GAS	Goal Attainment Scaling
GCS	Glasgow Coma Scale
GP	General Practitioner
HEE	Health Education England
HoNOS	Health of the Nation Outcome Scales

HRA	Health Research Authority
IAPT	Improving Access to Psychological Therapy
ICS	Integrated Care System
KPI	Key Performance Indicator
LAS	Locum Appointment for Service
LD	Learning Disabilities
LTFT	Less Than Full Time Training
LTP	Long Term Plan (NHS)
MDT	Multi-Disciplinary Team
MEWS	Modified Early Warning System
MH	Mental Health
MH5YFV	Mental Health 5 Year Forward View
MNC	Mountnessing Court
MRCPsych	Member of the Royal College of Psychiatrists
MSO	Medication Safety Officer
MTI	Medical Training Initiative
NACAP	National Asthma and COPD Audit Programme
NACEL	National Audit of Care at the End of Life
NACR	National Audit of Cardiac Rehabilitation
NAIF	National Audit of Inpatient Falls
NCAPOP	National Clinical Audit Patient Outcome Programme
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
NDFA	National Diabetes Foot Care Audit
NED	Non-Executive Director
NELFT	North-East London NHS Foundation Trust
NHS	National Health Service
NHSD - SDCS	NHS Digital – Strategic Data Collection Service
NHSFT	NHS Foundation Trust
NHSI	NHS Improvement
NICE	National Institute of Health and Care Excellence
NIHR	National Institute of Health Research
NOK	Next of Kin
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
OD	Organisational Development
ODESSI	Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness
OT	Occupational Therapist
OT	Out-turn
OOA	Out Of Area (placement)
OPMH	Older People's Mental Health
PHSO	Parliamentary and Health Service Ombudsman
PLACE	Patient-Led Assessments of the Care Environment
POD	Peer Open Dialogue
POMH-UK	Prescribing Observatory for Mental Health - UK

PREM	Patient Reported Experience Measures
PU	Pressure Ulcer
QI	Quality Improvement
QPR	Question Persuade Refer (suicide prevention training)
QSIR	Quality, Service Improvement and Redesign
RAID	Rapid, Assessment, Interface and Discharge (team)
RCA	Root Cause Analysis
RCP	Royal College of Psychiatrists
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RfPB	Research for Patient Benefit
RT	Rapid Tranquilization
SCR	Summary Care Record
SFFT	Staff Friends and Family Test
SI	Serious Incident
SMI	Severe Mental Illness
SSNAP	National Sentinel Stroke National Audit Programme
ST	Specialty Trainee
STP	Sustainability and Transformation Partnerships
UCL	University College London
UCLP	University College London Partners
UEA	University of East Anglia
UofE	University of Essex
VCSE	Voluntary, Community and Social Enterprises
YTD	Year to Date