Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public via Microsoft Teams
Wednesday 27 July 2022 at 10:00

Vision: Working to Improve Lives

PART ONE: MEETING HELD IN PUBLIC via Microsoft Teams

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
	PRESENTATION **Co-production at the Heart of Transformation** **(video)**			
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 25 May 2022	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	CEO Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	PS	Attached	Noting
(b)	Emergency Preparedness and Resilience Annual Report	PS	Attached	Noting
(c)	Infection Control Annual Report 2021/22	NH	Attached	Approval
(d)	Mental Health Act Annual Report 2021/22	NH	Attached	Approval
(e)	Learning from Deaths – Mortality Review Quarter 4 2021/22 information	NH	Attached	Noting
(f)	Health Safety and Security Annual Report	DG	Attached	Approval
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework 2021/22	PS	Attached	Approval
(b)	Standing Committees:			
	(i) Audit Committee	JW	Attached	Noting
	(ii) Finance & Performance Committee	LL	Attached	Noting
	(iii) Quality Committee	RH	Attached	Noting
	(iv) People, Equality and Culture Committee	ML	Attached	Noting

(c)	Board Oversight Safety Group	AR-Q	Attached	Noting
9	**RISK ASSURANCE REPORTS**			
10	**STRATEGIC INITIATIVES**			
(a)	Transformation Update Report	AG	Attached	Noting
11	**REGULATION AND COMPLIANCE**			
(a)	CQC Compliance Update	PS	Attached	Noting
(b)	Safe Working of Junior Doctors Quarterly Report (Apr, May, June)	MK	Attached	Noting
12	**OTHER**			
(a)	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
(b)	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
(c)	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
(d)	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
13	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
14	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
15	**DATE AND TIME OF NEXT MEETING** Wednesday 28 September 2022 at 10.00am			
16	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** Wednesday 30 November 2022 at 10.00am			

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 25 May 2022
Held Virtually via MS Teams Video Conferencing

Attendees:

Prof Sheila Salmon (SS)	Chair
Paul Scott (PS)	Chief Executive
Prof Natalie Hammond (NH)	Executive Nurse
Alex Green (AG)	Executive Chief Operating Officer
Milind Karale (MK)	Executive Medical Director
Trevor Smith (TS)	Executive Chief Finance and Resources Officer
Nigel Leonard (NL)	Executive Director of Major Projects and Programmes
Denver Greenhalgh (DG)	Senior Director of Corporate Governance
Janet Wood (JW)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director
Mateen Jiwani (MJ)	Non-Executive Director
Loy Lobo (LL)	Non-Executive Director
Rufus Helm (RH)	Non-Executive Director

In Attendance:

Angela Horley	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	Assistant Trust Secretary
Gina Trimble	Trust Secretary Coordinator
Clare Sumner	Trust Secretary Administrator
Martine Munby	Director of Communications
Marcus Riddell	Director of Organisational Development
Johnny Townson	Senior Business Support Manager
John Jones	Lead Governor
Paula Grayson	Governor
Paul Walker	Governor
Dianne Collins	Governor
David Short	Governor
Keith Bobbin	Governor
Pippa Ecclestone	Governor
Pam Madison	Governor
Judith Wooley	Governor
Julia Hopper	Governor
Pam Madison	Governor
Yogeeta Mohur	Freedom to Speak Up Guardian
Kerri Legg	Observer
Moji Fasanya	Observer
Gita Prasad	Observer
Nicole Rich	Director of West Essex Community Physical and Mental Health Services
Stephanie Rea	Associate Director West Essex Mental Health
Claire Lawrence	Head of Complaints

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

The meeting commenced at 10:00

048/22 APOLOGIES FOR ABSENCE

Apologies received from Amanda Sherlock, Non-Executive Director; Zephan Trent, Executive Director of Digital, Strategy and Transformation, Sean Leahy, Executive Director of People and Culture and Alison Rose-Quirie, Non-Executive Director.

049/22 DECLARATIONS OF INTEREST

There were no Declarations of Interest.

050/22 PRESENTATION: WEST ESSEX OUT OF HOSPITAL MODEL

SS welcomed Nicole Rich (Director of West Essex Community Physical and Mental Health Services) and Stephanie Rae (Associate Director West Essex Mental Health), who presented the context and update on the West Essex Out of Hospital Model.

NR advised that EPUT is a significant partner in the One Health and Care Partnership (OHCP) within the Hertfordshire and West Essex Integrated Care System and the Out of Hospital model of care was developed with commissioners in 2019. It was noted that the OHCP has a growing population (over 320,000) and each community having its own identify varying in demography and needs. The model addresses this variation with Primary Care Network Aligned Core Teams (PACTS). With the Care Coordination Centre navigating patients to services, creating a person centred and coordinated approach. This created a shift from unplanned to planned and managed urgent care to safety look after people outside of the hospital setting.

SR advised that the integration and reconfigured of the care units were key to enable the move to the next level and further realise the aspiration of working together as a PACTS to improve outcomes and experience by meeting the health and social care needs of the local population. It was important to note that each PACT operates within the wider community working with the voluntary sector, public health, fire services, police and district councils. Achievements to date included aligning both physical and mental health teams to the 6 Primary Care Networks; implementation of the integrated leadership structure; progressing the co-location of teams; development of the virtual ward; implementation of a 2 hour community urgent response.

SS reflected that this was a fabulous example of collaborative working at place, grounded by systemic analysis of population and health need. PS agreed, stating that this was a good use of data to support the needs of the population with a community based health and care solution. PS queried what conditions were in place to allow the focus to be on outcomes and not structure; and also how performance measured against these ambitious outcomes. NR advised of the history in west Essex of collaborative working with both primary care colleagues and system partners and due to this there was a long standing relationship of mutual trust that was agile and flexible. In terms of outcomes, NR advised that work was ongoing to develop baselines and a dashboard to enable all to be accountable and demonstrate outcomes.

AG stated the role that leadership the success of this model should not be underestimated and the significant contribution this has made to the growth of relationships in the system; adding that she was very proud of this piece of work. This had also brought to life the care unit through the system piece of work, enabling an insight into where to make the right changes to see integration. AG advised we learn from the experience and look to translate this to inform others, noting each system is different.

LL agreed that this was a fantastic example that had set the bar high for what we can do in the community setting. LL queried what is done to give patients access to care plans and make more patient user driven. SR responded that coproduction with the population is very important.

On behalf of the Board, SS thanked the team for their hard work on this excellent piece of work and looked forward to the next level of patient engagement as we go forward.

051/22 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 30 March 2022 were agreed as an accurate reflection of discussions held.

052/22 ACTION LOGS AND MATTERS ARISING

The action log was reviewed and noted that there were no other matters arising that were not on the action log or agenda.

The Board discussed and approved the Action Log.

053/22 CHAIRS REPORT INCLUDING GOVERNANCE UPDATE

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

SS was delighted to note the reestablishment of service visits and was pleased with the agreement of the executive team a move to reinstate the 15 step quality visits with governors. NH noted the recognition of International Nurses Day and recognised all that the nursing profession have done, especially in light of the recent wave of the Omicron variant. NH extended thanks to all staff across the Trust.

The Board received and noted the Chair's Report.

054/22 CEO REPORT

PS advised that along with other MH providers, EPUT had seen an increased demand, which combined with our ambition to be the leading MH provider drives creative working. PS was pleased to see the opening of the first Crisis House in Basildon as part of the new 24-7 Mental Health Crisis Response service, providing help and support for adults experiencing mental health crisis. He advised of the reestablishment of Virtual Wards to supplement face to face contacts with patients and the commitment to increasing virtual wards throughout 2022/23. This focussing particularly on the development of a Frailty Virtual Ward and the expansion of the successful Respiratory and Heart Failure Virtual Wards.

PS advised that he continued to meet with patients and their families to understand better how it feels to be a patient in our services. He commented that it was clear from these meetings, and feedback from other stakeholders, which whilst some of the changes and investments we have made are having an impact there is much more we can do to support people and their networks to manage their mental health. This feedback will drive our plans for the coming year.

The Trust continues to support the Essex Mental Health Independent Inquiry, in line with principles agreed by the Board, which remains on track to publish its findings in April 2023.

The Board received and noted the CEO's Report.

055/22 QUALITY AND PERFORMANCE SCORECARD

Safety and Quality
NH advised that we continue to be driven and provide assurance on the activities relating to the Safety Strategy through our spotlight reporting into the Executive Safety Oversight Group (ESOG). A full root and branch review of observations and continue to check and monitor through an assurance process.

The serious incident themes received from the Coroner's report have been organised into six common areas and have been mapped against our current safety priority activities and planned improvement projects. We will now analyse the action plans in more detail to further determine common areas of improvement, highlight any incomplete actions and put plans in place to address any requiring further action.

The EPUT Culture of Learning (ECOL) team continues to become more fully formed with the successful requirement of a Lessons Learned Communication Business Partner. This role has been instrumental in developing an infographic that is being used already to cascade information in Learning Lessons across the Trust. Recruitment for the outstanding roles in the team has also been successful. This new team will drive this programme of work to embed EPUT's culture of learning ambition.

A number of frameworks have also been approved by the Quality Committee, all of which have been influenced and driven by safety first, safety always, demonstrating the linkage and triangulation of the Trust safety ambition.

Finance
TS advised that the financial accounts for 2021/22 were now subject to audit and will be followed up at the Audit Committee. The Trust is now working to the new financial plan for 2022/23 as agreed by the Board of Directors. The new financial plan includes significant efficiencies to improve our use of resources and a number of investments with £14.3m of capital planned to improve the Trust's infrastructure, estate and medical devices. With reduced levels of COVID funding and a range of increasing cost pressures, the Trust will need to continue to manage its resources very closely and collaboratively with is system partners as we move forward.

Operations
AG noted that there had been no increases in inadequate performance for our commissioners and internal KPIs. The work to support the reduction in waiting times within psychology has continued to have a positive impact. There is improved visibility and oversight of the waiting list within the service and mitigations and progress are tracked through our accountability framework meetings. A project is now in place to enhance the management of the waiting lists.

A refreshed system Out of Area Placement (OOAP) plan is beginning to deliver with good system engagement and numbers of inappropriate placements reducing.

Inpatient capacity continues to fluctuate with a small increase in average length of stay in acute adult mental health services. We are about to embark on a process of flow coaching to support improvement and we have refreshed our approach to system escalation as part of our work on purposeful admission.

Occupancy levels are slightly reduced as are the number of beds closed due to COVID.

CPA reviews for specialist and Trust wide services continue to be above target at 100%. The Mid and South community services remain particularly challenged with a decrease in monthly performance, however the roll out of the new MaST (management and supervision tool) has commenced and will enable enhanced local performance management oversight at an individual level.

Major Projects
NL confirmed that the mass vaccination service had now completed over 1.3 million vaccinations. We are now beginning to see a new phase in the vaccination programme with a focus on younger people and the over 75s. The service is being flexed to step up into spaces to support colleagues in primary care but picking up vaccinations of care homes and housebound patients. There is a move to more mobile services which is fluid and continues to vaccinate as many people as possible to keep our population safe.

People
MR advised that work has progressed on creating the Trust workforce plans for 2022/23. The draft plans were submitted including a full Trust wide plan and separate mental health workforce plans for each ICS. The plans show a commitment to reducing staffing vacancies and completing the majority of the recruitment for the various transformation projects within the next twelve months. The workforce plans also include the introduction of new roles, including Band 4 nursing posts which will enhance the skills within our nursing teams.

Staff absence has remained high which has placed pressure on the ability to release time for training, which has impacted mandatory training compliance which has dropped by 1%. However the situation appears to be improving and it is hoped that the recovery plans can now be fully implemented.

The 2021 Annual Staff Survey results were encouraging with EPUT recognised as one of the strongest in the region scoring higher than the national average around staff morale, wellbeing and engagement.

Vacancy and turnover rates remain well within target levels and in March the Trust welcomed 133 new permanent and fixed term starters as well as having further reduced the recruitment time to hire to 23 days from shortlisting through to unconditional offer. We also continue to welcome international nurses and look forward to receiving further cohorts throughout the year as part of our international recruitment programme.

Medical Directorate
MK advised that the Trust is holding its first ever recruitment event for doctors on Friday 17 June with the aim of attracting new doctors at all levels into the organisation. A social media and digital campaign will be launched next week targeting areas of both London and Essex.

ML queried what the overall view on consultant review and retention stating that it appeared to be positive and optimistic. MK agreed that this was an exciting time and we were attracting different consultants there are some challenging areas but also a number of new opportunities.

MJ queried how we begin to become the employer of choice; MK responded that there are opportunities within the organisation regarding leadership and management roles as well as joint roles with the university and collaborative. There are also new services developing which are attracting clinicians.

SS added that there are also opportunities regarding innovation, research and development. The international recruitment has also been a success and we now move to focus on retention and the importance of infrastructure and support.

TS confirmed that a senior and experienced steering group were overseeing this work which reflected the importance of this work. A robust business case has been financially supported by local and national colleagues.

ML confirmed that assurance had been received at PECC and had been impressed with how systematic the Trust had been with regards to supporting new recruits, also having a focus group with some new recruits to directly helps improve and enable positive experiences.

SS thanked all for the Month 01 (April 2022) performance update noting that this has been reviewed by the Finance and Performance Committee. SS asked the Board to note the report noting variance against target / ambition at month one and actions being taken in regards to:

- CPA reviews
- Inpatient MH Capacity Adult and PICU
- Psychology
- Out of Area Placements (noting this is an NHSE/I Oversight Framework Indicator)
- Temporary staffing (from a financial perspective)

The Board of Directors received and noted the report.

056/22 COMPLAINTS ANNUAL REPORT

Clare Lawrence (Head of Complaints) presented the Complaints Annual Report. She highlighted the volume of complaints received had increased by 37% on the previous year's figure to 376 and that 92% of complaints were closed within agreed timescales. However, only 59 (20%) were resolved within the 40 working day target, with operational pressures associated with the COVID pandemic had impacted on response times. The average response rate was 75.5 working days against 44 working days two years previously. The quality of responses has improved, this was reflected in the NED quarterly review of complaints of which 86% were classed as good or very good against 59% in the previous year. Reflecting the positive impact of the changes made to the complaints process.

Four complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO) which is 1.3% of the total number of complaints closed. The top category for Formal Complaints, Rapid Reponses and MP complaints was 'lack of community support' and this was also the fourth highest PALS enquiry category. The number of compliments received outweighed the number of complaints about the service by over 5:1.

LL was pleased to hear that the process was being refreshed through a coproduction approach; CL advised that there is a rapid response process in place where less complex complaints are filtered with the aim to resolve within 15 working days and reiterated that every complaint is a learning opportunity. JW agreed that the quality of responses had improved and reflected NED feedback. JW continued that there was improvement to be made in regards to response times and a need to monitor formally through the year.

NH thanked CL for the open and transparent report and supported the coproduction element to the redesign of the process. AG acknowledged the hard work of the team and supported the drive to quality improvements. AG encouraged to consider all opportunities to listen while the episode of care takes place, and how we maximise opportunities for patients to speak up and express dissatisfaction.

TS commented that discussions had begun into how to draw complaints and compliments into accountability discussions and to share learning. It is pleasing to see that compliments outnumber complaints 5:1 and suggested there was also learning there.

CL shared thoughts around improvements that could be made, suggested that a less rigid process may have a positive impact. A coproduction workshop was held at which service users spoke eloquently about their experience, stating that they wanted to be heard and supported and often a

formal complaint was a last resort. Early intervention and understanding what the complainants' desired outcomes are is key.

SS noted that the level of engagement reflects the seriousness of the area and supported the transformation journey.

The Board of Directors:

1. **Approved the Annual Complaints and Compliments Report for EPUT 2021/22.**

057/22 DUTY OF CANDOUR ANNUAL REVIEW

NH presented the annual report which provided an update on the Trust position on the Duty of Candour compliance. SS noted the legal duty placed on the Trust as a provider registered with the Care Quality Committee to be open and transparent when an incident occurs (Regulation 20: Duty of Candour).

The Board of Directors:

1. **Received and approved the content of the report**

058/22 FREEDOM TO SPEAK UP REPORT

Yogetta Mohur (Freedom to Speak up Guardian) presented the annual report which provided an overview of EPUT's Freedom to Speak up Guardian Services for 2021/22.

Visibility of the F2SU Guardians had been reduced during the COVID pandemic and was now being to resume face to face visibility with services. YM commented on the important culture change to enable staff to speak up; noting that previously concerns had been raised anonymously, and that there was now a shift to staff being empowered to raise concerns and recommended the service to other colleagues.

MK noted that harassment and bullying had been a predominant theme and stated that it would be helpful to understand trends and factors, as well as resolutions. YM agreed that culture change remains a large scale piece of work and the F2SU team were working closely with the Staff Engagement Team to look at hotspot areas. YM advise that the regional officer from the General Medical Council was visiting the Trust to work with junior doctors and speak of their own experience of speaking up.

AG stated that it was important to not only empower staff to speak up through the guardian process, but also to feel confident to use the business processes; stating that this will help to create a change in approach to enable openness and transparency and willingness to engage in difficult conversations.

The Board noted that it has been a requirement of NHS Trusts to have a Freedom to Speak up Guardian in place since October 2016.

SS thanked YM for this helpful update and wished YM well in her new role; acknowledging the impact of her role as F2SU guardian and the legacy she leaves.

The Board of Directors: Received and approved the content of the report.

059/22 STANDING COMMITTEES

(i) Audit Committee (for January / March)

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

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

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

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

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

060/22 RISK ASSURANCE REPORTS

i) COVID 19 Assurance Report

The NHS has remained at its highest level of emergency preparedness – Incident Level 4 up to 19 May 2022, at which time the incident level was reduced to Level 3. The Trust's arrangements for managing COVID 19 remain effective and in line with national guidance, noting that currently going through governance approval for step down of Command and Control structures in line with moving to level 3.

The Board of Directors received and noted the content of the report and remitted oversight to the Executive Team with the caveat that reporting be re-instated if there is a further surge.

Action:
1. Remit the Covid-19 Assurance Report oversight to the Executive Team (PS)

061/22 COMMUNICATIONS, BRAND AND MARKETING STRATEGY

Martine Munby (Director of Communications) presented the report which provided an overview of the proposed strategy for Communications and Marketing across the Trust. This is a joint strategy that underpins the focus for both teams with a view to ensuring that EPUT is seen internally and externally as an open organisation that listens, learns and responds to feedback, where colleagues, patients, service users and the wider community have a voice and can be heard. This is a three year programme to improve communications and engagement and look at the enhancement of EPUT's reputation with the public and key stakeholders.

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

062/22 CQC UPDATE

Denver Greenhalgh (Senior Director of Corporate Governance) advised that the Trust, on advice from the Care Quality Commission inspection team, has applied for the removal of the Section 31 restriction imposed on registration for CAMHS Tier 4 inpatient services. The Section 31 application

for removal was completed and submitted on 30 March 2022 and can take up to 14 weeks to be processed by the CQC registration team.

The application to change the registered manager for Rawreth Court was approved by the CQC and confirmed in writing on 05 April 2022.

The CQC undertook an unannounced inspection of the CAMHS wards on 01 March 2022; the draft report for factual accuracy is awaited.

The CQC is actively focussing on Mental Health Act assurance and compliance with 6 MHA inspections undertaken in April 2022.

As the CQC re-establish their inspection programme, the Trust is ensuring readiness for the potential of a core and well led inspection of leadership and governance.

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

063/22 NHS ENGLAND / IMPROVEMENT SELF CERTIFICATION REQUIREMENTS 2021-22

Denver Greenhalgh (Senior Director of Corporate Governance) advised that NHS foundation trusts are required to self-certify a number of NHS provider licence conditions after the financial year end:

- Foundation Trust Condition (FT4) - the Trust has complied with required governance arrangements. A breakdown and narrative of our position was provided within the report. The statement of governor training will be reviewed and approved by the Council of Governors.

- Continuity of Service Condition (CoS7) - the Trust has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. Our accounts have been prepared on a going concern which is subject to external audit.

- Condition G6 - the Trust has taken all precautions to comply with the license, NHS Acts and NHS Constitution. Made up of 28 conditions within the license, a breakdown and narrative of our position is provided

- Condition G6 (4) - the Publication of condition G6 (3) self-certification on a compliant or non-compliant basis.

- Foundation Trust Code of Governance- the code is issued on a best practice advice basis but there are elements that are required to be included within the annual report. Therefore a breakdown of this was included for review.

The Board of Directors approved the detailed review of Trust compliance against the Provider Licence and therefore confirmed compliance and publication of certificates on to the website as per requirements.

Action:

1. **Complete Provider License Self-Certification documentation, sign and upload to the Trust website. (DG)**

064/22 SAFE WORKING OF JUNIOR DOCTORS QUARTERLY REPORT (JAN, FEB, MAR 2022)

MK presented the report which provided assurance that doctors in training are safely rostered and that their working hours are in compliance with the Terms and Conditions of the Service.

LL commented that there had been some press which had indicated an alarmingly high level of stress and suicide rate among junior doctors. LL queried how we measured this and how this may be addressed. MK responded that this report is to oversee and provide assurance that junior doctors are supported and not asked to undertake additional work outside of contractual terms. An independent guardian for the safe working of doctors is in place as well as regular supervision and the psychological wellbeing service. MK gave an example of where a junior doctor had approached a manager directly and received support.

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

065/22	**SAFE WORKING OF JUNIOR DOCTORS ANNUAL REPORT**

This report was presented and discussed with the Quarterly Report above.

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

066/22	**CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING**

There were no items of correspondence circulated to the Board.

067/22	**NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING**

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

068/22	**REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS**

AG reflected that there was a real thread of openness with a theme of accessibility of services, with the integration of mental health and physical services in west Essex to enable parity and accessibility in deprived areas.

There is a link between reports on compliments, F2SU, Duty of Candour, again with a theme of openness and encouragement to speak up; with a drive to continually strive to encourage a culture of speaking up.

069/22	**CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)**

It was noted that all Board members had remained present during the meeting and heard all discussions.

070/22	**ANY OTHER BUSINESS**

There was no other business.

Signed: …… Date: ……

071/22 DATE AND TIME OF NEXT MEETING

SS thanked all for joining the meeting.

The next meeting of the Board of Directors is to be held on Wednesday 27 July 2022, which will be held virtually via the MS Teams video conferencing facility.

072/22 QUESTION THE DIRECTORS SESSION

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

The meeting closed at 12:40.

Signed: …… Date: ……

In the Chair

Appendix 1: Governors / Public / Members Query Tracker (Item 072/22)

Governor / Member / Public	Query	Response provided by the Trust
Julia Hopper, Governor	Childhood obesity should be at least a small red flag for identifying a child with SEND. Those services are virtually non-existent and children are rarely identified. I would ask that be borne in mind.	Comment noted.
Julia Hopper, Governor	Those who have lost family members need this inquiry to be a Statutory one. Does EPUT support this?	PS acknowledged the strong feelings of those affected by the services within the scope of the inquiry; however stated that the Trust are independent of the decision making process. NL added that the Board are committed to supporting the Inquiry and recognise the significance for Essex residents as well as the NHS and how MH services develop in the future. NL understood the views of some of the families and the legal challenge to the status of the inquiry; however the decision remained with the Secretary of State and the Independent Chair of the Inquiry. NL continued that it was not appropriate for the Trust to take a view of the status of the Inquiry and reiterated that our role was to support the inquiry and the Board of Directors had made a major commitment to do so.
John Jones, Lead Governor	Query regarding benchmark figures – average length of stay is 69 days with a target of 35 days. This has been consistently over target over the past year. JJ queried where the issue was and what was being done to address it.	AG stated that this is reflective of the complexity and acuity seen coupled with the COVID pandemic. AG provided assurance that we had improved the setting of expected dates of discharge and also improved system escalation process with EPUT chairing the system escalation call. The predominant issue is the higher level of acuity and so recovery and treatment plans are more intensive over a longer period of time.
Pippa Ecclestone, Governor	1. 1.15 The '<16 Admission to adult facilities' metric for April [and presumably March also], is "0"….but an <16 child was apparently treated in the 136 suite at the Lakes for nearly 2 months from 14.2.22-12.4.22. Is there another metric that would clarify this? [bearing in mind the importance of treating <16 within a CAMHS facility?]	AG advised that the 136 suite is not considered as part of the whole bed base, which was in accordance with other Trusts. AG advised that in this case full oversight was had and the Trust worked in partnership with system partners. AG acknowledged that the situation was not ideal but the clinical decision was made for the safety of the patient.
Pippa Ecclestone, Governor	I was told back in March that 'a dedicated Psychology post had been established for the Rainbow Unit'. Has this position been filled yet? And if not, when can we expect this vacancy to be filled?	AG confirmed that the position had been appointed to and was due to be in post by August. In the meantime mitigations were in place with support from the clinical associate psychology service.
Owen Richard, Chief Officer, HealthWatch Southend	Under the Quality & Assurance scorecard, there is still no information about the complaint rate (4.1.1). I think I have raised this with the Board previously	The risk of using the rate of complaints received as a measure of success, is that is can encourage behaviours that seek to discourage feedback, and create a culture of fearing complaints. Instead we want to make it easy and accessible for people to complain, as this is valuable feedback for us. We would prefer to set measures around satisfaction scores and responsiveness to complaints.

Signed: …… Date: ……

In the Chair

Owen Richard, Chief Officer, HealthWatch Southend	I applaud the Trust for its openness in crafting its Annual Complaints Report. The Trust's commitment to working with complainants is welcomed. I remain disappointed that data is still presented by STP area, which makes it harder for me to see if there are any issues for the residents of Southend.	Our reports are driven by the way Datix is set up to report, and this is still currently under STP area. This would require some system development to change
Owen Richard, Chief Officer, HealthWatch Southend	I note within the Communications, Brand & Marketing Strategy that Healthwatch Essex and Healthwatch Suffolk are listed as stakeholders. It would be appreciated if Healthwatch Southend and the other local Healthwatch could be listed?	Happy to amend the stakeholder list in the Communications and Marketing strategy to include all local HealthWatch organisations.
Owen Richard, Chief Officer, HealthWatch Southend	Throughout the papers, there is the opportunity to indicate that service users and Healthwatch have been involved. This seems limited and I would welcome a discussion about how Healthwatch in particular might play more of a role in supporting your work.	Marcus Riddell, Senior Director for Organisational Development to respond to Owen directly.

Signed: …… Date: ……

In the Chair

Agenda Item 4
Board of Directors Part 1 Meeting
27 July 2022

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 25 May 2022)

Lead	Initials	Lead	Initials	Lead	Initials
Paul Scott	PS				
Denver Greenhalgh	DG				

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

Minutes Red	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
060/22 May	Remit the Covid-19 Assurance Report oversight to the Executive Team	PS	July 2022	July '22 – COVID 19 Assurance Report removed from the Board forward planner.	Complete	
063/22 May	Complete Provider License Self-Certification documentation, sign and upload to the Trust website.	DG	June 2022	July '22 – Action complete certificates are on the Trust Website. https://eput.nhs.uk/media/lonjccnb/self-certificates-2021_22.pdf	Complete	

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 July 2022**

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

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
Does this report mitigate the Strategic risk(s)?	~~Yes/~~ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes/~~ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

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

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

Summary of Key Issues

The report attached provides information in respect of:

- Governor Elections
- Non-Executive Director Recruitment
- CAMHS Services CQC Report and Lifting of S31 Restrictions
- Annual Members Meeting
- Service Visits
- NHS Parliamentary Awards – Family Group Conference Service
- International Recruitment

- Your Voice Meetings
- Public Governor Mark Dale Recognised as Platinum Champion

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

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

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

Acronyms/Terms Used in the Report			
CAMHS	Children and Adolescent Mental Health Services	NED	Non-Executive Director
CQC	Care Quality Commission		

Supporting Reports/ Appendices /or further reading
Main Report

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

Agenda Item: 5
Board of Directors Part 1
27 July 2022

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Governor Elections

The Governor Elections took place in June 2022 with results announced on the 1 July 2022.

Bedfordshire, Luton, Milton Keynes and Rest of England

- Paula Grayson
- John Jones

Essex Mid and South

- Owen Cartey
- Mark Dale
- Dianne Collins
- Megan Leach
- Stuart Scrivener

North East Essex & Suffolk

- Sue Tivy-Ward
- Cort Williamson

West Essex and Hertfordshire

- Jason Gunn
- Kate Shilling

Staff (Clinical)

- Sharon Green
- Edwin Ugoh

I would like to congratulate all successful Governors on behalf of the Board of Directors and welcome new Governors to EPUT. I would also like to thank those Governors that have left the role (Peter Cheng, Nosi Murefu, Michael Waller, and Judith Woolley) for their time and dedication during their term in office.

2.2 Non-Executive Director Recruitment

Two Non-Executive Director (NED) vacancies have arisen. Amanda Sherlock will complete her second term of office at the end of September and Alison Rose-Quirie has decided that she will be leaving her NED role at the end of October. The Council of Governors are therefore commencing a programme to search for and recruit two new NEDs. The expertise of executive recruitment agency Harvey Nash will be drawn upon to facilitate this process and I anticipate this to be concluded by the end of September 2022.

2.3 Lifting of Section 31 Restrictions for CAMHS Services and Publication of CQC Report

I am delighted to report that the Care Quality Commission (CQC) have confirmed the lifting of the Section 31 restrictions placed on EPUT Tier 4 inpatient CAMHS services in May 2021. CAMHS services have faced extreme pressure regionally and nationally over the past few years and I am

extremely proud of the team for the achievements made to improve patient safety and standards at these units.

2.4 Annual Members Meeting

We are looking forward to holding our Annual Members Meeting in September 2022 and are currently working on the logistics for holding this either face-to-face or virtually. The Annual Members Meeting is for the Trust to present the Annual Report and Accounts to the members, but is also an opportunity for us to reflect on the last year and look forward to the future.

2.5 Service Visits

As we began to return to life without social distancing restrictions, the NEDs and I are pleased that we have been able to conduct face-to-face visits to services to gain a real insight into the challenges experienced by our staff, but also to see the exceptional care provided and dedication of our workforce. Recent visits by NED colleagues and myself have included a virtual session with the West Essex Pain Management team, with in person visits to the Cumberlege Intermediate Care Centre (CICC), St Aubyn Centre, Avocet Ward – Saffron Walden Community Hospital, The Lakes, Basildon Mental Health Unit and Meadowview Ward – Thurrock Hospital. Covid-19 restrictions permitting, we also look forward to the recommencement of the 15 Step Quality Visits with Governors, the first of which is scheduled for 29 July 2022.

2.6 NHS Parliamentary Awards – Family Group Conference Service

Congratulations to Dr Lynn Prendergast and the ground-breaking Family Group Conference Team who have recently won the regional mental health award in the NHS Parliamentary Awards. The service, which has been recognised as best practice by the Social Care Institute of Excellence, has a family / community orientated approach to decision making when the patient at the centre of the planning is vulnerable and the network around them is under extreme stress. Board members were particularly impressed with the innovative approach and enthusiasm of the team during the recent presentation to the Board of Directors from this service; this is another fantastic example of colleagues driving innovation to improve the care we give to those who rely on us.

2.7 International Recruitment

Our international recruitment programme continues with a number of allied health professionals and nurses joining us from Nigeria, Ghana and India. Our overseas staff will receive robust support and guidance to help them settle into their professional roles as well as life in the UK. Many thanks to the international recruitment team for their ongoing efforts to recruit and support international recruits and a warm welcome to the UK and EPUT to our new colleagues.

2.8 Your Voice Meetings

A series of Your Voice meetings for EPUT Members and staff are scheduled throughout the year, each with a different theme. The Your Voice meeting held on 29 June focussed on volunteers, celebrating our unsung heroes. Thank you to Mark Dale, Public Governor for chairing this informative meeting where volunteers and EPUT staff shared their experience of the value that volunteering brings to EPUT, and how their support and dedication helps improve patient care across the Trust.

2.9 Public Governor Mark Dale Recognised as Platinum Champion

Congratulations to Mark Dale, Public Governor, on receiving a Platinum Champion Award as part of an official Platinum Jubilee project celebrating exceptional volunteers across the UK. Out of thousands of nominees, Mark was chosen as one of 490 Platinum Champions for his outstanding commitment to volunteering in the mental health and companionship category. Mark's contribution in sharing his lived experience has been invaluable in shaping and improving our services.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

3.1 The new Procurement Bill – MEAT to MAT:

The Proposed Change from MEAT to MAT - Another change proposed by the Bill is to shift the basis of the evaluation of tenders from Most Economically Advantageous Tender (MEAT), as set out

in the Public Contracts Regulations 2015, to Most Advantageous Tender (MAT). The Government published its Green Paper "Transforming Public Procurement" on 15 December 2020, with its aim to provide a modern, fit for purpose set of rules, improving and simplifying the procurement process. For information: Link

4.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by

Angela Horley
PA to Chair, Chief Executive and NEDs

On behalf of
Professor Sheila Salmon, Chair of the Trust

		Agenda Item No: 6
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 July 2022**

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

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	X
	SR2 People (workforce)	X
	SR3 Systems and Processes/ Infrastructure	X
	SR4 Demand/ Capacity	X
	SR5 Essex Mental Health Independent Inquiry	X
	SR6 Cyber Attack	X
	SR7 Capital	X
	SR8 Use of Resources	X
Does this report mitigate the Strategic risk(s)?	~~Yes/~~ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes/~~ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

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

Recommendations/Action Required

The Board of Directors is asked to:

1 Receive and note the contents of the report.

Summary of Key Issues

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

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **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			
ICS	Integrated Care System	CQC	Care Quality Commission
ICB	Integrated Care Board	CAMHS	Children and Adolescent Mental Health Service
ICP	Integrated Care Partnership	PSIRF	Patient Safety Incident Response Framework

Supporting Reports/ Appendices /or further reading
Main report

Lead
Paul Scott  **Chief Executive Officer**

Agenda Item: 6
Board of Directors Part 1
27 July 2022

CHIEF EXECUTIVE OFFICER (CEO) REPORT

1.0 INTRODUCTION

Operational Pressures

There has been a significant increase of pressure on services over the last two months, reflected in the volume of referrals into teams throughout the organisation. This pressure has been mirrored right across the NHS, with ambulance services reporting significant delays and acute hospitals operating at considerably high bed occupancy levels. Our staff in both community and mental health services remain focused on working with our acute partners in ensuring people receive treatment at home, and accelerating discharge from acute to community settings where possible.

Alongside these operational pressures, we have seen another rise in COVID levels, impacting on staffing levels. In response to this new wave we are reverting back to previous infection prevention and control guidelines including mask wearing in all clinical settings. We know how difficult this is for all our staff, service users and families, exacerbated during a time of unprecedented high temperatures. The recent heat wave resulted in the Met Office issuing a level three heat-health alert for the East of England, which meant teams had to implement emergency guidelines, including the Trust's Heatwave Plan, and conducting further risk assessments, with a particular focus on vulnerable service users, all whilst working in uncomfortable conditions. I continue to be in awe of our staff's agility and ability to continue to deliver services during such challenging conditions.

Formation of Integrated Care Systems (ICSs)

As of 01 July 2022, all 42 ICSs across England became operational as statutory bodies as per the Health and Care Act 2022. Under the Act, two bodies are given statutory status and will collectively make up the ICS through an Integrated Care Board (ICB), responsible for NHS services, funding, commissioning, and workforce planning across the ICS; and an Integrated Care Partnership (ICP), responsible for ICS-wide strategy and broader issues such as public health, social care, and the wider determinants of health.

EPUT continues to work closely with our system partners across the four ICSs we work within, and the nomination process for ICB membership has now concluded. EPUT will be represented by Alex Green on the Hertfordshire and West Essex ICP, Zephan Trent on the Suffolk and North East Essex ICP and myself on the Mid and South Essex ICB. We all look forward to working alongside our partners in a more integrated way to plan and deliver services which meet the local needs of our service users, carers, communities and partners, through improved health and care outcomes and experiences, creating healthier environments and inclusive and sustainable economies.

Update on our children and adolescent mental health services

I am delighted to confirm that the restrictions on our children and adolescent mental health services (CAMHS) have been removed by the CQC. I would like to thank and congratulate our CAHMS Team for their unrelenting passion, dedication and commitment to supporting the young people who rely on us.

There has been considerable investment across CAMHS from estates, technology, training and increased staffing. We have seen the introduction of new technologies, including Oxehealth to improve safety, and greater access to video calling, making it easier for children to contact their families. Ward environments have been developed to be safer and more comfortable, with features such as attractive gardens and therapeutic rooms. An education video link is in place on Poplar Ward so that children who cannot safely move to the education centre do not miss out on lessons.

Investments have been made in staff training and recruitment. We have increased staffing levels and created new roles including senior nursing roles, a new service manager role, a dedicated safeguarding lead and activity coordinators, who engage patients during evenings and weekends.

EPUT now has a brilliant platform and we can now look to the future – further developing and improving the services for our patients and communities. I extend a massive thank you to all involved.

Innovation

This week sees the launch of the Time to Care Programme. Following a comprehensive evaluation process, Deloitte were selected to work alongside our staff to design alternative approaches to traditional ways of working, and build a workforce for the future with redesigned roles to release more time to care. Beginning with our inpatients and progressing across our community services, Time to Care offers an exciting opportunity to transform the way we deliver our services and enable our staff to focus on what they love and do best – proving the highest quality of compassionate care to our communities.

EPUT and Carradale Futures have begun working in partnership to develop best-in-class Standard Operating Procedures (SOPs) to support and enable staff to deliver Mental Health and Community Services safely, effectively, and consistently. Carradale Futures is working alongside clinical and operational colleagues to review, enhance and document critical processes and procedures in the form of detailed, step-by-step, practical guides for completing a given task. When complete, the gold standard SOPs will be made available to all relevant staff across all sites and EPUT systems.

We have also recently signed a Memorandum of Understanding with Concept Health which will see us embark on an exciting six month trial in the use of virtual reality goggles within our pulmonary rehabilitation service in West Essex.

RISE Programme

Last week EPUT celebrated the graduation of its first cohort of colleagues through the Resilience Intelligent Strength and Excellence (RISE) Programme. The RISE Programme is a customised talent development programme introduced in order to support black, Asian, and minority ethnic colleagues into senior leadership roles. Nurturing rising stars within EPUT, the programme supports the Trust's Safety First, Safety Always Strategy, and addresses the gaps identified in the Workforce Race Equality Standard 2020 data, through increasing the confidence and upskilling colleagues working in band 2-8b roles. I am delighted to congratulate the first ever cohort of forty-seven colleagues who successfully completed the programme, and look forward to seeing them contribute to the growing quality of leadership we have here in the Trust.

2.0 PERFORMANCE AND OPERATIONAL ISSUES

Safety and Quality – Natalie Hammond, Executive Nurse

We continue through weekly meetings and spotlight reporting to provide assurance on the activities relating to the Safety Strategy via the Safety Oversight Groups.

Safety Strategy Update

Work is underway to review our progress and to provide further assurance that the initiatives proposed in the "Safety First, Safety Always" strategy are all being fully addressed.

The strategy is split into seven priorities: leadership, culture, continuous learning, wellbeing, innovation, enhancing environments, and governance and information. A mapping exercise of all initiatives contained in the strategy and the progress/status has been completed alongside the identification of other initiatives linked to our safety agenda. This was presented to the Board Safety Oversight Group on the 21 June 2022.

It was agreed that the Transformation Team will continue to provide monthly deep dive into each of the priorities. The first of these was presented in July and focussed on Leadership, and clearly demonstrated the progress we have made. These include the implementation of the Accountability Framework, the NHS People

Plan, and enhanced learnings from serious incidents through our early adoption of the Patient Safety Incident Response Framework (PSIRF) along with many other examples.

The deep dives will be developed with input from the Executive team and subject matter experts for each area which will then form the "pages of the book" and content of the Safety Strategy report to the Board in January 2023.

Finance – Trevor Smith, Executive Chief Finance and Resource Officer

Revenue YTD deficit of £2.6m, £0.5m better than planned expectations. Favourable position relates to over-delivery against the Trust's efficiency programme. Capital there is a current underspend £1m associated with mobilisation of schemes with recovery expected in future months. Clinical and operational engagement undertaken to agree priorities associated with ward refurbishments and recommendation that programme of ward refurbishment/improvement is commenced.

Improvement in receivables position with longstanding debt with neighbouring Provider resolved.

Efficiency – improvement in level of identified efficiency schemes but residual unidentified schemes of £2m-£3m remain. Care Units to run workshops to identify residual efficiencies.

National pay award announcement with systems to receive allocations in August 2022 followed by a distribution process.

Trust has submitted MH ED OBC to Regional office to assist in securing capital resource. Revenue consequences being discussed with commissioners.

Updated purchasing policy approved.

MSE / ICB finance strategy shared for Information

Major Projects – Nigel Leonard, Executive Director of Major Projects and Programmes

Essex Mental Health Independent Inquiry

We continue to support the Essex Mental Health Independent Inquiry, who are still in phase 2, collecting evidence from a range of people including families, carers, patients, and members of the public. Our Project Team have been working on new requests received from the Secretariat, and we do so with full transparency and an unwavering commitment to learning lessons and improving our services. We remain grateful to all of those who have taken the time to share their experiences with the Inquiry so far, and we continue to encourage anyone who wishes to provide their views to come forward, making use of the wellbeing measures EPUT have made available wherever needed.

COVID-19 Vaccination Programme Update

The Trust has continued to work with partners to play a key role in the roll out of the COVID-19 vaccination programme across Essex and Suffolk, with the large-scale vaccination centres operated by EPUT having now delivered in excess of 1.397 million vaccinations.

Since the last report to the Board, we have seen a decrease in footfall through our centres as the Spring Booster campaign reaches its conclusion. However, we continue to see a steady flow of individuals within the following groups:

- Those aged 75 years and over
- Those with a weakened immune system.
- Those aged 5 – 11 years

Following on from successful 5 – 11 year old vaccinations throughout the Easter holidays this cohort has become eligible for second doses. The child friendly environments created in the centres continue to be

appreciated and feedback from children and parents remains very positive. The centres have been busy with this cohort and on a number of occasions have had to add more capacity due to these sessions being fully booked which has been recognised regionally. As well as running sessions within the vaccination centres, we continue to deliver a number of “pop up” sessions through the local library networks and events such as agricultural shows and music festivals to ensure ease of access to the vaccination.

We have worked closely with our system partners and played a significant role in the delivery of the Spring Booster campaign in care homes and those eligible individuals who are housebound, where these cohorts are not being covered by a GP led local vaccination service (LVS). Subsequently our Suffolk and Essex team leads were asked to present at a National Webinar on good practice for care home vaccinations.

We have continued to work with our system partners to look at innovative ways to increase vaccination opportunities for people who have yet to take up the offer of a vaccination, particularly those in the immunosuppressed cohort. This has included continuing the mobilisation of our vaccination buses particularly within areas of lower uptake and areas with high demand. In addition to running sessions within the vaccination centres, we delivered sessions via a roving model in other locations to ensure ease of access to the vaccination. We have included Making Every Contact Count activities during vaccination sessions to offer individuals attending information on other local health and wellbeing related services.

We are still offering first doses of the vaccination at all our centres and pop up sessions and continue to urge those who have not yet taken up the offer to come forward.

I would like to express my continued thanks to staff, volunteers and partner organisations for all their efforts in achieving such a successful programme of vaccination.

Operations – Alex Green, Executive Chief Operating Officer

Despite a period of sustained demand across our service areas, with a Bank Holiday period and increased incidence of COVID outbreak, our operational performance has remained relatively stable. There has been a slight increase in the number of indicators within target, areas of inadequate performance have remained the same, with a reduction in the number of areas requiring improvement which fell from 12 to 11 during June 2022.

I am pleased to report that there has been continued improvement in waiting times for psychology, with areas seeing a pattern of backlog reduction. We continue to have contact with patients who are waiting to ensure appropriate risk management and mitigation.

Our adult mental health inpatient flow and capacity has undoubtedly been impacted by both the rise in COVID outbreaks and an increasing proportion of formal admissions. This has affected our ability to maintain our improvement in the number of patients being cared for in inappropriate out of area placements and length of stay and occupancy rates have also risen; this is not unique to EPUT and is reflective of a more widespread pattern. More positively, our length of stay in PICU however improved in month, falling below the national benchmark and the occupancy rate also reduced. Our continued work on delayed transfers of care and escalation processes has resulted in further reduction and we are performing well against the national benchmark.

CPA performance for our specialist areas has remained above target, with the Trust wide service performance improving. Our community locality areas remain below target with risks mitigated using a RAG rated approach to determine the frequency of patient contact whilst we continue to work on the transformation of services with our system partners on the move away from CPA with a more universal offer for all.

We have an improvement plan in place to address the challenging waiting times for community podiatry in South East Essex which is beginning to impact positively on referral to treatment time breaches.

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

Workforce Systems

Work is progressing on optimising workforce systems. On 1st July a new e-expenses system was launched. The new system has been implemented due to the current supplier withdrawing the existing system. The new system will streamline expenses processes allowing more intuitive mileage claim processes and improving governance. The Trust will also plan to roll out the accompanying app in coming months allowing maximum flexible and saving time for those submitting claims.

A new Occupational Health management referral system has been launched this month. The new system will streamline management referrals to OH and allow managers improved access to occupational health information relating to their staff. The new system will also bring about improvements to accessing reports on key performance indications of the occupational health provision.

Work is also underway on optimisation of both electronic staff record through the introduction of management and maximisation of healthroster, through streamlining rostering processes to ensure the right staff, with the right skills are in place.

Employee Relations

The Annual Employee Relations Activity Report for 2021/22 has now been presented to the People, Equality and Culture Committee and demonstrates a significant reduction in conduct cases from 84 in 2020/21 to 33 in 2021/22 this demonstrates our progressive achievements against the Trust's culture of learning principles and strategy.

Sickness absence related to both general sickness and COVID-19 sickness is increasing and is now at 5.58% (as at 30 June 2022) which is 1.08% above our targeted recovery rate. In accordance with the Trade Union (Facility Time Publication Requirements) Regulations the Trust has submitted information to the Cabinet Office portal and this will be published after the portal closes on 31 July 2022.

Recruitment and Retention Highlights

Vacancy rate – In May the Trust reports a vacancy rate of 18.6%, over the target of <12%. This is due to the full year effect of Transformation Services uploaded in 2022/23, Lighthouse Service budget uploaded in 2022/23 and SDF Transformation Services.

Turnover rate – In May the Trust reports a turnover rate of 11.8%. Within target of <12%. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.

Starters and Leavers

During the month of May the Trust had a total of 135 substantive (permanent & fixed term) new starters. This is split between external starters of 91 and internal promotions of 44. The Trust also had a total of 48 substantive (permanent & fixed term) voluntary leavers during the period. The Trust has also reported that 141 new staff bank workers joined EPUT in May.

Time to Hire

	March	April	May
Recruitment	23.1	23	20.2

For the month of May time to hire was 20.2 days (inclusive of pre-employment checks). This is measured from the shortlisting to unconditional offer.

The resourcing team track each part of recruitment as a KPI and this is split across directorates to compare and contrast figures.

Retention Plan

EPUT continue to work with MSE partners via the ICS to create a workable retention strategy. A target was set in August 2021 "To reduce EPUTs Turnover rates to 9% by August 2022", which was seen to be achievable with the suggested targets put in place. It was agreed that the 'Primary Action's' would be to:

1. Assess High Turnover areas,
2. Improve Career pathways,
3. Targeted support and development opportunities and
4. Improve Recruitment.

Each of these primary actions also had secondary targets aligned to them.

Recruitment Highlights

National nurse recruitment prioritisation/fast track - 108 recruited since November 2021 (registered/qualified).
HCA recruitment prioritisation/fast track - 119 recruited since November 2021 (35 on apprenticeship programme).
Student nurse recruitment – newly qualified nurses 86 recruited since November 2021
Trainee Nurse Associate recruitment - 19 recruited so far and have a target of 50 by December 2022.

Medical Directorate – Dr Milind Karale, Executive Medical Director

Medical Recruitment Fair

The trust successfully held its first doctors recruitment event on Friday 17 June at the Crystal Centre. The event created great visibility of the trust with over 0.3 million web impressions. The Trust met with a number of doctors across UK and the world. We are currently working on converting 23 expressions of interest into appointments, three of these are at consultant grade. In addition, the project delivered a recruitment brochure, landing web page, dedicated e-mail and now a planned annual recruitment event calendar for the future.

Dependence forming Drugs Service

North Essex care unit has now launched a pilot project that supports Colchester GPs with addressing patients dependent on primary care prescribed medication that are habit forming. This one-year pilot project aims to use a Holistic approach in supportive reductions delivered by a Multi-disciplinary team.

Substance Misuse and End of Life Pathway

The STaRS team and End of Life care team have jointly launched a clinical pathway that ensures dignity and companionate care towards the end of life for people with Substance Issues. This pathway traverses, mental health, Acute Hospital, Addictions services and Hospices in the area.

Dr Vyasa Immadisetty has been nominated to the Addictions Faculty Executive of the Royal College of Psychiatrists.

FIRST (Functional Intensive Response & Support Service) has been established and live since May 2022**.**

The team is supporting patients from the ward during the home leave and providing in reach to support early discharge.

Secure Provider Collaborative Update – Dr Raman Deo

Engagement with clinical scrutiny panels by regional consultants remains mixed. Efforts to repatriate patients from out of area into region remains slow, although much work has been done to map and allocate full cases for consideration. Dr Deo is to hold a meeting open to all regional forensic consultants to discuss moving towards a single regional referral and bed management meeting so that decision around repatriation and

allocation can be considered with the maximum number of clinicians available, which it is hoped will ensure a speedier impact on repatriations. Community Forensic Services continue to be a success.

Perinatal Update – Dr Rina Gupta

Community Achievements

1. Across Essex we are exceeding national performance target of 8.6% birth population for 21/22 at 10.9% over 21/22 – 3400 women referred and 2323 accessed service in last year
2. Near completion of over 60wte significant multi-professional 3yr recruitment programme
3. Significant transformation and service design with innovative features (pathways, novel disciplines/roles and intervention development, integration with maternity, numerous tools designed to support practice)
4. Second positive Peer Review of CCQI Community Quality Standards in Winter 2021
5. Positive relationships building with multiple system partners across 5 hubs

Rainbow has attended EPUT lab regarding development of a 'Rainbow MBU parents app' to support and improve the involvement and contact of the second parent with their child which will allow staff to write notes, upload photos and short videos to the second parent. This has been fully supported by the lab and meetings are currently ongoing to initiate/develop. Successful expansion of the MBU from 5 beds to 6 beds.

3.0 RECOMMENDATIONS / ACTION REQUIRED

The Board of Directors is asked to:

1 Receive and note the contents of the report.

Report prepared by:

Paul Scott
Chief Executive Officer

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 July 2022**

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

Risk Assessment of Report		
Summary of risks highlighted in this report	All inadequate and requiring improvement indicators.	
State which of the following Strategic risk(s) this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	✓
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	Continued monitoring of Trust performance through integrated quality and performance reports.	

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

Performance Reporting

This report presents the Board of Directors with a summary of performance for month 3 (June 2022)

The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) have reviewed performance for June 2022.

Four inadequate indicators (variance against target/ambition) have been identified at the end of June 2022 and are summarised in the Summary of Inadequate Quality and Performance Indicators Scorecard.

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

There is one inadequate indicator which is an Oversight Framework indicator for June 2022

- Out of Area Placements

There are no inadequate indicators in the EPUT Safer Staffing Dashboard for June 2022.

There are no inadequate indicators within the CQC scorecard. The CAMHS wards were previously inspected in May 2021, following this inspection an action plan was created, which ESOG approved closure of on 31st May 2022.
Therefore there are no open CQC action plans.
The Trust continues to await the final report from this latest CAMHS inspection.

Within the Finance scorecard two items have been RAG rated inadequate for June.

- Temporary Staffing
- Maximising Capital Resource - The underspend largely relates to the commencement of a number of BAU and strategic ICT schemes.

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

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

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

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

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

CPA	Care Programme Approach	NHSI	NHS improvement
CQC	Care Quality Commission	OBD	Occupied Bed days
CRHT	Crisis Resolution Home Treatment Team	OT	Outturn

Supporting Documents and/or Further Reading
Quality & Performance Scorecards

Lead
Paul Scott **Chief Executive**

NHS
Essex Partnership University
NHS Foundation Trust

Trust Board of Directors
EPUT Integrated Quality and Performance Score Cards
June 2022

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

Report Guide

Use of Hyperlinks

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

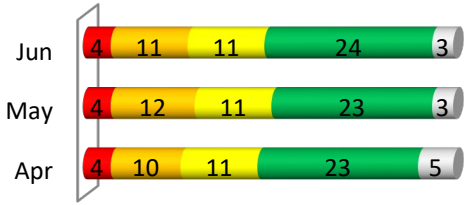
How is data presented?

Data is presented in a range of different charts and graphs which can tell you a lot about how our Trust is performing over time. The main chart used for data analysis is a Statistical Process Chart (SPC) which helps to identify trends in performance a highlight areas for potential improvement. Each chart uses symbols to highlight findings and following analysis of each indicator an assurance RAG (Red, Amber, Green) rating is applied, please see key below:

Statistical Process Control (Trend Identification)					
Variation			Assurance		
					
Common Cause – no significant change	Special Cause or Concerning nature or higher pressure due to (H)igher or (L)ower values	Special Cause of improving nature of lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting and passing and falling short of the target	Variation indicators consistently (P)assing the target	Variation Indicates consistently (F)alling short of the target
Assurance (How are we doing?)					
Meeting Target EPUT is achieving the standard set and performing above target/benchmark	Requiring Improvement EPUT is performing under target in current month/ Emerging Trend	Inadequate EPUT are consistently or significantly performing below target/benchmark / SCV noted / Target outside of UCL or UCL	Variance Trust local indicators which are at variance as a whole or have single areas at variance / at variance against national position	For Note These indicate data not currently available, a new indicator or no target/benchmark is set	Indicators at variance with National or Commissioner targets. These have been highlighted to Finance & Performance Committee.

SECTION 1 - Performance Summary

Summary of Quality and Performance Indicators

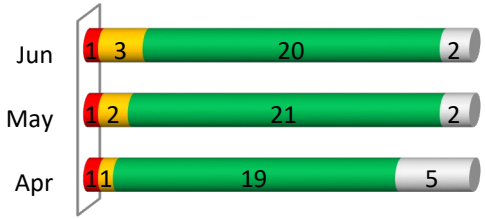


June Inadequate Performance

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

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

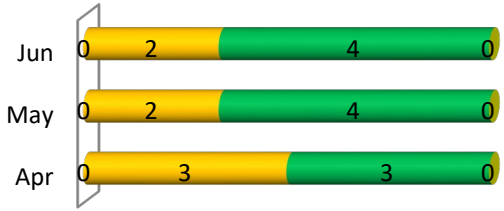
Summary of Oversight Framework Indicators



June Inadequate Performance

- Out of Area Placements

Summary of Safer Staffing Indicators



Two risks identified within the Safer Staffing section.

This data is collected from SafeCare.

There is currently a project underway being led by the Head of People Programmes to enhance the staffing reporting with new metrics which will enable improved monitoring and mitigation

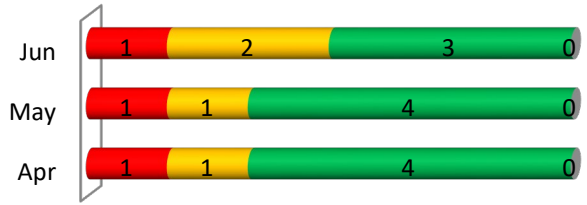
Summary of CQC Indicators

The CAMHS wards were previously inspected in May 2021, following this inspection an action plan was created, which ESOG approved closure of on 31st May 2022. Therefore there are no open CQC action plans.

CQC have undertaken a new inspection of the CAMHS Wards on 1st March 2022. This involved unannounced site inspections at all 3 wards and follow up information request, which has been submitted.

The draft feedback report for the CAMHS Ward inspection in March 22 was received on the 20th June 2022. Factual accuracy checking has been undertaken and a response sent back to the CQC within their deadline of 10 working days. The Trust continues to await the final report from this latest CAMHS inspection.

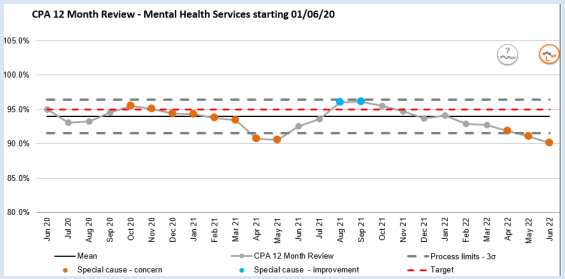
Finance Summary

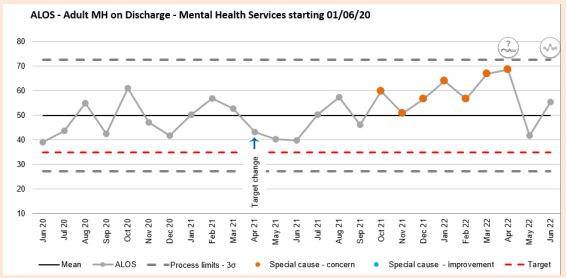
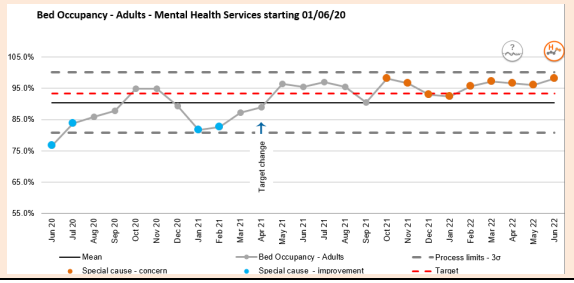


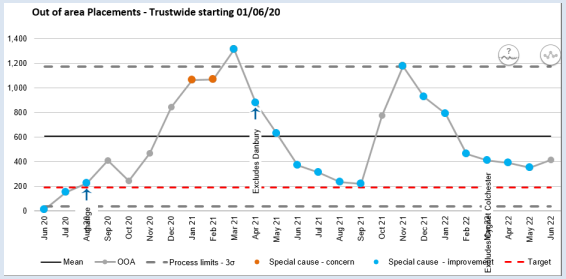
June Inadequate Performance

- Temporary Staffing
- Capital Resources

SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.3 CPA Review Committee: Quality Indicator: National Data Quality RAG: **Amber**	**Inadequate** Overall performance continues to be below target at 90.1%, this is a further reduction from the position reported in May (91.1%). In June both North East & West and Mid & South witnessed a further decline and remain below target. Specialist services remained consistently above target and Trust wide services have improved however remain below target. With staffing levels and COVID pressures continuing to impact performance the service continues to mitigate risk by undertaking RAG ratings on caseloads. Clients are rated red, amber, or green and from this, the frequency of contacts is determined. These calls maintain regular contact with clients whilst they wait to be seen. Those RAG rated red are contacted on a daily basis, those amber is weekly, and green is monthly. Staff continue to review their cases as part of their routine supervisions and continue to have the support of the Operation Productivity team who liaise with the staff to support with those breaching. The new MaST tool (management and supervision tool) continues it's rollout, which enables staff to further monitor their caseloads.						
	People on CPA will have a formal CPA review within 12 months **Target 95%**	90.1%	●	Above Target = Good 	●	There were 15 Teams in the South, four Teams in Mid, three Teams in NE, two Teams in West and one Trust Wide Team below target.	

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.9 Inpatient Capacity Adult & PICU MH Committee: Quality Indicator: Local Data Quality RAG: TBC	**Inadequate** In June adult average length of stay increased and remains outside the benchmark of <35 with performance at 55.5, this is an increase on 42.0 in May. There were 108 discharges in June, 18 of whom were long stays (60+ days). There have been more discharges and less long stays in June. Adult occupancy rates have increased to 98.1% in June, compared with 96.2% in May. This does remain outside the benchmark of <93.4%. The number of beds closed due to COVID has increased in recent weeks due an increased number of outbreaks. Additional work is ongoing working with Flow & Capacity leads to ensure recording of Delayed Transfers of Care are being recorded on both EPR's. Essex wide daily sitreps remain in place as well as the locality joint inpatient and community review and discharge planning meetings. System DTOC are raised in weekly meetings with Health and Social Care commissioning. Discharge Coordination teams continue to lead a monthly review of clinical information for all Adults with LOS 28+ days to ensure all have an active treatment plan, an allocated care coordinator, barriers to discharge are understood and that there is progression to discharge with escalation to Clinical Director, Service Manager and Associate Director for review if required. Monthly review continues to indicate clients with an extended LOS are in active treatment and extended inpatient admission is clinically appropriate.						
	2.9.2 Adult Mental Health ALOS on discharge less than NHS benchmark **Target: <35** (Adult Acute Benchmark 2020 35)	55.5 days	●	Below Target = Good 	●	Consistently failing target 108 discharges in June (18 of whom were long stays (60+ days)). Adult Acute 2020 benchmark EPUT result was 31, against a National mean of 35	TBC
	2.9.4 % Adult Mental Health Bed Occupancy below national benchmark **Target: 93.4%** (Adult Acute Benchmark 2020 93.4%)	98.1%	●	Below Target = Good 	●	Adult Acute 2020 benchmark EPUT result was 99.7%, against a National mean of 93.4%.	N/A

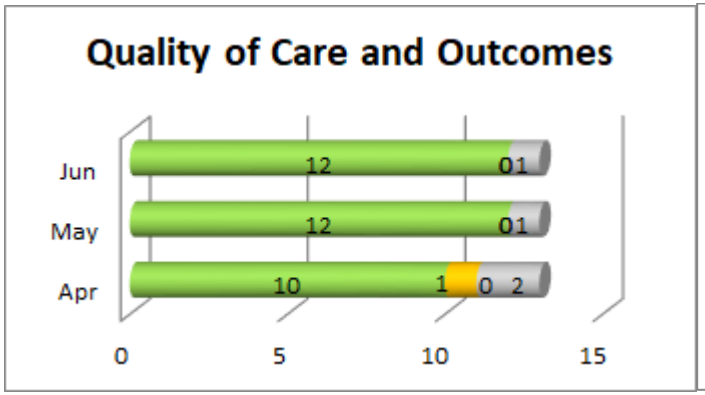
Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.5 Out of Area Placements Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Amber**	June has seen an increase in out of area bed days, 417 (excluding Danbury & Cygnet). Recent increases in mental health presentations to A&E have affected this indicator as well as an increasing number of closed beds due to COVID. The revised NHSE/I target has now been set to 0 placements by the end of March 2023. There continues to be comprehensive action plans in place across the Trust to meet this. Neighbouring Trusts also face similar challenges in reducing their placements. More oversight is now available on the placements to the Priory (Danbury ward) and a new contract for 7 male beds with Cygent Colchester has recently been approved. NHSE/I have confirmed these placements are to be classed as appropriate and are therefore not included in these numbers. Ten new clients were placed OOA (seven Adult & three PICU) in June, and following the repatriation of five (four Adult & one PICU), there were 16 remaining (12 Adult & four PICU) OOA at the end of the month.						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by end of June 2022**	417 Days		Below Target = Good 		Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Data excludes patients placed on Danbury Ward & Cygnet Colchester.	Jun 2022

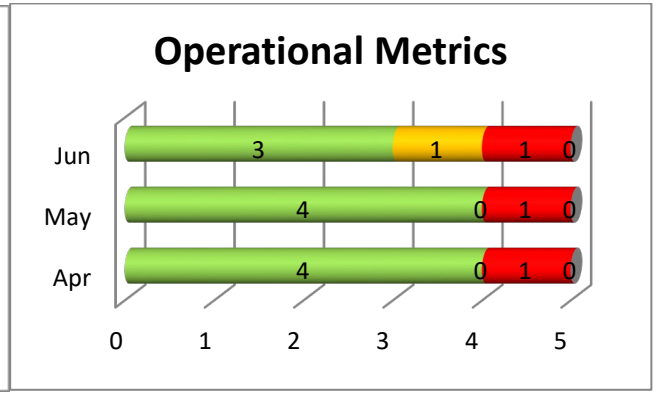
4.10 Psychology Committee: Quality Indicator: Local Data Quality RAG: **Blue**	4.10 Clients waiting on a Psychology waiting list	Compared to a year ago in the South East the number of people waiting to access their initial intervention point and second phase specialist therapy remains a stable reduction of 27%. This percentage decrease matches the percentage of people we have transferred from specialist mental health psychological services to Therapy for You+ (step 4) since February 2022. A collective effort to work through screening assessments for the complex needs pathway (DBT and STEPPPS interventions) has resulted in an 83% reduction of people waiting compared to a year ago. People are currently waiting an average of just 5 weeks for a screening review. The number of people waiting to access DBT and STEPPS has increased with wait times increasing from 6 to 8 months. This is due to both the high volume of screenings completed in recent months and the duration of both the DBT (8 weeks per module with attached pre-treatment sessions increasing to 10 weeks) and STEPPS groups (20 weeks). A new STEPPS group is due to start at the end of July which will offer 12 people access. The service is also now running hybrid online and face to face groups, further enhancing access. Projected wait times for November 22 are reduced across all stages of our clinical pathway with exception of DBT and STEPPS which are predicted to remain stable. A preceptorship post has been recruited to for one year, this post includes delivering a STEPPS intervention. An additional nurse therapist role is also being seconded into the service for a year to further boost DBT delivery. The waiting times across localities in the South West were stable for some time before step 4 was introduced and afterwards. However, they are now starting to show a pattern of reducing. It is a positive step showing that despite no reduction in demand the service is starting to reduce the backlogs in both adult community psychology and DBT/STEPPS pathways. Two new members of psychotherapy staff will be joining the adult community psychology team in July. Although the service will be losing a counselling psychologist, this overall increase in resource should help further reduce waiting times. There is an ongoing recruitment drive to fill vacancies to ensure adult community psychology South West are fully resourced and more able to meet demand. Risk calls are being made to those waiting (not on CPA) and to ensure any additional needs have a care plan and are documented. Waiting List update June 2022: South East – There are 247 clients awaiting intervention. Individual therapy currently has the longest wait with 11 months, there are 102 clients waiting for this. South West – There are 244 awaiting intervention. Individual DBT informed therapy and schema therapy currently have the longest waits both at 27 months. There are 3 clients waiting for individual DBT informed therapy and 8 clients waiting for schema therapy.

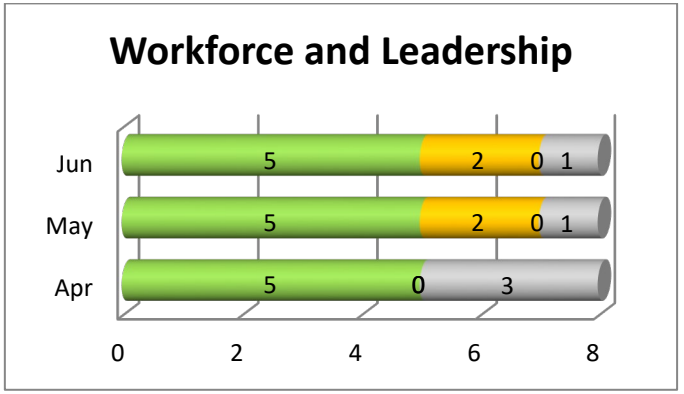
SECTION 4 - OVERSIGHT FRAMEWORK

Click here to return to summary page

Please note this reporting is against the national Oversight Framework published in August 2019. A new NHS System Oversight Framework has been published and a project is underway to develop reporting for this.





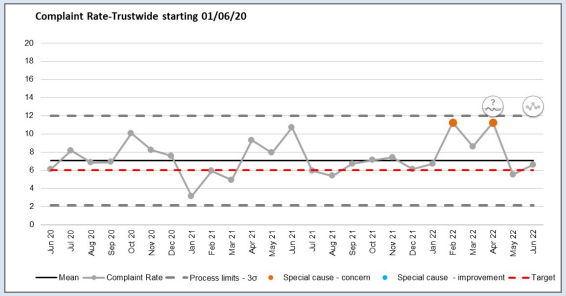


Inadequate

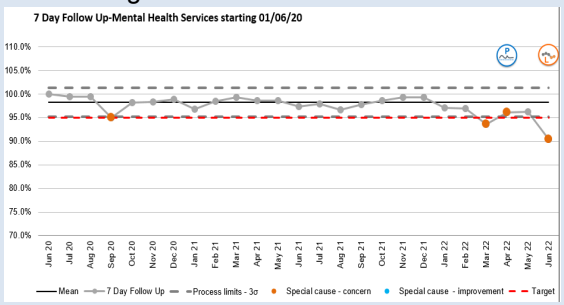
- Out of Area Placements

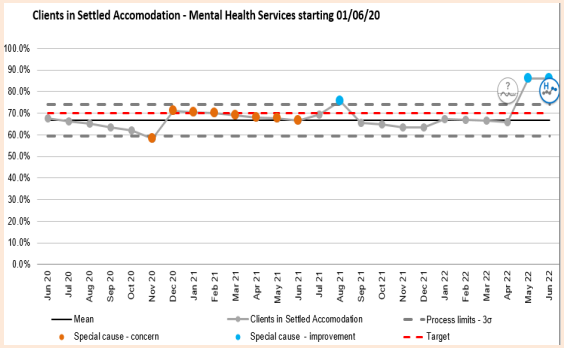
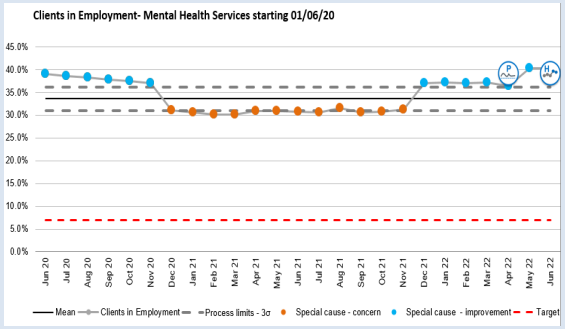
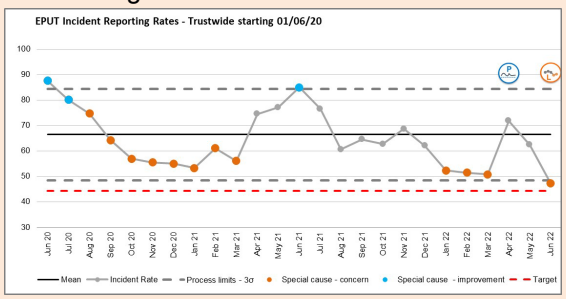
Requires Improvement

- Data Quality Maturity Index
- Staff Sickness
- Tempoaray Staff (Agency)

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1.1 CQC Rating Committee: FPC Data Quality RAG: **Green**	Achieve a rating of Good or better	Good	●	The restrictions on our children and adolescent mental health services (CAMHS) have been removed by the CQC.			
	No action plans past timescale		●	The CAMHS wards were previously inspected in May 2021, following this inspection an action plan was created, which ESOG approved closure of on 31st May 2022. The CQC have undertaken a new inspection of the CAMHS Wards on 1st March 2022. This involved unannounced site inspections at all 3 wards and follow up information request, which has been submitted. The draft feedback report for the CAMHS Ward inspection in March 22 was received on the 20th June 2022. Factual accuracy checking has been undertaken and a response sent back to the CQC within their deadline of 10 working days.		
4.1.1 Complaint Rate Committee: FPC Indicator: Oversight Committee Data Quality RAG: **Green**	4.1.1 Complaint Rate **OF Target TBC** Locally defined target rate of 6 each month	6.6	●	Below Target = Good 	●	This will move to an emerging risk should performance increase further. In June the areas with the highest number of complaints are Chelmsford and Colchester.	N/A
5.6 Staff FFT	5.6.1 Staff FFT recommend the Trust as place to work **Target 63%**	The Staff FFT has been replaced with the National Quarterly Pulse Survey. In the most recent publication we were pleased to see positive results across all questions, with more favourable scores on five out of nine questions compared to last quarter (2021/22 Q4).					

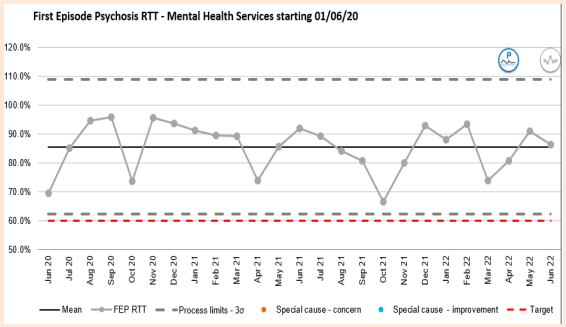
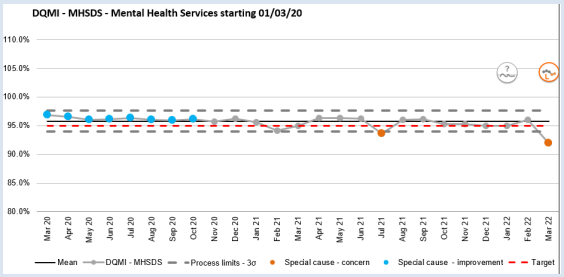
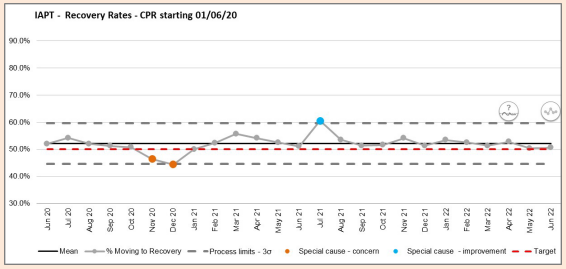
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: FPC Data Quality RAG: **Green**	5.6.2 Staff FFT recommend the Trust as a place to receive treatment **Target 74%**						
1.1 Never Event Committee: Quality Indicator: OF Data Quality RAG: **Blue**	0 Never Events **2019/20 Outturn 0**	0	●	Year to Date 0	●		N/A
1.6 Safety Alerts Committee: Quality Indicator: OF Data Quality RAG: **Green**	There will be 0 Safety Alert breaches **2020/21 Outturn 0**	0	●	Year to date there have been no CAS safety alerts incomplete by deadline.	●		N/A
3.1 MH Patient Survey Committee: Quality	Positive Results from CQC MH Patient Survey	The 2021 survey results have now been published. 1,250 EPUT clients were invited to take part, and 324 responded. This is a response rate of 27%. EPUT achieved “about the same” for 26 questions in the 2021 survey when compared with other Trusts. 2 questions scored “somewhat worse than expected”. These 2 questions fell under the NHS Talking Therapies domain.					

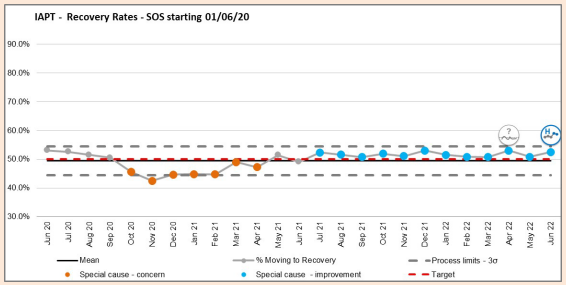
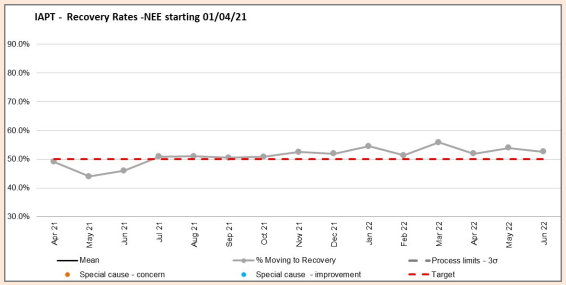
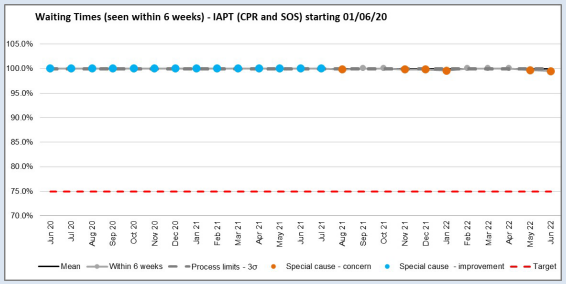
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: Oversight Framework Data Quality RAG: **Green**							
3.3 Patient FFT Committee: Quality Data Quality RAG: **Green**	3.3.1 Patient FFT MH response in line with benchmark Target = 88% (Adult Acute 2020 Benchmark 88%)			I Want Great Care was implemented across the Trust from 23rd January 2022. We are awaiting further FFT configuration. We are hoping to hear from the iwantgreatcareteam shortly.		91.9% for the positive score in June. This is currently not split between MH and CHS.	
	3.3.2 Patient FFT CHS response in line with benchmark Target = 96%						
2.8.1 Mental Health Discharge Follow up Committee: Quality Data Quality RAG: **Blue**	2.8.1 Mental Health Inpatients will be followed up within 7 days of discharge **Target 95% Benchmark 98%** (Adult Acute 2020 Benchmark 98%)	90.4%		Above Target = Good 		Discharge follow ups form part of EPUT's "10 ways to improve safety" initiative. June performance : Total 113 / 125 – awaiting validation Adult Acute 2020 benchmark EPUT result was 92%, against a National mean of 98%	

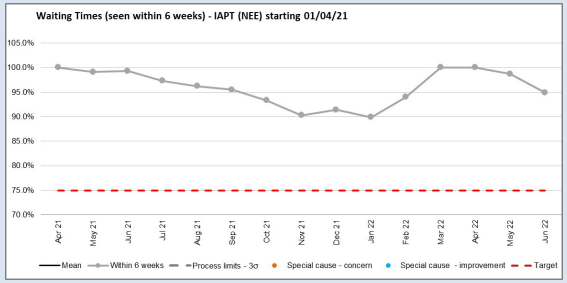
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.4 MH Patients in Settled Accommodation Committee: Quality Indicator: Oversight Framework Data Quality RAG **Green**	We will support patients to live in settled accommodation **Target 70% (locally set)**	86.2%	●	Above Target = Good 	●	June performance : Paris 88.0% Mobius 80.0% (New valid (Settled Accommodation) codes added to Paris, not previously used)	N/A
2.5 MH Patients in Employment Committee: Quality Indicator: Oversight Framework Data Quality RAG: **Green**	We will support patients into employment **Target 7% (locally set)**	40.3%	●	Above Target = Good 	●	June performance : Paris 47.0% Mobius 17.3% Assurance indicates consistently passing target.	N/A
1.8 Patient Safety Incidents Reporting Committee: Quality Data Quality RAG: **Amber**	Incident Rates will be in line with national benchmark **>44.33** MH Benchmark	44.6	●	Above Target = Good 	●	This is achieving target for June, with the EPUT total at 47.2. Staffing pressures are impacting on the time available for staff to sign off all incidents. This data is also extracted very early in the month due to reporting timescales and does usually improve on refresh.	

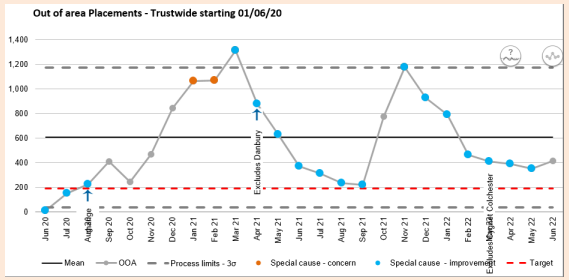
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
1.15 Admissions to Adult Facilities of under 16's Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	0 admissions to adult facilities of patients under 16	0	●	Zero admissions in May	N/A		N/A

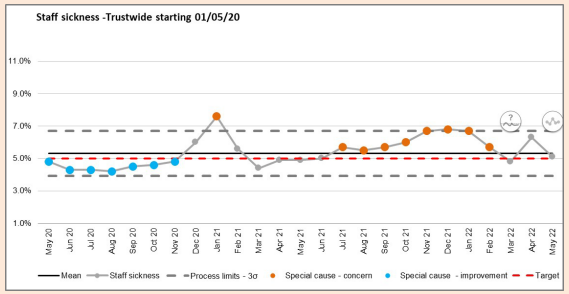
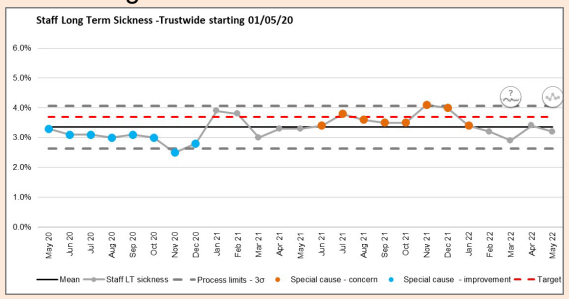
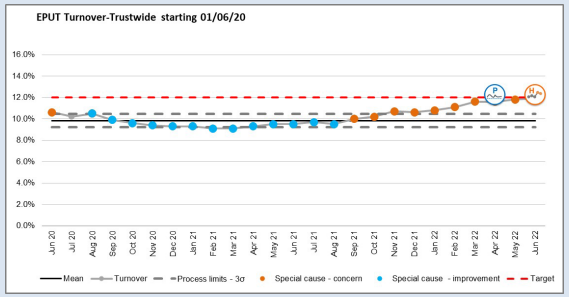
Click here to return to Summary

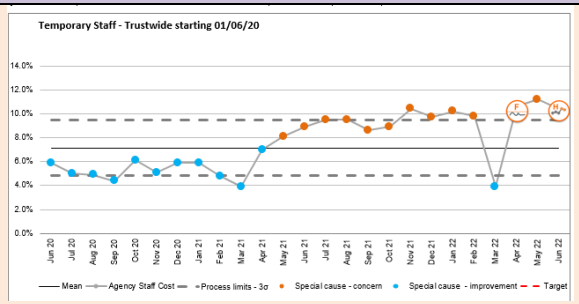
Operational Metrics							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.6 First Episode Psychosis Committee: Quality Data Quality RAG: **Green**	All Patients with F.E.P begin treatment with a NICE recommended package of care within 2 weeks of referral **Target 60%**	86.4%	●	Above Target = Good 	●	June performance represents: 19 / 22 patients.	N/A
2.2.1 Data Quality Maturity Index Committee: FPC Data Quality RAG: **Green**	2.2.1 Data Quality Maturity Index (MHSDS Score – Oversight Framework) **Target 95%**	91.9%	●	Above Target = Good 	●	Latest published figures are for March 2022. This decline is currently being investigated.	
2.16.4/5/6 IAPT Recovery Rates Committee: FPC	2.16.4 IAPT % Moving to Recovery CPR **Target 50%**	50.6%	●	Above Target = Good 	●		

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: National Data Quality RAG: **Green**	2.16.5 IAPT % Moving to Recovery SOS **Target 50%**	52.5%	●	Above Target = Good 	●		
	2.16.6 IAPT % Moving to Recovery NEE **Target 50%**	52.6%	●	Above Target = Good 	●		
2.16.7/8 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.7 % Waiting Time to Begin Treatment – 6 weeks CPR & SOS **Target 75%**	99.5%	●	Above Target = Good 	●		

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.16.8 % Waiting Time to Begin Treatment – 6 weeks NEE **Target 75%**	94.9%	●	Above Target = Good 	●		
2.16.9/10 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.9 % Waiting Time to Begin Treatment – 18 weeks CPR & SOS **Target 95%**	100%	●	Above Target = Good	●		
	2.16.10 % Waiting Time to Begin Treatment – 18 weeks NEE **Target 95%**	100%	●	Above Target = Good	●		
4.5 Out of Area Placements ● Committee: FPC	June has seen an increase in out of area bed days, 417 (excluding Danbury & Cygnet). Recent increases in mental health presentations to A&E have affected this indicator as well as an increasing number of closed beds due to COVID. The revised NHSE/I target has now been set to 0 placements by the end of March 2023. There continues to be comprehensive action plans in place across the Trust to meet this. Neighbouring Trusts also face similar challenges in reducing their placements. More oversight is now available on the placements to the Priory (Danbury ward) and a new contract for 7 male beds with Cygent Colchester has recently been approved. NHSE/I have confirmed these placements are to be classed as appropriate and are therefore not included in these numbers. Ten new clients were placed OOA (seven Adult & three PICU) in June, and following the repatriation of five (four Adult & one PICU), there were 16 remaining (12 Adult & four PICU) OOA at the end of the month.						

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: Oversight Framework Data Quality RAG: **Amber**	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by end of June 2022**	417 Days	●	Below Target = Good 	●	Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Data excludes patients placed on Danbury Ward & Cygnet Colchester.	Jun 2022

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3.1 Staff Sickness Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Blue**	5.3.1 Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**	5.1%		Below Target = Good 		The sickness figures are reported in arrears to allow for all entries on Health Roster. National data February 2022: The overall sickness absence rate for England was 5.6%. This is lower than January 2022 (6.7%) but higher than February 2021 (4.6%). Anxiety/stress/depression/other psychiatric illnesses is consistently the most reported reason for sickness absence. EPUT reported below the England average for this period at 5.4%.	
	5.3.2 Long Term Sickness Absence below 3.7% **Target 3.7%**	3.2%		Below Target = Good 	N/A		
5.2.2 Turnover Committee: FPC Data Quality RAG: **Green**	5.2.2 Staff Turnover (Benchmark 2020 MH 12% / 2017/18 CHS 12.1%) **OF Target TBC** **Target <12%**	11.9%		Below Target = Good 		Special Cause of concerning nature of higher pressure due to higher values. Performance remains outside of the limits of expected variation. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.	N/A
5.7.3 Temporary Staffing (Agency)	5.7.3 Proportion of temporary Staff (Provider Return)	10.4%		Below Target = Good	N/A		

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: FPC Indicator: Oversight Framework Indicator Data Quality RAG: **Green**	No Oversight Framework Target						
5.5 Staff Survey Committee: FPC Data Quality RAG: **Green**	5.5 Outcome of CQC NHS staff survey	The 2022 Staff Survey will launch in late September 2022. **<u>Information from the 2021 Staff Survey</u>** The Staff Survey ran from September to November 2021. This year saw the biggest change in how results were formalised. The themes have been aligned to the People Promise which means in some areas we are unable to compare results against previous years. The Trust was measured against nine themes in the 2021 Survey. EPUT scored above average in three themes, in line with average on three themes, and below average against three themes. **Actions:** • Internal Communications Campaign to share results after embargo is lifted. This is to be a regular item moving forward to ensure engagement and staff feedback is a continuous topic and agenda item at EPUT. A clear focus on 'you asked, we delivered'. • Focus groups with staff to understand the survey results co-create solutions/ actions to tackle from areas of focus below, share good practise and work on improvements in their local areas. • Focus groups to support with the development of a trust wide action plan. • Update to Engagement Champions with a focus on their role in sharing results and supporting with 'you asked, we delivered'. **Areas of Focus:**			

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				

- We are recognized and rewarded-Pay, benefits, recognition and value.
- We each have a voice that counts-autonomy, empowerment, control and raising concerns.
- We are a team-Team working and Line management
- Morale-in relation to work pressures and particularly retention of staff.
- Discrimination in relation to ethnicity

Highlights of each theme:

Theme: We are Compassionate and Inclusive	**Score**
89% agree or strongly agree and 2% above average. In reference to questions about compassionate culture, we can celebrate the fact that people are fulfilled and can understand how their day-to-day role affects service users.	Average

Theme: We are Recognised and Rewarded	**Score**
My level of pay; 31.9% were satisfied or very satisfied and is 6% below the average. In employee surveys, questions on pay are traditionally lower scoring. There is an opportunity for us at EPUT to look at our overall benefits package for staff.	Below Average

Theme: We each have a voice that counts	**Score**
I am trusted to do my job; 92.1% agree or strongly agree and 1% above average. This is a positive story around autonomy and control and a very high scoring question.	Below Average

Theme: We are Safe and healthy	**Score**
I am able to meet all the conflicting demands on my time at work; 49% agree or strongly agree and 5% above average. This question really captures the context of how we are performing in comparison to other organisations like us. Work and staffing pressures are not unique to EPUT and actually, with this question, the average was 44.9%.	Above Average

Theme: We are always Learning	**Score**
It helped me to improve how I do my job; 25.2% selected yes definitely to this question on appraisals and this was 5% above average. This is a positive message on the impact of the new appraisal process.	Average

Theme: We work flexibly	**Score**

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M03** **Perf**	**RAG**	**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**

I can approach my immediate manager to talk openly about flexible working; 78.3% selecting agree or strongly agree and 1% above average. Conversations around flexible working with line managers is scoring very well and is a positive message for work-life balance.	Average

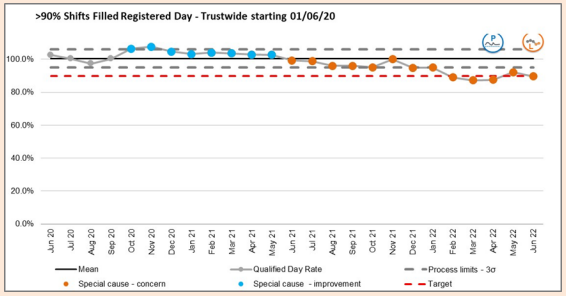
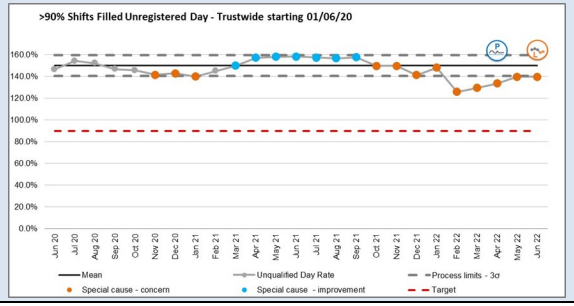
Theme: We are a team	**Score**
My immediate manager takes a positive interest in my health and wellbeing; 77.2% said agree or strongly agree In reference to the questions on line management, there is a positive message that shows that even through unprecedented circumstances and change, managers are showing resilience. Line managers often get a tough time, but the results show that managers are supporting.	Below Average

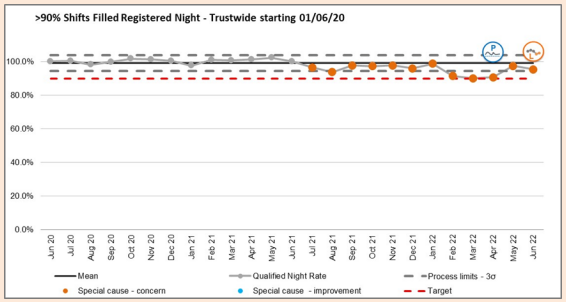
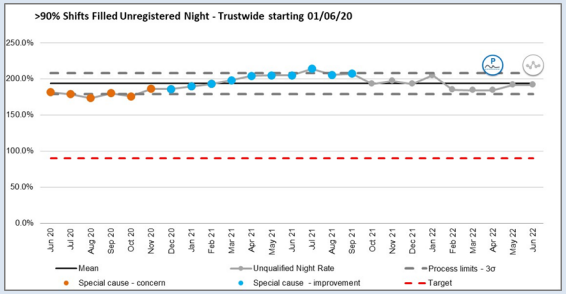
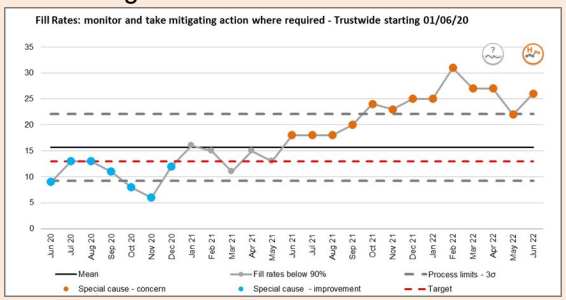
Theme: Staff Engagement	**Score**
I am enthusiastic about my job; 72% selected often/always and 2% above average. In reference to questions about motivation, here we can see that there is an opportunity for us here at the trust as despite the pressures our staff members are facing, they are still passionate about their roles and purpose.	Above Average

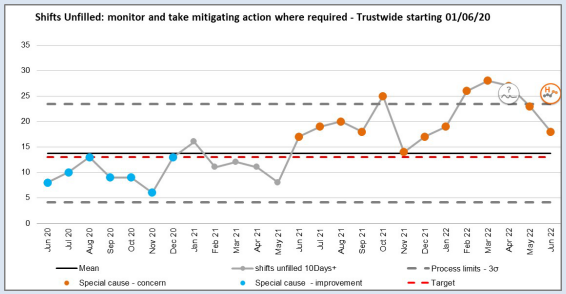
Theme: Morale	**Score**
I will probably look for a job at a new organisation in the next 12 months; 20.5% agreed/strongly agreed. In reference to questions relating to retention/ thinking about leaving, this area warrants concern as we already have staffing levels pressures.	Above Average

SECTION 5 - SAFER STAFFING SUMMARY

Click here to return to summary page

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards. From February 2022 this data is being extracted from SafeCare. There is currently a project underway being led by the Head of People Programmes to enhance the staffing reporting with new metrics. Safe staffing performance continues to be monitored by the Quality SMT and Quality Committee.							
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	89.6%		Trend above target = good 		The following wards were below target in June: Adult: Ardleigh, Willow, Chelmer, Finchingfield Galleywood, Kelvedon, Cherrydown Adult Assessment: Peter Bruff CAMHS: Larkwood, Poplar CHS: Cumberlege Centre Nursing Home: Rawreth Court Older: Beech(Rochford) Henneage, Meadowview, Ruby, Tower Specialist: Edward House, Fuji, Lagoon, Rainbow	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	139.9%		Trend above target = good 		The following wards were below target in June: Adult: Finchingfield, Galleywood Specialist: Rainbow, CHS: Cumberlege, Poplar Nursing Home: Rawreth Court Older: Topaz	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	95.5%		Trend above target = good 		The following wards were below target in June: CHS: Cumberlege CAMHS: Poplar, Larkwood, Longview Nursing Home: Rawreth, Clifton Older: Beech, Tower Specialist: Rainbow Adult: Galleywood	N/A
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts filled	191%		Trend above target = good 		The following wards were below target in June: CHS: Beech, Cumberlege Specialist: Edward House, Rainbow	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required	26		Below Target = Good 		The following wards had fill rates of <90% in June: Adult:, Finchingfield, Galleywood, Nursing Homes: Rawreth Court, Specialist: Rainbow CHS: Beech, Cumberledge, Poplar Older: Topaz	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M03**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	18		Below Target = Good 		The following wards had more than 10 days without shifts filled in June: Specialist: Robin Pinto,Causeway CHS, Beech Older, Roding, Gloucester, Kitwood Adult: Chelmer,Stort LD: Heath Close	N/A

Fill Rates

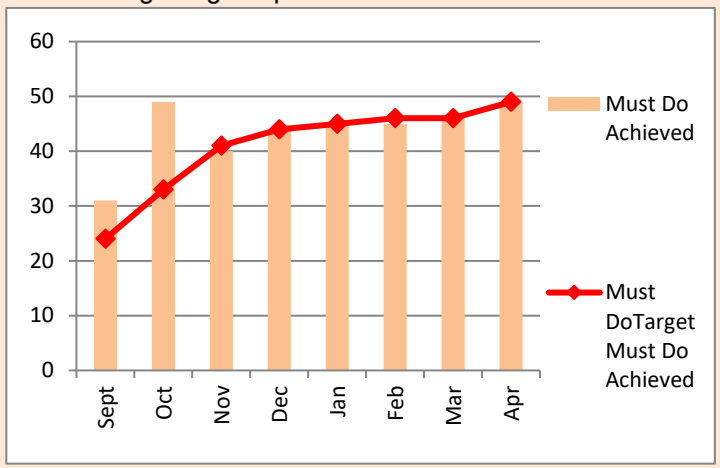
	Day Rates		Night Rates		Day Rates		Night Rates		Day Rates		Night Rates	
	Apr-22				May-22				Jun-22			
	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED
TARGET >90%												
MH ADULT ACUTE												
ARDLEIGH WARD	63.9%	96.9%	72.6%	141.0%	69.2%	123.8%	104.4%	162.6%	72.5%	147.7%	104.4%	185.0%
CEDAR	117.3%	244.7%	97.5%	279.3%	121.0%	238.6%	101.9%	268.4%	119.4%	263.6%	102.1%	256.6%
WILLOW	78.7%	338.1%	108.5%	436.9%	81.8%	268.0%	102.6%	298.8%	70.9%	225.8%	111.2%	312.3%
CHELMER WARD	91.9%	305.1%	87.8%	607.1%	108.7%	307.6%	97.1%	646.4%	86.7%	323.3%	95.3%	509.1%
FINCHINGFIELD WARD	38.4%	69.1%	203.6%	228.6%	38.4%	68.4%	198.8%	201.6%	42.7%	60.8%	182.6%	177.1%
GALLEYWOOD WARD	61.4%	57.6%	84.6%	85.6%	52.6%	54.4%	95.2%	69.9%	59.5%	71.0%	90.0%	96.7%
GOSFIELD WARD	71.9%	180.1%	66.7%	251.1%	87.9%	275.9%	103.1%	513.3%	91.7%	240.0%	102.0%	360.0%
KELVEDON			111.7%	419.2%	105.6%	375.6%	111.8%	426.3%	76.7%	235.2%	109.9%	310.9%
STORT WARD	90.3%	335.8%	86.7%	253.3%	101.8%	128.2%	95.1%	267.3%	102.7%	149.7%	93.3%	272.9%
CHERRYDOWN	100.3%	148.0%	98.2%	545.1%	90.6%	394.2%	101.1%	580.8%	78.0%	387.3%	100.7%	571.4%
MH ASSESSMENT UNIT												
BASILDON MHAU	83.7%	350.0%	102.7%	384.7%	80.8%	330.0%	102.4%	362.8%	93.5%	346.6%	112.9%	372.3%
PETER BRUFF UNIT	63.6%	112.1%	73.9%	154.9%	112.6%	111.7%	100.0%	205.1%	79.6%	173.7%	94.5%	203.1%
MH OLDER ADULT												
BEECH (ROCHFORD)	70.9%	134.5%	91.2%	264.6%	84.8%	146.1%	100.0%	89.8%	87.0%	162.2%	85.8%	384.9%
GLOUCESTER	94.0%	140.2%	96.6%	184.3%	100.3%	157.6%	97.8%	165.3%	109.4%	165.9%	100.0%	211.5%
HENNEAGE WARD	74.9%	137.2%	64.0%	235.7%	88.7%	197.9%	94.6%	412.2%	88.3%	239.5%	93.2%	329.7%
KITWOOD WARD	102.1%	137.3%	133.3%	146.7%	110.6%	126.3%	141.7%	163.3%	99.3%	132.2%	146.7%	138.1%
MEADOWVIEW	94.5%	114.8%	93.3%	145.7%	77.0%	154.6%	98.4%	178.0%	88.8%	157.0%	98.3%	199.3%
RODING WARD	106.4%	129.4%	117.2%	138.5%	108.6%	104.7%	135.8%	109.2%	105.1%	172.5%	140.0%	178.3%
RUBY WARD	67.5%	276.3%	176.7%	158.2%	64.3%	276.6%	190.3%	164.0%	55.0%	297.7%	177.0%	232.1%
TOPAZ WARD	90.1%	89.0%	95.6%	227.5%	81.3%	90.5%	97.0%	204.4%	93.4%	79.1%	97.1%	259.9%
CHERRYDOWN	100.3%	148.0%	43.3%	149.1%	90.6%	394.2%	101.1%	580.8%	78.0%	387.3%	100.7%	571.4%
MH ADULT PICU												
CHRISTOPHER UNIT	95.7%	178.3%	87.9%	244.3%	99.1%	207.8%	101.6%	270.4%	101.9%	237.5%	100.0%	288.9%
HADLEIGH PICU	111.8%	281.9%	121.3%	541.5%	120.0%	300.1%	109.8%	599.4%	97.2%	250.7%	108.6%	485.0%
MH ADULT REHAB												
IPSWICH ROAD	96.5%	98.1%	99.0%	190.4%	107.7%	98.5%	101.4%	203.2%	110.2%	112.8%	108.3%	206.7%
CAMHS SERVICES												
LARKWOOD	77.4%	204.2%	75.6%	163.7%	74.8%	197.4%	60.3%	129.8%	100.3%	226.5%	81.6%	326.9%
LONGVIEW	115.9%	246.5%	75.3%	387.1%	107.3%	288.6%	95.1%	425.6%	78.0%	180.8%	63.9%	98.9%
POPLAR	115.3%	169.7%	95.0%	223.5%	96.8%	71.4%	90.7%	236.1%	82.7%	256.1%	85.7%	301.5%

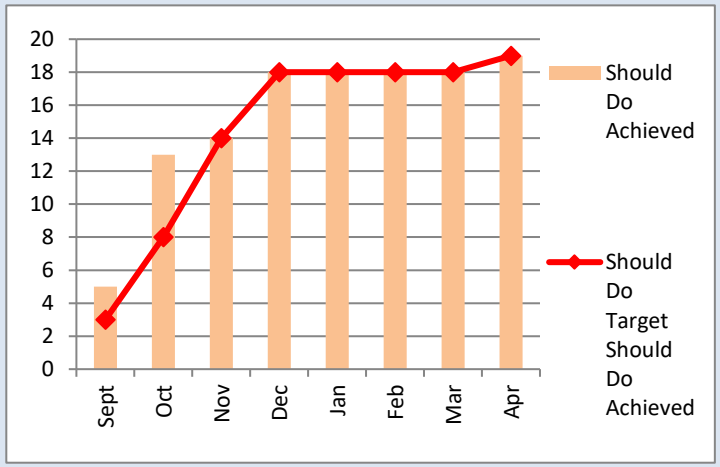
	Day Rates		Night Rates		Day Rates		Night Rates		Day Rates		Night Rates	
	Apr-22				May-22				Jun-22			
	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED
TARGET >90%												
SPECIALIST SERVICES												
EDWARD HOUSE	71.4%	107.9%	99.9%	82.9%	79.5%	104.7%	105.4%	81.5%	73.0%	111.4%	98.3%	93.8%
ALPINE	109.4%	112.8%	103.7%	135.8%	95.4%	106.9%	97.3%	103.1%	98.9%	94.1%	100.0%	100.9%
AURORA	100.8%	186.3%	103.8%	96.7%	100.2%	154.9%	100.3%	100.0%	115.2%	100.8%	100.0%	100.0%
CAUSEWAY	243.5%	174.8%	96.7%	98.7%	223.2%	151.8%	98.5%	98.3%	221.9%	164.2%	98.5%	101.1%
DUNE	83.5%	124.1%	93.0%	94.7%	101.8%	100.2%	96.6%	100.1%	99.1%	97.0%	96.5%	98.3%
FOREST	155.8%	95.4%	93.4%	98.6%	146.4%	104.4%	96.8%	96.3%	159.1%	102.7%	95.2%	98.3%
FUJI	101.0%	98.1%	97.5%	92.4%	94.2%	138.2%	96.4%	128.4%	82.5%	125.8%	96.8%	121.9%
LAGOON	73.4%	100.5%	100.3%	95.4%	82.9%	106.4%	97.0%	105.1%	88.0%	133.2%	100.5%	131.7%
ROBIN PINTO UNIT	123.4%	124.7%	100.0%	203.3%	133.3%	127.1%	98.4%	200.0%	131.9%	120.5%	96.0%	226.7%
WOODLEA CLINIC	136.3%	109.8%	106.7%	99.5%	130.4%	119.5%	111.4%	122.1%	118.5%	110.3%	103.4%	122.0%
RAINBOW UNIT	123.4%	124.7%	50.0%	107.9%	74.8%	57.7%	50.0%	69.2%	78.8%	48.7%	50.0%	68.9%
LEARNING DISABILITY SERVICES												
HEATH CLOSE	111.4%	129.9%	85.7%	147.9%	78.5%	172.5%	97.3%	111.7%	98.0%	117.4%	98.5%	113.5%
NURSING HOMES												
CLIFTON LODGE	98.6%	108.0%	96.7%	212.5%	114.1%	105.4%	91.2%	234.4%	99.9%	110.2%	77.7%	224.0%
RAWRETH	95.3%	79.2%	81.0%	175.0%	82.0%	80.0%	69.5%	172.8%	66.2%	84.3%	51.8%	173.2%
COMMUNITY HEALTH SERVICES												
CUMBERLEGE ICC	63.2%	55.3%	67.1%	80.0%	68.4%	57.3%	67.6%	80.0%	58.6%	58.1%	63.3%	83.2%
AVOCET	115.6%	108.3%	83.8%	161.0%	123.8%	114.5%	106.0%	154.1%	118.7%	105.5%	91.8%	115.1%
BEECH WARD	103.3%	102.4%	103.3%	89.8%	119.7%	101.8%	100.0%	89.8%	114.8%	99.9%	100.0%	87.3%
PLANE	97.2%	112.7%	100.0%	98.7%	130.4%	106.7%	103.3%	97.8%	127.5%	96.3%	103.3%	98.7%
POPLAR UNIT	101.7%	76.0%	95.0%	107.1%	96.8%	71.4%	100.0%	103.1%	99.3%	76.6%	100.0%	103.3%
GIBBERD	90.7%	97.9%	90.0%	95.0%	-	-	-	-	-	-	-	-

SECTION 5 – CQC

Click here to return to summary page

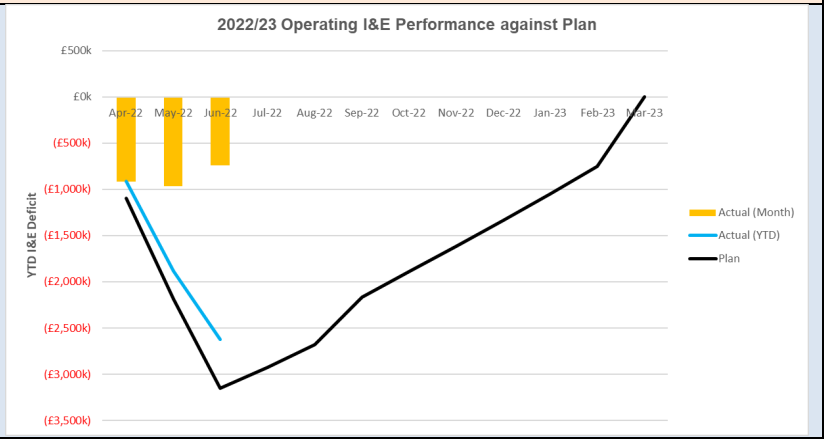
The CAMHS wards were previously inspected in May 2021, following this inspection an action plan was created, which ESOG approved closure of on 31st May 2022. Therefore there are no open CQC action plans.
The Trust continues to await the final report from the latest CAMHS inspection.

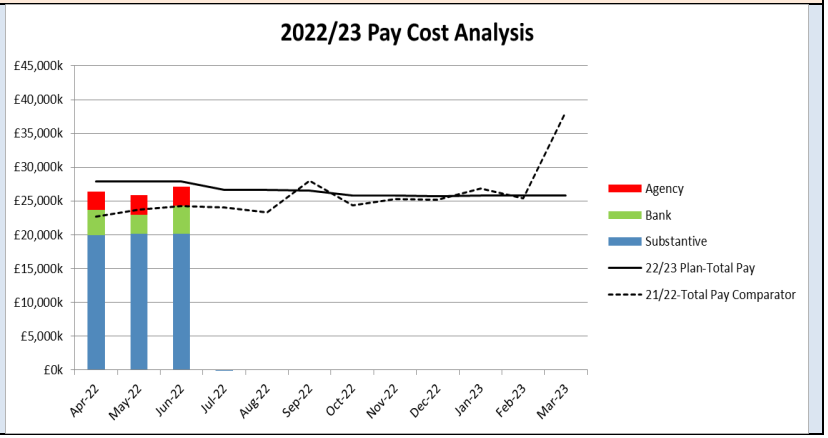
RAG	Ambition / Indicator	Position M3	Trend (above target = good)	Narrative
CQC Must do Actions	There will be 0 CQC Must Do actions past timescale		Achieve target = good performance 	

RAG	Ambition / Indicator	Position M3	Trend (above target = good)	Narrative
CQC Should do Actions	There will be 0 CQC Should Do actions past timescale		Achieve target = good performance 	

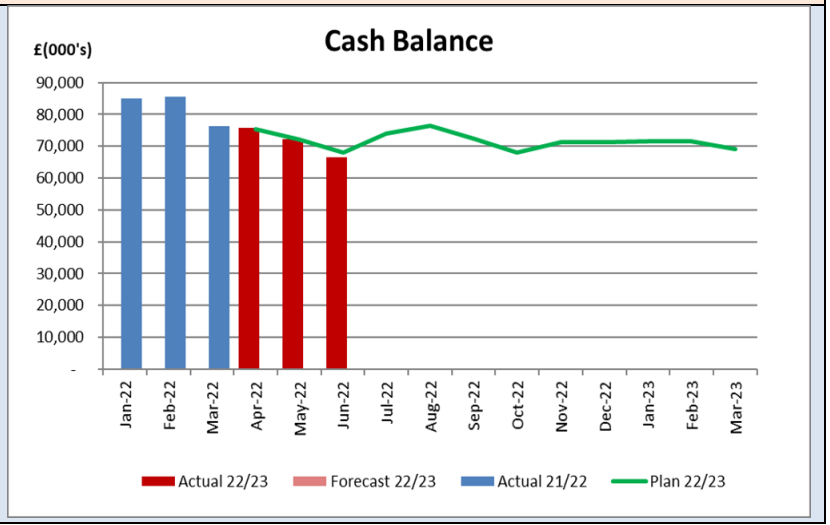
SECTION 6 - Finance

Click here to return to summary page

RAG	Ambition / Indicator	Position	Trend
Capital Expenditure	Maximising Capital Resources	The Trust plan for 22/23 is £12.3m (of which £11.3m relates to system allocation). As at M3, the Trust has incurred capital expenditure of £1.3m against YTD plan of £2.3m. The underspend largely relates to timing of the commencing a number of BAU and strategic ICT schemes.	**Capital** Annual Plan £000 / Year to Date Plan £000 / Actual £000 / Variance £000 2021/22 Carry Forward: 2,319 / 1,313 / 1,058 / 255 Business As Usual: 3,873 / 295 / 47 / 248 Strategic Schemes: 5,064 / 648 / 154 / 494 **Charge against Capital Allocation**: **11,256 / 2,256 / 1,259 / 997** Critical Cybersecurity: 39 / 0 / 0 / 0 New Leases (fleet): 877 / 0 / 0 / 0 PFI Residual Interest: 113 / 28 / 28 / 0 **Net CDEL**: **12,285 / 2,284 / 1,287 / 997** Variance (%): 44%
Operating Income and Expenditure	Operating Income and Expenditure	The YTD month 3 position is a defect of £2.6m which is £0.5m favourable variance against plan mainly due to over-delivery against efficiency plan.	

RAG	Ambition / Indicator	Position	Trend
Efficiency Programmes	Planned improvement in productivity and efficiency	The YTD reported delivery is £0.9m, £0.5m better than plan. The Trust has further identified a numbers of schemes to reduce the level of unidentified savings. These schemes are subject to quality assessment reviews prior to inclusion in the plan.	
Temporary Staffing	Level of Temporary Staffing Costs	In month temporary staffing was £7m; bank spend £4.2m and agency spend £2.8m. This position includes cover to ensure safe staffing levels with drivers of increases in cover including ; (i) activity and acuity demand, and (ii) bank holiday and mandatory training cover.	

	Efficiencies £000	YTD Plan £000	YTD Delivery £000	YTD Variance £000
	£000s	**£000s**	**£000s**	**£000s**
Identified	7,087	415	889	474
Unidentified	10,203	0	0	0
Total	**17,289**	**415**	**889**	**474**

RAG	Ambition / Indicator	Position	Trend
Capital Resources	Maximising Capital Resources	The Trust plan for 22/23 is £12.3m (of which £11.3m relates to system allocation). As at M3, the Trust has incurred capital expenditure of £1.3m against YTD plan of £2.3m. The underspend largely relates to the commencement of a number of BAU and strategic ICT schemes.	**Capital**
Cash Balance	Positive Cash Balance	Cash balance as at end of M3 was £66.7m against plan of £68m.	

Capital	Annual Plan £000	Year to Date Plan £000	Year to Date Actual £000	Year to Date Variance £000
2021/22 Carry Forward	2,319	690	457	233
Business As Usual	3,873	32	35	(3)
Strategic Schemes	5,064	324	0	324
Charge against Capital Allocation	**11,256**	**1,046**	**492**	**554**
Critical Cybersecurity	39	0	0	0
New Leases (fleet)	877	0	0	0
PFI Residual Interest	113	20	20	0
Net CDEL	**12,285**	**1,066**	**512**	**554**

END

	Agenda Item No: 7b

SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 July 2022**

Report Title:	Emergency Preparedness, Resilience and Response (EPRR) Annual Report					
Executive/Non-Executive Lead:	Nigel Leonard, Executive Director of Major Projects and Programmes					
Report Author(s):	Amanda Webb, Senior Emergency Planning and Compliance Officer Jane Cheeseman, Head of Compliance and Emergency Planning					
Report discussed previously at:	Executive Team Health, Safety & Security Committee (HSSC) Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report is provided to the Board of Directors to provide assurance that EPUT has effective organisation resilience measures in place to respond to a Major Incident, Critical Incident or Business Continuity issue. The report provides evidence of the Trusts achievements and continued commitment to the organisational resilience during 2021-22	**Approval**	
	Discussion	✓
	Information	✓

in order to meet the requirements of the Civil Contingency Act 2004 and NHS England's Emergency Preparedness, Resilience and Response Framework 2015.		

Recommendations/Action Required

The Trust Board of Directors are asked to:

- Receive and note the contents of the report.

Summary of Key Issues

Assurance

EPUT is compliant with all of its statutory duties under the Civil Contingencies Act 2004 and associated Cabinet Office Guidance

The Department of Health and Social Care (DHSC) requires all NHS Trusts to be prepared to a category 1 responder and EPUT has systems and processes in place to be prepared to this level and fulfils its civil protection duties.

The Trust has identified an Accountable Emergency Officer (AEO) who is an Executive Director of the Board (Nigel Leonard) and Deputy AEO who is a Non-Executive Director of the Board (Janet Wood). The Chief Executive Officer, Paul Scott holds overall responsibility.

In addition there is a dedicated EPRR team, which is led by Jane Cheeseman, Head of Compliance and Emergency Planning supported by Amanda Webb, Senior Emergency Planning and Compliance Officer for day to day actions

The Head of Compliance and Emergency Planning successfully undertook and passed the Level 4 Award in Health Emergency Preparedness, Resilience and Response.

EPUTs Major Incident Plan and relevant individual plans have been reviewed as required and incorporating learning from Covid 19. These were approved at Health, Safety and Security Committee June 2021.

EPUT has undertaken EPRR exercised in line with National Guidance.

NHS England EPRR Core Standards 2021-22

EPUT scored 91.8% - substantially compliant for the 2021-22 Core Standards following the 'confirm and challenge' meeting with the Regional EPRR Team. EPUT were praised for all the work undertaken and the achievements to date as it was made tougher this year following the 'light touch' in 2020. There were 3 standards identified where improvements can be made and these have been added into the EPRR Workplan.

Major Incident Covid-19

Throughout 2021/22 EPUT has continued to enact the Major Incident Plan in response to Covid-19. In 2021-22, we have continued to see Covid-19 impacting on the country as a whole including NHS services. Impact has been varied throughout 2021/22 ranging from initial reduced prevalence with lifting of restrictions and a start to look at recovery and reset to increase prevalence with a new Omicron wave and peak.

The Trust continues managing EPUTs response to Covid 19 and has remained in a major incident response throughout 2021/22. The virtual Incident Control Centre (ICC) remains operational 7 days a week 8am to 6pm to ensure appropriate and timely action is taken as new information is

received. Information has continued to be cascaded via email. In addition, the ICC ensures the mandated daily sit rep submissions are completed.

The full command structure initiated at the start of Covid-19 continues with three levels of command Gold, Silver and Bronze. Command meetings were initially held daily but the frequency has been continually reviewed as the system pressures change. Command is currently held via Microsoft Teams weekly. An electronic log is being maintained by a team of trained Loggists with the support of the EPRR team.

A range of actions have been taken at different points in the year to respond to the Covid-19 pandemic including opening and closing of Covid-19 dedicated wards, enacting surge plans, enacting BCPs and continuing work at home where possible

EU-Exit
The Trusts EU Exit Task & Finish Group was formerly stood down in July 2021. Limited impacts were identified following the EU Exit and the risk was reduced and removed from Risk Registers in July 2021.

Business Continuity Plans (BCP)
Throughout 2021/22 BCPs have successfully been enacted at different times in response to a range of events including:

- Fuel Disruption
- Power Outage Brockfield House
- Anti-Vax Protest

Partnership Working and Local Responders
Under the CCA 2004, cooperation between local responder bodies is a legal duty and working jointly with partner agencies is critical to ensuring effective emergency planning and response. EPUT attend and contribute with NHSE/I, CCG's and other Trusts via Strategic and operational local resilience heath forums with representation from the EPRR team.

EPUT is part of 2 Local Resilience Forums (Bedfordshire and Essex).

Lessons Learnt
Learning continues as a key part of the Trust response to COVID19 as well as following all EPRR events. Some key lessons identified in 2021/22 are:

- Establishment of a recovery plan identifying 5 key milestones and trajectories
- IPC live event on lessons learnt from outbreaks
- Understanding impact of 'Long Covid' on colleagues and putting in place a range of health and wellbeing offers of support that can be accessed by staff with long Covid and managers in supporting staff.
- Staff will be permitted to wear only their name badge as Mass Vaccination Centre (which has only forename) rather than ID badges including surnames to reduce the risk an any action to the staff outside of work.
- A code name has been introduced when an individual phones requesting details of the site lead in order to assist with their needle phobia. When individuals arrive on site and ask for that code name, site staff know to go and get the actual site lead who can deal with the situation and, if a genuine needle phobia, can manage the clinical situation – without having divulged personal identities.
- Advice has been given by the LSMS in terms of caution with social media usage etc.

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

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

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

Acronyms/Terms Used in the Report			
EPRR	Emergency Preparedness Resilience and Response	BCP	Business Continuity Plans
AEO	Accountable Emergency Officer	EPRR	Emergency Preparedness, Resilience and Response
CCA	Civil Contingencies Act	BLRF	Bedfordshire Local Resilience Forum
ERF	Essex Resilience Forum	NCSC	National Cyber Security Centre
RAAC	Reinforced Autoclaved Aerated Concrete	LHRP	Local Health Resilience Partnerships
ICC	Incident Control Centre		

Supporting Documents and/or Recommended Further Reading
Emergency Preparedness, Resilience and Response Annual Report 2021-22 Emergency Preparedness, Resilience and Response Workplan 2021-22

Lead
 **Nigel Leonard** **Executive Director of Major Projects and Programmes**

NHS
Essex Partnership University
NHS Foundation Trust

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL REPORT

2021-22

CONTENTS

Report Prepared By:
Amanda Webb, Senior Emergency Planning and Compliance Officer
Jane Cheeseman, Head of Compliance and Emergency Planning

On behalf of:
Nicola Jones, Director of Risk and Compliance

INTRODUCTION

PURPOSE

The purpose of this annual report is to provide assurance to the Trust Board of Directors, that EPUT has robust and effective organisational resilience measures in place to respond to a Major Incident, Critical Incident or Business Continuity event.

This report also presents evidence of the Trust's achievements and continued commitment to organisational resilience during 2021-2022.

ACCOUNTABILITY

The NHS Act 2006 (as amended) places a duty on relevant service providers to appoint an individual responsible for discharging their duties under section 252A. This individual is known as the Accountable Emergency Officer (AEO) who is an Executive Director of the Board (Nigel Leonard) and Deputy AEO who is a Non-Executive Director of the Board (Janet Wood). However, the Chief Executive Officer, Paul Scott holds overall responsibility.

In addition there is a dedicated EPRR team, which is led by Jane Cheeseman, Head of Compliance and Emergency Planning supported by Amanda Webb, Senior Emergency Planning and Compliance Officer for day to day actions.

RELEVANT GUIDANCE

This report confirms that the Trust is compliant with all its statutory duties under The Civil Contingencies Act 2004 and associated Cabinet Office Guidance and other relevant legislation and guidance such as:

1. The NHS Act 2006
2. The NHS Constitution
3. The requirements for EPRR as set out in the NHS Standard Contract(s)
4. NHS England EPRR guidance and supporting materials including:
5. NHS England Core Standards for Emergency Preparedness, Resilience and Response
6. NHS England Business Continuity Management Framework (service resilience)
7. Other guidance available at http://www.england.nhs.uk/ourwork/eprr/
8. National Occupational Standards for Civil Contingencies
9. BS ISO 22301 Societal security – Business continuity management systems

NHS ENGLAND EPRR CORE STANDARDS 2020-2021

NHS England carries out an annual EPRR assurance process in order to seek assurance that both NHS England and NHS organisations in England are prepared to respond to emergencies, and are resilient in relation to continuing to provide safe patient care. The NHS EPRR process concludes with a submission to the NHS England Board and assurance is provided thereafter to the Department of Health and Secretary of State for Health.

NHS England Core Standards for EPRR set out the minimum requirements expected of providers of NHS funded services in respect of EPRR and are split into ten domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN)

A self-assessment of compliance with the national EPRR core standards is required to be submitted on an annual basis providing assurance that the Trust is meeting all standards and supply relevant evidence on request. This initial self-assessment assessed the Trust as being fully compliant with the 37 standards applicable to mental health and community care trusts for 2021/22

As part of the national process, the Trust had a "confirm and challenge" meeting with the Regional EPRR team on 30th September 2021 where it has been confirmed that EPUT scored 91.8% - substantially compliant. EPUT were praised for all the work undertaken and the achievements to date as it was made tougher this year following the 'light touch' in 2020.

The table below illustrates the three standards assessed, as "partially compliant" and the action required which is being taken forward:

Areas of Improvement	Mitigation for the Areas of Concern	Level of Assurance
(18) Mass casualty	Develop guidance / Flow chart on arrangements in the event of mass casualty incident and mutual aid needed Action to be taken: Add as annex to Major Incident Plan	Partially Compliant
(53) Business Continuity Management	Process in place to set internal audit schedule that is based on organisational risk. Action Taken: Business Continuity on Internal Audit Programme for 22/23 Q4	Partially Compliant
(57) HAZMAT/CBRN planning arrangements an initial role card in place, national guidance on internet and incidents referenced in Major Incident Response Plan and to be managed via Major Incident Plan framework	Develop guidance linked to patient coming into to hospital / community visit that is contaminated Action to be taken: Add as annex to Major Incident Plan	Partially Compliant
OVERALL SCORE= 91.8 %, SUBSTANTIALLY COMPLIANT 37 total		

CIVIL CONTINGENCIES ACT 2004

The Civil Contingencies Act 2004 outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at local level.

Under Section 1 of the CCA 2004, an "emergency" means:

(a) An event or situation which threatens serious damage to human welfare in a place in the United Kingdom;
(b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom;
(c) War, or terrorism, which threatens serious damage to the security of the United Kingdom.

For the NHS, incidents are classed as either:

- **Business Continuity Incident** - an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed)

- **Critical Incident** - any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

- **Major Incident** - any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS this will include any event defined as an 'emergency' as detailed above.

The CCA 2004 specifies that responders will be either Category 1 (primary responders) or Category 2 responders (supporting agencies).

Category 1 responders are those organisations at the core of emergency response and are subject to the full set of civil protection duties:

1. Assess the risk of emergencies occurring and use this to inform contingency planning
2. Put in place emergency plans
3. Put in place business continuity management arrangements

4. Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
5. Share information with other local responders to enhance co-ordination
6. Cooperate with other local responders to enhance co-ordination and efficiency

The information contained throughout this report provides assurance in terms of how the Trust is meeting these duties.

RISK ASSESSMENTS

The Civil Contingencies Act 2004 places a legal duty on responders to undertake risk assessments and publish risks in a Community Risk Register. EPUT is a member of both Bedfordshire Local Resilience Forum (BLRF) and Essex Resilience Forum (ERF) that undertakes this activity.

The purpose of the Community Risk Register is to reassure the communities of Bedfordshire and Essex that the risks of potential hazards have been assessed, and that preparation arrangements are undertaken and response plans exist.

The top five risks currently identified on both Risk Registers relate to

- Flooding
- Influenza-type disease (pandemic) / major outbreak
- Emerging infectious disease
- Energy/Fuel disruption
- Severe Weather - Hot or Cold

The Trust Major Incident Plan details the following as more specific risks for the Trust relating to the above:

- **Flooding:** Essex Coast Line, Thames Estuary and the Ouse
- **Energy / Fuel disruption:** Pipelines and Oil Storage facilities

The Trust's approach to emergency planning ensures that we would be in a position to respond appropriately in the event of an incident relating to those significant risks identified in the community risk registers. The Trust also uses its standard risk management framework and processes to identify any specific local risks relating to business continuity / resilience and these are managed in line with standard Trust risk management processes.

The Trust has developed a number of detailed plans to address the significant risks identified in the Local Resilience Forums' community risk registers. These align where appropriate with Local Resilience Forum plans for the same incident types and are as follows:

- Influenza Pandemic Plan
- Heatwave Plan
- Cold Weather Plan
- Flood Plan
- Fuel Shortage Plan

MAJOR INCIDENT PLAN

A Major Incident Plan has been developed by EPUT that details the role of EPUT in a major incident and how this role fits with those of other NHS organisations and the emergency services.

The Major Incident Plan is formally reviewed at least every three years but is under continual review to ensure any required amendments are made to reflect changes within the health sector, the Trust or Emergency Planning legislation.

The Major Incident Plan (RM14) and relevant individual plans were presented and approved at Health, Safety and Security Committee June 2021 following a full review which took into account learning from the Covid-19 pandemic.

BUSINESS CONTINUITY PLANS

The Business Continuity Plan is the tactical document that supports the Major Incident Plan and ensures that in the event of a business interruption the organisation will be able to maintain critical activities and restore normal business activities as soon as possible given the circumstances prevailing at the time. The processes via which a Business Continuity Plan would be created and maintained were approved by the Health, Safety and Security Committee in July 2018.

As a provider service, the Business Continuity plan is the key plan within our Organisational Resilience planning. This plan underpins all other plans as it prioritises our critical activities and allows us to effectively manage our business whatever the incident may be including Pandemic, Severe Weather and Industrial Action etc.

An organisational Business Continuity Plan is in place which priorities services that should be provided in the event of a business continuity incident. To underpin the organisational Business Continuity Plan, all services across EPUT have developed Business Continuity plans which:

- Prioritise their service activities into 5 levels of priority from critical activities which need to be restored within 1 hour through to activities which can be progressively restored after 7 working days; and
- Detail the strategies for continued delivery of these activities.

The EPRR team developed a new improved BCP template that was approved in May 2021 by the Health, Safety and Security Committee. Since approval, the EPRR Team have been actively transferring services from the existing BCP. The transfer project is complex and as such has been split into 3 phases:

- Phase 1 – Individual Inpatient Sites (i.e. 439 Ipswich Road, Byron Court)
- Phase 2 – Sites with multiple inpatient wards (i.e. Basildon MHU, The Lakes)
- Phase 3 – Community Services

The EPRR team has successfully mapped all of Phase 1 & 2 transfers across. This has included a review of the original BCP's in addition to meeting and communicating with the Services however, there remain some key areas to be filled in which we would like to bring to the attention of the committee:

- Key Premises details (Location of Fuse box, Water Stop Cock, Asbestos Register etc.) were unknown by the services. A request has initially been sent to two estates officers for 2 locations to ensure they are able to identify the details. In the event of an incident, Services should be able to locate the relevant locations in the interim until Estates can be available on site.
- Details regarding supplies and IT systems – Upon review the decision has been made to link with Corporate BCP's which detail what to do instead of documenting all the suppliers for each item they order.

The National Cyber Security Centre (NCSC) has urged organisations in the UK to bolster their cyber security resilience in response to malicious cyber incidents as a result of the ongoing situation in the Ukraine therefore a further review is being made with the BCP template.

COMMUNICATIONS PLAN

A well-informed public is better able to respond to an emergency and to minimize the impact of the emergency on the community so it is vital to ensure consistent messages appropriate to the needs of the audience.

The trust has a Communications plan in place to ensure that this happens in a timely manner. There are various means available to be utilized i.e. Pando, WhatsApp, intranet, cascade text messages, resilience direct etc.

PARTNERSHIP WORKING

Under the CCA 2004, cooperation between local responder bodies is a legal duty and working jointly with partner agencies is critical to ensuring effective emergency planning and response. It is thus important that, as well as coordination within individual NHS organisations, the planning for incidents is coordinated between health organisations and at a multi-agency level with partner organisations.

EPUT attend and contribute with NHSE/I, CCG's and other Trusts via Strategic and operational local resilience heath forums with representation from the EPRR team.

Regional Resilience Mental Health Partnership Proposal

A Regional Resilience Mental Health partnership is being proposed in order to provide a forum for Mental Health Trusts Emergency Preparedness Resilience and Response (EPRR) Teams to work collaboratively in the planning, response and recovery of emergencies.

This Partnership will not replace Mental Health Trust participation at LHRP but supplement it with the opportunity for Mental Health to Mental Health Trust cooperation that is lacking within the LHRPs due to Mental Health Trust-footprints being as large as or larger than a single LHRP area.

The purpose of the partnership is:

- Enhance Mental Health Trust preparedness by provision of a forum for discussion between all Mental Health EPRR Teams across the Region.
- Allow for sharing of information and best practice between Trusts
- Enable any necessary production of regional plans to respond to emergencies such as the new collaborative approach to evacuation.
- To demonstrate excellence in Mental Health EPRR.

The Trusts Head of Compliance and Emergency Planning has a Mental Health nursing qualification (RMN Dip HE) and as such can provide Mental Health expertise to the new forum on behalf of the trust.

LOCAL RESPONDERS

Local Resilience Forums

- Bedfordshire Local Resilience Forum (BLRF)
- Essex Resilience Forum (ERF)

Local Resilience Forums (LRFs) are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others (i.e. Category 1 Responders, as defined by the Civil Contingencies Act).

The LRFs aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.

An NHS England representative represents the Trust at the BLRF and ERF, along with all other NHS providers. Two-way feedback into and from the LRFs is facilitated via Local Health Resilience Partnerships.

Local Health Resilience Partnerships (LHRP)

Local Health Resilience Partnerships (LHRPs) were established in August 2012 across the country as part of 'The Arrangements for Health Emergency Preparedness, Resilience and Response from April 2013' published by the Department of Health in March 2012.

Their purpose is to deliver the national Emergency Preparedness, Resilience & Response (EPRR) strategy in the context of local risks. They bring together the health sector organisations involved in EPRR at the Local Resilience Forum (LRF) level and provide a forum for coordination, joint working and planning for emergency preparedness and response by all relevant health bodies. The LHRPs' footprints map to the LRFs. They therefore offer a coordinated point of contact with the LRF and reflect a national consistent approach to support effective planning of health emergency response.

The Head of Compliance & Emergency Planning and the Senior Emergency Planning and Compliance Officer attended the Essex LHRP Strategic Meeting on 23 November 2021 and the Essex LHRP Working Group on 8 February 2022.

Due to the meetings being re-instated following the suspension due to Covid19; in addition to the implementation of the ICS', the main focus of the meetings were around setting up the governance and structure of the meetings moving forward

Some of the key aspects to note from the meetings are:

Strategic aims and direction of the LHRP Executive Group
The group discussed the purpose of the LHRP working group moving forward. It was agreed that a risk-based approach should be adopted with direction provided by the executive LHRP

group regarding the content of the groups work plan.

Surge & Capacity, including winter planning
A verbal summary of the work currently being undertaken across the health system to tackle ongoing pressures. Colleagues from mid and south, northeast, and west Essex continue to work in close collaboration to feed into the Essex Resilience Forum (ERF) to provide a single health voice. Each area also has their own processes in place for surge and escalation.

National & Regional updates, including the top five regional risks
There has been a change of approach in the assessment and understanding of risks regionally with a switch to looking at risk themes which have been identified as:

- Transition to ICS
- Major Incident Response
- Weather
- Infrastructure
- Supply Chain

Covid-19 is now seen as business as usual, although acknowledged that it is likely to be an ongoing challenge for the system.

EPRR EXERCISES

National Guidance states that as a minimum requirement, NHS organisations are required to undertake the following exercised:

- Communications - every six months
- Table top - every year
- Live Play - every three years
- Command Post - every three years

COMMUNICATIONS EXERCISE

Exercise Starlight is a Major Incident Communications Cascade Exercise. NHS England and NHS Improvement, East of England initially identified that Exercise Starlight would be undertaken in September 2021 with the following objectives:

- To confirm that NHS England and NHS Improvement are able to contact CCGs via their on-call contact number;
- To confirm that CCGs are able to contact Providers via their on-call contact number;
- To ascertain that CCGs and Providers can respond to messages via their on-call contacts;
- To review and amend, as necessary, Incident Response Plans or contact directories to ensure lessons are learnt;

Exercise Starlight was later due to occur during the weekend of 1st – 4th October however was suspended due to technical issues with the Regional Operations Centre telephone system. Confirmation has been received that they will aim to give at least 14 days' notice of their intent to carry out the exercise once the technical issues have been resolved.

The EPRR team provided detailed systematic guidance and support to the Contact Centre and on-call Director who would have been contacted in preparation for the exercise and will update as soon as future dates are provided.

TABLETOP EXERCISES

Security Incident Exercise
Mass Vaccination Centre Security Incident workshops / Tabletop exercises were held on 21 January 2022 for the Mid & South Essex site leads and 25 January 2022 for the Suffolk & North East Essex sites leads. The aims of the sessions were to provide the opportunity in a safe learning environment to

- Work through possible security scenarios (based on current highest threats);
- Seek expert advice;
- Develop specific plans for response for specific centre/s;
- Identify possible challenges in responding and any resultant actions to be taken;
- Build confidence to manage such an incident if necessary; and

The exercises were well received with good attendance, including from partner agencies such as Essex Police. Staff contributed to the identification of areas for further learning and development as part of the exercises. It was agreed due to the success of the exercises that it would be beneficial to run further local events at different centres for key staff/ volunteers

An action plan was identified following the exercises with a focus on the main corporate areas:

- Site
- Security
- Communications
- Procedure / Protocol
- Testing

This was reviewed by the EPRR team to ensure actions are in line with the BCP/EPRR protocols and where required definitive guidelines developed.

LIVE PLAY

Exercise Walker (Regional)
East of England region initially arranged a Reinforced Autoclaved Aerated Concrete (RAAC) face-to-face exercise with an Emergo element to be held on 3 November 2021.

The aim of the exercise was to explore and manage the impacts of a catastrophic RAAC Plank failure within an Eastern Region Hospital focusing on the Regional response looking at the following objectives:

- To simulate patient tracking across the region in an evacuation from an acute trust
- To explore realistic management of media and communications across the region
- To ensure all health organisations and multi-agency partners understand their responsibilities in relation to an escalating RAAC plank catastrophic failure
- To consider patient co-ordination and distribution using the revised East of England planning assumptions and latest pre-evacuation modelling

Due to significant increase in COVID19 cases with a number of providers experiencing challenges with ambulance handovers, ambulance queuing and a number of critical incidents, the decision was made to defer the exercise.

The exercise has now been rescheduled for Wednesday 11th May 2022 and will be attended by a member of the EPRR team to represent the Trust.

COMMAND POST

The Trust has processes in place within the EPRR team to ensure that the Incident Control Centre (ICC) at both The Lodge and the Hawthorn Centre is ready to be used in the event of a major incident. The equipment and rooms are checked quarterly to ensure they are ready to be used at any time. The checks include room suitability, telephone lines, major incident paperwork, stationary box and loggist folders. The checks are documented for auditing purposes.

Due to Pandemic, we have a virtual Incident Control Centre which remains operational 7 days a week as per request from National. Command is currently held via Microsoft Teams due to the Social Distancing. An electronic log is being maintained as required by a team of trained Loggists with the support of the EPRR team.

EPRR Events

COVID-19

The Covid-19 pandemic first emerged at the end of 2019 leading to a national wide lockdown in March 2020. The pandemic has a significant impact on all NHS organisations as well as the wider country and EPUTs response was reported on as part of the EPUT 20-21 EPRR annual report including details of command structures put in place. As at the end of March 2021 the national incident level for the NHS reduced to Level 3 and full roll out of the Covid Mass Vaccination Programme was underway.

In 2021-22 we have continued to see Covid-19 impacting on the country as a whole including NHS services. At the start of 2021-22 we saw a reducing of lockdown restrictions and the Government continued with their roadmap out of lockdown. The country saw the lifting of restrictions in the spring and summer of 2021. NHS IPC guidance remained in place. At this time EPUT stepped back our command structures and a move towards prevalence monitoring and initial rest and recovery work.

In the autumn of 2021 Covid prevalence started to increase which lead to the Government introduction of 'plan b' which brought back wearing of masks in public places and the ask for people to work from home where possible. The National UK Covid-19 Alert level increased to level 4 on 13th December 2021 and the NHS incident Response level increased to level 4 on 14th December 2021. At this time a new variant of Covid-19 was identified as the Omicron variant.

Reduction started to be seen in January 2021 and all 'plan b' measures were lifted on 27th January 2022. Lifting of restrictions has continued throughout February and March and a new set of guidance has been issued in April 2022 for NHS organisations to move to more of a living with Covid business as usual.

In response to the increased prevalence EPUT gradually stood back up our command structures back to 7 days a week at the peak. This was continually reviewed based on risk and timings adjusted as needed.

We remain in major incident response, with the Gold and Silver Commands currently meeting individually once a week on a Thursday. The command frequency remains flexible in regards to reducing / increasing meetings for COVID-19 activity in addition to the winter pressures over the coming months. Bronze command meetings continue to mirror the Silver and Gold commands to ensure decisions made and information received continues to cascade through the organisation at pace, and that we are responsive to changes required.

The (virtual) Incident Control room remains operational 7 days a week 8am until 6pm in line with the East of England Operational Centre working hours, which is being covered by the Compliance and Assurance Directorate including on bank holidays in addition to usual working hours.

The regular sit rep submissions required by the Centre continue, namely the National Covid

daily sitrep, Community discharge daily sit rep, (both also required at weekends) the regular Lateral Flow Testing numbers and Long Covid activity.

Covid-19 Outbreaks have also been reported through the ICC in line with national guidance. Any services where 2 or more staff and/or patients are tested as Covid positive are reported as an outbreak to NHS England. Daily submissions are made provided changes to NHS England until the service has seen 28 days without any new cases.

The incident control inbox continues to receive the national and regional information/guidance alongside a wider remit of information sharing. The continued monitoring of the inbox ensures that should anything of urgency come through we are able to remain responsive. Any national/ regional guidance, information and/or requests are cascaded to the appropriate Directors and through discussion at the Command meeting for information and consideration of the actions required with a timely response. In excess of 4000 notifications have been received and actioned through the virtual ICC over 2021-22. This has included many new pieces of national guidance.

In the peak of the Omicron Wave EPUT initiated Surge plans in response to challenging staffing levels. Surge plans were developed by operational services and agreed in advance by the Trust Ethics Committee and Silver and Gold Command to ensure timely action could be taken to address predicated risks.

The Omicron Wave has had a significant impact on EPUT in a number of areas often exacerbated by impacts still being felt from earlier Covid waves. EPUT has undertaken analysis of the core impact of the Omicron Wave and has developed a recovery plan which is being taken forward.

EU Exit - 2020

The Trusts EU Exit Task & Finish Group was established in 2020 in response to the EU Exit. Initial assessment of likely impacts was undertaken in 2020 but the group was suspended when the Covid-19 Pandemic hit throughout 20-21. EPUT stood back up the EU Exit Task and Finish group in 21-22 which met by exception up until July 2021 at which point there had been no requirement to meet for a couple of months. The group was formerly stood down in July 2021.

The requirement for highlighting any areas of concern relating to EU EXIT on the Daily Sit Rep return to NHSEI also ended in 2021.

This indicated that due to the lessening impact of EU Exit, reduction of notifications and reducing risks there are no significant concerns at a regional level following the transitions period of EU Exit. Key messages and correspondence continued to be monitored by the Emergency Planning team and cascaded to relevant parties for information/action as required. It was agreed that the Task and Finish Group can be stood up at any time should this be necessary.

The Executive Team BAF Sub-Group agreed the recommendation to reduce the risk score to threshold on the BAF23 action plan and close due to the lessening impact of EU Exit, reduction of notifications and reducing risks. This recommendation was agreed by Board agenda that met on 28 July 2021.

Fuel Disruption (Q3 2021/22)

On 24th September 2021, increased buying of fuel occurred nationally following the announcement that BP had some delivery issues due to driver shortages. This led to garages running out of supply in addition to large queues to access the supplies that were available. Shortages were in affect from 24/09/21 – 14/10/21.

EPUT Emergency Planning Team pre-empted the situation and circulated the Trust Fuel Plan in preparation for the envisaged disruption on Friday 24th September 2021. The disruption developed quicker than expected with the effect felt almost immediately.

The existing COVID19 Joint Gold and Silver Command meeting held on 27 September 2021 included review of the fuel position. As at 27.09.21, it was confirmed there was not a national fuel shortage but additional buying of petrol had led to fuel stations running out ahead of usual deliveries and causing long queues at petrel stations who did still have fuel.

The joint Silver/Gold Command enacted service BCPs and the Trust Fuel Plan (as far as possible without a declaration of a national fuel shortage). Key actions included:

- Strong communication messages to staff
- Advised staff to route plan
- Advised staff to check laptop accessibility to networks from home
- Sought light of key workers should fuel prioritisation be needed
- Identified high risk patients
- Identified high risk activities including PPE delivery, Swab collections, Medication delivery and COVID19 vaccine deliveries

Over the course of the following week, Joint Gold / Silver Commands were stepped up on a daily basis as required. EPUT used the Command meetings to then feed into the System escalation sit-reps.

- 28th September 2021 – Silver Command held, continued to enact BCPs. No change to situation.
- 29th September 2021 – Joint Silver/Gold Command held, continued to enact BCPs. No change to situation.
- 30th September 2021 – Joint Silver/Gold Command held, no significant concerns escalated
- 7th October 2021 – Joint Silver/Gold Command held, no significant concerns escalated
- 14th October 2021 - Joint Silver/Gold Command held, agreed to close incident and undertook debrief.

Fortunately, the situation resolved with minimal disruption to services however, the EPRR team recognized that it is still important that a reflection be made in order to improve practices. Directors were therefore asked to comment on what they felt went well, what didn't go as well and any recommendations moving forward

Aspects that did not go well:

- Poor communication nationally, which induced the increased buying and caused the shortages at fuel stations.

- The delay in sharing of guidance on IPC issues like car sharing as multiple queries came in but information was not available.
- The lack of access for health and social care to be treated as a priority to buy fuel as the National Fuel Plan was not activated.
- Staffing details were not always up to date

Aspects that went well:

- EPUT EPRR anticipated the issue early on therefore reviewed the policy and circulated prior to the main incident.
- The dedication, resilience and commitment of health and care staff to queue and locate petrol after their shifts and at weekends to make sure they could continue to see patients.
- The sharing of information via Pando between local teams relating to fuel availability between teams.
- Enactment of BCP's - BCP's worked and high risk patients were known, working practices were identified for alteration in anticipation of problems which in the event did not arise.
- Good communication and cooperation from Operation leaders. They knew what was going on at an individual staff level and this was communicated up where there were individual issues.
- EPUT Command meetings stood up rapidly at all levels
- For the very small number of staff who could not get to work, rosters were adjusted and staff moved around to ensure there was no impact on clinical care – good flexibility
- Internal Mutual Aid when deliveries could not be made to ensure all services has appropriate IPC supplies
- Ability to work from home
- The use of the Pando messages and team local messages to direct people to where fuel was available was a really good resource

Recommendations that actioned following learning:

- All EPUT guidance to be reviewed in the event of any concern to ensure a speedy response to queries raised.
- Services need to ensure staff contact details are fully up to date
- Promote the use of digital transformations to support in an emergency situation

Feedback has been shared with the System EPRR Leads to identify Regional learning and potential recommendations to National.

Power Outage Brockfield House (Q3 2021/22)

On 2nd October 2021 at 22:35hrs there was a Power Outage at Brockfield House and the generator was unable to restore power to the unit. The power was returned at 23:55hrs following an engineer attending site.

It became apparent that the generator had been providing power to the site for approx. 20hrs therefore the generator had run dry of fuel leading to the power outage. The site were unaware that the generator was in operation.

The power outage affected the phones, radios, computers, lights and CCTV. Certain doors around the unit unlocked including the entrance doors to the ward however, the airlock doors to the wards remained locked. The airlock doors in reception, the reception doors and the entrance gate unlocked with no lights in the grounds working creating a security risk. Some issues remained for a further 24 hrs.

Brockfield House initiated BCPs were necessary.

An action plan was identified following the incident as the subsequent issues were identified:

- Site unaware the generator was providing power to the building
- Radios were not working
- Mobile phones were not working
- Torches were not strong enough
- Gates opened creating a security risk
- Front entrance to wards unlocked

A similar incident occurred on the 5th April 2021 at The Lakes, Colchester whereby the site were not aware the generator was providing power to the building therefore the diesel had run dry leading to a power outage. Following the incident, a process was implemented whereby a text message is activated when the generator is powering the building. Unfortunately, Brockfield House is a PFI building therefore the estates is managed by GFM. Assurance cannot be provided by GFM that this will not happen again as they have no reasonable measures in place to notify the site users that the generator is in operation other than *'the light dim and power goes out for approx. 10secs'.* This risk was escalated to the Trust Risk Register

Anti-Vax Protest (Q4 2021/22)

In January 2022, Anti-vax protests took place at two mass vaccination sites:

1. On the 28th January 2022; a Peaceful Anti-vax protest took place at Chelmsford County Hall vaccination site. The Anti-vaccine protesters had congregated at the main entrance to the building. County Hall Security staff prevented their entry, the protesters requested to speak to the Director of Education. Vaccine centre staff requested that Oak Park security based themselves at the 2nd main entrance to the vaccine centre and prevent entry to any protesters.

   2 protesters then approached the 2nd entrance, one dressed in an outfit depicting a baby and the second person with a megaphone. A third person was then found sitting in the marriage ceremony office within the building on their mobile phone. The clinical manager asked them to leave the building, which they did with no resistance.

2. On the 31st January 2022; a Peaceful Antivax protest took place at Colchester Football Club vaccination site. Anti-vaccine protesters congregated at the entrance of the vaccination centre, to serve a notice of liability. They refused to move to the designated area when prompted. Police were called and the Operational Director made aware. Vaccination centre activity continued with no aggravations.

   Protestors asked for a name to serve papers, but when given the programme director's

name and address as per protocol, they were not satisfied. The senior nurse on site offered her details but they still weren't satisfied and asked for the Site 8A by name, she wasn't at the site, so papers were left with the senior nurse on site.

Police attended and moved protestors off site quite quickly

Immediate learning was identified:

- Staff will be permitted to wear only their name badge (which has only forename) rather than ID badges including surnames to reduce the risk of any action to the staff outside of work.
- A code name has been introduced when an individual phones requesting details of the site lead in order to assist with their needle phobia. When individuals arrive on site and ask for that code name, site staff know to go and get the actual site lead who can deal with the situation and, if a genuine needle phobia, can manage the clinical situation – without having divulged personal identities.
- Advice has been given by the LSMS in terms of caution with social media usage etc.

LESSONS LEARNED

Covid-19

Learning continues to be a key part of the Trust response to COVID19 and a number of activities continue to take place, alongside some new initiatives and incentives to support our staff, such as

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

Over the past year there have been a number of key changes that have taken place due to the rapid spread of the Omicron variant and declaration of the level 4 national incident these have been reflected on as follows

Ramp-up of Vaccination Programme

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

Maximize availability of COVID19 treatments for people at highest risk

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

Maximize capacity across acute and community settings to enable discharge

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

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

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

Support staff and maximize their availability

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

Revisited staff wellbeing offers

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

Prepare surge plans and Incident Control Centre (ICC) processes

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

Response to national guidance changes

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

The Trust have since been developing the recovery plans incorporating the learning from the changes made following the impact of Omicorn wave and implementation of the surge plans. The plan has identified 5 key work streams for recovery which are being reviewed weekly. A further full reflection will be undertaken once the level 4 national incident status is stepped down.

TRAINING 2020-2021

During the year a number of Organisational Resilience training courses have been completed by EPUT staff:

Internal Training

General Awareness Training
E-learning resources in relation to organisational resilience and response are available on the Trust's intranet and introduction training is provided as part of the Risk Management section on the staff induction course.

EPRR Award

The Diploma in Health Emergency Preparedness, Resilience and Response Programme has been available since 2005 (previously known as the Diploma in Health Emergency Planning) and is now recognised as the leading qualification for Health Emergency Preparedness, Resilience and Response professionals.

There are extremely limited spaces available for the course and for the first time EPUT were successful in gaining one space, which was undertaken by the Head of Compliance and Emergency Planning. The Head of Compliance and Emergency planning has since successfully completed and passed the Level 4 Award in Health Emergency Preparedness, Resilience and Response.

External Training

Strategic Commanders Training (Gold)
This programme is run by NHS England (East) and provides those who may become involved in managing a major incident response with appropriate knowledge and skills to undertake the role. A number of directors and staff are trained and up to date with their training. Trust is waiting for further dates from NHSE/I to increase the number of staff trained.

Loggist Training
This programme is run by NHS England and the Joint Commissioning Team (based on Public Health England Loggist training) and provides staff with the knowledge and skills to be able to undertake the role of loggist in a Major Incident Response Team. A number of directors and staff are trained and up to date with their training. The Trust is waiting for further dates from NHSE/I to increase the number of staff trained.

Loggist Train the Trainer
The Senior Emergency Planning and Compliance Officer (EPRR Lead) has been in communication with NHSE/I regarding becoming a Loggist Train the Trainer. NHSE/I welcome and support the proposal in light of the knowledge and qualifications held by the EPRR Lead. This will enable EPUT to support NHSE/I deliver the Loggist training course in conjunction with them but also means we can dedicate more time and resources within the Trust to support the Loggist role. The EPPR Lead is waiting for confirmation of a Train the Trainer course being available by PHE.

Culture and Wellbeing

Covid-19 has now been in existence for over 2 years and as such it has again been another challenging year for everyone and created specific challenges for the NHS. The Trust staff have continued to provide services to our population throughout this ongoing challenging period and have worked in partnership with the wider system to support pressures on acute colleagues. The Trust has supported in a range of ways as detailed in section 11 above relating to;

- Ramp-up of Vaccination Programme
- Maximize availability of covid 19 treatments for people at highest risk
- Maximize capacity across acute and community settings to enable discharge
- Support patient safety in urgent care pathways and ask for MH and LD services are retained throughout surge and face to face care retained as far as possible
- Support staff and maximize their availability
- Revisited staff wellbeing offers
- Prepare surge plans and Incident Control Centre (ICC) processes
- Response to national guidance changes

Throughout the year the Trust (and wider public) have recognised staff hard work and dedication and celebrated successes with staff.

Throughout the Covid-19 Pandemic the Trust has continued to increase support available to our Staff including:

- Here for you services (24/7 service for all staff)
- Mindfulness Sessions
- Rest Nests
- Live staff briefings
- Virtual events
- Range of support and wellbeing tools available on the intranet
- Change to Appraisal and 1:1 processes in the Trust moving to Wellbeing support sessions

Innovation

As previously reported in response to Covid 19 the organisation moved rapidly to a virtual workforce and where possible providing staff with the equipment needed to work from home. A central part of this has been the implementation of technology such as Microsoft Teams. This has enabled the Trust to continue to operate all Trust committees and a virtual Incident Control Centre.

The Trust has also continued with the live briefings and information webinars via virtual technology. This has enabled Covid 19 messages to be shared in person regularly from the CEO and Executive Team to all staff members.

The ways of virtual work have been fully embraced and have led to a number of benefits including less travel for clinical staff to meetings (particularly during the fuel incident) and less use of office space enabling social distanced working.

EPRR WORKPLAN

EPRR Work plan for 2021-22 was developed to incorporate the actions required to fully comply with the Core Standards in addition to development actions identified by the EPPR Lead. This is attached in appendix one.

It should also be noted that during 2021-22 there were the following significant achievements by the EPRR team:

- The Head of Compliance and Emergency Planning successfully completed and passed the EPRR Award training
- Transfer of Inpatient BCP's commenced
- Refreshed Lockdown Plans and Action Cards circulated to inpatient areas
- Attendance and participation at the Local Health Resilience Partnerships (LHRPs)
- Involvement in two live EPPR incidents one of which remains ongoing.
- Successful Core Standards Self-Assessment
- Exercises held and lessons learnt have been taken forward
- Learning from 3 Critical Incidents
- Ongoing cover of the ICC 365 days a year, Covid19 outbreak and sitrep submissions and the preparation and organization of Gold and Silver Commands

ASSURANCE

The Health, Safety & Security Committee holds responsibility for and oversees delivery of the Trusts annual Emergency Planning, Resilience and Response work plan.

The committee is chaired by the Director of Risk & Compliance and includes representatives from all services areas. The Committee meets monthly and considers progress against the work plan as a standing agenda item on a quarterly basis.

A quarterly EPRR report is provided to the Trust Quality Committee, a standing committee of the Trust.

EPRR risks have been highlighted in 2021/22 and have been escalated to appropriate risk registers and included on the Board Assurance Framework presented to the Trust Board of Directors.

The Executive Director and Non Executive Director who lead on EPRR have been actively involved in the EPRR work required in 2021/22 and have provided support to the EPRR Team.

		Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 July 2022**

Report Title:	**Infection Prevention and Control Annual Report 2021/22**					
Executive/ Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Katheryn Hobbs Head of IPC on behalf of Angela Wade Director of Nursing and IPC					
Report discussed previously at:	Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	Yes/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Board of Directors with a yearly review of services provided by the Infection Prevention and Control (IPC) Team and related activity from the last financial year	**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 any further information or action

Summary of Key Issues
The attached annual report provides details of the following: 1. Covid-19 response 2. Compliance 3. Audit programme 4. Surveillance of infections 5. Training 6. Management of sharps injuries and bodily fluid exposure 7. Staff influenza vaccination programme 8. Safer water systems 9. Partnership working 10. Key achievements 11. Review of 2021/22 work programme 12. Plan of work for 2022/23

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

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

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

Acronyms/Terms Used in the Report			
UKHSA	UK Heath Security Agency	BAF	Board Assurance Framework
IPC	Infection Prevention and Control	IMT	Incident Management Team
CQC	Care Quality Committee	FFP3	Filtering Face Piece
DIPC	Director of Infection Prevention and Control	OH	Occupational Health
AE	Authorised Engineer		

Supporting Reports/ Appendices /or further reading
Infection Prevention and Control Annual Report 2021/22

Lead

Natalie Hammond
Executive Nurse

Infection Prevention and Control Annual Report

2021 - 2022

Report prepared by

Katheryn Hobbs
Head of Infection Prevention and Control (IPC)

on behalf of

Angela Wade
Director for Infection Prevention and Control

June 2022

Contents

1. Executive Summary

The Director of Infection Prevention and Control (DIPC) and Infection Prevention and Control (IPC) team have continued to work through unprecedented demand during 2021/ 22 due to the continued COVID 19 pandemic.

Specialist advice has been provided to all levels of the organisation both from a clinical and non-clinical perspective in order to support COVID 19 safety to service users and staff.

Assurance of policy has been provided through regular updating of the Board Assurance Framework, which is currently updated bi monthly and reported through Quality committee.

During the pandemic, the Trust command structure meetings have representation from the DIPC and IPC teams to ensure decision-making, information dissemination and monitoring and assurance of IPC principles in accordance with national guidance is robust.

The IPC Team are committed to ensuring learning from cases of health care associated infection (including outbreaks) is shared across the organisation. Work is ongoing with the clinical teams to identify learning points, which are then communicated via live events and education sessions.

In order to give assurance of compliance with the Hygiene Code an audit programme is undertaken each year, in part by the IPC Team members and in part self-audit carried out by clinical teams. Key elements such as the environment, hand hygiene, cleaning, and mattresses are audited. The COVID 19 pandemic has meant this has been a challenge during 2021/ 22. However, COVID 19 secure audits of the environments has continued throughout the period.

The IPC team play an active role in essential safety committees including Water quality and Medical Devices and holds quarterly Infection Prevention and Control Committee meetings as a part of the wider clinical governance structures within the organisation.

Our commitment to closer working with our care partners has seen us have regular discussion and moves towards policy alignment with our partners in order to promote a smooth patient journey. EPUT is the lead provider for IPC within our MSE community collaborative, which contributes to the collaboration and joint approaches pertaining to key IPC principles.

The team have continued to provide training for staff as part of the induction programme and ongoing mandatory training is provided via E-learning. A move was made in March 2022 to take on the National IPC training E Learning programme to align with key care partners across Essex.

The IPC team have successfully recruited a staff member who is responsible for fit testing staff for the use of filtering face piece masks which are required when performing aerosol generating procedures, and a new Head of Infection Prevention and Control joined the team in February 2022. Both are welcome additions to the team and will support the ongoing plan of work.

2. Background

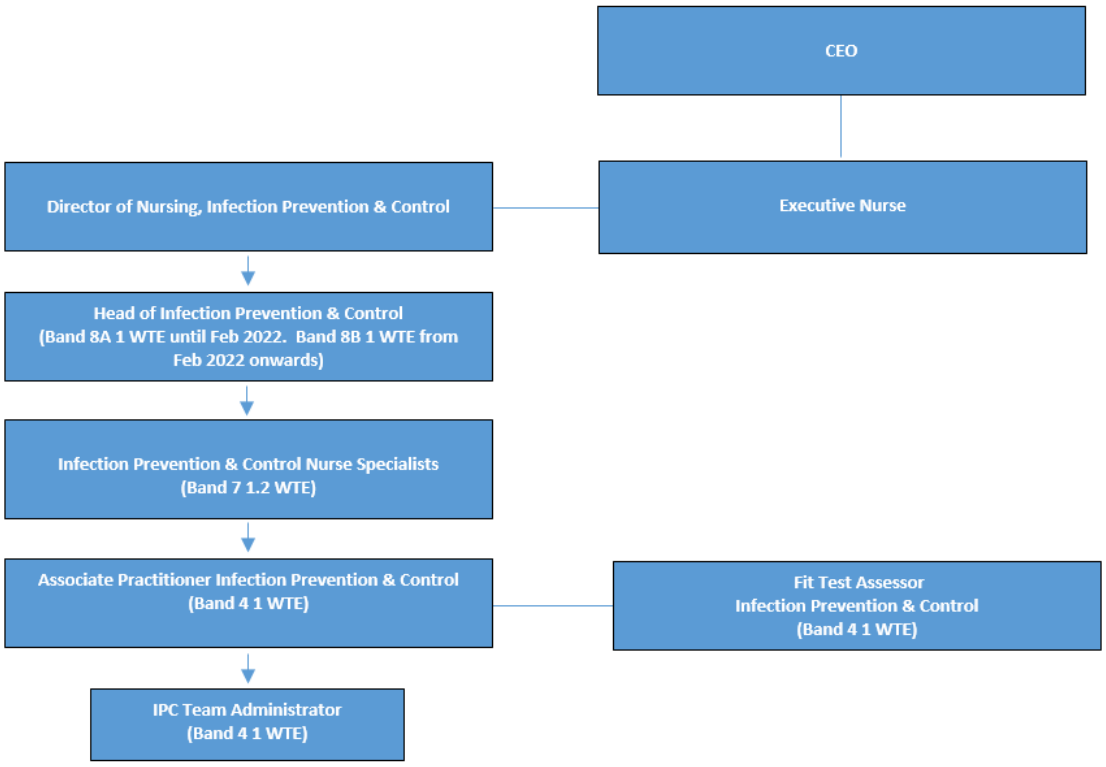
The purpose of this report is to provide assurance that the Trust provides a robust, proactive and effective Infection Prevention and Control (IPC) service. Additionally, the report provides assurance that the Trust is compliant with the Health and Social Care Act 2008: Code of Practice on the prevention 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 2021/2022.

The programme is 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 services.



The Infection Prevention and Control Team Structure

2. Covid-19 response

This past year has continues to see unprecedented demands placed upon the DIPC and IPC team in relation to the Trust's response to managing the Covid 19 pandemic. This included:

- Providing critical roles within the Covid emergency command structure meetings
- Providing specialist IPC advise to all Trust staff on managing the day to day Covid challenges,
- Assisting teams with implementing the Covid Secure requirements for all Trust sites,
- Developing and delivering training documents, videos, posters, live events, MS teams learning forums
- Daily monitoring of government guidance and immediate updating of trust procedures and guidelines with each new change in guidance
- Clinical visits to support, review and audit covid practices
- Implementing and coordinating the staff and patient swabbing processes
- Coordinating and advising on outbreak management
- Chairing Outbreak management meeting with both Trust teams and external partners for NHSEI, UK Health Security Agency (UKHSA) and commissioners
- Facilitate outbreak learning with clinical teams , amending Trust guidelines as a result where required
- Structured judgement review panels for Covid nosocomial deaths
- Complete, monitor and present Covid BAF reports to board.
- Develop, monitor and support inpatient teams covid assurance dashboard
- Implementing a staff track and trace service and taking and following up all calls coming into that line, undertaking contact tracing and advising on actions and management
- Implementing, coordinating and Monitoring of staff fit testing for FFP3 masks for Aerosol Generating Procedures
- Attending bed management meetings
- Provide specialist advise at multiple task and finish groups set up for Covid management
- Creating a Covid environment audit tool within Tendable electronic auditing programme
- Creating Covid safety huddle smart form with high reliability principles for Covid care in ward settings
- IPC visits and sign off of all Covid vaccination centres

This does not represent an exhaustive list but a reflection of the workload as a result of the Covid pandemic. Due to the size of the IPC team, additional hours and bank resources were necessary to ensure IPC functionality was maintained.

3. Compliance

The Trust has declared full compliance with the Code of Practice and maintained registration for 2021/2022. 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.

4. Audit

Some elements of the usual work programme i.e. annual environmental audits have had to be stopped for most of the reporting period due to resource pressure within the IPC team. However, environmental auditing by the IPC team has been reinstated form April 2022

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 each 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 2021/22

Please note: The Audit Programme for this year was not fully completed due to the resource pressure of the Coronavirus Pandemic. 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 devices:**	**MRSA screening:**	**Environment** Rating Scale : Compliant – 95-100% Partial compliance – 80-94% Minimal compliance -<79%
Nursing Homes	100%	100%	-	91.0%
Specialist services Bedford and Essex	Patient observed: 84% Inpatient: 97.8%	-	-	90.4%
Learning Disability Services Essex	Patient observed: Nil Received Inpatient: 98.6%	-	-	-
South Essex MH inpatient and Comm' Services	Patient observed: None received Inpatient: 99.5%	-	-	88.2%
North Essex MH and Comm' Services	Patient observed: Nil Received Inpatient: 99.8%	-	-	80.8%
South East Essex Community Services	Comm: 100% Inpatient: 100%	100%	100%	94.0%
West Essex Community Service	Comm: 100% Inpatient: 100%	100%	100%	94.0%

The table above indicates low scores in some areas in relation to IPC environmental audits. This is not specifically always 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 significant refurbishments or a rebuild would be required to achieve higher scores. 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 continue to liaise with other healthcare providers and commissioners to ensure high-risk findings in shared premises are communicated and addressed. 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.

To counterbalance the reduction in annual IPC audits being carried out, the IPC team supported Ward Managers by carrying out additional Covid compliance audits. Compliance with this was monitored via the IPC Covid dashboard and shared at Silver command meetings on a weekly basis

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.

5. 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 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 attend quarterly HCAI/IPC network meetings in South and West Essex. EPUT is leading on the integrated care system network from an IPC perspective and work is underway to align policy and care pathways

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 *Clostridium difficile* cases in 2021/22 that involved EPUT services, there were no incidents with noted lapses in care that resulted in attribution to EPUT. Both patients had required antibiotics following major surgery and sepsis in the acute trust.
Identified learning was shared with the clinical team and Commissioners. Action plans were followed up after post infection review. The resulting teaching session created for clinical staff is to be shared across all EPUT community wards during 2022

Two cases of MRSA blood stream infection were identified during the reporting period. Both patients had part of their care provided by EPUT services and both had chronic wounds. No lapses in care related to services provided by EPUT in case one. The post infection review for case two acknowledged a gap in the communication between the GP, Care Home and the EPUT teams involved in the patient care. Commissioners are reviewing this with GP services in order to improve timely communication within all key stake holder groups

Incidence of Mandatory Reportable HCAI (MRSA) 2021-2022			
	Community Services (Including 6 Inpatient Units)	Mental Health, LD and Secure Services (Inpatient Units)	Nursing Homes (2)
Incidence of Mandatory Reportable HCAI (MRSA) 2021-2022			
MRSA Bacteraemia **Avoidable cases**	0	0	0
MRSA Bacteraemia **Unavoidable**	0	0	0
HCAI (MRSA) **Cases with EPUT involvement**	2	0	0
Incidence of Mandatory Reportable HCAI (*C. difficile*) 2021-2022			
Clostridium difficile **Avoidable cases**	0	0	0
Clostridium difficile **Unavoidable**	0	0	0
HCAI (*C.diff*) **Cases with EPUT involvement**	2	0	0

Outbreaks:

The Trust reports all outbreaks of infections to the commissioners and public health partners - an outbreak being defined as two or more connected cases of infectious disease in either patients, staff or visitors. The outbreaks seen within the Trust are usually reflective of trends in the wider community. Outbreaks across EPUT services during 2021/2022 were all related to COVID 19 infection.

The submission of daily IIMARCH reports to NHS England continues at the end of 2021/22 as per national policy Regular Incident Management Team (IMT) meetings have been held for all outbreaks – at the initial identification, during the course of the outbreak, and to agree when safe to close the outbreak. These outbreaks were all reported as required, to UKHSA.

Extensive analysis is carried out to identify causative factors, good practice and learning points. These feed into the Trust wide virtual learning events chaired by the DIPC and Head of Infection Prevention and Control as part of our culture of learning in the organization An example of this can be seen below .Representatives from each department are encouraged to attend in order to share lessons learned with their team colleagues.

EPUT recognise that the complexity of our patient groups and challenges in some of the working

environments have negatively impacted case numbers during outbreaks of COVID 19 in some departments

There were no nosocomial outbreaks of infection that were attributed to organisms other than COVID 19 during 2021/22

The table below provides a summary of the outbreaks during this period

Coronavirus Outbreaks:

Service area	No' of Outbreaks	Number of staff affected	Number of patients affected	No of deaths
Nursing Homes	0	0	0	0
Specialist services Bedford and Essex	11	39	31	0
South Essex MH inpatient and Comm' Services	19	95	123	1
North Essex MH and Comm' Services	18	311	216	0
South East Essex Community Services	4	21	9	1
West Essex Community Service	6	12	30	1
TOTALS	58	478	409	3

NHS
Essex Partnership University
NHS Foundation Trust

COVID-19 UPDATE AND LESSONS LEARNED FROM OUTBREAKS

March 2022

COVID-19 testing update

Staff:

- All staff should continue to carry out twice weekly lateral flow testing and report results on the gov.uk website stating they are working for EPUT.

Any staff member who has symptoms, tests positive or who has contact with someone who has tested positive must:

- not come to site to work
- contact their line manager
- contact the EPUT track and trace line for instructions on **01375 364631**

Patients:

- A COVID-19 risk assessment must be completed on admission of all patients.
- Transferring departments must provide accurate information regarding vaccination status, COVID-19 contacts/exposure and provide a test result within 48hrs of transfer.
- Patients are to be tested for COVID-19 on day 1, 3 and 7, then every 7 days whilst they remain an inpatient.

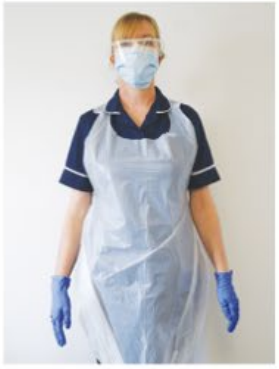
COVID-19 precautions in our departments

Personal Protective Equipment:

- Our use of appropriate PPE continues in all health care environments.

This includes:

- **fluid-repellent surgical face masks** (sessional use)
- **eye protection** (goggles/visors for sessional or individual use)
- **disposable aprons and gloves** for any procedure where there is a risk of exposure to bodily fluids for individual patient use



COVID-19 precautions in our departments

2-metre distancing:

- Patients' communal furniture should be separated to 2 metres' distance.
- Furniture in staff break rooms is to be distanced at 2 metres.
- All office spaces and staff rooms must display a poster displaying the maximum number of people that can enter the room at any one time.

COVID-19 precautions in our departments

Hand washing:

- Ensure all staff working in a clinical department are bare below the elbow.
- Clean hands using either soap and water or hand sanitiser regularly.
- Think about the risk of the task you are performing and which option is most appropriate.
- Always wash hands after removing PPE.

COVID-19 precautions in our departments

Equipment and environment:

- Declutter your working and patients environments to help your cleaning teams effectively clean all equipment.
- Clean all multi-patient use equipment after each patient use
- Complete daily cleaning schedules in your area.
- All staff, whatever your role, have a responsibility to support a clean, safe environment for our patients and colleagues
- Report any concerns you have with regards to equipment or the environment to your line manager to allow you to manage any risks safely.
- Continue with increased cleaning of frequently touched points.

Themes we have learned from our outbreaks:

What happened?

- Patients have tested positive in circumstances relating to:
  - return from leave
  - having visitors
  - transfer from other units and hospitals
- Staff have attended work with mild symptoms and have subsequently tested positive.
- Breaches in PPE and social distancing – mainly in staff break areas.
- Spread from patient to patient when cared for in bays and where patients have close contact in communal areas.

Themes we have learned from our outbreaks:

Why did it happen?

- Patient movement between hospital sites or having leave can impact on the COVID-19 status of our patients, but is recognised as an essential part of their care.
- Breaches in PPE and social distancing in some departments (particularly in staff break areas) have contributed to the transmission of infection.
- Lack of insight into the effects of behaviour at times (patients and staff).
- Omicron variant has seen an increase in transmission of infection.
- Some of our staff work across multiple sites during the working week, which increases risk.

Themes from our outbreaks:

What are we doing about it?

- daily safety huddles include information on current COVID-19 status of the department and reminders about following IPC policy
- discussions with regards to IPC policy in staff 1:1 meetings
- encouraging patients to isolate
- increased cleaning of frequently touched points
- professional challenge of those who are breaching policy
- reinforcement of the COVID marshal role on each shift
- daily case reporting to allow safe decision making
- regular review of EPUT policies in line with changes in national guidance and our current experience of case numbers and outbreaks within our Trust
- ensure in all inpatient areas the elements of the COVID-19 dashboard are adhered to and monitored with appropriate action to improve where required
- all areas with an outbreaks have reviewed and shared the learning from their own experiences

Themes from our outbreaks:

What did we do well?

- provision of isolation packs for patients struggling with isolation
- video visiting calls for those who are unable to receive face-to-face visitors
- Activity co-ordinators providing activities suitable for use in single rooms or that encourage improved social distancing
- keeping patients and relatives up to date
- individual risk assessment for patients who require face to face visitors due to their current condition
- closer physical monitoring of patients during an outbreak to facilitate timely identification of any deterioration in condition
- leadership and IPC support for teams involved

Themes from our outbreaks:

What have we learned?

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

6. 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 have continued with the programme of training on request (mostly via Teams) to support compliance and will continue to provide these sessions for 2022/2023.

Other infection prevention and control training sessions delivered during the year include Trust Induction, topic-specific ad hoc sessions as required by individual departments

Covid 19 training materials were instrumental in creating guidelines, posters, training videos PPE self-assessment of competence and regular training and update live events.

The IPC link worker network has been dormant during the past year. Demands on staff time and the IPC team has meant that it has proved challenging for the link workers to attend training sessions. The IPC team are planning to reinvigorate the link worker programme during 2022/2023 as part of the IPC work plan

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	Bdford	Essex	Bdford	Essex
	83.8%	86.5%	99.5%	93.2%
South Essex MH inpatient and Comm' Services	86.5%		93.2%	
North Essex MH inpatient and Comm' Services	85%		91.4%	
South East Essex Community Services	86.3%		90.4%	
West Essex Community Services	85.8%		94.9%	
Learning Disability Services	96%		100%	
South East Essex Nursing Homes	91.6%		84.3%	

Training compliance is monitored directly by Service Managers as one of their key responsibilities. The IPC team will continue to offer targeted bespoke training to teams when requested to ensure compliance levels are reached. For the coming year training figures will be collated following the care group approach.

7. Sharps Injuries

The IPC team are 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.

Sharps Injuries / Body Fluid Exposure Incidents

	2019/2020	2020/2021	2021/2022
South East Essex Community Health			**15**
Needle Stick Injury - Dirty Needle	12	8	10
Needle Stick Injury - Clean Needle	1	1	1
Sharps Injury - Other Instrument	0	0	4
Needle Stick Injury - Unknown Source	0	1	0
Mid & South Essex Mental Health inpatients	**All Mental Health Services**	**All Mental Health Services**	**6**
Needle Stick Injury - Clean Needle	-	-	0
Needle Stick Injury - Dirty Needle	7	12	6
Sharps Injury - Other Instrument	1	1	0
Needle Stick Injury - Unknown Source	0	2	0
North Essex & West Essex Mental Health Inpatients only			**5**
Needle Stick Injury - Clean Needle	0	0	1
Needle Stick Injury - Dirty Needle	0	0	3
Specialist Services & Learning Disability			**1**
Needle Stick Injury - Dirty Needle	1	1	0
Needle Stick Injury - Clean Needle	-	1	1
Sharps Injury - Unknown Source	-	-	0
Sharps Injury - Other Instrument	1	-	0
West Essex Community Health Services ALL			**5**
Needle Stick Injury - Dirty Needle	6	4	4
Sharps Injury - Other Instrument	-	-	0
Needle Stick Injury - Clean Needle	-	1	1
Sharps Injury - Unknown Source	-	1	0
Corporate Services (Covid Vaccination			**39**
Needle Stick Injury - Clean Needle	-	9	15
Needle Stick Injury - Dirty Needle	-	4	19
Sharps Injury - Other Instrument	-	1	2
Needle Stick Injury - Unknown Source	-	0	3
Nursing Homes			**1**
Needle Stick Injury - Clean Needle	-	-	1
Total			**72**

The use of sharp safe products as per the EU Directive (May, 2013) has been successfully embedded across the Trust.

With the help of the Procurement and Clinical teams, this market is constantly under review and

new/improved products are introduced when appropriate. The use 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.

There has been a reduction in sharps injures during the reporting period. It is unknown if this is as a result of reduced reporting. A plan is in place for 2022/23 to ensure that regular communications are shared regarding the importance of reporting all sharps injuries and what actions staff are to take.

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.

Bites and Scratches (Assault)

Assault including Scratch, Bite or Body Fluid Exposure	18/19	19/20	20/21	21/22
Bite	86	67	111	112
Body Fluid Exposure	143	161	216	222
Scratch	273	316	263	268
Total	**502**	**544**	**590**	**602**

Bite and scratch injuries (assault) are followed up, where required, by Occupational Health Services who request support from the IPC team and Local Security Management Specialist when required.

8. Staff Flu Vaccination Programme

The IPC, COVID 19 mass vaccination, and Medicines Management teams were involved in the delivery of the Staff Flu Vaccination programme in 2021/ 2022.

Drop-in clinics were held in a variety of venues across the organization and staff were also encouraged to take up the vaccine when attending for their COVID 19 vaccinations.

Uptake figures were reduced on the previous year. It is felt that the requirement to take up COVID 19 vaccinations and concern relating to the requirement for several vaccinations in quick succession may have led to this reduction.

There were 52% of patient facing and 55% of non-patient facing staff took up the offer of the influenza vaccination during the reporting period.

Lessons learned have been discussed within the organization in order to prepare for the vaccination programme in the coming year.

It is expected that in 2022/23 there will be a CQUIN related to the uptake of Influenza vaccination again.

9. Safe Water Systems

The Trust continued throughout Covid to effectively undertake water management and governance with the Water Safety Group continuing to meet on a bi-monthly basis. There has been the annual review of the previous water management structure with several appendices now incorporated into the policy

itself along with definitive definitions on roles and responsibilities included in the structure. The Trust has worked in partnership with its water maintenance contractor, Clearwater, who also now sit on the Water Safety Group providing a report detailing maintenance successfully completed as well as data on those PPM's outstanding. Training programmes are due to be drafted for legionella awareness training; all relevant senior managers are fully trained in relation to Duty to Manage water systems within the Trust.

Work and 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, the Trusts appointed Authorised Engineer, Responsible Persons, Authorised Persons and IPC Team. The Trust is in the process of appointing a Consultant Microbiologist.

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 and has provided 6 monthly audits on EPUT's water management, looking at all aspects across the Trust and stated an overall improvement from the previous year.

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
Pre-Planned Maintenance
Flushing Audits
Capital Programmes involving changes to water systems

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.

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. The past year has seen commissioned new Water Risk Assessments in the South and West with remedial programmes ongoing.

NHS Property services have also alerted EPUT to positive legionella counts at Saffron Walden Community Hospital which has been ongoing for the last 3 years, leading to new tanks being installed, auto chlorination dosing unit and filters being installed on all showers within Avocet ward. EPUT collaboration with NHS Property Services has further identified fundamental systemic challenges within Avocet Ward relating to current pipework, which NHS Property Services is now in the process of resolution. St Margaret's has also recently been flagged with legionella counts although the most high risk areas relate to non EPUT blocks on the site with works to shower units and structural water pipework systems throughout the site due to take place.

10. 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 System One, Remedy and Mobius records has enabled the IPC team to support root cause analysis and post-infection review investigations.

11. Key Achievements

Key achievements for 2021/2022 have included:

- The IPC team have continued with the robust response with to requests from National Government, UKHSA and NHS England Regional team in relation to the management of the Covid 19 Pandemic.
- Support of the Trust Command and control structure during the pandemic by ensuring national guidelines are put into practice at local level with user friendly policies to support staff clinical decision making
- Development of the COVID-19 assurance dashboard
- Over 5000 staff have received individual support by the IPC team nurses when testing positive for COVID-19 or been in contact with a case via the robust track and trace system set up and delivered by the IPC team
- Delivery of staff education events using virtual platforms
- Employment of a fit testing health care assistant to support the provision of safe working for clinical staff during the pandemic
- Provision of expert advice and leadership on the management of nosocomial outbreaks of infection within the organization
- Bi- monthly review and submission of the national boards assurance framework
- Maintained levels of support in relation to non COVID 19 related IPC issues/ queries
- Carried out site visits to support clinical team and provide bespoke responses to IPC needs in specific clinical areas
- Supported the Trust estates teams in refurbishment projects providing advice in line with national Health Technical Memorandums to ensure health care standards are met with environmental refurbishments and changes of use of buildings/ rooms
- Welcomed the regional IPC representatives to site visits to the organization
- Attendance and provide practical expert advice at the Trust Water Safety Committee
- Work alongside the facilities team to support development of the Trust response to the National Cleaning Standards
- Providing assessment and sign off of all covid-19 vaccination sites
- The lead IPC provider in the MSE community collaborative working to unify aspects of IPC standards and policy across Essex for example; common policy, training and audit programmes
- Leading on the provision of the staff influenza vaccination campaign with the support of the mass vaccination and occupational health teams

Work Programme 2021/22

During the reporting period, 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.

The work programme for 2012/22 was completed with the COVID-19 pandemic at the forefront of all

IPC activity

Policies evolving over the year, and IPC standards continue to be the foundation of care provision whilst ensuring other aspects of the care provided for our patient groups are taken into account for their safety.

There were two elements of the work programme which were not fulfilled during the last year. The IPC link worker forums and training sessions were not completed. However, a plan is in place to re-establish this important network within the Trust, with members of the IPC team specifically tasked with this as a project in 2022/23. The aim of this will be to support more robust IPC practices in all clinical areas going forward. Work will begin with the collating of information of those who wish to take on/ continue with the roles followed by conferences relating to those in inpatient and community settings

The second element that has not been fulfilled during the last year is that of involving the IPC team at the early stages of new build and refurbishment projects. This has caused some challenges during the year. The Head of IPC and Estates are meeting in May 2022 in order to determine how this can be progressed in a robust manner and be embedded in the practices of the key stake holders of such projects.

As the country moves to the approach of living with COVID -19 it is acknowledged that these polices will continue to change. 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.

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 2022/23

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 2022	AW						
	• Quarterly quality reports submitted to the appropriate commissioners.	Quarterly	Compliance team	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	Review of KPI reporting to be undertaken Q1 to ensure accurate reporting going forward- review completed					
	• Water safety group and water safety plans are in place. • Head of IPC attend meetings. • Ventilation Safety committee	Quarterly	AW/ Estates Lead	Ventilation safety committee established Q1 by Estates team. Authorised Engineer employed to support					

	• Collaborative working with CCG's and other providers in area.	Ongoing	IPCT	IPC team attends CCG/STP network meetings Working a ICS leader of community providers in Essex involving close collaboration with Provide/ NELFT in order to align policy and provide support for colleagues					
	• 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	Reviewed at IPCC	IPCT	Risk related to Consultant Microbiologist raised May 2022					
	• Keep up to date with emerging national guidance on the management of Covid-19 and risks posed to patients and staff and advise on mitigation actions.	As each new guidance is delivered	!PCT	DIPC attends Silver command meetings. Gov.UK updates scanned daily by the team and amendments to guidance implemented immediately, where appropriate to services. Team members attend Bronze command meetings to support Operational staff.					
	• Keep up to date with emerging guidance related to Monkeypox ensuring procedural guideline in place to advise staff on mitigating actions	As each new guideline is developed	IPCT	Flow charts created May 2022					
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 in community clinic settings for assurance purposes.	Ongoing	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. IPC team working with estates to produce revised cleaning policy in alignment with national cleaning standards 2021					
	• Involvement in drawing up and monitoring of cleaning/laundry/waste contracts	Ad Hoc	IPCT	IPC team support of consideration of new laundry contract April 2022. Feedback given to Estates team					

	• inclusion in planning for new builds and refurbishments	Ad Hoc	IPCT	Work ongoing to ensure IPC are involved in projects from the beginning in order to reduce risk of required changes Head of IPC/ Estates meeting May 22 to discuss further					
	• Advise on environmental and medical device decontamination.	31/3/2022	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	Re- commenced April 2022 as capacity within team allowed. Review of audit programme required for 2022/23. Review of reporting of KPIs to be undertaken May 22					
	• 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	Quarterly peer-observed hand hygiene audits on Perfect ward App in all inpatient units (10 observations per quarter) 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). Review of hand hygiene audit frequency in outpatient settings May 22					
	• Mattress audit programme	6 monthly	IPC AP	On Tendable App. 6 Monthly in all inpatient settings.					
	• Invasive Device Care Bundle Audits – CHS and nursing homes only.	Quarterly	IPCT	On Tendable 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.	31/03/23	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.	Quarterly	MMT/IPCT						
	• Local antimicrobial stewardship policy.	Ongoing	MMT						
	• Prescriber induction and training in prudent	Ongoing as part of trust induction	MMT						

	antimicrobial use, antimicrobial resistance and stewardship competencies	programme							
	• Work with and assist Meds Management team to raise awareness for European Antimicrobial Awareness day in Nov 2021	31/3/2023	IPCT						
	• Support of West Essex and Herts Urinary tract Infection/ Gram Negative reduction work stream	31/03/23	IPCT/ MMT	Team members have volunteered to take part in this piece of work					
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	Ongoing	IPCT/ Communications team						
	• 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, refresh, and standardise to suit all new areas of the organisation.	Ongoing and as policy is reviewed	IPCT/ MMT/ Communications team						
	• Issue timely and appropriate audit feedback to teams – for display in public areas.	Ongoing at time of audit	IPCT						
	• Support clinical areas in the updating of audit action plans to close the audit loop	Ongoing following audit	IPCT						
	Clinical IPC support: • Telephone advice for clinical staff in relation to treatment for identified infection and preventative measures to minimise risk from infection.	As required	IPCT						

	• Lead on providing all staff in the Trust with the most up to date national guidance on the management of Covid-19 and risks posed to patients and staff and advise on mitigation actions.	Ongoing as national policy is updated	IPCT	Gov.UK updates scanned daily by the team and amendments to guidance implemented immediately, where appropriate to services. Team members attend Bronze command meetings to support Operational staff.					
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	Ongoing as required	IPCT						
	• Co-ordinate (in liaison with clinical leads) and advise on management of outbreaks	Ad Hoc	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. • Provide lessons learned teaching to clinical staff	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	31/05/2022	IPCT	Review of MRSA policy being undertaken Spring 2022 to be followed up with education event for clinical staff in relation to MRSA screening					
	• Support and advise clinical staff with known colonised/infected patients.	Ongoing as cases arise	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	Ad Hoc	IPCT/ Tissue Viability						

	wounds/wound care.								
	• Carry out investigative case reviews and identify learning on any patients believed to have acquired nosocomial Covid 19 infection.	Ongoing as outbreaks occur	IPCT	IPC team have daily updates of sitreps, carrying out all Test and Trace contacts during working hours and comm's with the wards re; new cases. Reviews carried out as when criteria met for possible nosocomial spread.					
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**	31/03/23	IPCT	Reinvigoration of link worker programme planned for 2022/23 Conferences to be organized for inpatient and community link workers					
	Restructure of and recruitment into the IPC team to provide alternative way of working which supports each care group in the Trust	September 2022	DIPC/ Head of IPC	Review and creation of job descriptions May/ June 2022					
	Ongoing work with purchasing and clinical areas to standardise equipment/products used across Trust, with regard, to IPC, in order to ensure consistency of equipment provision and reduce cost	Quarterly	IPCT/ Procurement Lead						
	Review of Aseptic non technique competencies and practices to align with national guidance	31/03/2023	IPCT/ Education team						
	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.	Ongoing as cases occur	IPCT/ OH team						
	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	Monthly	IPCT	Training figures reported on monthly KPI sheets.					
	• Deliver topic specific sessions when requested.	Ad Hoc	IPCT	Cdiff lessons learned training May 22					
	• Raise Trust wide awareness of sepsis recognition and treatment.	31/3/2023	IPCT/ Head of Deterioratin g Patient	.					
	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.		IPCT	Reported on Community inpatients KPI's.					
	Support patient placement when infection is suspected or confirmed	Ongoing	IPCT						
8: Secure adequate access to laboratory support as appropriate.	• Review and monitor new organisation wide contract with Microbiology department in CHUFT.	31/3/2023	DIPC/ IPCT	Work on securing Consultant Microbiology support ongoing May 22					
	• Advise on the collection, storage, transport and interpretation of specimens/samples, including Covid-19 swabs.	Ongoing	IPCT						

	• Promote collaborative working with acute trust laboratory and microbiological partners, particularly with regard to effective antimicrobial stewardship.	Ongoing	IPCT						
	• Continue to explore ongoing issues surrounding MH units accessing electronic microbiological results and information for patients.	31/3/2022	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.	31/3/2023 and as national guideline change	IPCT	Infection Prevention and Control manual released April 22					
	Collaborative approach to the prevention and management of invasive group A infections by use of aligned: Policy Audit tools Communication strategy Surveillance systems Collaboration with system partners		IPCT and community collaborative						
	• **Antimicrobial prescribing –** programme of audit and staff/management feedback. • Work with Meds Management team to amalgamate and standardise processes.	31/3/2023	MMT/ IPCT						
	• **Control of outbreaks** Have in place alert organism system.	Ongoing	IPCT	.					
	• Provide guidance and support to staff in the event of a Coronavirus outbreak in inpatient units.	As outbreak occur	IPCT	Covid 19 Outbreak guidelines developed, to be used in conjunction with existing outbreak management guidelines.					

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.	Ongoing	IPCT/ OH						
	• Planning and coordinating the Influenza vaccination programme. • Develop method for capturing data relating to staff accessing vaccination outside of the Trust.	31/3/2023	IPCT/ CQUIN team/ OH team						
	• coordinating a Coronavirus vaccination programme, for staff and members of the public. Reviewing as national guidance changes	31/3/2023	Vaccination team						
	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.	31/3/2023	Head of Deteriorating Patient/ IPCT and relevant specialist nurses						

		Agenda Item No: 7d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 July 2022**

Report Title:	**Mental Health Act Annual Report 2021/22**					
Executive/ Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Lynn Proctor, on behalf of Angela Butcher, Associate Director of Professional Development					
Report discussed previously at:	Quality Committee Mental Health Act and Safeguarding Sub Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report 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 2021-2022.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors are asked to:

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

Summary of Key Issues

This is the fifth 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 2021/22 and the outcomes of its deliberations, and looks ahead to developments and challenges anticipated in 2022/23.

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, 2021 to 31st March, 2022. 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.

The Mental Health Act Office continues to monitor Mental Health Act activity across the Trust, including the number and type of detention (i.e. Section 5(4), Section 5(2) etc) and instances of detained patient's absence without leave (AWOL). The Mental Health Act Office also monitors detentions by ethnicity. Whilst there is some fluctuation in data, it remains consistent with previous years and in the expected range.

The CQC carried out six Mental Health Act inspections during the period April 2021 – March 2022. Overall, the feedback from the CQC reviews was positive with a small number of points of learning/themes identified and addressed. Following these inspections, the CQC also commented on a number of good practices, particularly relating to patient care during the pandemic.

The September 2020 Mental Health Act Internal Audit assessed the Mental Health Act Office as having substantial assurance over the control design and moderate assurance over the control effectiveness. As a result of the audit, a review of the Mental Health Act Administration Policy and Procedure and the Associate Hospital Manager Operational Manual was undertaken and implemented

Following elections in Q3 2021, a new Independent Chair and Vice Chair of the Associate Hospital Managers were appointed, who continue to work closely with the Mental Health Act Office Senior Management.

The Trust's Target Compliance figure of 85% for Mental Health Act mandatory training, covering both registered and un-registered staff, was met for the period April 2021 – March 2022.

The Mental Health Act Office continues to provide Mental Health Act administration support to several local acute care partners for patients detained to them under a Service Level Agreement. As part of the agreement the Mental Health Act Office also provides training to our acute care colleagues which helps ensure those individuals detained under the Act are in receipt of their rights as a detained patient.

Going forwards, work will continue going forward in continuing to address and streamline the functions of the Mental Health Act Administration, ensuring compliance under the Mental Health Act and prepare for any changes in legislation resulting from the Mental Health Act White Paper.

The Mental Health Act Team remains committed to providing a quality, supportive function to EPUT clinicians to ensure that those individuals detained under the Act are in receipt of their rights as a detained patient.

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

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

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

Acronyms/Terms Used in the Report			
MHA	Mental Health Act	AWOL	Absence without leave
CQC	Care Quality Commission		
AHM	Associate Hospital Manager		

Supporting Reports/ Appendices /or further reading
Mental Health Act Annual Report 2021/22

Lead

Natalie Hammond
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

MENTAL HEALTH ACT ANNUAL REPORT 2021-22

EPUT

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

MENTAL HEALTH ACT ANNUAL REPORT

1 APRIL 2021 TO 31 MARCH 2022

CONTENTS

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

FOREWORD

Providing high quality mental health care for the most vulnerable in our communities remains at the heart of our organisation and our new strategic vision **'to be the leading health and wellbeing service in the provision of mental health and community care'**.

This year's 2021/2022 Mental Health Act Administration Annual Report demonstrates not only our performance in relation to the Mental Health Act but also our commitment to providing the best possible care to our service users. This report shows a sustained improvement in the care that we are giving to those who rely on us and underlines our commitment to supporting people in the community, with inpatient treatment being used only when needed. Our focus is on discharge and support outside hospital because evidence tells us that is where people do best in terms of treatment and recovery.

The flexibility and innovation that staff have shown throughout the COVID-19 pandemic has been incredible – sustaining services and care for our patients.

Safety First, Safety Always

Now in its second year, our inpatient safety strategy 'Safety First, Safety Always', is firmly embedding across the Trust. Our staff care for some of the most vulnerable children and adults in society and work in often challenging circumstances. We have made great strides in developing a learning culture with a focus on improving systems and standard operating procedures and sharing information across the Trust.

Partnership working

Working with our partners from health and neighbouring services is key to delivering the best possible care. Earlier this year, we were delighted to sign Service Level Agreements (SLA) for Mental Health Act administration with Mid and South Essex NHS Foundation Trust covering Broomfield, Basildon and Southend Hospitals. This builds on the successful agreements already in place with Princess Alexandra and Colchester General Hospitals.

Looking to the future, we will work alongside a newly elected Independent Associate Hospital Manager Chair and Vice Chair and welcoming new volunteers to the important independent roles of Associate Hospital Managers.

I would also like to take this opportunity to thank the staff across EPUT for all they have done in caring for those who rely on us – day in day out I am humbled by the care, compassion and innovation shown across the Trust.

Natalie Hammond
Executive Nurse

Essex Partnership University NHS Foundation Trust

EXECUTIVE SUMMARY

Context and introduction

This is the fifth 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 2021/22 and the outcomes of its deliberations, and looks ahead to developments and challenges anticipated in 2022/23.

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.

Scope of the report

This report reviews the operation of the Mental Health Act for the year 1st April, 2021 to 31st March, 2022. It provides an overview of the work undertaken in the administration of the Mental Health Act 1983 (as amended by the Mental Health Act 2007).

The Mental Health Act Office continues to monitor Mental Health Act activity across the Trust, including the number and type of detentions (i.e. Section 5(4), Section 5(2) etc) and instances of detained patients' absence without leave. The Mental Health Act Office also monitors detentions by ethnicity. Whilst there is some fluctuation in data, it remains consistent with previous years and in the expected range.

CQC inspections

The CQC carried out six Mental Health Act inspections during the period April 2021 – March 2022. Overall, the feedback from the CQC reviews was positive with a small number of points of learning/themes identified and addressed. Following these inspections, the CQC also commented on a number of good practices, particularly relating to patient care during the pandemic.

Internal audit

An internal audit of the Mental Health Act Office took place in September 2020 and concluded that there was substantial assurance over the control design and moderate assurance over the control effectiveness. As a result of the audit, a review of the Mental Health Act Administration Policy and Procedure and the Associate Hospital Manager Operational Manual was undertaken and changes implemented.

Following elections in Q3 2021, a new Independent Chair and Vice Chair of the Associate Hospital Managers were appointed and they continue to work closely with the Mental Health Act Office Senior Management.

Mandatory training

The Trust's Target Compliance figure of 85% for Mental Health Act mandatory training, covering both registered and un-registered staff, was met for the period April 2021 – March 2022.

Partnership working

The Mental Health Act Office continues to provide Mental Health Act administration support under a service level agreement to several local acute care partners. As part of the agreement the Mental Health Act Office also provides training to our acute care colleagues which helps ensure those individuals detained under the Act are in receipt of their rights as a detained patient.

Looking forward

Work will continue going forward in continuing to address and streamline the functions of the Mental Health Act Administration, ensuring compliance under the Mental Health Act and prepare for any changes in legislation resulting from the Mental Health Act White Paper.

The Mental Health Act Team remains committed to providing a quality, supportive function to EPUT clinicians to ensure that we work collectively to ensure that those individuals detained under the Act are in receipt of their rights as a detained patient.

DETENTIONS UNDER THE MENTAL HEALTH ACT – 2021/2022

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 in October, 2021

National data – Mental Health Act Statistics – annual figures 2020/2021 – published October 2021

The key findings of the statistical report which was published on the 26th October, 2021 reports that there were 53,239 new detentions nationally under the Mental Health Act were recorded, but the overall national totals will be higher as not all providers submitted data and some submitted incomplete data.

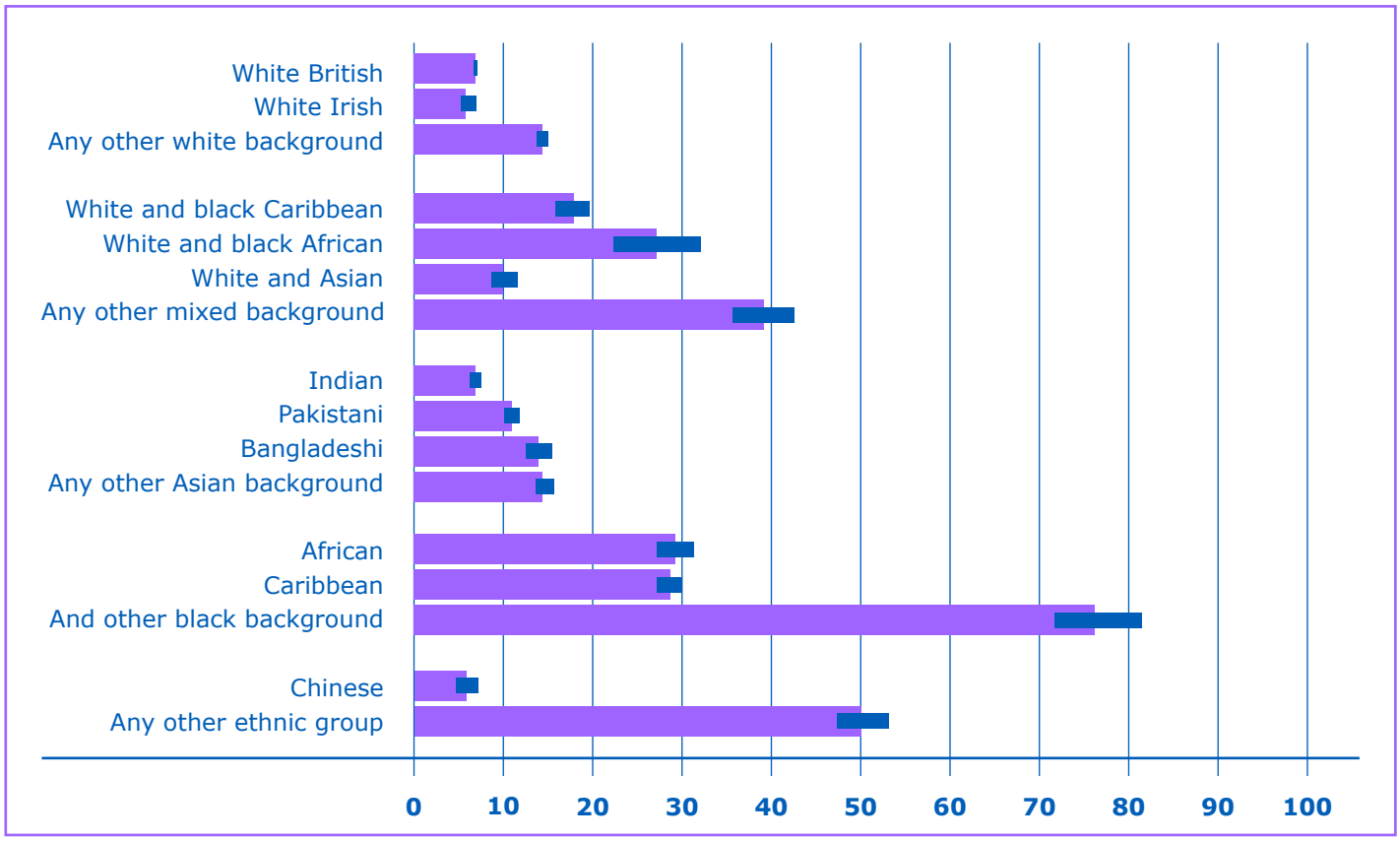
Comparisons can still be made between groups of people using population based rates, even though the rates are based on incomplete data. Known detention rates were higher for males (94.8 per 100,000 population) than females (87.9 per 100,000 population).

Detention rates by ethnicity *(see table overleaf)*

A more detailed breakdown of the five broad ethnicity groupings shows that the detention rate was highest for those with 'Any other black background', which forms part of the 'Black and black British' group.

At 764.4 detentions per 100,000 people, this was over ten times the rate for the 'White British' group (71.6 detentions per 100,000 people) in 2020-21.

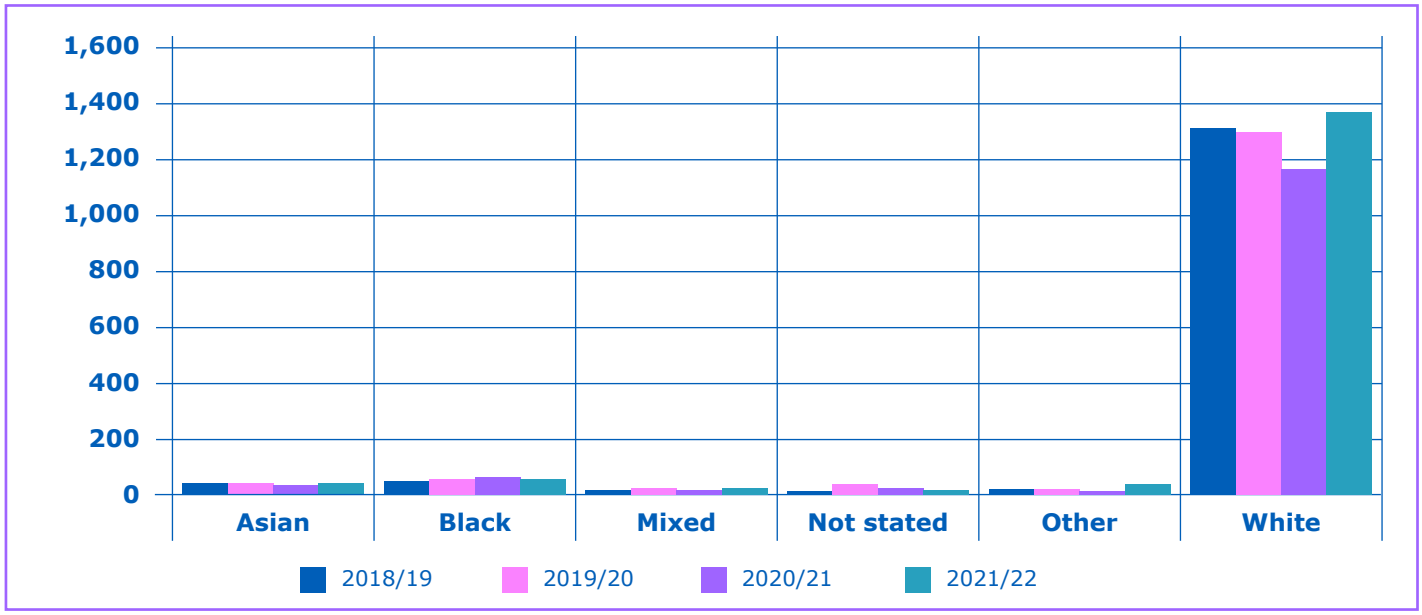
The 'Any other ethnic group' had the second highest rate of detention (502.2 detentions per 100,000 population) followed by 'Any other mixed backgrounds' group at 389.8 detentions per 100,000 population.



National Data – Mental Health Act Statistics – Annual Figures. Published October 2021. Standarised detention rate per 100,000 population for the UK.

EPUT detention rates by ethnicity

The table below details the ethnic grouping of detained patients in receipt of care from EPUT. Although the data indicates a slight decrease in the detentions of black individuals and a slight increase in the detention of white individuals, the data, as in previous years, remains relatively stable and appears to be consistent with the demographic profile of EPUT's geographical area. The Mental Health Act Office will continue to monitor and analyse the data for emerging trends and will review and adapt policy and procedure, as well as training to ensure cultural and ethnicity needs are reflected.



Data provided by EPUT Information Department

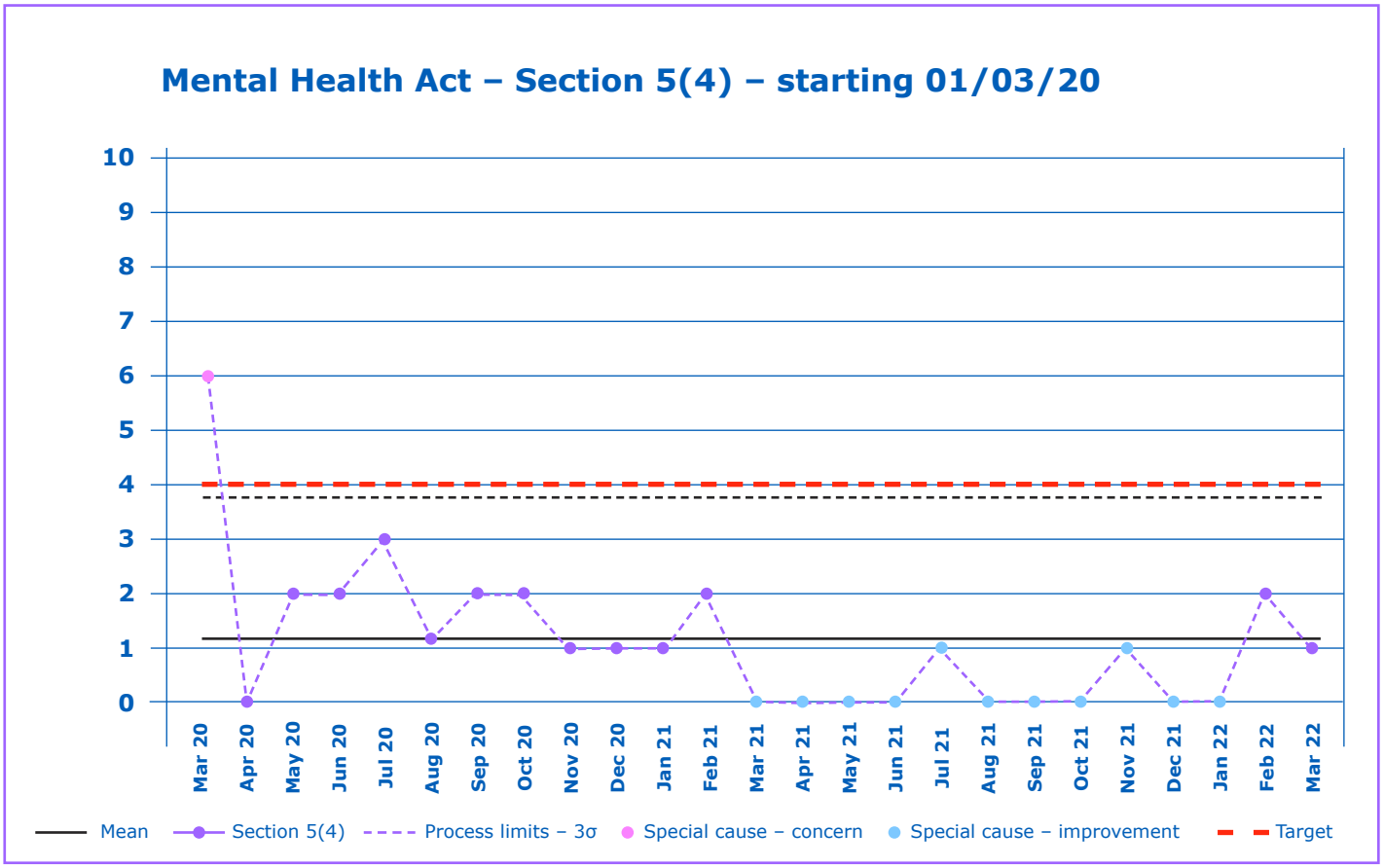
EPUT Mental Health Act Detention Activity Data

Mental Health Act Activity (number of detentions) is monitored on a monthly basis in order to identify emerging trends and any anomalies and presented at the Mental Health Act Business Meeting and Mental Health Act & Safeguarding Sub-Committee. Any anomalies and emerging trends identified are further investigated to understand the context and circumstances; and remedial action taken as appropriate.

The below SPC Charts provides an overview of Mental Health Act Activity. Whilst there is some fluctuation in the use of some of the detentions, they are all within the expected range

Section 5(4)

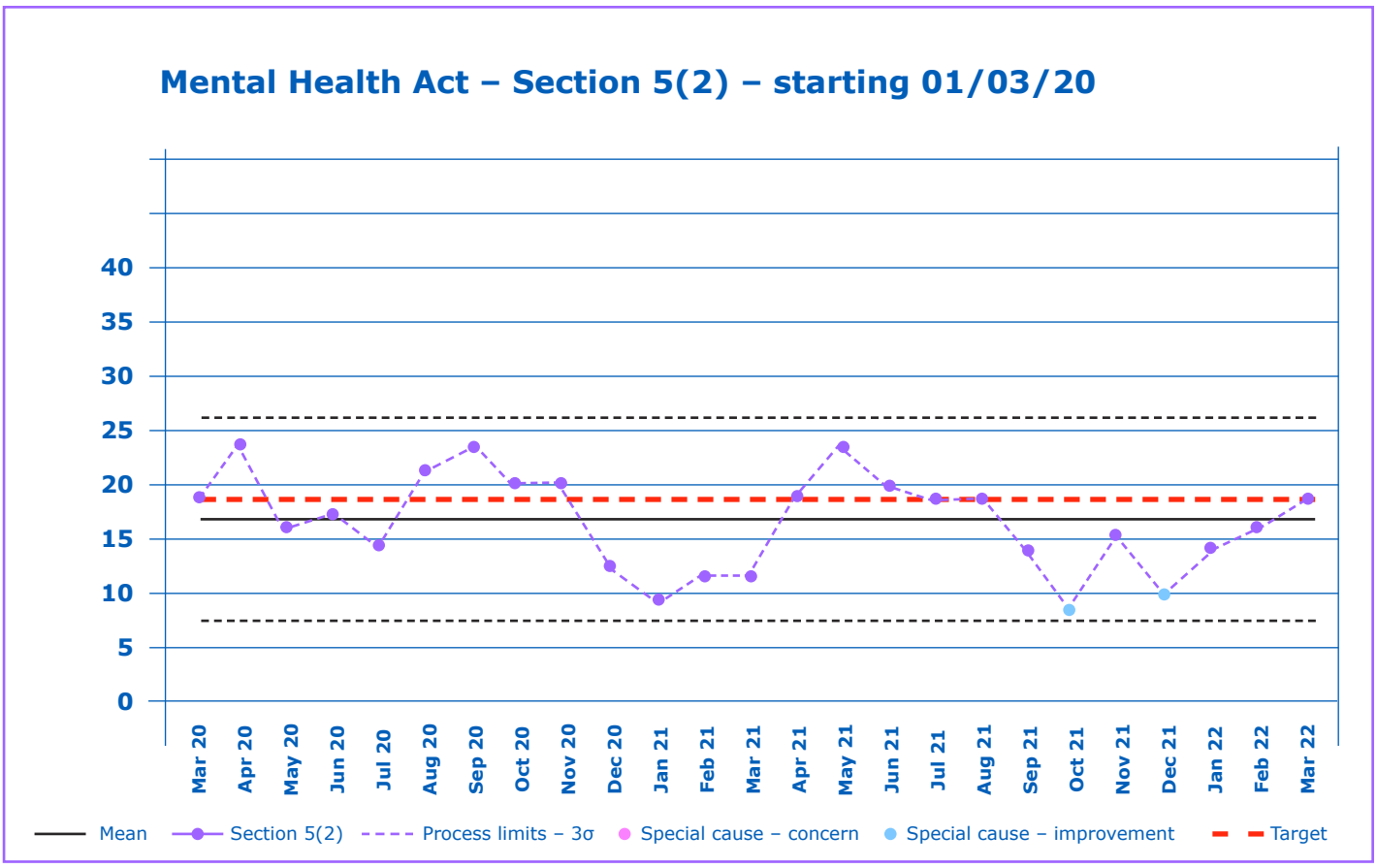
A Section 5(4) allows a nurse of the 'prescribed class' to detain an in-patient who is already receiving treatment for mental disorder. The definition of 'prescribed class' is any nurse registered in sub-parts 1 or 2 of the register maintained by the Nursing & Midwifery Council (NMC) whose entry on the 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 to ascertain if the patient requires further detention. The use of Section 5(4) whilst fluctuates remains low and within single figures. Where there is an increase in numbers, the Mental Health Act Office will undertake further investigation to ascertain rationale and identify any practice or training issues. In addition to this, the data is reviewed and discussed at the Mental Health Act Business Meeting and the Mental Health & Safeguarding Sub Committee.



Data provided by EPUT Information Department

Section 5(2)

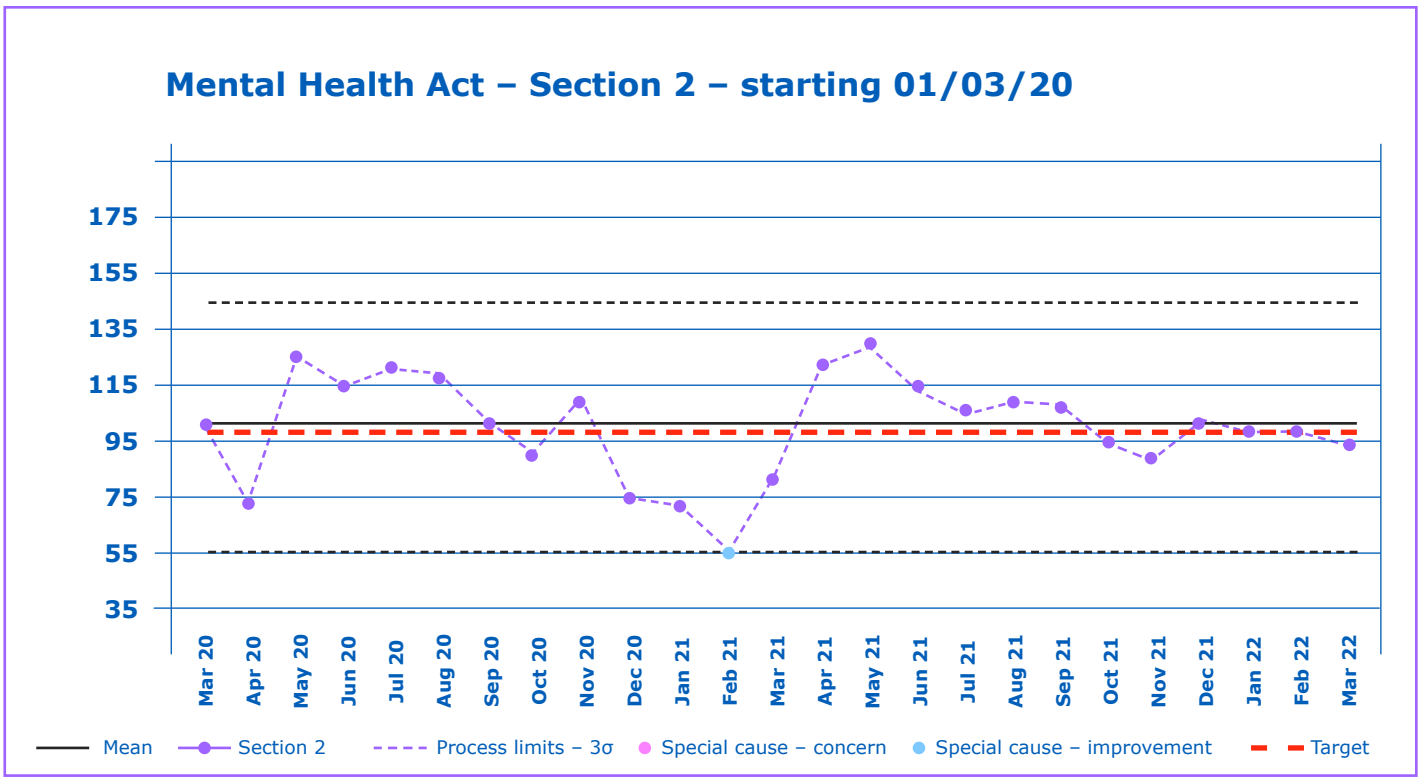
Section 5(2) is a holding section of an informal or voluntary patient on a mental health ward in order for assessment to be arranged under the Mental Health Act 1983. A Section 5(2) is only used where the patient has expressed the intention to discharge themselves and there is an assessed risk to themselves or others should they do so. The usage of a 5(2) can therefore fluctuate from month to month demonstrated as common variation. This data is monitored and any unexpected increases are reviewed by the Mental Health Act Office. Where necessary, the office will undertake further investigation to ascertain rationale for increase and identify if there are any practice or training issues that need to be addressed. To date for the period covered by the annual report, no issues have been identified.



Data provided by EPUT Information Department

Section 2

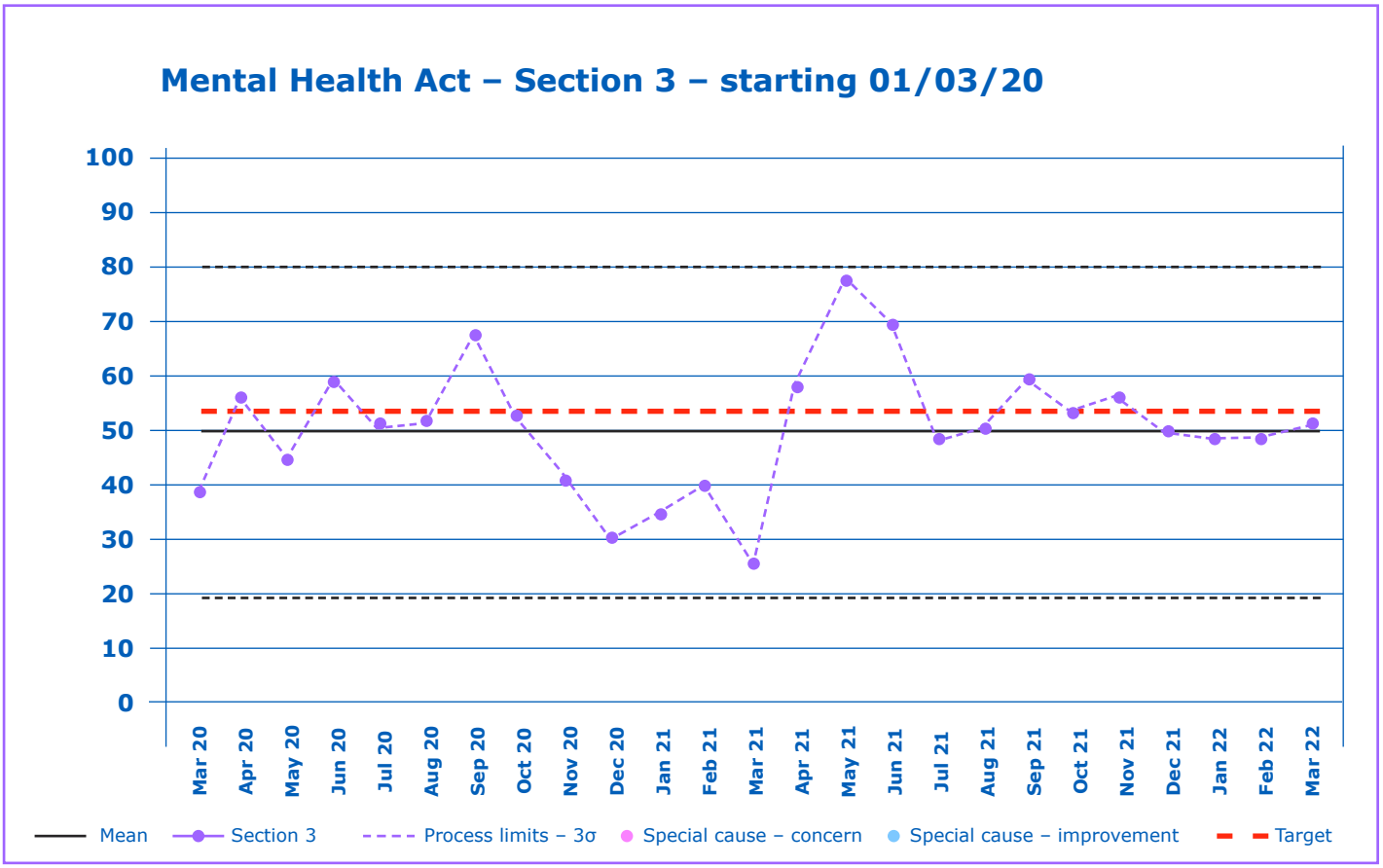
Section 2 is an assessment & treatment section for detention up to 28 days. Clinicians during the period of assessment will be looking for an improvement in the patient's mental state and would towards the end of the twenty eight day period be looking for the least restrictive option of the patient remaining in hospital informally rather than being detained further under Section 3. The use of Section 2 (as highlighted in the chart below) has fluctuated over the last twelve months, however it is now within the expected range. Whilst it is difficult to provide a definitive rationale for this fluctuation, it could be attributed to a number of factors including client presentation, impact of COVID-19 and the impact of and success of crisis services negating the need for admission.



Data provided by EPUT Information Department

Section 3

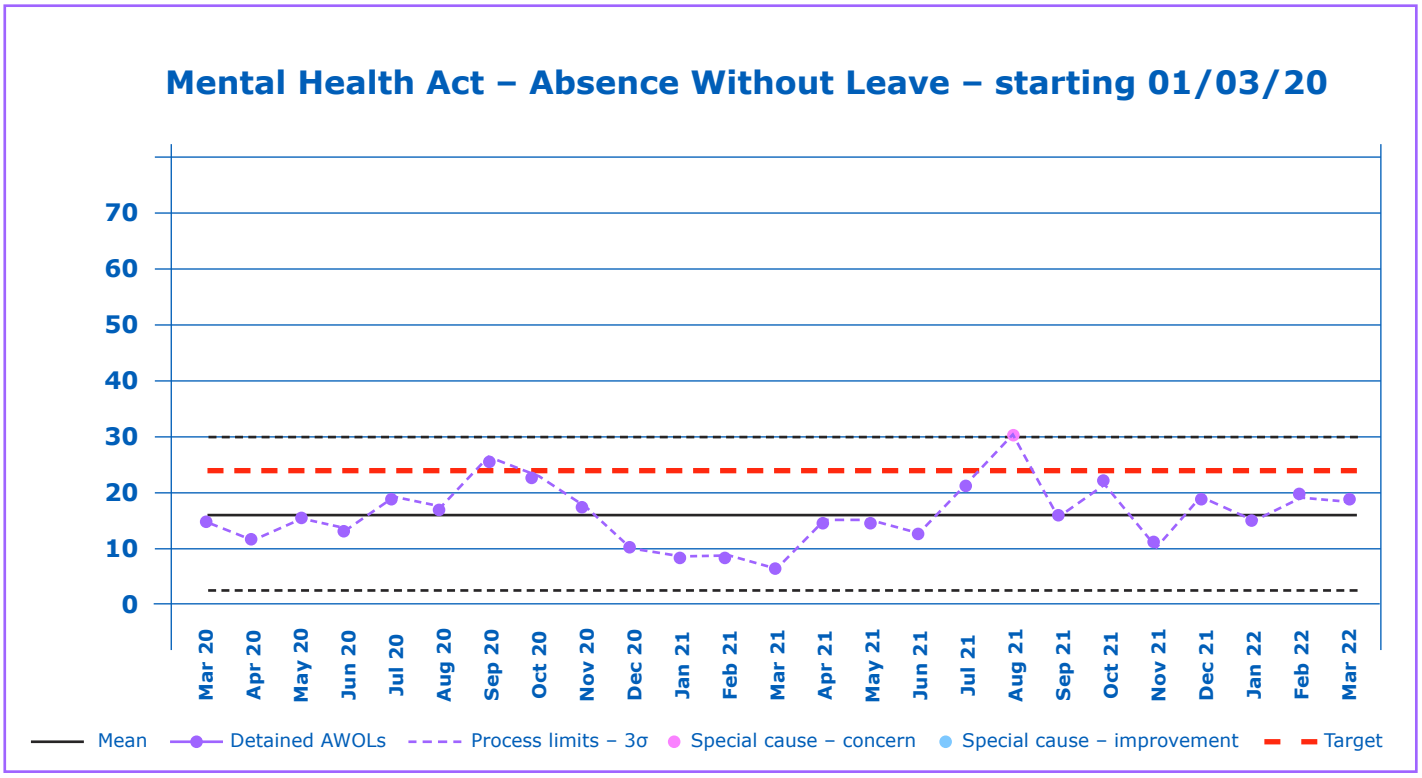
Section 3 is a longer term treatment section for up to six months, renewable at six months and then yearly. The data fluctuates, with an increase in May 2021 and slight increases in October, 2021 and February 2022. However these increases are still within expected range, and could be attributed to patients being transferred from a Section 2 to a Section 3 if they are assessed as requiring long term treatment, or being admitted to hospital under Section 3, (Those patients who have previously been assessed under Section 2 or detained under Section 3).



Data provided by EPUT Information Department

Absence Without Leave

Section (18) of the Mental Health Act sets out the definition and the powers available when a person is absent without leave. A high percentage absence without leave 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 absent without leave, e.g. escorted as opposed to un-escorted leave.



Data provided by EPUT Information Department


NHS

SERVICE LEVEL AGREEMENTS WITH OTHER CARE PROVIDERS

The Trust continues to have in place Service Level Agreements with Princess Alexandra Hospital, Harlow and East Suffolk and North Essex NHS Foundation Trust who are responsible for services in Colchester General Hospital.

On 1st March, 2022, Mid & South Essex NHS Foundation Trust signed a Service Level Agreement for the ensuing year to March 2024.

The Service Level Agreement will cover Broomfield Hospital, Basildon General Hospital and Southend General Hospital. As with existing Service Level Agreements for the other Trusts, the agreement provides Mental Health Act Administration expertise and support with patients detained to an acute hospital under the Mental Health Act.

A vital part of the Service Level Agreement is the provision of Mental Health Act training to our acute care colleagues, all of which helps ensure those individuals detained under the Act are in receipt of their rights as a detained patient.

CARE QUALITY COMMISSION

The Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. They do this by looking across the whole patient pathway experience from admission to discharge.

Following the outbreak of the Coronavirus pandemic, the CQC introduced new remote monitoring methods. This included collecting data from a range of sources via phone, email or video calls. If the CQC believe that, there were risks of harm, ill-treatment or human rights breaches for people detained in services they would, if required, carry out site visits.

Continuing on from 2021 into 2022, in light of the introduction of remote reviews, the Mental Health Act Office continues to provide a supportive process for the wards to help co-ordinate the visit. This involves pre and post meetings with the ward manager, an audit of all Mental Health Act documentation prior to the visit and the support of a named Mental Health Act Manager or Officer on the day of the visit. The Mental Health Act Office also help compile any responses that may be required to the CQC, during or following their visit. To date this has proved a very successful process.

CQC Mental Health Act Reviewers undertook the following:

1. Identify services that require monitoring based on emerging concerns and their previous contacts with the service;

2. For some services, a desktop activity was carried out. Where more information was needed, the Mental Health Act Reviewer would begin a two-week programme work, gathering as much information as they could remotely, but they would also offer contact with local advocacy services or other local stakeholders to understand issues impacting detain patients.

3. If the review identified concerns that indicated a site visit would be needed, this would be discussed with the inspection teams and escalated for a final decision from the CQC Chief Inspector of Hospitals or their Deputy.

4. From August 2021 the CQC have been carrying out both remote and unannounced visits to the wards.

The CQC have given formal provider action plans and letters detailing the outcome of the visit indicating any points where they would expect action to be taken. The Care Quality Commission made the following visits to the Trust from the 1st April, 2021 to the 31st March, 2022:

7th May, 2021
Alpine Ward, Brockfield House
- Announced Remote Review

12th July, 2021
The Christopher Unit
- Announced Remote Review

16th July, 2021
Woodlea Clinic
- Announced Remote Review

26th July, 2021
Roding Ward
- Unannounced visit

2nd August, 2021
Cedar Ward
- Unannounced visit

2nd August, 2021
Beech Ward
– Unannounced visit

Overall, the feedback from the CQC reviews was positive, however, a small number of points of learning/themes were identified, such as ensuring that the patient receives the required paperwork in a timely manner when detained under the Act. Where the points were patient specific these were addressed immediately, for example, provision of a copy of their Section 17 leave form and confirmation provided by the Ward Manager to the Mental Health Act Team.

The general themes identified were shared both at the Mental Health Act Business Meeting and the Mental Health Act & Safeguarding Sub Committee and action taken to mitigate against a recurrence. This has included a review of Mental Health Act training; reminders to staff via Matrons, adjustments made to the Mental Health Act audit tool and where necessary, bespoke training for specific areas.

In addition to the points of learning, the CQC also commented on a number of good practices, some of which relate to how patients were cared for during the COVID-19 pandemic and lockdowns. These included flexibility around mealtimes to facilitate social distancing, the purchasing of additional televisions for patients to be utilised where patients needed to isolate, the purchasing of iPads to be used to maintain family contact when visiting was limited. The CQC acknowledged EPUT's use of technology; utilisation of Microsoft Teams to ensure Mental Health Act Tribunals proceeded and Associate Hospital Manager Hearings were held in a timely manner, as well as instillation of Oxehealth, a remote monitoring system that is used as an adjunct to existing physical observations

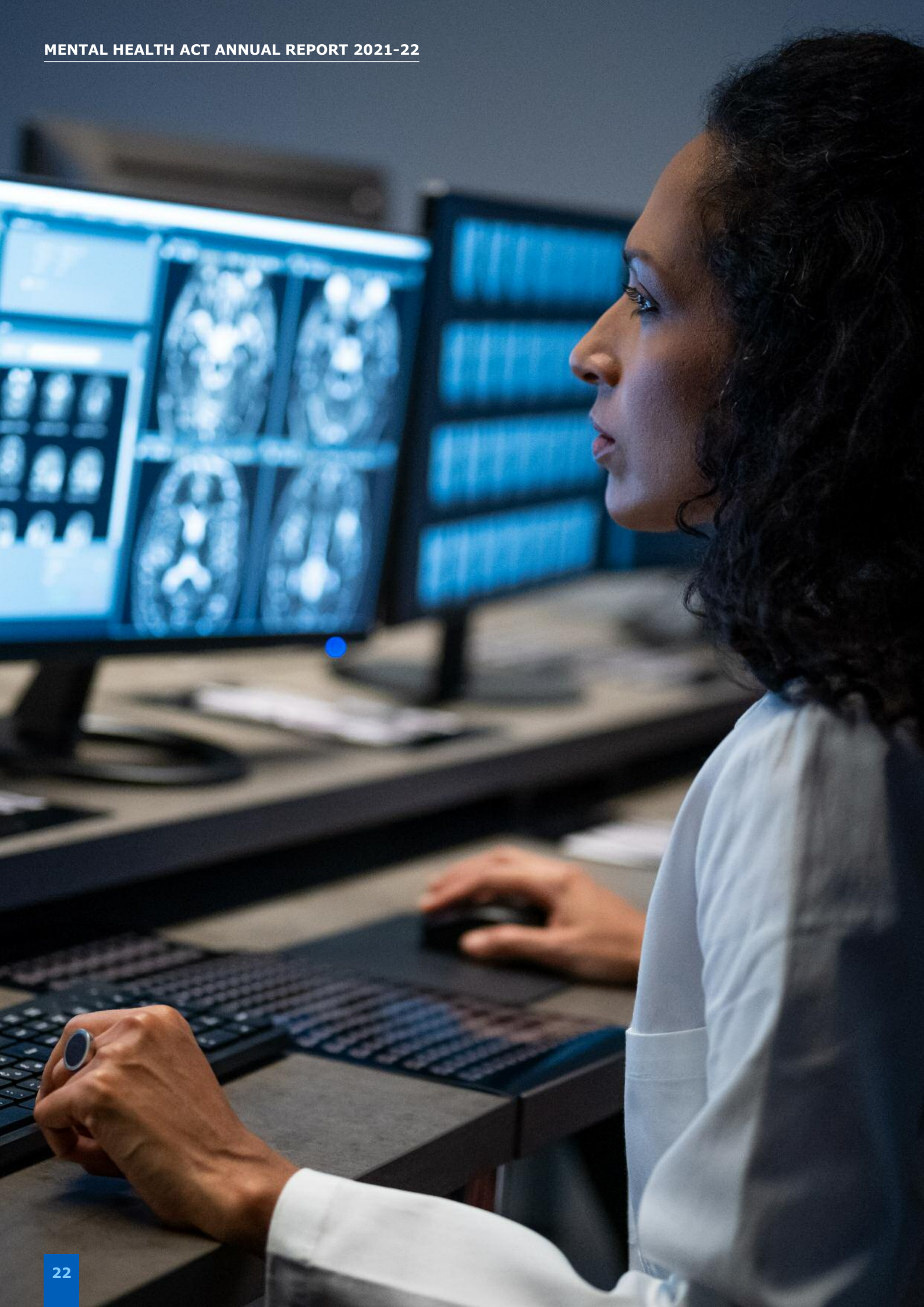
It was pleasing to note that in addition to areas for improvement a number of positive comments from patients, relatives and carers provided to the CQC Reviewer (as part of the Mental Health Act review):

- A relative told us that her son has not always given the team permission to share details about her son to her and he does so when he wants to. She stated she has been impressed how the team respect this although they continue to speak to her and respect his wishes. She stated the team are understanding about her anxieties being a mother and she feels supported. She stated her son is particular about his appearance which is important to him and a member of staff agreed to give him a haircut as he was not able to get one due to the lock down. She stated the staff are respectful and caring with the patients;

- A relative described staff as 'caring' and 'professional', staff are very good with her son and 'treat him well';

- A relative told us the consultant 'has been really good, whatever they have decided to do has turned out well' for their relatives good and 'I have definitely seen positive improvement';

- Another relative was equally positive. She stated the ward is brilliant. He has been there for 2-3 years. He had covid-19 and was at the local hospital for 3 months and was on a ventilator for a while. He is much better now and continues to recover. She can't fault the staff/ward in any way. She visits the ward now and the staff have followed government's guidelines during the pandemic. He has a provisional target date for discharge for 20.12.22. The ward has been wonderful in support of him and her.



EPUT GOVERNANCE

Mental Health Act Internal Audit

In September 2020 the Mental Health Act Office were party to an Internal Audit to review documentary evidence around Mental Health Act forms, 'e' mails, minutes of meetings, supporting guidance documents and Trust policies to assess the design and effectiveness of the processes and procedures in place.

In general, it was identified that there was a good sound system in place, although a few instances of non-compliance were identified and have been rectified. Overall, this led to a final assessment of substantial assurance over the control design and moderate assurance over the control effectiveness.

As a result of the audit and the recommendations made, a review of the Mental Health Act Administration Policy and Procedure and the Associate Hospital Manager Operational Manual was undertaken to ensure that they reflect the training and detailed reporting processes of the Mental Health Act activity. In addition to reviews of the policies, a Mental Health Act Team Operational Procedure was developed and introduced, outlining the roles and function of the Mental Health Act team.

Mental Health Act Training in EPUT

Mental Health Act Training is an online training module and is mandatory to both registered and un-registered staff. Compliance with training requirements is monitored monthly and where compliance falls below the target, this is escalated to the Mental Health Act Business Meeting and Mental Health Act & Safeguarding Sub Committee.

Training needs are 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. Where training needs are identified the Mental Health Act Office provided bespoke training either via Microsoft Teams, or supported one to one telephone discussions.

The online training is regularly reviewed and will be updated in light of any identified training needs, changes in legislation or internal and external processes.

The Trust's Target Compliance figure is 85%. The table below depicts the figures both registered and unregistered staff:

Mental Health Act Team Development

As an organisation, EPUT supports development of its workforce and supports staff to offer the best possible care to our patients and service users.

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 and The London Mental Health Network and the Law Society. This knowledge enhances the skills within the team and helps to ensure the team can support clinicians to continue to provide high quality care within the legal framework of the Act.

Mental Health Act Team – Covid 19 Arrangements

Following the onset of COVID-19 and in line with Government

Overall competence – 01/04/21 to 31/03/22

Total target	Trained	
	No	%
MHA registered staff – 1,529	1,345	88%
MHA non-registered staff – 1,084	1,015	94%

Data source from Workforce Development

guidelines, Mental Health Act staff were required to adopt a flexible approach to working both at home and in the office to minimize the risk of an outbreak within the team and thus ensure continuity of service. In order to support this new way of working a Standard Operational Procedure for Mental Health Act staff working at home was devised and remains in place. The purpose of the document was to provide guidance and identify the functions that were to be carried out by those members of staff working at home in relation to admissions only.

Working from home has proved successful, both in terms of team members experience and in terms of productivity. Whilst the government has now removed all restrictions regarding COVID-19, at the time of writing this report, restrictions are still required in health care settings with the requirement to still wear masks and maintain social distancing. With this in mind, the Mental Health Act Team will continue the flexible approach to working at home, as well as in the office on a rota basis, to minimize the risk of outbreak and infection.

Mental Health Act Team – Staffing

As outlined in last year's annual report, the need to 'grow our own' and develop a career pathway, a review of the Mental Health Act team structure was undertaken and the team reconfigured to provide a structured career pathway with a Band 3 Mental Health Act Administrative Support post to Band 7 Mental Health Act Senior Manager.

This reconfiguration has provided a robust structure, which allows continued development of the team as well as individuals going forward.

In recognition of the need to 'grow our own' and provide opportunities for individuals to gain experience of working within the NHS, and in particular in the Mental Health Act Office, in July 2021 the Mental Health Act Team welcomed a 'Kick Start Apprentice' to the Team for six months. It is pleasing to note that following the conclusion of the individual's apprenticeship, they were successful in obtaining a substantive Band 3 post in the Mental Health Act Team.

ASSOCIATE HOSPITAL MANAGERS

Section 145 of the Mental Health Act gives the designated Hospital Managers various powers and duties. 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. Associate Hospital Managers are lay individuals who work on a voluntary basis and they receive a small remuneration for their time.

The key function of the Associate Hospital Managers is to consider patients' requests for discharge from detention under certain Sections of the Mental Health Act in accordance with Section 23 of that Act, (including from Community Treatment Orders) and reviewing detention following renewal of such Sections or following the barring by the Responsible Clinician of an application for discharge by the patient's nearest relative.

The Trust currently has twenty-nine Associate Hospital Managers who undertake Hospital Manager hearings and to ensure that their Mental Health Act knowledge remains current, they participate in regular relevant training and professional development is made available.

The Associate Hospital Managers meet three times per year. As a result of COVID-19, these meetings have been held virtually and given the success and increased attendance, the plan is to continue with virtual meetings.

Six Associate Hospital Managers resigned during 2021/2022. Reasons for resignations include work/life balance and other commitments. The Mental Health Act Office, in conjunction with the Independent Chair and Vice Chair, regularly review the number of Associate Hospital Managers to ensure there is sufficient capacity to facilitate hearings in a timely manner.

Independent Chair and Vice Chair Elections

The Associate Hospital Managers elect an Independent Chair and Vice Chair, who work closely with the Mental Health Act Office, to ensure Associate Hospital Managers are supported in their role and are provided with relevant training. The Independent Chair and Vice Chair are responsible for undertaking the appraisals of the Associate Hospital Managers. These appraisals are used to determine training, both specific to the individual as well as general training.

The Associate Hospital Manager Independent Chair and Vice Chair have a tenure of two years and elections were held in October and November 2021. Following election, Associate Hospital Manager Phil Barlow was elected to the role of Independent Chair and Associate Hospital Manager Dawn Hillier was elected to the role of Independent Vice Chair.

The Trust would like to acknowledge the hard work and commitment of the Val Evans, the outgoing Associate Hospital Manager Independent Chair who had served in the role from the 1st November, 2019.

AUDITS 2021/22

Audits are undertaken either annually or monthly to ensure and monitor EPUT's compliance with the Mental Health Act and to ensure that patients are legally detained and their rights protected.

Associate Hospital Manager Audit

The Independent Chair of the Associate Hospital Mangers, in conjunction with the Mental Health Act Office, undertake two audits a year; a decision form audit and a full panel audit.

Decision Form Audit

This audit involved 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 decision form audit took place during December 2021.

The 12 decision forms audited were dated between the period May 2021 to November 2021. In the vast majority of cases, forms were completed in line with expectations.

A small number of process improvements were identified, as detailed below:

1. The Learning Disability box is rarely properly completed – as a result of this finding the decision form is being reviewed to ensure all sections are fully completed with a rationale provided. In addition, the findings of the audit are shared with the Associate Hospital Managers and a reminder given for them to complete any decision form in its entirety.

2. The decision form should make reference to all aspects of treatment, including leave (from hospital) granted under Section 17 of the Act. The recommendation is that the decision form should make reference to the benefits of leave and, where appropriate, reference least restrictive options. The decision form review, as noted above, will incorporate this recommendation.

Full Panel Audit

The purpose of the Full Panel Audit is to reflect on what has occurred within hearings in order to learn lessons and improve practice and procedures within EPUT. The Audit Team will seek to ensure that the process of the hearing complied with principles of clinical governance and that the rights of the patient were considered and, where appropriate, protected. This includes ensuring that reports were received in a timely fashion and were of an appropriate standard, that the notes and Associate Hospital Manager Decision Form of the hearing are clear and comprehensive and also to discuss and identify any best practice points for clinicians, administrators and Mental Health Act Hospital Managers.

The full panel audit took place in March 2022. The Audit Team looked at the case of a patient that was detained on a Section 3. The Psychiatric Report, Social Circumstances Report and the Nursing Report were reviewed as part of the audit process. In the main, all the reports provided the necessary evidence to support the continued detention of the patient. The decision form was satisfactory and provided clear and sufficient evidence.

A report identifying the themes was presented to the Mental Health Act & Safeguarding Sub-Committee. An action plan has been be devised to address the themes identified by the audit and developed in conjunction with the Associate Hospital Manager Chair and Vice Chair. The action plan will be shared at an Associate Hospital Manager Meeting to ensure the dissemination of learning of all the points raised through the Associate Hospital Manager Audit to Associate Hospital Manager colleagues as well as Responsible Clinicians.

Tendable Report (previously known as the Perfect Ward App)

A monthly audit is undertaken at ward level by Ward Manager or delegate, to ensure the ward's individual compliance with the Mental Health Act. Tendable, the audit tool designed to assist health and care professionals to own patient safety and conduct quicker and more efficient quality audits, is used to facilitate this audit and has proved effective in helping monitor compliance. Audits are undertaken on a monthly basis, the results of which are produced and viewed through an Inspection Summary. The Inspection Summary is made up of various components containing previously agreed questions that are required to be asked of individual wards regarding compliance.

In response to comments received regarding the questions contained in the audit tool, and in order to support completion, the Mental Health Act Office reviewed the audit tool to provide clarity and remove repetition. The Mental Health Act Office review the Inspection Summary each month. The five wards with the lowest compliance scores are re-audited by the Mental Health Act Senior Manager. Based on the findings of these audits, specific support training is offered to the ward and, where applicable, individual clinicians.

The results of the Mental Health Act Tendable audits are a standing agenda item at the Mental Health Act Bi-Monthly Meeting as well as the Mental Health Act & Safeguarding Sub Committee. Any emerging themes and points of learning are discussed, escalated if necessary and any remedial action taken, for example, bespoke training, review of online training and review of policies and procedures.

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.

GOVERNMENT WHITE PAPER

The White Paper sets out what needs to change in both law and practice in order to deliver a modern mental health service that respects the patient's voice and empowers individuals to shape their own care and treatment. It also made recommendations on how to address the disparities in how the Act affects people from Black, Asian and minority ethnic minority (BAME) backgrounds.

The Government's proposed changes were laid out in the White Paper issued by the Department of Health and Social Care on 13th January, 2021. There was a consultation period of three months ending on 21st April, 2021. Following the end of the consultation period, it was understood that the intention of the Government was to publish a draft Mental Health Bill in 2022. The proposals are potentially wide ranging and may have a significant impact on the way mental health services are delivered. Once any changes are published along with timescales, the Mental Health Act Office will finalise the draft Implementation Plan, which addresses both policy and training needs.

INNOVATIONS

The Mental Health Act Office have been able to continue support the below innovation from last year's Mental Health Act Annual Report.

- Electronic Statutory Forms and Signatures – an amendment to the Mental Health (Hospital Guardianship and Treatment)(England) Regulations 2008 enables the Mental Health Act statutory forms to be communicated electronically. The introduction of the Electronic Statutory Forms has had a positive impact on the Mental Health Act Team's ability to identify and request any rectifications needed in documentation, within the required timeframe, to ensure that patients are detained appropriately. The introduction of the Electronic Signatures enables the submission of the Electronic Statutory Forms.

HOTSPOTS

Previous hotspots

- **Associate Hospital Manager Appraisals:** Outstanding Associate Hospital Manager Appraisals, which will be completed using the current platform – Microsoft Teams. Valuable work has continued to be undertaken during the last year by the Associate Hospital Manager Chair and Vice-Chair in revising the current Appraisal Forms. It is expected that all Associate Hospital Manager Appraisals will be completed during 2022. In order to accommodate the completion of the Associate Hospital Manager Appraisals, the current Associate Hospital Manager Agreement has been extended up to and including the 31st October, 2022. New agreements will be issued at the conclusion of the appraisals from 1st November, 2022 for two years. The importance of appraisals is to ensure that Associate Hospital Managers are suitably prepared and trained to undertake their independent role.

- **Mental Health Act Team Workload Pressures:** Significant workload pressures have been experienced by members of the Mental Health Act Administration Team during 2020/2021 and continue. Robust support through one to one meetings and twice daily situation report meetings via Microsoft Teams, has been provided to members of the team to enable them to meet the compliance required for the administration of the Mental Health Act. A review will be undertaken of the staffing requirements for the Mental Health Act Team to provide an enhanced service.

FORWARD PLAN

As in previous years, work will continue to address and streamline the functions of the Mental Health Act Administration, ensuring compliance under the Mental Health Act for all patients detained within EPUT

The Mental Health Act Team Core Competencies Booklet for Mental Health Act Team staff and Nursing staff has been delayed in light of the White Paper consultations and the Government's proposed reforms to the Mental Health Act. It is expected that the development of the booklet will take place following any changes to the Mental Health Act.

The Mental Health Act Senior Team members and the Mental Health Act Team meet at regular intervals 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 both virtual and in person visits carried out by the Care Quality Commission during 2021/2022

Mental Health Act Managers, have during the pandemic faced challenges in the delivery of Mental Health Act Training across the Trust. It is acknowledged that the Trust has in place a robust 'e' learning module that provides training to all staff around the required compliance of the Mental Health Act. In addition, Mental Health Act Managers have offered any further support for bespoke training needs via Microsoft Teams. The Mental Health Act Team have a fully functioning Trust Intranet page which provides support to all staff in regards to the complexities of the Mental Health Act. The Mental Health Act Managers and their team continue to promote 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.

CONCLUSION

The Mental Health Act 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 Officers, Mental Health Act Administrators and Mental Health Act Assistant who work within the legal framework, which continues to continually improve 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. 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. The Information Technology department will continue to explore the introduction of a single patient clinical information system. Going forward, the Mental Health Act Team will be charged to continue to embrace changes in the way they work, promotion of equal workload, a standardised way of practice and enhancement of knowledge.

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		Agenda Item No: 7e
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 July 2022**

Report Title:	Learning from Deaths – Mortality Review Summary of Quarter 4 2021/22 information					
Executive/ Non-Executive Lead:	Prof Natalie Hammond, Executive Nurse / Dr Rufus Helm, Executive Director					
Report Author(s):	Michelle Bourner, Project Co-ordinator					
Report discussed previously at:	Mortality Review Sub-Committee Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	Not applicable	
Describe what measures will you use to monitor mitigation of the risk	Not applicable	

Purpose of the Report		
This report presents to the Board of Directors: • Information relating to deaths in scope for mortality review for Q4 2021/22 (1st January – 31st March 2022) together with updated information for Q1-Q3 2021/22, 2020/21, 2019/20 and 2018/19; and • Learning that has been identified within the Trust as a result of mortality review undertaken since the last report to the Board of Directors.	**Approval**	
	Discussion	
	Information	✓

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

Summary of Key Issues

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

2. There were **55** deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in Q4. This is in line with quarters not impacted by COVID-19 in previous years.

3. Of the 55 deaths in Q4, 9 were inpatient deaths and 6 were nursing home deaths. 5 of the 9 inpatient deaths and all 6 of the nursing homes deaths have been confirmed as due to natural causes. The remaining causes of death, with the exception of one, are currently under determination. There was one inpatient death which was due to unexpected unnatural causes and this death is subject to a comprehensive Patient Safety Incident Response Framework (PSIRF) investigation.

4. The attached report includes details of the grade of review to which deaths are being subjected and the timeliness of completion of those reviews. It indicates that the timeliness of consideration via the Deceased Patient Review Group has continued. It also indicates that the significant majority of deaths continue to either be closed at Grade 1 desktop review by the Deceased Patient Review Group or investigated at Grade 4 serious incident investigation (or PSIRF investigation), with limited use of the Grade 2 case note review option. This will be addressed via the new learning from deaths processes that were implemented from 1st April 2022.

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

6. The Mortality Review Sub-Committee also oversees 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. There are no issues of concern to report.

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

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

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

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

Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			N/A
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed		**If YES, EIA Score**	

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

Supporting Reports/ Appendices /or further reading

Attached –
Report on Mortality Information and Learning from Deaths for Q4 2021/22

"National Guidance on Learning from Deaths" *Quality Board March 2017*

https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

"Implementing the Learning from Deaths framework: Key requirements for Trust Boards" *NHS Improvement July 2017*

https://improvement.nhs.uk/uploads/documents/170720_Implementing_LfD_-_information_for_boards_proofed_v2.pdf

Lead

Natalie Hammond
Executive Nurse

Agenda item: 7e
Board of Directors Part 1
27th July 2022

EPUT

LEARNING FROM DEATHS – MORTALITY REVIEW PUBLICATION OF MORTALITY DATA AND LEARNING QUARTER 4 2021/22

1.0 PURPOSE OF REPORT

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

- Information relating to deaths in scope for mortality review for Q4 2021/22 (1st January – 31st March 2022);
- Updated information relating to deaths in scope for mortality review in Q1-Q3 2021/22, 2020/21, 2019/20 and 2018/19; and
- Learning that has been identified within the Trust as a result of mortality review since the last report to the Board of Directors.

2.0 BACKGROUND AND CONTEXT

2.1 The effective review of mortality is an important element of the Trust's approach to learning and ensuring that the quality of services is continually improved. "National Guidance on Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care" (National Quality Board March 2017) set out extensive guidance for Trusts in terms of approaches to reviewing mortality, learning from deaths and reporting information. The Trust subsequently implemented a Mortality Review Policy and agreed its approach to reporting mortality data. This Policy has recently been reviewed and new learning from deaths processes aligning to the new Patient Safety Incident Response Framework (PSIRF) arrangements were implemented from 1st April 2022.

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. Prior to this, they are presented to the Quality Committee. This report presents data for Q4 2021/22 (and updated data for previous quarters / years) as at the day the report was prepared (ie 26th May 2022).

3.0 SCOPE OF DEATHS INCLUDED IN THIS REPORT

3.1 The scope of deaths included within this report is in line with the scope defined in the Trust's Mortality Review Policy applying in Q4. Deaths "in scope" include expected deaths due to natural causes as well as unexpected deaths.

3.2 The Mortality Review Sub-Committee also monitors the deaths of patients who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death. The data for Q4 has been considered by the Mortality Review Sub-Committee and there are no issues of note or concern to report.

4.0 TOTAL NUMBER OF DEATHS IN SCOPE FOR REVIEW

4.1 There were **55 deaths** which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in **Q4 2021/22**. These figures are in line with quarters not impacted by COVID-19 in previous years.

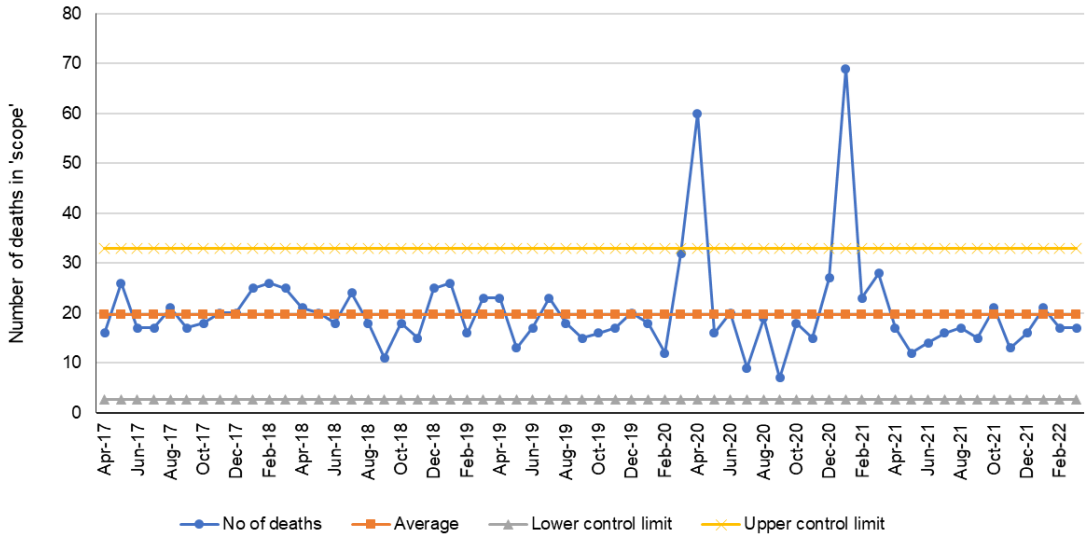
Table 1: Breakdown of total deaths in scope for review

Period	Total 2018/19	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	Total 2019/20	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	Total 2020/21	2021/22 Q1	2021/22 Q2	Oct 2021	Nov 2021	Dec 2021	2021/22 Q3	Jan 2022	Feb 2022	March 2022	2021/22 Q4	2021/22
Deaths in scope	**235**	**53**	**56**	**57**	**62**	**228**	**96**	**35**	**60**	**120**	**311**	**43**	**48**	21	13	16	**50**	21	17	17	**55**	**196**

4.2 There are no trends of concern in terms of category / service breakdown for Q4, with totals being broadly in line with previous quarters.

4.3 Figure 1 below shows the total number of deaths that fell within the scope of the policy each month in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2017 – November 2018). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. Figure 1 below indicates that the number of deaths in scope in Q4 fall within control limits.

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



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

4.5 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 55 deaths in Q4, 9 were inpatient deaths and 6 were nursing home deaths. 5 of the 9 inpatient deaths and all 6 of the nursing homes deaths have been confirmed as due to natural causes. The remaining causes of death, with the exception of one, are currently under determination. There was one inpatient death which was due to unexpected unnatural causes and this death is subject to a comprehensive Patient Safety Incident Response Framework (PSIRF) investigation.

5.0 GRADE AND PROGRESS OF REVIEWS / INVESTIGATIONS

5.1 The Trust has assurance that all deaths within scope have been or are in the process of being reviewed. The table below outlines the grade of review / investigation to which deaths in scope have been / are being subjected to. Please see paragraphs 5.4 - 5.6 below for information in terms of timeliness of review progress.

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

Grade 1 = Desk Top Review (by Deceased Patient Review Group)
Grade 2 = Clinical Case Notes Review (by Clinician)
Grade 3 = Critical Incident Review
Grade 4 = Serious Incident Investigation / review under Patient Safety Incident Response Framework (PSIRF)

Grade of review / investigation	2018/19 total	2019/20 Total	2020/21 Total	2021/22 Q1 total	2021/22 Q2 total	2021/22 Q3 total	2021/22 Q4 total	2021/22 Total YTD
Grade 1 Deceased Patient Review Group	**148**	**145**	**223**	31	27	22	**14**	**80**
	63%	**64%**	**72%**	72%	56%	44%	**25%**	**41%**
Grade 2 Case Note Review	**18**	**16**	**12**	0	3	0	**0**	**3**
	8%	**7%**	**4%**	0%	6%	0%	**0%**	**1%**
Grade 3 Critical Incident Review	**0**	**1**	**0**	0	0	0	**0**	**0**
	0%	**1%**	**0**	0%	0%	0%	**0%**	**0%**
Grade 4 Serious Incident Investigation / PSIRF	**69**	**66**	**72**	12	11	14	**20**	**57**
	29%	**29%**	**23%**	28%	23%	28%	**36%**	**29%**
Final grade under determination	**0**	**0**	**4**	0	7	14	**21**	**42**
	0%	**0%**	**1%**	0%	15%	28%	**38%**	**21%**
TOTAL	**235**	**228**	**311**	43	48	50	**55**	**196**

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

- closed at Grade 1 desktop review by the Deceased Patient Review Group (ranging from 63% to 72% in previous years); or
- being investigated as Grade 4 serious incident investigations or under PSIRF (ranging from 23% to 29% in previous years).

This trend has continued into 2021/22, with 41% being closed at Grade 1 thus far and 29% being investigated at Grade 4 / under PSIRF.

5.3 There has been limited use of the Grade 2 clinical case note review option (ranging from 4% to 8% in previous years). This has been taken into account in implementation of the national Patient Safety Incident Response Framework (PSIRF) arrangements and the new Learning from Deaths arrangements put in place across the Trust.

5.4 Progress has continued since the last report to the Board of Directors in terms of the timely consideration of deaths via mortality governance processes, with only 21% of deaths in 2021/22 and 1% of deaths in 2020/21 requiring the grade of review to be determined. All other deaths have had their grade determined.

5.5 There has also been good progress with completing Case Note Reviews and investigations under the new Patient Safety Incident Response Framework (PSIRF) arrangements since the last report to the Board of Directors.

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

Year	Reviews complete	Reviews in progress	Comments
2018/19	234	1	Case Note Review (completed and due for sign off by Deceased Patient Review Group (DPRG) at next meeting)
2019/20	228	0	N/A
2020/21	301	10	6 x Case Note Reviews (2 completed and due for sign off by DPRG at next meeting) and 4 x awaiting closure by DPRG (further info required by DPRG)
2021/22	124	72	27 x PSIRF investigations in progress; 42 x awaiting closure by DPRG (31 of which are recently identified SMI deaths from clinical systems); 3 x Case Note Reviews

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

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

Score	2018/19 (Number)	2018/19 (as a %)	2019/20 (Number)	2019/20 (as a %)	2020/21 (Number)	2020/21 (as a %)	2021/22 YTD (number)	2021/22 YTD (as a %)
6 - definitely less likely than not	191	81%	170	75%	244	78%	94	48%
5 - slight evidence	22	9%	29	13%	22	7%	1	1%
4 - not very likely	11	5%	15	7%	8	3%	0	0%
3 - probably likely	6	3%	4	2%	0	0%	0	0%
2 - strong evidence	1	1%	0	0%	0	0%	0	0%
1 - definitely more likely than not	0	0%	0	0%	0	0%	0	0%
Under determination	4	2%	10	4%	37	12%	72	37%
PSIRF not scored	N/A	N/A	N/A	N/A	N/A	N/A	28	14%
TOTAL	235	-	228	-	311	-	196	-

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

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

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

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

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

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

8.0 LEARNING FROM MORTALITY REVIEW OF DEATHS

8.1 Since the Trust implemented the Patient Safety Incident Response Framework (PSIRF) the way in which learning is identified and disseminated has adapted. When an incident occurs within the Trust and it meets the nationally or locally defined criteria to be investigated as a Patient Safety Incident Investigation (PSII), the learning from the investigation is collated and reported to the Executive Team, senior managers, the learning oversight committee, bulletins, quality matters leaflet and with the clinical teams involved in the patient's care. When a number of incidents occur of a similar nature, a thematic review is undertaken, with the view that an overarching Safety Improvement Plan for the Trust is developed and implemented.

8.2 For incidents that occur that do not meet the nationally or locally defined criteria, they are discussed at the weekly Clinical Review Group. The appropriate patient safety incident review method is decided and commissioned. How the learning is disseminated is agreed on a case by case basis, and will form part of the thematic review and overarching Safety Improvement Plan.

8.3 The Trust have adopted several methods of review following a patient safety incident:

- After Action Review – a reflective discussion with clinicians involved in the patient's care. This is usually completed within 72 hours to 14 days of the incident. This has been welcomed by clinicians as this method empowers reflective conversations and early learning from the incident, with the view that another method of review can be commissioned thereafter if there is opportunity for further or wider learning.
- A Clinical Review – a desk-top review of the patient's notes and conversation with clinicians involved in the patient's care in order to specifically review areas of the patient's care pathway, such as initial assessment, community care, crisis intervention, transfer and discharge. This review method is completed within 30 working days of the incident, which allows for the learning to be collated, acknowledged and cascaded in a timely manner.
- A Patient Safety Incident Review – this method uses the same methodology as the Patient Safety Incident Investigation and is completed within 30 working days, which encourages acknowledgement of early learning.

8.4 Within the review templates, there are specific key areas of care and service delivery strengths, which encourages the investigators/reviewer to consider these areas of practice in the same way they would consider the weaknesses. The outcomes of this are shared in the same way the future learning points are.

8.5 A thematic review was completed for falls, for which the Safety Improvement Plan is being populated.

8.6 There is a formal quality review process in place to monitor embedded learning from patient safety incident investigations in the following areas:

- Mental health and Specialist Services inpatient deaths
- Regulation 28 Prevention of Future Deaths Notice

8.7 For each of these incidents, the quality reviewer (Nurse Consultant for Patient Safety or Patient Safety Incident Management Clinical Lead) will carry out a detailed review of the completed investigation action plan, in conjunction with the service, to identify evidence that the learning has been embedded. This is completed in collaboration with the operational services. The quality review will be conducted three to six months after the action plan has been completed and signed off. Following completion of the quality review, the reviewer presents their findings to the Patient Safety Incident Executive

Assurance Group who will identify any further actions required. The Trust also uses these quality reviews to demonstrate a culture of reflection and learning within EPUT. They have been shared with HM Coroner and Commissioning bodies and have received positive feedback.

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

- **Review of the Active Engagement Guidance including Did Not Attend** – the learning from incidents which involved disengaging patients has been shared so that it can be reflected and incorporated within the current guidance/policy review being undertaken Trust wide including community health services. The revised guidance was presented to the Clinical Governance Sub-Committee in June. The updated guidance includes flowcharts with actions to take if someone DNAs or does not answer the door.
- **Care coordination** – From incident investigations/reviews and inquest hearings, it has been identified that there was no specific training for care coordinators. A training pack has been made and the training is in progress. Prompts have been included within the intranet for staff to complete the training, where relevant.
- **24 hour follow up calls** – Investigation reports highlighted the use of paper copies of information being scanned into the clinical records, in particular in relation to the follow up call completed by inpatient services. This is now an electronic form within Paris and Mobius.
- **Handover & Clinical Dashboards** – the dashboard testing period has been completed and a sign off process is in progress. Once this is completed, a review of the Handover process utilising the dashboards will take place to inform any further requirements to move towards a full electronic handover. In addition, handover assurance questions have been added to the Matron's assurance (Tenable) tool to support matrons to quality check handover creating a monitoring cycle for improvement in practice.
- **Observation & Engagement** – the Task & Finish group has completed its actions and a report was presented. Video guides on engagement and supportive observations have been made for staff to view.

8.9 In May, the EPUT Culture of Learning Project was launched. At EPUT, we want learning to be an 'Always Event' where we all have a responsibility to seek improvement, learn from mistakes or good practice and adopt positive changes to provide safe and excellent care. Since her appointment as Director of Safety and Patient Safety Specialist in May 2021, Moriam Adekunle has established the EPUT Culture of Learning (ECOL) framework, aiming to create conditions that support effective learning and serve as enablers for operational teams.

8.10 The EPUT Culture of Learning (ECOL) represents our commitment to excellence and our willingness to learn from the experience of others. The concept enables us to identify and share learning through safe, effective and constructive pathways, ensuring this learning is embedded and sustained at all levels within the organisation. The framework will enable us to achieve the Safety First, Safety Always Strategy outcomes.

8.11 The culture of learning work programme aims to facilitate learning by promoting a fair, open, and compassionate culture that moves away from a blame approach. It enables the belief that 'incidents cannot simply be linked to the actions of individuals involved but rather the system in which the individuals were working'. Looking at what was wrong in the systems and processes helps organisations learn lessons that can prevent incidents from reoccurring.

8.12 The Trust is proud of its status as an early adopter of the Patient Safety Incident Framework (PSIRF). The System Engineering Initiative for Patient Safety (SEIPS) principles will be used to determine the contributory factors in the investigation of Patient safety Incidents that meet the local and national criteria.

8.13 A number of key resources have been made available for staff to support the above.

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

Report prepared by:

Michelle Bourner, Project Co-ordinator

On behalf of:
Professor Natalie Hammond, Executive Nurse

July 2022

		Agenda Item No: 7f
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 July 2022**

Report Title:	**Health, Safety and Security Annual Report 2021-2022**					
Executive/ Non-Executive Lead:	Denver Greenhalgh, Senior Director of Corporate Governance and Affairs					
Report Author(s):	Sarah Pemberton, Health and Safety & Violence and Abuse Prevention and Reduction Manager Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Health, Safety & Security Committee (30.05.2022), Executive Team (21.06.2022)					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	No new risks identified. Annual report confirms there continues to be a risk with completion/review of General Workplace Risk Assessments	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
The purpose of this report is to present the Annual Health, Safety and Security Report 2021/22. The report provides an update on the activity of the Health, Safety and Security team from 1 April 2021 – 31 March 2022 and provides assurance that satisfactory arrangements have been in place for the management of Health, Safety and Security across the organisation.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Trust Board is asked to:

1 Receive and approve the report

Summary of Key Issues

Introduction

This report provides assurance that the Trusts is fulfilling its statutory obligations under the Health & Safety requirements (Health & Safety at Work Act 1974 and Management of Health & Safety at Work Regulations 1999) and sets work plan priorities for 2022/23.

The report has been reviewed by Executive Operational Sub Group. Further to this it has been reported and endorsed at the Quality Committee and is now recommend to the Board of Directors for approval.

Key points:

- **Violence, Abuse Prevention & Reduction -** the report introduces the new Violence, Abuse Prevention and Reduction Standards and the work planned to be undertaken in 2022/23. The new standards are focused in a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression, and violence. The Trust is utilising advice from NHSE in transitioning to the new system.

- **Governance -** The Trust meets its legal duty by having in place suitable arrangements to manage health & safety at work, including the Risk Management Team (which includes Health & Safety expertise); policies and procedures; roles and responsibilities through the organisation including individual responsibilities outlined within job descriptions; workplace risk assessments; and routine internal health & safety inspections.

- **Independent Assurance -** the Trust's internal auditors, carried out a limited assurance review under site visits programme as part of the 2021/22 testing of a range of policies and procedures this included 2 Risk Management policies and procedures (Adverse Incident and Security).

- **Continuous Learning -** The Trust continues to use DATIX for a range of reporting functions including incident reporting, CAS Alerts, ligature actions, Claims, Complaints and PAL's to record, track and report. Information from the DATIX system is used to identify trends and support learning. The Trust continues to have a positive reporting culture which is consistently above the National Reporting & Learning System (NRLS) cluster benchmark, the latest issued in September 2021 showing EPUT reporting 95.4 incidents per 1000 Occupied Bed Days (OBD) compared to the national benchmark of 64.1 incidents per OBD.

- **National Learning** - the Trust was compliant with all timelines in relation to achieving actions in relation to safety alerts issued during 2021/22

- **Enhancing Environments -** The Trust continues to work to ensure the provision of a safe and therapeutic environments. Examples of projects completed in 2021/22: Refurbishment of Cherrydown Ward, Kelvedon Ward and 439 Ipswich Road; Small works projects at St Aubyn Centre; Poplar HDU; Beech Ward; and Garden improvement works including furniture.

- **Training –** The Trust has in place a range of Health & Safety training starting with induction. And examples being: Fit for Work – Mandatory Training; Virtual DATIX training; Management Development Program (MDP) - General Workplace Risk Assessment Module which is a CORE element of MDP. Linking with culture of learning a new provision to each inpatient ward of coaching on ligature management, which aims to empower wards to manage ligature risks and share learning.

- **Innovation -** The Trust continued to develop new ways of working and focused on utilising technology. Innovations this year have included: Redeveloped General Workplace Risk Assessment tool (electronic) to simplify the tool; Streamlined process for H&S inspections; and Phase 1 roll out of Body Worn Cameras

- **Core Activities 2021-22 -** The Trust H&S and Security Team have continued with the following core activities in 2021-22:
  - All inpatient MH wards received an annual ligature inspection (undertaken jointly between Risk Management, Estates and Ward staff) and ligature support visits undertaken 6 months follow up.

- Management of Lone Worker Devices
- Providing support for wards following high levels of violence and aggression
- Continued focus on relationships with local Police force
- Supported services in developing local General Workplace Risk Assessments
- DATIX developments
- Range of Incident analysis reports bespoke for different committees / groups

- **RIDDOR Reporting -** The Trust reported 44 cases under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) to the Health & Safety Executive (HSE) during 2021/22, this is a reduction on the 271 which were reported in the previous year (2020/21). In the previous year the increase was attributed to the HSE requiring all industries to submit cases of staff testing positive for COVID-19 which may have been contracted at work which have reduced this year.

Plans for 2022/23 - the Health & Safety Team have a number of aims and objectives for 2022/23 including:

- Increased compliance for General Workplace Risk Assessments
- Enhancing training available to staff
- All Trust premises to have undergone a full Health and Safety inspection by 31st March 2023.
- A review of protocol for DSE assessments aligned to hybrid working
- Roll-out of phase 2 for body worn cameras
- Support ward staff undertaking TASID Training in ward environment

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

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

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

Acronyms/Terms Used in the Report			
LSMS	Local Security Management Specialist	BWC	Body worn Camera

VPRS	Violence, Protection & Reduction standards	TASD	Therapeutic and Safe Intervention and De-Escalation
SPOC	Single Point of Contact	HSSC	Health Safety and Security Committee
GWPRA	General Workplace Risk Assessment	CCTV	Close Circuit Tele Vision
NAHS	National Association of Healthcare Specialists	PMVA	Prevention and Management of Violence and Aggression
H&S	Health and Safety	HSE	Health and Safety Executive

Supporting Documents and/or Further Reading

Health, Safety & Security Annual Report 2021-2022

Lead

Denver Greenhalgh,
Senior Director of Corporate Governance and Affairs

NHS
Essex Partnership University
NHS Foundation Trust

HEALTH, SAFETY AND SECURITY ANNUAL REPORT

2021-22

CONTENTS

Report Prepared By:

Sarah Pemberton, Health, Safety and LSMS Manager

Phil Stevens, DATIX Risk Manager

On behalf of:

Nicola Jones, Director of Risk and Compliance

INTRODUCTION

The annual report for Health, Safety and Security provides assurance that there are satisfactory arrangements in place for managing Health, Safety and Security risks across the organisation.

The organisation is required to fulfil the statutory Health & Safety requirements (Health & Safety at Work Act etc. 1974 and Management of Health & Safety at Work Regulations 1999) and ensure there is the identification of control measures to suitably reduce Health, Safety, security and ligature risks so far as is reasonably practicable.

EPUT recognises the need for the effective management of health and safety and security. Day-today management of Health, Safety and Security is undertaken by the Risk Management Department in cooperation with unit and locality managers and all staff according to their level of responsibility.

The Health Safety and Security Committee co-ordinates the implementation and management of health, safety and security and non-clinical risk management across the Organisation, the committee has wide representation from both operational and support services with a representative from each area. It receives assurance on Health Safety and Security at a local level from the Health and Safety/Quality sub-groups and receives action plans on a regular basis for monitoring.

NHS Protect no longer exists and has been replaced by NHS Improvement (NHSI). NHSI are in the process of publishing Violence Prevention and Reduction Standards and work has already started to benchmark EPUT position against these. A new strategy/framework and work plan will be developed using the outcome of the benchmarking and will be developed and overseen by a task and finish group.

The Trust is compliant against the previous NHS Protect Standards until the new standards are fully ready to be implemented. Of the revised 43 Standards, the Trust is compliant with 22 of these and which the remainder will be included in the work-plan. Updates on the progress of the implementation of the new standards and actions taken by the task and finish group will be provided in regular reports to the HSSC and in any future Quarterly and Annual Report(s). The initial task and finish group has been arranged for early June to ensure full collaboration with key stakeholders within the Trust.

As part of this review, it must be noted that the NHS Protect function has been replaced with NHS Improvement and, there is a recommendation that the LSMS function should re-named to reflect the proposed Core Standards. Therefore, the Local Security Management Specialist (LSMS) function and job title LSMS Advisor will be imminently replaced with Violence Prevention and Reduction Team and Violence Prevention and Reduction (VPR) Advisor(s).

INDEPENDENT ASSURANCE

Part of effective risk management is assessing if we are doing what we need to do.

BDO, the Trust's internal independent auditors, carried out an internal audit which testing policy compliance at ward level. The audit was carried out to test systems in place with the focus on a range of polices which local sites are responsible for adhering to, this includes two policies overseen by the EPUT Risk Management Department: Adverse Incident and Security. Two further policies were included Trust local induction and clinical risk policies

The audit found moderate assurance for design "generally a sound system of internal control designed to achieve system objectives with some exceptions and limited assurance for effectiveness "non-compliance" with key procedures and controls places the system objectives at risk). The audit highlighted some good areas of practice and made recommendations which have been taken forward by the Trust.

GOVERNANCE

Core Elements of Managing for H&S

Organisations have a legal duty to put in place suitable arrangements to manage for health and safety. This is undertake by EPUT through:

- The Trust Directorate of Compliance and Assurance which provides Leadership and management
- A trained/skilled workforce which is achieved through the Risk Management Team of experts and appropriate training for all Trust staff
- Fostering an environment where people are trusted and involved in H&S and Security through Trust policy and procedure, relationships built by the Risk Team and through H&S inspections and GWRA.

This is underpinned by the Trust risk profile managed through the Risk Management Assurance Framework

Risk Management Team

The Trust Health and Safety Team and Local Security Management Specialists are part of the wider Risk Management Team that sits within the Directorate of Compliance and Assurance. The Team provides expert advice and guidance to the organisation and is responsibility for overseeing Health Safety and Security. The directorates provides leadership for the organisation on all Health Safety and Security requirements.

Throughout the year various members of the team have assisted on special projects with the Ligature Risk Reduction Group, with Estates and Projects teams and with targeted projects and tasks as requested by the HSSC.

The Trust incident management team is also part of the Risk Management Team which provides incident analysis and oversight for all Health and Safety and Security incidents.

The Team continues to maintain professional development and training, for example:

- April 2021: A Health and Safety Advisor was awarded GRAD IOSH Status by The Institute of Occupational Health and Safety (IOSH)
- May 2021: A Health, Safety and LSMS Manager was appointed who holds the Level 6 NEBOSH Diploma in Occupational Health and Safety
- January 2022: Two members of the H&S Team successfully completed their TASI Training (now mandatory for all team members)
- December 2021: All members of the LSMS team have been trained to deliver in-house training for Body Worn Cameras and the subsequent software.

EPUT recognises the need for the effective management of health, safety and security. While day-to-day management of health, safety and security is undertaken by the Risk Management Department this is in cooperation with unit and locality managers and all staff according to their level of responsibility.

H&S and Security Policies and Procedures

The Trust's Corporate Statement and Policy on Health and Safety (RM01) sets out the organisational structure for managing Health and Safety and how the Board of Directors fulfils its statutory obligations as required by the:

- Health and Safety at Work etc., Act 1974;
- Management of Health and Safety at Work Regulations 1992;
- Workplace (Health, Safety, and Welfare) Regulations 1992.

The Management of Health and Safety at Work Regulations 1999 require employers to put in place arrangements to control health and safety risks.

Within EPUT the following processes and procedures are in place required to meet the minimum legal requirements, including:

- Corporate Policy on Health and Safety as the written health and safety policy
- General Workplace Risk Assessment and Risk Management Assurance Framework as the documents outlining processes for assessments of the risks to employees, contractors, customers, partners, and any other people who could be affected by activities. These include the requirements to record the significant findings in writing and provides templates for 'suitable and sufficient' risk assessments. These also include arrangements for the effective planning, organisation, control, monitoring and review of the preventive and protective measures that come from risk assessment;
- An expert H&S Team providing access to competent health and safety advice
- General Workplace Risk Assessments and Organisational risk registers providing employees with information about the risks in the workplace and how they are protected;
- instruction and training for employees in how to deal with the risks through a range of in-house training including at induction
- Supervision policy and procedure which ensures there is adequate and appropriate supervision in place;
- Local Quality and Safety Groups which provide a focus for consulting with employees about their risks at work and current preventive and protective measures

A Project has been undertaken in 2021/22 to streamline the Trust General Workplace Risk Assessment template with the aim of ensuring health and safety documents in the Trust are functional and concise.

The Health, Safety and Security Committee co-ordinates the implementation and management of health, safety & security as well as non-clinical risk management across the organisation and the Trust has a range of policies and procedures in place to support staff in maintaining compliance with health and safety requirements and sets out training required for all staff.

Testing compliance with H&S and Security arrangements is undertaken through the Trust Risk Management Team and internal audit (see Independent Assurance Section).

The following polies have been reviewed over this reporting period:

Full reviews

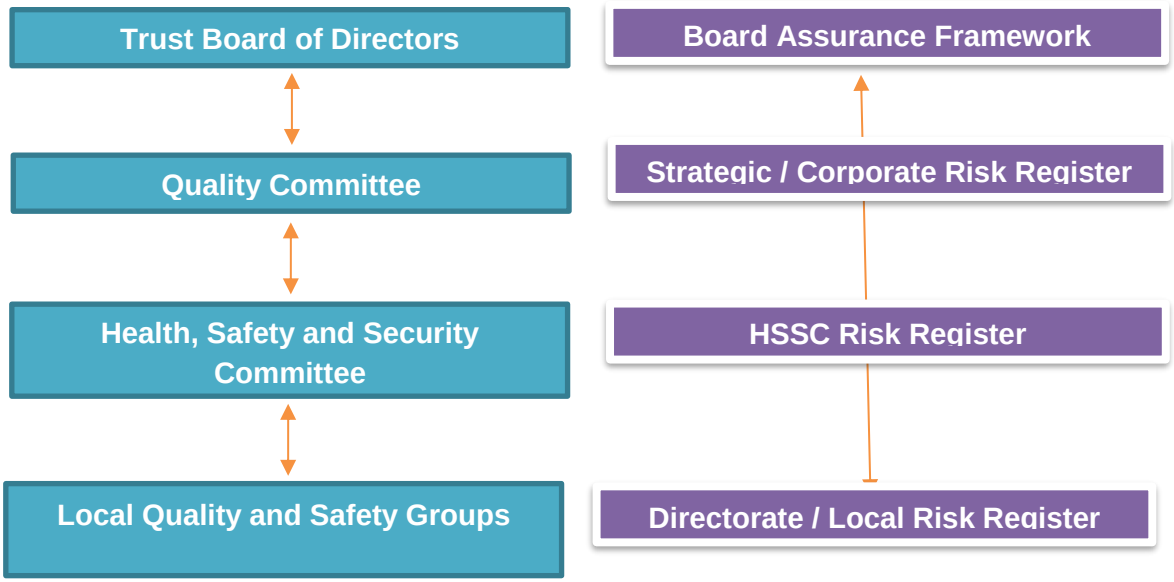
- Fire Safety Policy
- Ligature Risk Assessment & Management Policy
- Health and Safety of Young Persons Policy
- Major Incident Plan
- Emergency Planning and Preparedness Policy ☐ Lone Working Policy
- Security Policy & Procedure.
- Therapeutic & Safe Intervention and De-escalation (TASID) Policy.
- Zero Tolerance Policy.
- Water Safety Management Policy
- Search Policy
- Safety Alert Bulletins
- Corporate Health and Safety Policy & Procedure.
- DSE (Display Screen Equipment) Policy & Procedure.
- General Workplace Risk Assessment Policy & Procedure.
- First Aid Policy & Procedure

Minor amendments

- Security Procedure, Appendix 3;
- Access Control
- Work-related Driving Procedure.
- Lone Worker Device Procedure, Appendix 5; Staff User Template.
- Ligature Procedure, Appendix 9; EPUT Fixtures and Fittings Standards
- Pinpoint Operational Procedure.
- Search Policy, Appendix 6; Suspect Packages.

Ward to Board

The Trust Health Safety and Security reporting has continued through the committee governance structure as outlined in Fig 1 below. The Trust Risk Management Framework is used to escalate risks when appropriate:



CONTINUOUS LEARNING

DATIX Risk Management System

The DATIX Risk Management system continues to be reviewed and upgraded to enhance its functionality. EPUT uses DATIX for a range of items including incident reporting, CAS alerts, ligature actions and the Claims, Complaints and PALs Department continue to use the DATIX system to record, track and report cases on a daily basis.

The DATIX dashboard module continues to be utilised by both clinical and support staff across the Trust providing real time access to information and reports to assist in the monitoring of specific types of incidents or areas of concern on a self-service basis.

The DATIX system has been amended to facilitate the reporting of incidents under the Patient Safety Incident Response Framework (PSIRF), adopted by the Trust in May 2021. This includes updates to both the incident reporting form and the various manager review forms, with all references to 'Serious Incidents' (SI's) being removed. The requirement for reporting is limited to identifying if the DATIX relates to a Patient Safety Incident, with help text advising the user this replaces the former

'SI' question. The Patient Safety Incident Management Team are continuing to record all details relating to Patient Safety Incident Investigations (PSII's) via DATIX.

The Trust has a positive reporting culture; EPUT has consistently been above the National Reporting & Learning System (NRLS) cluster benchmark in published reports. The latest NRLS report was issued in September 2021 covering the period April 2020 – March 2021. EPUT reported 95.4 incidents per 1000 Occupied Bed Days (OBD) compared to the national benchmark of 64.1 incidents per OBD. EPUT reporting rate includes incidents from all clinical services provided by the Trust, including the Community Health Services and Nursing Homes.

The tables below detail incidents reported during the financial year. The latest benchmark provided by the National Reporting and Learning Services (NRLS) is included for information; this however may change depending on overall cluster reporting.

Area	Measure	20/21 Outturn	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	21/22 YTD
SEECHS	Total Incidents	2057	535	435	430	468	1868
	Incidents per 1000 bed days	559.6*	305.5	243.0	233.7	290.7	267.2
WECHS	Total Incidents	1315	287	302	334	259	1182
	Incidents per 1000 bed days	61.4	54.7	46.2	57.0	49.0	51.5
Community Health Services	Total Incidents	3620	840	860	888	784	3372
	Incidents per 1000 bed days	87.2	166.0	168.5	119.8	104.2	134.4

Table 1: Mental Health and Specialist MH services

Table 2: Community Health Services

Area	Measure	NRLS Benchmark	20/21 Outturn	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	21/22 YTD
MH Services	Total Incidents	64.1 Incidents per 1000 bed days	8004	2837	2548	2586	2000	9971
	Incidents per 1000 bed days		67.7	85.7	71.7	76.2	61.0	73.6
Specialist (incl. LD)	Total Incidents		4104	1121	951	545	1067	3684
	Incidents per 1000 bed days		63.7	71.2	66.7	38.4	74.3	62.9
EPUT (MH/LD & Specialist Services)	Total Incidents		12108	3958	3499	3131	3067	13655
	Incidents per 1000 bed days		66.3	81.0	70.2	65.0	65.0	70.4

*CICC recorded no occupied bed days between May – October 2020 resulting in a nil return, which is reflected in the inflated incident rate for 2020/21.

The NRLS cluster group for NHS Community trusts was discontinued as a result of the NHS Transforming Community Services programme. Due to structural changes within these organisations, many no longer have inpatient services and the provision of diverse services between them mean this cluster could not be described as a homogenous group. A comparative reporting rate per 1,000 bed days is not appropriate within this cluster and comparing organisations based on this rate can be misleading. However, the incidents reported below are included in EPUTs patient safety incident reporting and reflected in the overall reporting rate.

Table 3: Nursing Homes:

Area	Measure	20/21 Outturn	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	21/22 YTD
Nursing Homes	Total Incidents	183	81	59	86	53	279
	Incidents per 1000 bed days	9	14.1	10.6	16.2	11.6	13.2

Incidents reported at the two Nursing Homes are reported separately to the Mental Health & Community Health services and area detailed below. However, the incidents reported below are included in EPUTs patient safety incident reporting and are reflected in the overall reporting of incidents per 1000 bed days

H&S and LSMS Incidents

H&S and Security related incidents are reported by all services through the Trust DATIX system and overseen by the Trust Health, Safety and Security Committee.

Members of the Trust H&S and LSMS Teams review all H&S and security incidents to ensure appropriate actions are taken and identify any lessons learnt.

Safety Alerts

The Risk Management Team reviews Safety Alerts issued via the Central Alerting System (CAS) and creates an internal alert on the DATIX Safety Alert module. The Trust nominated Safety Alert Assessment Leads are notified and required to respond via the DATIX, advising if relevant to any Trust services and if action is required. This process will include input from specialist leads, such as Pharmacy and the Medical Device Committee where appropriate.

Alerts assessed as relevant to Trust services are cascaded for action across the organisation and responses are required via DATIX within specified timescales. Overall Compliance is monitored by the Health Safety & Security Committee. The Clinical Governance & Quality Sub-Committee review all National Patient Safety Alerts and these are also added to the Trust intranet page for all staff to review as required.

Once compliance is assured or the alert is assessed as not being relevant to Trust services, the alert will be signed off as complete on the CAS online portal by the Director of Risk & Compliance/ Associate Director of Risk & Compliance or their nominated deputy. Where appropriate alerts are added to the Trust Risk Register.

The Trust was compliant with external sign off in relation to safety alerts during 2021/22. There were 46 alerts issued to the Trust via CAS during the period and all were assessed for relevance.

10(21.7%) were assessed as requiring action and a response was completed. 11 alerts issued as National Patient Safety Alerts were assessed as relevant to Trust services and were monitored to completion via the Clinical Governance & Quality Sub-Committee.

The Risk Management Team distributes and monitors Safety Alert information. Compliance is evidenced through the Health Safety and Security Committee and via local Health & Safety Meetings. Additionally, Ward/Team Managers have been requested to include Safety Alerts as a standing item agenda in their Team Meetings.

ENHANCING ENVIRONMENTS

The team have worked collaboratively with the Capital Projects teams in relation to refurbishment projects, ensuring fixtures and fittings are to Trust standards and that we continue to provide a safe and therapeutic environment to our Service Users.

During 2021/22 we have supported on many projects, including:

- Refurbishment of Cherrydown Ward
- Refurbishment of Kelvedon Ward
- Refurbishment works at 439 Ipswich Road
- Small works projects at St Aubyn Centre
- Small works projects at Poplar HDU
- Small works projects at Beech Ward
- Aesthetic works throughout the Trust including murals
- Garden improvement works including furniture

CULTURE

The Trust has continued to deliver a programme of H&S training including:

- Fit for Work (Mandatory)
- DATIX Training
- Management Development Programme – General Workplace Risk Assessment Module
- Live learning sessions

Face to face DATIX training was suspended as part of the Trusts response to the COVID 19 pandemic, however this has continued to be facilitated on request via MS Teams. The training includes sessions for reporting staff and managers to highlight the importance of recording patient safety incidents and to improve the quality of DATIX incidents. Additionally a section relating specifically relating to DATIX is included in the Risk Management presentation, included on the Trusts induction programme.

The Management Development Programme was paused in 3rd quarter of 2021 and recommenced in February 2022. The Risk Team have delivered General Workplace Risk Assessment module which is now a core element for attendance by all EPUT managers and those who have been identified (band 6 and above) as suitable.

As part of the Trust culture of learning the H&S Team have developed in conjunction with the Compliance Team a new annual support visit to all MH inpatient wards to provide coaching on ligature management. This new process aims to empower wards to manage their ligature risks and share learning.

INNOVATION

The General Workplace Risk Assessment (GWPRA) tool has been re-developed into a simplified document. This has been approved and incorporated in the General Workplace Risk Assessment Policy (RM11) and full training (optional) has been arranged for all staff. The new tool is in an Excel document that can easily be completed on-line. It incorporates a more comprehensive follow up and loop completion phase with a simpler front end and interface.

The Health and Safety team has developed a streamlined process for Health and Safety inspections and aligned the inspections to Trust occupied premises and not teams to ensure each building is inspected fully and any non-conformances are identified and escalated to Estates and Facilities.

The LSMS team have further rolled out the use of Body Worn cameras to a range of Trust wards following the successful pilot. The aim is to reduce incidents of violence and aggression towards staff.

CORE ACTIVITIES

Health & Safety

EPUT recognises the requirement for the effective management of Health, Safety and Security. Day-to-day management of Health, Safety and Security is undertaken by the Risk Management Department in conjunction and cooperation with ward/unit and locality managers and all staff according to their level of responsibility.

In line with Trust guidance and Health & Safety Executive (HSE) recommendation relating to COVID-19, there was an increase in H&S inspection activity during the 3rd and 4th quarter of 2021 to ensure the Trust remain compliant with workplace inspections.

All Services are asked to undertake a General Workplace Risk Assessment (GWRA) which is updated regularly or as new risks are identified. The Risk Team continues to support staff with the completion of their GWPRA and these have been included in an exemplar Risk Assessment document.

During 2021, the Risk Management team continued to support staff with Secure COVID-19 Risk Assessments (where required). Following advice from the Health and Safety Executive and NHS England that there is no longer a requirement for specific workplace COVID-19 risk assessments to be undertaken, the decision was made to withdraw these and so successive to this recommendation the Covid19 element has been included in the General Workplace Risk Assessment (GWPRA) tool and is reviewed as part of any H&S inspection.

General Workplace Risk Assessments

It is a requirement that all areas have a General Workplace Risk Assessment (GWPRA) that identifies the type of unit, the hazards, risks and control measures required to provide assurance that a duty of care is being undertaken by the organisation and the staff. This requirement is included in the Managers Health & Safety training course to increase the knowledge and understanding of risk assessment requirements; it is on the risk register and is part of the H&S inspection checking process.

Compliance remains an issue and the risk team have created an improved and revised risk assessment template that makes the task simpler to complete and understand and can be completed electronically. This is expected to be rolled out from this month (April 2022) and a training package is currently being created to expedite this. An amendment to the GWPRA Procedure is likely on the back of this.

Lone Working

The safety of EPUTs staff is paramount with a full review of the lone worker process undertaken in 2019. The Contract for this service will be extended for a further two years. There has been a 50% increase in issuing these devices due to demand and staff feel valued and safe. Regular ad-hoc training is provided by the team if required and the usage of each device is monitored via the user's 1:2:1 Support/Supervision. There has been an increase in requests for LWD's from reception staff.

The Contract for this service has been recently approved at ET in April 2022 for a contract extension for a further 24 months. There has been a 50% increase in issuing these devices purely due to staff demand, although a number of requests have been from reception staff who often work out-of-hours and on their own. As a result of this provision, staff feel valued and safe – we have now provided 1448 devices to staff within the Trust. Regular ad-hoc training is provided by the team if required and the usage of each device is monitored via the user's 1:2:1 Support/Supervision. Managers have access to the lone worker device portal to update escalation details and usage. Monthly audits of usage and escalation details by the LSMS have commenced and have not highlighted any concerns to date. The call centre has access to the portal for these details in an emergency.

Shared devices have been issued to inpatient wards for staff to accompany patients on leave. These are for the purposes of Section 17 escorted leave for staff safety. Staff members requiring a device will provide the LSMS with a self-assessment and escalation form to cover the requirement of the staff member's risk.

Lone worker device compliance is monitored via the relevant management structure with a high level summary presented to the HSSC. LWD continue to be requested on an ad hoc basis and allocation is via the agreed process based on assessed levels of risk.

	Nov-21	Dec-21	Jan-21	Feb-22	Mar-22	Apr-22
Number of people registered for the service	1332	1345	1357	1385	1313	1400
number of devices	1393	1435	1448	1481	1500	1505
app activation in the period	0	6	4	0	1	0
module activation in the period	822	642	673	660	737	524
alert call yellow/red alerts raised	1404	1145	1154	1073	1222	950
Genuine 999/Safe Alerts handled by the ARC	0	0	0	0	0	0
False Alerts handled by the ARC	106	121	114	109	110	86

Violence Prevention and Reduction

Since April 2017 NHS Protect ceased to exist but EPUT has remained compliant with NHS Protect standards. In December 2020, the new Violence Prevention and Reduction Standards were released and work started to consider how these will be implemented into Trust working systems. The LSMS Team has liaised with NHSE/I to gain a greater understanding of the new standards.

The LSMS team has evaluated these and are in the process of benchmarking the Trust's position of compliance against the previous NHS Protect Core Standards. From this benchmarking a new strategy framework will be developed to take forward Violence Prevention and Reduction across the Trust. A multi-disciplinary task and finish group is being established with the objective of instigating a work-plan to fulfil the needs of these new Core Standards.

The Trust has a process in place for Zero Tolerance which includes sending formal letters perpetrators of violence and aggression. This will be reviewed as part of the new Violence Prevention and Reduction programme.

The LSMS team continues to support all staff (including Bank and Agency) with any incident relating to violence and aggression and regularly conduct visits to wards on a scheduled and ad-hoc basis. The LSMS team have developed a regular schedule of visits to ensure all staff are supported regardless of employment status and will aide any staff member with Police engagement, they will explain processes and procedures and support (if required) through criminal sanction or court proceedings. When a serious incident occurs, contact will be made with the victim within 24 hours and a visit scheduled. The team work closely with the Police Single Point of Contacts with ongoing cases ensuring these are dealt with appropriately and that staff feel adequately supported throughout the process.

We hold monthly Police and Key stakeholder meetings (Mid, North, South and West) which includes attendance from ward staff and Police. There is ongoing collaboration with the clinical team(s) to ensure the best approach and positive outcomes. These meetings provide all parties with assurance on joint working and that the required standards are met.

Each incident reported via the DATIX system is treated individually and ward staff liaised with and, where necessary Staff Support Letters, Zero Tolerance Letters and Behavioural Contracts will be considered.

With the implementation of the Body Worn Cameras across 30 MH Inpatient Wards, we have seen an increased level of engagement with staff and the LSMS team. Wards have been provided with comprehensive training for all staff, support with software. The team has a dedicated Body Worn Camera administrator who is the first point of contact for any queries or issues.

Ligature Risk Assessment Inspections

The Trust Health and Safety Team holds the responsibility for facilitation of Ligature inspections to be undertaken in all Trust Mental Health inpatient wards. A team of professionals made up of a member of the H&S Team, member of the Estates team and the ward manager or Charge Nurse undertake each Ligature Risk Assessment. This has been further extended to invite the Ward Medical Consultant and a Person with Lived Experience (this is currently on hold due to the COVID-pandemic).

Each assessment is undertaken on the ward over a ½ day period inspecting all un-supervised and supervised areas. Areas on the wards patients cannot access are not included. This ensures robust inspection of the environment and actions identified that require Estates intervention can be taking forward immediately.

A draft inspection outcome report is shared with all parties for agreement and includes action identification. Once all parties agree a final report is issued and actions monitored until completion. Any concerns are escalated to the LRRG. Closing of actions within set timescales has been a challenge in 2020/21 and work is underway between the H&S and Estates Teams to make processes more robust.

Ligature Inspections are carried out annually with a follow up support visit 6 months after inspection in line with the Ligature Policy and Procedure requirements.

During 2021/22 the ligature inspections continued to be carried out, with mindfulness of any wards declared as having an outbreak. Where an outbreak has been declared, an individual holistic risk based approach as to whether the inspection should be rescheduled or take place is undertaken; this includes when the outbreak has been declared, the number of patients and/or staff affected. Where it is deemed unsafe to conduct the inspection, this was rescheduled once the outbreak is closed.

Throughout 21/22 a total of 50 full inspections were completed and 38 support visits.

The Trust has a Ligature Risk Reduction Group (LRRG) in place which has an overview of the ligature work streams and requirements; the group meets on a monthly basis and is a sub-committee of the HSSC. Membership includes the Executive Director of Mental Health and Deputy CEO (Chair), Director of Mental Health (Deputy Chair), Associate Director of Compliance & Risk, Estates representatives, the Ligature Co-ordinator and Senior Leads from Clinical Services.

The Trust also has an Estates Expert Reference Group (EERG), who the LRRG make recommendations for patient safety work and agreed standards in line with policy.

EERG have an agreed risk stratification and prioritisation programme to ensure that projects are achieved. These groups work collaboratively and have supported

the following implementation programs:

- Ligature risk assessment and management policy and procedure
- Ligature awareness eLearning training program
- Risk Stratification
- Related ligature safety alert(s) compliance.

The groups have also commissioned further activity such as

- Commissioned audits of a number of identified hazards
- Site visits following incidents
- Testing of equipment

In addition to the above the Trusts ligature risk assessment tool has reviewed regularly throughout 2020/21 with improvements and recommendations approved by the LRRG Committee and as an action from this group, the H&S team are undergoing a review process of all ligature-related actions in order to ensure these are 'closed' accurately with the Ward Manager or Service Manager.

A separate annual report is available detailed further work around Ligature Management.

Incident Reporting

The DATIX team produce regular reports for various committees/groups to facilitate incident and trend analysis. This includes cleansing datasets and contributing to the 'SAFE' section of the monthly Performance Report, producing and presenting the Risk Management Report for the Health Safety & Security Committee (HSSC), and the Clinical Incident Report for the Clinical Governance & Quality Sub Committee.

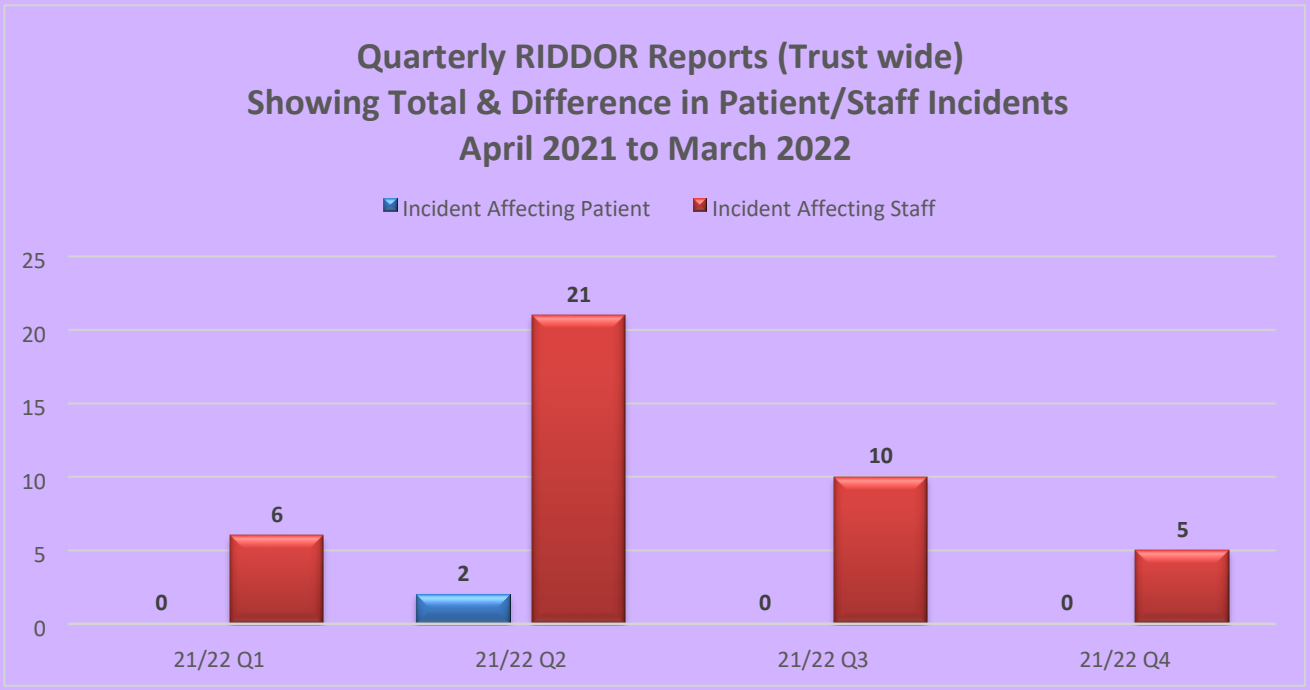
The team also provide DATIX training to staff and contribute to the Trust Corporate Induction programme, presenting information relating to Health & Safety, (Local Security Management Specialists, DATIX, the Restorative Just Culture, Compliance and Assurance.

Other regular reports include the following: Quality & Safety Group Incident reports, Commissioner Incident reports, Restrictive Practice reporting, Ligature Risk reports, Medication Incident reporting, Mass Vaccination Incident reporting, Accountability Framework reporting.

Adhoc requests for information are produced on request and these include incident listings for clinical colleagues relating to individual patients to be used for review and planning meetings and listing reports of incidents involving Doctors as part of the annual appraisal process.

RIDDOR REPORTING

Graph 1 below outlines RIDDOR reporting for 2021-22



There were 44 RIDDOR reports submitted to the Health & Safety Executive (HSE) during the 2021/22 reporting period, 271 were reported in the previous year (2020/21) which was due to the HSE requiring all industries to submit cases of staff testing positive for COVID 19 which may have been contracted at work. This process was managed by the Trusts HR department, with a review of each case of staff sickness against set criteria to establish the likelihood of the virus having been contracted at work.

The general reporting process for incidents other than COVID 19, continues to include the Director of Compliance & Assurance, the Associate Director of Risk & Compliance and Operational Directors which has ensured a robust informed decision is made prior to reporting to the HSE.

Incidents of inpatient falls which have resulted in fractures are assessed on a case by case basis and if any omissions in care are identified which contributed to the fall, the incident will be considered under the agreed process for reporting to the HSE.

PLANNING 2022/23

The Health and Safety Team have the following aims and objectives for 2022/23:

- Increased compliance for General Workplace Risk Assessments
- Development of a 'Directing Safely' training module for AD's and above
- Ward Staff Search Training for Service Users
- Every Trust building to have undergone a full Health and Safety inspection by 31st March 2023.
- A review of protocol for DSE assessments aligned to Hybrid Working
- Implementation of Healthcare Managers Managing Safely course
- General Workplace Risk Assessment Training package for all staff
- Roll-out of Phase 2 for Body Worn Cameras
- Ligature Knife Awareness Training for all clinical staff
- Support ward staff undertaking TASID Training in ward environment

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Board Assurance Framework

27 July 2022 Board of Directors

EPUT

CONTENTS

Board of Directors 27 July 2022

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Introduction

The purpose of this Board Assurance Framework (BAF) is to record and report the key strategic risks, their controls and controls assurances to the Board.

The risks (where appropriate) have a strategy underpinning them and will have longer-term actions with deliverables, and expectation on movement is slow burn.

Each risk is aligned to a Board Committee as a second line of 'controls assurance'.

In addition to the strategic risks, the report provides an overview of corporate risks (those risks with a high risk exposure which could jeopardise operational delivery).

Recommendations / Action Required

EPUT Board of Directors is asked to:

- Receive the Board Assurance Framework report for July 22, noting the revised reporting format.
- Note and approve the addition of the two new Strategic Risks: Risk of insufficient capital resource; and Risk of inefficient use of resources (Slides 10 -11)
- Note one new Corporate Risk: Risk to the delivery of new mass vaccination programme (Slide 12)
- Note closure of six Corporate risks (Slides 13-17)

Corporate Impact Assessment	
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	

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02 - BAF Dashboard

July 2022

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Strategic Risks

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Existing Risks	Recommended New Risks	Recommended for Downgrading	Recommended for Closure
6	2	0	0

Risk Score Increases	Risk Score Decreases	No change in Risk Score	% Risks Reviewed by owners	On RR more than 12 months
0	0	6	100%	2

% Risks with Controls Identified	% risks with assurance identified	% risks with actions overdue
100%	100%	0%

ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score 20+ (Existing risks)								
SR1	1	Safety	Safety, Experience, Compliance, Service Delivery, Reputation	NH	5x4=20	20 → 20 → 20	Rising demand for services; Government MH Recovery Action Plan; Covid-19; Challenges in CAMHS and complexities; Systemic workforce issues in the NHS	• Patient Safety Team fully recruited to • Working with Human Engine to create an assurance dashboard template for Quality Committee • Service Improvement Plans from thematic analysis developed • New learning group established • Learning icon added to desktops
SR2	2	People	Safety, Experience, Compliance, Service Delivery, Reputation	SL	5x4=20	20 → 20 → 20	Replaced BAF50 Skills, Resource and Capacity National challenge for recruitment and retention	• Delivered 83 international nurses since Dec 21 • Instigated relationships with international universities. • 137 bank and agency conversion • 185 active apprenticeships across EPUT • Awarded the contract and launched the Time to Care Programme • Successful launch of recruitment branding across Mid and South Essex footprint
SR4	All	Demand and Capacity	Safety, Experience, Compliance, Service Delivery, Reputation	AG	5x4=20	20 → 20 → 20	Covid-19. Long-term plan. White Paper. Transformation and innovation National increase in demand on services	• All operational directors in post • MAST rollout across community • Developed clear roadmap for portfolio, service areas, using modelling, health system learning and integration of physical/ mental health • Agreed key design principles of Service Delivery Model

Strategic Risks

NHS Essex Partnership University NHS Foundation Trust

ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score 20+ (New risks for approval)								
SR7	All	Capital Resource	Safety, Experience, Compliance, Service Delivery, Reputation	TS	5x4=20	20	The need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	• New risk approved at EBAF 12/07/22 • Prioritisation of Capital Spend • EPR capital resource, the Trust has approached the national team to request change of cohort from those receiving 50% to 80% match funding. • The Executive Chief Finance Office represents EPUT at system finance forums. • Chief Executive has been confirmed as MH member of the MSE ICB
SR8	All	Use of Resources	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x3=15	15	The need to devolve financial management and ensure EPUT makes effective and efficient use of its resource	• New Strategic Risk that replaces closed financial risks on Corporate Risk Register approved at EBAF 12/07/22 • The Executive Chief Finance Office represents EPUT at system finance forums. • Chief Executive has been confirmed as MH member of the MSE ICB

ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score <20 (Existing risks)								
SR3	All	Systems and Processes/ Infrastructure	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x3=15	15 15 15	Capacity and adaptability of the support service infrastructure including Estates & Facilities, ITT /Digital Systems, Estates, Finance, Procurement and Business Development/ Contracting to support frontline services. Recovery from HSE and Covid-19. Need to release clinical time.	• Out to consultation on new structures • Discussing structures for service development and clinical transformation • Meeting on Trust Strategy procurement • Roadmap and action plan for implementation of Interim Digital Strategy • PMO to align organisational programmes • Surveys completed and results for new ways of working board • Appointed P2P for 2-year contract oversight of PFI contract • NHSPS – Open Space Programme now in discussion
SR5	1	Independent Inquiry	Compliance, Reputation	NL	5x3=15	15 15 15	Government led independent inquiry into Mental Health services in Essex	• Awaiting Memorandum of Understanding. • One page methodology in place.
SR6	All	Cyber Attack	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x3=15	15 15 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	• Cyber Essentials documentation submitted for accreditation • DSPT submitted 30 June 2022

Corporate Risks

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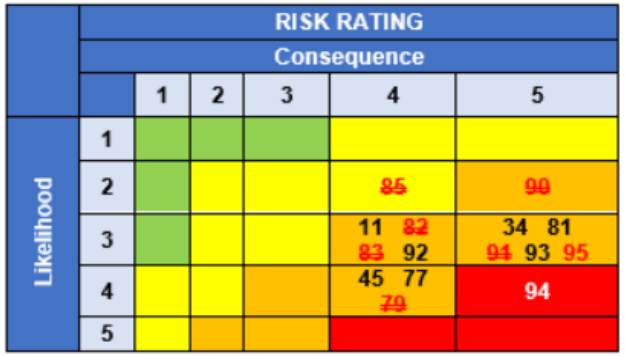
Existing Risks	Recommended New Risks	Recommended Downgrading from SRR to CRR	Recommended Downgrading From CRR to DRR	Recommended for Closure
8	1	0	0	6
Risk Score Increases	**Risk Score Decreases**	**No change in Risk Score**	**% Risks Reviewed by owners**	**On RR more than 12 months**
0	0	8	100%	9



% Risks with Controls Identified	% risks with assurance identified	% risks with actions overdue
100%	100%	0%

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score 20+ (Existing Risks)							
CRR94	Engagement and supportive observation	Safety, Compliance	AG	5x4=20	20 → 20 → 20	CQC found observation learning not embedded in last inspections	Project Complete and new Policy and Procedure launched. Revised training material launched Piloting E-Observations 23 wards scored 100% in Tendable observation audit

ID	Title	Impact	Lead	CRS	Context	Comments
New Risks for Approval						
CRR95	Delivery of new vaccination programme	Service Delivery, Financial	NL	5x3=15	Focus has changed around delivery of the new autumn programme of mass vaccinations	New risk replacing CRR85 Awaiting JCVI guidance on new programme Uncertainties around EPUT role and financial budget to operate the programme

ID	Risk Closed by EBAF 12 July 22	Impact	Lead	Rationale
Closed Risks				
CRR79	Seasonal flu 21-22	Service Delivery	NH	Season for 21/22 complete. Will be a system rather than organisation CQUIN for 2022/23
CRR82	Efficiencies 21/22	Financial	TS	Reframed as strategic risk for 2022/23
CRR83	Covid-19 Financial	Financial	TS	Reframed as strategic risk for 2022/23
CRR85	Mass Vaccination	Service Delivery	NL	Change of focus and a new risk CRR95 has been developed to replace
CRR90	Management of Covid-19	Service Delivery	NL	National incident rate reduced (Level 3). Robust Covid management BAU
CRR91	CAMHS Tier 4 System Bed Pressures	Safety, Compliance	AG	CQC section 31 lifted

Corporate Risks

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ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score <20 (Existing Risks)							
CRR11	Suicide Prevention	Safe	MK	4x3=12	12 12 12	Implementation of suicide prevention strategy	Proposed suicide prevention outcome measures presented to QC. Revised strategy following SPG comments
CRR34	Suicide Prevention - training	Safe	MK	5x3=15	15 15 15	Implementation of suicide prevention strategy	95% of staff have completed dedicated suicide prevention training Poor engagement with STORM Training, working with Workforce Development and Learning to address
CRR45	Mandatory training	Safe	SL	4x4=16	16 16 16	Training frequencies extended over Covid-19 pandemic leaving need for recovery	Rapid recovery plan in place but requires increase in attendance rates Induction and Training policy and procedure identified for review
CRR77	Medical Devices	Safe, Financial, Service Delivery	NH	4x4=16	16 16 16	Number of missing medical devices compared to Trust inventory	Head of Deteriorating Patients and Clinical Governance now in post and working through IA recommendations
CRR81	Ligature	Safe, Compliance, Reputation	TS	5x3=15	16 16 16 15 15 15	Patient safety incidents	LRRG revitalised to improve clinical representation. Gap analysis of ligature related training completed 3i version 10 rollout commenced w/c 27/6
CRR92	Addressing Inequalities	Experience	SL	4x3=12	12 12 12	Risk was escalated from Corporate Risk Register to the BAF in March 2021 – de-escalated November 21	WRES and WDES data highlighting areas of focus – concerns on discrimination, performance management and reasonable adjustments.
CRR93	Continuous Learning	Safety, Compliance	NH	5x3=15	15 15 15	HSE and CQC findings highlighting learning not fully embedded across all Trust services	Culture of Learning project: • Patient Safety Team fully recruited to • Working with Human Engine to create an assurance dashboard template for Quality Committee • Service Improvement Plans from thematic analysis developed • New learning group established • Learning icon added to desktops

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03 - New Risks

July 2022

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SR7: CAPITAL RESOURCE

Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT does not have sufficient capital resource, e.g. digital and EPR (***Cause***), then we will be unable to undertake essential works or capital dependent transformation programmes (***Effect***), resulting in non achievement of some of our strategic and safety ambitions (***Impact***).

Likelihood based on: percentage of capital programme unable to deliver / deferred

Consequence based on: what not delivered and the impact on the strategic plans.

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	TBC

Risk Appetite: TBC

Risk Tolerance: TBC

Progress :

- New risk 2022/23 approved at Executive Board Assurance Framework Group 12 July '22.
- Prioritisation of capital spend – established clinical and operational prioritisation, being presented at ET. Following which the risk score will be confirmed.
- In reference to EPR capital resource (Digital Strategy), the Trust has approach the national team to request change of cohort from those receiving 50% to 80% match funding.
- EPUT Capital programme totals £12.3m. The programme has been set equal to resource allocation and has been developed based on clinical and operational prioritise. Outside these allocations the Trust intends to submit bids for strategic business cases with a view to access additional capital funding for schemes outside of main allocations e.g. Mental Health ED.
- The Executive Chief Finance Office represents EPUT at system finance forums.
- Chief Executive has been confirmed as MH member of the MSE ICB

Executive Responsible Officer:
Trevor Smith, Executive Chief Finance Officer

Executive Committee: Executive Team
Board Committee: Finance & Performance Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
Develop Estates Strategy (co-dependent on Clinical Strategy)	End Dec 2022	Charles Hanford – Director of Estates & Facilities	Road Map
Develop Digital Strategy (co-dependent on Clinical Strategy)	TBC	Jan Leonard – Director of IMT	Road Map
Develop a medical devices replacement programme	TBC	Natalie Hammond – Executive Chief Nurse	Road Map
Identify priorities for capital spend over the next 5 years (best value)	July 2022	Trevor Smith – Executive Chief Finance Officer	Control
Horizon scan to maximise opportunities both regional and national to source capital investment	Ongoing	Simon Covill – Director of Finance	Control

Controls Assurance

Key Control	Level 1 Department	Level 2 Organisational Oversight	Level 3 Independent
Finance Team (Response to new resource bids and financial control oversight)	Team in place		
Purchasing / tendering policies	Policy Register	IA reviews	
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2022/23	Capital Project Group Reporting - £14.3m	Capital Resource reporting to Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£New resource secured	Capital Resource reporting to Finance & Performance Committee	
ICS representation re: financial allocations and MH/Community Services	ECFO or Deputy Attendance at ICS Meetings		
	CEO or Deputy membership of ICB		

SR8: Use of Resources

Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT and / or MSE ICS does not effectively manage its use of resources (***Cause***), then we may not meet Trust nor System financial control total ***(Effect)***, resulting in potential failure to sustain and improve services for the community we serve ***(Impact)***.

Likelihood based on: EPUT financial risk and opportunities profile

Consequence based on: assessed impact on long financial model for EPUT and the System

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L3 = 15	TBC

Risk Appetite: TBC

Risk Tolerance: TBC

Progress:

- New risk approved by Executive Board Assurance Framework Group 12 Jul '22
- Budget setting for 2022/23 completed with a control total of breakeven
- Budgets signed off by senior budget owners
- Efficiencies worked up £10.2m (unidentified with further work £2m)
- Non-pay additional allocation secured £4.7m

Assurance:

- Month 3 reporting showing 'on plan' detail which is positive assurance.
- Cost improvement plan update here – assurance given
- Auditor opinion – vfm opinion no matters of concern.
- Attendance at meeting to represent EPUT
- System financial reporting to F&P Committee established.

Executive Responsible Officer:
Trevor Smith, Executive Chief Finance Officer

Executive Committee: Executive Team
Board Committee: Finance & Performance Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
National HFMA Checklist Audit	Sept 2022	*Simon Covill Director of Operational Finance*	*Assurance*
Improve financial maturity (Training and development for budget holders and business partners)	End March 2023	*Lauryn Gable*	*Control*
Efficiency workshops to identify remaining efficiency savings	End May 2022 (delayed due to additional national planning activities now Sept '22)	*Simon Covill Director of Operational Finance*	*Control*
Deliver Financial Efficiency Target (All Budget Holders)	End Mar 2023	*Trevor Smith Executive Chief Finance Officer*	*Control*
In year forecast outturn (FOT) and risk and opportunities assessments	End Sept 2023 (monthly thereafter)	Simon Covill	Assurance
Deliver Operational Plan 2022/23	End March 2023	Alex Green / Trevor Smith	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Finance Team	Team Established	Use of Resources Assessment	Use of Resources NHSE Assessment
Financial Policies (SFI; SRD; AF)	Policy Register	IA Reviews	External Audit of Annual Accounts
Budget Setting (I&E and Delivery of Efficiency Target)	Accountability Framework Reporting	Finance Reporting to Finance & Performance Committee	Annual vfm (External Auditors)
	In year forecast outturn (FOT) and risk and opportunities assessments	National HFMA Checklist Audit	
Model Health System (Benchmarking)		Corporate Benchmarking Reports	
EPUT Representation at ICS forums (e.g. Strategic Effectiveness Group)	Chief Finance Officer or Deputy attends meetings.		

CRR95 Delivery of new Mass Vaccination Programme

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Summary	Potential Risk	Context	Key Controls that mitigate the risk	Controls Assurance	Gaps in Controls	Action Plan
CRR95 Delivery of new Mass Vaccination Programme Initial and current score **5 x 3 = 15** Target score 5 x 2 = 10 by Oct 22	If EPUT is uncertain of its role and available budget to deliver the autumn vaccination programme then then there may be significant cost and workforce shortfalls resulting in a challenge to delivering future programmes and potential reputational damage	Start date for EPUT booster programme unknown (costs involved for days not in programme)	Internal plan to reduce direct and indirect costs	Level 1: Mass Vaccination Team Level 2: Project Board	Awaiting guidance from JCVI on autumn programme. Uncertainty on financial budget that EPUT will have to operate the programme, creating a financial and operational risk in delivery of the autumn programme. Other provider shares of vaccine delivery may impact on our ability to deliver. Contract implications for EPUT and how financial risk will transfer to providers. Vaccine position unknown.	1. Working with each system to develop system plans and joint vaccination programme 2. Reviewing delivery models and associated costs

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04 - Risks Closed

July 2022

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Lead: Executive Nurse

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Rational for Closure
CRR79 SO2 Lead NH Quality Committee	Seasonal flu Current Risk – eliminated. Initial Risk Score 4 x 4 = 16 Target March 22 4 x 2 = 8 16 16 X	If EPUT's alternative approach to seasonal flu is unsuccessful then it may suffer outbreaks in the workforce resulting in failure to meet national programme of expectations	Annual Flu vaccination programme	• Project management in place • Clinical oversight in place • Plan to commence flu programme in September in conjunction with Covid-19 boosters • Weekly task and finish group established • Local measures agreed • Communications plan • Platform designed for staff checks on Covid vaccinations suitable for flu • Data Dec 2021 52% (Dec) direct patient care and 55% indirect. Slightly under last year position.	Flu season ended Flu will not be a CQUIN for 2022/23 at organisational level.

Lead: Executive Chief Finance and Resources Officer

NHS Essex Partnership University NHS Foundation Trust

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Rational for Closure
CRR82 **SO1** **Lead** **TS** **F&PC**	Efficiencies 21/22 Current risk score eliminated Initial Risk Score 4 x 4 = 16 Target March 22 4 x 2 = 8 12 → 12 → x	If EPUT does not identify and deliver the 2021/22 efficiency programme then it may not achieve a break even position at year end resulting in a challenge to develop and deliver a recurrent 2022/23 efficiency programme	Contract requirements	• H2 (second half year) financial plan approved and reduced the annual efficiency requirement from £10.1m to £9m. • Partnership work with Regional, ICS partners and service efficiency groups to deliver efficiency plans. • The key activities and work streams communicated to the Finance & Performance Committee with a focus on delivery plans, quantification and implementation • Efficiency work stream meetings with all Directorates and Corporate functions • Engaged external support to help develop efficiency schemes for 2022/23	Financial year 2021/22 complete and Trust achieved plan. New risk developed for 2022/23 financial year see SR7 Use of Resources.
CRR83 **SO1** **Lead** **TS** **F&PC**	Covid-19 Financial Plan Current risk score eliminated Initial Risk Score 4 x 3 = 12 Target March 22 4 x 2 = 8 12 → 12 → 12	If the COVID-19 crisis continues then EPUT may experience an adverse impact on its financial plan as a knock on from system wide financial planning resulting in additional risk for EPUT to its sustainability	Financial regime during Covid-19	• The Trust's 21/22 financial plan has been set to deliver a breakeven position. • Continuous monitoring of the financial position through reporting to F&PC, EOSC finance and performance meetings and the Board. • Efficiency requirements are included in the financial plan and schemes under development. • H2 (second half-year) plan has now been approved and has reduced any uncertainty over the financial envelope • Non-recurrent benefit associated with resolution of PropCo dispute has been accounted for • Discussions on funding options for yearend with Commissioners and NHSE/I	Financial year 2021/22 complete and Trust achieved plan. New risk developed for 2022/23 financial year see SR7 Use of Resources.

Lead: Executive Director - Major Projects

NHS Essex Partnership University NHS Foundation Trust

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Rational for Closure
CRR90 SO1 Lead NL QC	Management of COVID-19 Current risk score 5 x 2 = 10 Initial Risk Score 5 x 3 = 15 Target March 22 5 x 2 = 10 10 10 10	If EPUT does not manage COVID-19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements	Covid-19 pandemic	• Business Continuity Plans • Command and control structure • Sit rep daily monitoring • COVID-19 intranet page and staff training • COVID-19 dashboard issued weekly to monitor prevalence • NED (JW) and Executive Lead for Emergency Planning agreed (NL) • Demonstrating lessons learnt from COVID-19 through bi-monthly Trust Board reports and EPRR quarterly report • Action Plan completed	National incident rate reduced (Level 3). Robust COVID management in place and part of business as usual.
CRR90 SO1 Lead NL QC	Mass Vaccination Current risk score decreased to threshold 4 x 2 = 8 Mar 22 Initial Risk Score 5 x 4 = 20 Target Ongoing 4 x 2 = 8 8 8 8	If EPUT does not effectively direct and implement the entire mass vaccination programme during challenging times then it may not meet level 4 deliverables and timescales resulting in a compromise to the programme	Covid-19 pandemic	• Mass Vaccination Risk Register • BCPs developed for vaccination centres • Working in partnership, with Local Resilience Forums, Local Authorities and other providers • Clinical oversight and governance in place at all vaccination centres discussed daily • All costs passing through NHSE • Robust communication in place • Pre-assessment model in place • Managing alternative models for vaccination delivery including pop ups and large trailer, drive through pilot and buses • Maintaining workforce at vaccination centres with forward planning to identify workforce challenges • Maintaining vigilance and awareness on security • 12-15 age group School Immunisation Teams now delivering vaccines mainly in schools • Process for standing up temporary vaccination centres	Change of focus to mass vaccination programme, new risk developed to replace CR90

Lead: Executive Chief Operating Officer

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Key Assurances (Evidenced)
CRR91 **SO3** **Lead AG** **Quality Committee**	CAMHS Tier 4 system bed pressures Current risk score 5 x 2 = 10 Initial Risk Score 5 x 4 = 20 Target March 2022 extended to June 22 5 x 2 = 10 	If EPUT does not plan to resettle the CAMHS Tier 4 service then recovery of services is compromised resulting in remaining closed to admissions	CQC S31 System bed pressures/ lack of specialist CAMHS beds	• Increased establishment and new Service Manager role in post • Ward Managers focusing on patient care and colleague coaching/ support • Enhanced clinical and operational leadership • Increased clinical workforce • Seclusion room investment at Longview • Observation audits via Tendable • Obs and Engagement Training video storyboards • Intensive Clinical Support Group Established (now closed) • Clinically led improvement plan (Complete and closed May 22) • CAMHS recovery and reopening group (closed) • Monitoring report (now closed May 22) • Fortnightly reported to CQC (now closed) • All three CAMHS wards can now take admissions • 72 hour crisis pathway • CQC preparation plan in place lifted S31	CQC have lifted S31 and all wards now open to admissions – and returned to business as usual.

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05 – Strategic Risks

July 2022

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SR1: SAFETY

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At a Glance:

If EPUT does not invest (time and resource) in safety or to effectively learn lessons from the past (***Cause***), then we may repeat past mistakes or not be working to current best practice (***Effect***), resulting in avoidable harm, loss of confidence in our services and potential regulatory sanctions (***Impact***).

Likelihood based on: Incidence of incidents, non-compliance with standards (clinical audit outcomes) and regulatory sanctions imposed historically

Consequence based on: Avoidable harm incident impact and extent of regulatory sanctions

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	C5 x L2 = 10 March 2023

Progress since last report:

- Current risk score remains the same
- The Patient Safety Team has been fully recruited, with the expectation that all will in post by End Sept '22.
- Restructure of Patient Safety Team and Culture of Learning Team to form one hub for the organisation.
- Thematic analysis driven Safety Improvement Plans developed (part Patient Safety Incident Response Plan) and will be reported to the Learning Collaborative.
- Culture of learning programme [pick up last update from BSOG for update – drop in tomorrow]

Assurance

- 6 out of the 16 core services continue to be rated as 'requires improvement' and 1 'inadequate' associated with the CAMHS (noting the various timelines of when inspections carried out) and therefore marked as negative assurance.
- The S31 restrictions on CAMHS removed (28 June 2021) following inspection of service, providing positive assurance on improvement actions taken.
- Safety First Safety Always – Leadership update presented at ESOG 12 July '22 noting [add update]

Executive Responsible Officer:
Natalie Hammond, Executive Chief Nurse

Executive Committee: Executive Safety Oversight Group
Board Committee: Quality Committee (BSOG)

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Refresh deliver Patient Safety Incident Response Plan	TBC (When data Available)	Moriam Adekunle Director of Safety and Patient Safety Specialist	Road Map
2. Deliver the Patient Safety Incident Response Plan	March 2023	Moriam Adekunle Director of Safety and Patient Safety Specialist	Controls
3. Deliver the Patient Safety Strategy (Safety First Safety Always	End March 2023	Natalie Hammond Executive Chief Nurse	Road Map / Control
4. Culture of Learning Programme	Ongoing	Moriam Adekunle Director of Safety and Patient Safety Specialist	Control

Controls Assurance

Key Control	Level 1 Department	Level 2 Organisational Oversight	Level 3 Independent
Patient Safety Team and Culture of Learning Team	Patient Safety Team fully recruited.	Report Safety First Safety Always – Leadership	PSIRF Pilot Feedback
PSIRF / Complaints / Claims	Policy Register	IA of PSIRF reported at Audit Committee (May 2022)	Fundamental Standards Safety ratings from CQC Inspections
		Incident Reporting Data to Quality Committee	Regulatory action arising from safety concerns.
			Incident Reporting Benchmark Data from NRLS.
Safety First Safety Always Strategy	ESOG Reporting	Safety First Safety Always Strategy Annual Report (BSOG / Board)	As above for PSIRF/Complaints/ Claims
Culture of Learning Programme	ESOG Reporting	Report Safety First Safety Always – Culture of Learning	
Revenue and Capital investment	Capital funds allocated 2022/23	Report Safety First Safety Always – Enhancing Environments	

SR2: People

Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT does not effectively address and manage staff supply and demand (***Cause***), then we may not have the right staff, with the right competencies, in the right place at the right time to deliver services (***Effect***), resulting in potential failure to provide optimal patient care / treatment and the resultant impact on safety / quality of care (***Impact***).

Likelihood based on: Establishment of existing and new roles verses the vacancy factor and shift fill rate.

Consequence based on: Impact of staffing levels on service objectives; length of unsafe staffing (days) through the sit rep return; staff morale; availability of key staff; attendance at key training.

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	C5 x L3 = 15 (Mar '23) C5 x L2 = 10 (Mar '24)

Risk Appetite: TBC

Risk Tolerance: TBC

Progress since last report:

- Delivered 83 international nurses since December '21.
- Instigated relationships with international universities.
- 137 bank/ agency conversion
- 185 active apprenticeships across EPUT
- Awarded the contract and launched the Time to Care Programme
- Successful launch of recruitment branding across Mid and South Essex footprint (on behalf of the Integrated Care Board).

Assurance:

- 7 of our core services are rated as 'requires improvement' for safety by the CQC of which 3 identified staffing as a breach in regulations.
- HR policies and procedures – a plan is in place to have all items on extension reviewed by September '22.

Executive Responsible Officer:
Sean Leahy, Executive Chief People Officer

Executive Committee: Executive Team
Board Committee: People, Equality and Culture Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
Rolling recruitment programme	Ongoing	Matt Gall Associate Director Resourcing	Control
Deliver International Recruitment Programme	December 2022 / Ongoing	Marcus Riddell Senior Director of OD	Control
Bank/Agency Conversion Programme	Ongoing	Matt Gall Associate Director Resourcing	Control
Student Recruitment	Ongoing	Annette Thomas-Gregory Director of Education & Learning	Control
Apprenticeship Programme Relaunch	October 2022	Annette Thomas-Gregory Director of Education & Learning	Control
Time to Care Programme	December 2023	Paul Scott Chief Executive	Control
Refresh and Deliver Recruitment and Retention Strategy	December 2022	Matt Gall Associate Director Resourcing	Road Map / Control
Develop People Commitments (strategic plan)	December 2022	Marcus Riddell Senior Director of OD	Road Map
Employee experience road map	October 2022	Lorraine Hammond Director Employee Experience	Road Map

Controls Assurance

Key Control	**Level 1** *Department*	**Level 2** *Organisational Oversight*	**Level 3** *Independent*
HR Team (e.g. Engagement / Resourcing and OH)	Team in place		
HR Policies	Policy Register	IA Reviews Workforce Reports to PECC	
Workforce Plans	Workforce Safeguards Workforce Establishment Reviews	Workforce Safeguards Workforce Establishment Reviews Workforce Reports to PECC	CQC inspections NHSE Workforce Returns System Workforce Returns / benchmarks
Sit Rep Meetings	Staffing Sit-Rep		CQC inspections
Use of Bank and Agenda Staff (when needed)	Staffing Sit-Rep	Workforce Reports to PECC	CQC inspection reports
			Use of Resources Assessment
Recruitment Branding	Branding in place from March '22	Direct Hire Numbers within the Workforce reporting to PECC	
Rolling recruitment programme		Workforce Reports to PECC (vacancy factor)	
International Recruitment Programme	IR Report to ET	IR Report to PECC	

SR3: Systems and Processes / Infrastructure

Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT systems, processes and infrastructure do not continue to adapt to support clinical services **(*Cause*),** then we may not have the right facilities / resources to deliver safe, high quality care (***Effect***), resulting in not attaining our safety, quality, experience and compliance ambitions (***Impact***)

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L3 = 15	TBC

Risk Appetite: TBC

Risk Tolerance: TBC

Progress since last report:

- Estates and Facilities structure out to consultation
- Roadmap and action plan for implementation of Interim Digital Strategy in place
- Transformation Steering Group Established
- Appointed external advisors for 2-year to challenge PFI contract arrangements
- Strategy development in progress with support from NWCSU

Assurance:

- Digital Strategy Group in place
- Weekly PMO/ ITT Integration meetings
- HIE in place

Executive Responsible Officer:
Trevor Smith, Executive Chief Finance and Resources Director
Zephan Trent, Executive Director Strategy Transformation and Digital

Executive Committee: Executive Team, ESOG
Board Committee: Finance and Performance Committee, Audit Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Fully recruit to all finance, resources, strategy, transformation and digital systems teams including agreeing portfolios and jointly funded posts	September 2022	Trevor Smith, Executive Chief Finance and Resources Director & Zephan Trent, Executive Director Strategy Transformation Digital	Full establishment
Develop EPUT Strategy	October 2022	Zephan Trent, Executive Director Strategy Transformation Digital	Roadmap
Develop Commercial Strategy	December 2022	Liz Brogan, Director of Contracting & Service Development Lauren Gable, Director of Finance Commercial	Roadmap
Develop Estates Strategy	December 2022	Charles Hanford Director of Estates and Facilities	Roadmap
Deliver Interim Digital Strategy	March 2027	Zephan Trent, Executive Director Strategy Transformation Digital	Control
Deliver on the Target Operating Model	End March 20223	All Executives	Control

Controls Assurance

Key Control	Level 1 Department	Level 2 Organisational Oversight	Level 3 Independent
Teams in place	Establishment		
PMO	Established		
Audit programme/ ISO in place		Audit Committee Internal Audit	CQC CAMHS inspection highlighted effectiveness of HIE BSI data external assessment
ERIC Assessment		ERIC Return	
Premises Assurance		Premises Assurance Model (PAM) Assessment	

SR4: Demand and Capacity

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT does not effectively address demands (***Cause***), then our resources may be over-stretched (***Effect***), resulting in an inability to deliver high quality safe care, transform, innovate and meet our partnership ambitions (***Impact***).

Likelihood based on: Average length of stay / occupancy / PTLs /delayed safe transfers of care/out of area placements/RTT's/safe staffing levels

Consequence based on: Mismanagement of patient care and length of the effects./ Staff vacancy/feedback from system partners

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L3 = 15	TBC

Risk Appetite: TBC

Risk Tolerance: TBC

Progress since last report:

- Recruitment is progressing for Care Unit Leadership Structure with interviews happening this month.
- Started a programme of work to establish a consistent operational and governance structure across the Care Units.
- Workshops underway to develop the service strategies and on track.
- Launched accountability meetings
- Awarded the contract and launched the Time to Care Programme

Assurance:

- Refreshed daily sit reps in place
- Use of SMART
- MAST Roll out across community
- All operational directors in post

Executive Responsible Officer:
Alex Green, Executive Chief Operating Officer

Executive Committee: Executive Team
Board Committee: Finance & Performance Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Recruitment and Development of the Care Unit leadership structures.	December 2022	Milind Karale Executive Medical Director Natalie Hammond Executive Chief Nurse	Control
Embedding of Care Units (Operational and governance structures)	September 2022	Alex Green, Executive Chief Operating Officer	
Development of individual Care Unit Service Strategies	September 2022	Zephan Trent Executive Director Strategy Transformation & Digital	Road Map
Implement Service Delivery Strategy	March 2023	Alex Green, Executive Chief Operating Officer	Control
Model service need (population health / bed model)	TBC	Zephan Trent Executive Director Strategy Transformation & Digital (Supported by KPMG)	Control
Time to Care Programme	December 2023	Paul Scott Chief Executive	Control

Controls Assurance

Key Control	Level 1 Department	Level 2 Organisational Oversight	Level 3 Independent
Operational staff	Established		
Operational Plan 2022/23	Accountability Meeting Outcomes	Performance Reports	
		Flow and Capacity Metric Reporting	
Refreshed Out of Area Plan		F&P Committee Reports	
Integrated Director posts covering mental health and physical health	Established		
MAST (management and supervision tool)	CPA Review Performance	Performance Reports	
Skilled temporary workforce via Trust Bank	Staffing Sit Rep / Fill Rate	Workforce Reports	
Mutual aid from collaborative partners			
Business Continuity Plans	EPRR Standards – annual assessment	Internal Audit	EPRR Standards submission review by NHSE/I

SR5: Independent Inquiry

Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT is not open, transparent or demonstrate learning from or effectively manage the Essex MH Independent Inquiry (***Cause***), then we may not deal with consequences of past failings (***Effect***), resulting in not attaining our safety, quality, experience and compliance ambitions (***Impact***)

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L3 = 15	TBC

Risk Appetite: TBC

Risk Tolerance: TBC

Progress since last report:

- Developed a one page methodology for dealing with inquiry internally.
- National terms of reference published externally and internally.

Assurance:

- Learning Log in place
- Investment in internal support for the inquiry.

Executive Responsible Officer:
Nigel Leonard, Executive Director Major Projects

Executive Committee: Executive Team
Board Committee: Audit Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Carry out internal audit on learning	March 23	BDO	Assurance
Appoint to Data Specialist, Team Leader, Project Co-ordinator and Head of Communications as part of the Inquiry Team internally	September 22	Gill Brice Project Director	Establishment
Respond to information requests	Ongoing	Gill Brice Project Director	Assurance

Controls Assurance

Key Control	Level 1 Department	Level 2 Organisational Oversight	Level 3 Independent
Internal Inquiry Team	Establishment		
Independent Director			Independent Director in place.
Internal methodology for dealing with inquiry		In place and used for reporting	
Learning Log		In place and used for reporting to ET Audit Committee and BOD	

SR6: Cyber Security

Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT experiences a cyber-attach (***Cause***), then we may encounter system failures and downtime (***Effect***), resulting in a failure to achieve our safety ambitions, compliance, and consequential financial and reputational damage (***Impact***).

Likelihood based on: Prevalence of cyber alerts that are relevant to EPUT systems.

Consequence based on: assessed impact and length of downtime of our systems

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L3 = 15	TBC

Risk Appetite: TBC

Risk Tolerance: TBC

Progress since last report:

- Cyber Essentials documentation submitted for the accreditation process.
- Data Security and Protection Toolkit self assessment submitted 30 June '22.

Assurance:

- DSPT standards met
- Cyber Team in place
- IGSSC and Digital Strategy Group
- NHS Digital Data Security Protection Toolkit (DSPT)
- Cyber Essentials+ Accreditation
- EPUT engaging in MSE ICS IG & Cyber Levelling Up Project
- EPUT Cyber team action CareCert alerts from the NHS Digital Cyber Team and resolve within 14 days unless there is an external factor preventing this
- Alerts are logged, actioned and signed off at IGSSC with additional risk log in place

Executive Responsible Officer:
Zephan Trent, Executive Director of Strategy Transformation and Digital

Executive Committee: Executive Team
Board Committee: Audit Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Appoint to Cyber Governance Manager and Cyber Security Operational Manager	March 2023	BDO	Control
Complete recommendations from internal audit	March 23	Adam Whiting Deputy Director, ITT and Business Analysis and Reporting	Controls and Assurance
Develop business continuity plan and disaster recovery for each system	TBC	Adam Whiting Deputy Director, ITT and Business Analysis and Reporting	Controls and Assurance
Take actions to meet gaps identified in Cyber Essentials Accreditation	October 22	Adam Whiting Deputy Director, ITT and Business Analysis and Reporting	Controls and Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place	New Cyber Governance Manager post to act in independent policing type role Existing Cyber Security Manager role	IGSSC	NHS Digital Data Security Protection Toolkit (DSPT) Cyber Essentials Accreditation
Policies and frameworks in place	Virtual and site audits Compliance with mandatory training	IGSSC BDO internal audit May 22 – overall Moderate Confidence level Medium	As above MSE ICS IG & Cyber Levelling Up Project (annual)
Investment in prioritisation of projects to ensure support for operating systems and licenses			
IG & Cyber risk log	Risk working group	IGSSC and Digital Strategy Group	DSPT
Business Continuity Plans and National Cyber Team processes			Annual Testing as part of DSPT NHS Digital Data Security Centre, Penetration Testing, Cyber Essentials+

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06 – Corporate Risks

July 2022

EPUT

Executive Medical Director

Essex Partnership University NHS Foundation Trust

Ref	Summary	Potential Risk	Context	Key Controls that mitigate the risk	Controls Assurance	Gaps in Controls	Actions
CRR11: Suicide Prevention Strategy **Objective: SO1** **Lead: MK** **Standing Committee: Quality Committee**	Suicide Prevention Initial Risk Score 4 x 4 = 16 Current Risk Score 4 x 3 = 12 Target March 22 4 x 2 = 8 Risk Movement last 3 months: 12 → 12 → 12	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	Implementation of suicide prevention strategy	Resources • Medical lead in place Policy • Suicide Prevention Strategy 2021-23 (launched Sept 2021) • Implementation plan • Detailed work plan in place Innovation • Rolled out Breaking the Silence • Rolled out safety plans • Rolled out 10 ways to improve safety from NCI into Suicide and Safety in MH Lessons Learnt • Local reflective sessions and safety huddles • Research into family involvement I • Focus groups with patients and families Technology • Oxehealth digital monitoring of vital signs Detection • Suicide prevention outcome measures • Monitoring delivery and annual assessment against the NCISH toolkit	Level 1: • Suicide Prevention Group Level 2: • Mortality Sub-Committee/ ESOG / Quality Committee • Annual Report to Quality Committee Measures • Zero instances of preventable deaths • 19.3% downward trend in instances of self-harm • 95% patients have Personal Safety Plan in place	Evidence that Suicide Prevention Strategy is working	• Implementation of revised Strategy / Implement work plan and dashboard • Align with Safety First, Safety Always Strategy • Project support requested • Complete recommendations from Annual Report • Patient group to explore social media impact • Implement outcome measures • SPG to discuss suggested changes to strategy (May 22)
CRR34: Suicide Prevention Training **Objective: SO2** **Lead: MK** **Standing Committee: Quality Committee**	Suicide Prevention - training Initial Risk Score 3 x 3 = 9 Current Risk Score 5 x 3 = 15 Target March 22 3 x 2 = 6 15 → 15 → 15	If EPUT does not train and support staff effectively in suicide prevention then staff may not have the necessary skills or confidence to support suicidal patients resulting in self-harm or death and a failure to achieve our safety first, safety always strategy	Implementation of suicide prevention strategy	Training • Training is now virtual Innovation • Suicide prevention month • New community assessment model. • The new Crisis 24 team • Community transformation paper, redesign of CMH pathways and provision of IAPT through EPUT (NEE signed off) Lessons Learnt • MH/LD network members discussion on Suicide Prevention Training Detection • Transparent monitoring through contracting	Level 1: • Suicide prevention group • Suicide awareness training targets achieved • Seven people trained and additional eight in Feb/March as part of existing roles. • 95% staff completed dedicated suicide prevention training Level 2: • Mortality Sub-Group and ESOG / Quality Committee	May 22 – STORM training - no trainers coming forward and services not putting staff forward for training. Poor engagement.	• Refresher course required due to attrition in numbers • Moving to STORM training • Exploring training offers and frequency • Improvement trajectory and reporting on suicide prevention training. • Recruit 1.5 WTE trainers and service based trainers once finance agreed • Develop a quality improvement project

Executive Director of People and Culture

NHS
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Ref	Summary	Potential Risk	Context	Key Controls that mitigate the risk	Controls Assurance	Gaps in Controls	Actions
CRR45 Mandatory Training **Objective SO2** **Lead: SL** **Standing Committee: PECC**	Mandatory training Initial Risk Score 4 x 3 = 12 Current Risk Score 4 x 3 = 12 Target June 22 4 x 2 = 8 12 12 12	If EPUT does not achieve mandatory training policy requirements then patient and staff safety may be compromised resulting in additional scrutiny by regulators and not meeting the IG Toolkit requirements	Training frequencies extended over Covid-19 pandemic leaving need for recovery	Recourses • Training Team Policy • Induction and Training Policy • Managers reminded to check training trackers and prompt staff whose training is overdue Innovation • Training Recovery Plan Innovation • National OLM issue resolved Detection • Local trajectory in place for safety focused and IG mandatory training as a priority • Monthly reporting to ET	• Level 1: Training Team • Level 2: Training Reports to range of committees including Accountability and Finance and Performance and PECC • Level 3: IG DSPT	Training compliance remains below target with face to face courses particularly affected	• Implement recovery plan • Review Mandatory training policy (currently on extension) • Low course uptake and high DNA rates
CRR92 Inequalities **Objective: SO2** **Lead: SL** **Standing Committee: PECC**	Addressing inequalities Initial Risk Score 5 x 4 = 20 Current risk score 4 x 3 =12 Jan 21 Target March 22 3 x 2 = 6 12 12 12	If EPUT does not address inequalities then it will not embed, recognise and celebrate equality and diversity resulting in a failure to meet our People Plan ambitions	Risk was escalated from Corporate Risk Register to the BAF in March 2021 – de-escalated November 21	Resources • Employee experience team inc Director Policy • E&D Policies Innovation • Four EDI networks • Equality and Inclusion Hub on InPut • Staff Network pages and virtual networks • Equality Champions • Collaborative working with ICS, • Root and branch Culture reviews Training • EPUT 'RISE' Programme, Mentors allocated to Emerging and Aspiring Leaders.	Level 1: • Team established Level 2: • Equality and Inclusion Sub-Committee with Exec Lead • PECC • RISE Cohorts 1, 2 and 3 complete. Level 3: • EDS2 2020/21 scored positively by stakeholders, • EDS2 2021/22 approved by stakeholder focus group and E&ISC	WRES and WDES data highlighting key areas of focus: concerns on discrimination, performance management and reasonable adjustments	• EDI • Annual update of Equality Delivery System (EDS2) with stakeholder input (Mar-Apr 22) • Creation of extensive EDI dashboard, (Nov 21 – Mar 22) • Improve EDI learning offer for EPUT (Nov 21-Mar 22) • End of Kickstart Scheme admissions (Mar 2022), project to be continued independently within the Trust

Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

Ref	Summary	Potential Risk	Context	Key Controls that mitigate the risk	Controls Assurance	Gaps in Controls	Actions
CRR77 Medical Devices **Objective SO1** **Lead: NH** **Standing Committee: Quality Committee**	Medical Devices Initial Risk Score 4 x 4 = 16 Current Risk Score 4 x 4 = 16 Target August 22 4 x 2 = 8	If EPUT does not track missing/ unregistered medical devices or address the clinical rationale/ pathway then unsafe, non-serviced, non-calibrated and inappropriate devices may be in use resulting in a failure to achieve our safety first, safety always strategy	Number of missing medical devices compared to Trust inventory	Resources • New Head of Deteriorating Patient Pathways • Corporate Nursing Team and Datix Team Policy • Procurement process in place • Medical Devices Policy • Physical Health Sub-Committee • Medical Devices Group is the Governance group • Maintenance contractor • eQuip asset register Training • Training arrangements Detection • Incident reporting and monitoring	Level 1: • Corporate Nursing Team established Level 2: • Medical Devices Group • MDSO provides assurance on medical device safety/ management • Tendable audits Level 3: • Internal audit report draft received, level of assurance – Design: Moderate, Operational Effectiveness: Limited	Remains significant number of missing devices	Complete actions from recommendations in Internal audit report:
CRR93 **SO1** **Lead NH** **ESOG/ ET** **Quality Committee**	Continuous Learning Initial Risk Score 5 x 3 = 15 Current Risk Score 4 x 4 = 16 Target Date TBC 5 x 2 = 10 Risk Movement 	If EPUT does not continuously learn and improve then patient safety incidents will occur resulting in failure to achieve our safety strategy ambitions and maintain or improve CQC Good ratings	HSE and CQC findings highlighting learning not fully embedded across all Trust services	Resources • Patient Safety Team • Appointment of patient safety co-ordinators; Policy / Process • Framework CQC action plan testing Innovation • EPUT Culture of learning Project • Collaboratives of learning – QI hubs • Schwartz Rounds • Structured feedback programme • New learning collaborative partnership meeting • Learning Icon on desktops	Level 1 • Patient Safety Team established Level 2 • ESOG and BSOG - Culture of learning is a key priority project • Accountability framework	Two KPIs proposed	• Renegotiated date for two day workshop through MASS team until posts recruited to and in post end 20-21 July • Stakeholder communications plan and series of workshops scheduled and developing need sign off by steering group • Review Human Engine process maps to incorporate into patient safety incident team standard operating procedure – ongoing including learning from deaths in process charts • Review and explore learning from other organisations including non-NHS - ongoing • Shared learning audit part of IA Audit Programme • Revised learning oversight sub • committee to stand up on 28 July, revised TOR approved by QC. updated to reflect the new care group model structure

Executive Chief Finance and Resources Director

NHS Essex Partnership University NHS Foundation Trust

Ref	Summary	Potential Risk	Context	Key Controls that mitigate the risk	Controls Assurance	Gaps in Controls	Actions
CRR81 Ligature **Objective: SO1** **Lead: TS** **Standing Committee: Quality Committee**	Ligature Initial Risk Score 4 x 3 = 12 Current Risk Score 3 x 3 = 15 Target March 22 4 x 3 = 12 Risk Movement 15 → 15 → 15	If EPUT does not continue to implement a reducing ligature risk programme of works (environmental and therapeutic) that is responsive to ever changing learning, then there is a likelihood that serious incidents may occur, resulting in failure to deliver our safety first, safety always ambitions	Patient safety incidents	Resources • Estates Ligature/ Patient Safety Co-ordinator • H&S Team and Compliance Team • LRRG / EERG (Revitalise LRRG to improve clinical representation. Group must focus on practice as well as environmental issues – July 2022) • Ligature Project Group Policy • Ligature Policy and Procedure including environmental Standards Training • Ligature Training and Tidal training Learning • Monthly ligature safety bulletin including learning and safety alerts Innovation / Investment • Quality improvement project on self-strangulation in place (funding for North of EPUT) • Heat maps with photos Detection • Reviewed all fixed point incident since April 21 • Annual ligature inspection for all MH wards followed by 6 month support visit • Ligature wallet audits in place	Level 1 • Teams established • Ward ligature wallets Level 2 • Reporting to LRRG • ESOG and BSOG - Dashboard of top four Trust priorities • Accountability framework • Annual Ligature Inspections Level 3 • Internal Audit BDO 2021 • ELFT Independent Review 2021 • Action plan in place from BDO internal audit recommendations actions completed	• Safety issue identified following installation of outdoor furniture at The Linden Centre (raised fittings) – being addressed • Ligature actions differences in Datix and 3i • overdue actions	• Completion of ELFT Independent review Action Plan • Identify right system for recording ligature actions (overseen by Project Group) • Introducing local area ligature forum – initial meeting March 22 • Review of Cambridge University work on management of ligature risk • Strengthen mitigation statements for any actions where there is reliance on clinical monitoring • Increase awareness and ownership of ligature reduction work • Review standards on outdoor garden furniture to avoid raised fittings ligature risk

Executive Director – Major Projects

NHS
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Summary	Potential Risk	Context	Key Controls that mitigate the risk	Controls Assurance	Gaps in Controls	Action Plan
CRR95 Delivery of new Mass Vaccination Programme Initial and current score **5 x 3 = 15** Target score 5 x 2 = 10 by Oct 22 New Risk	If EPUT is uncertain of its role and available budget to deliver the autumn programme then then there may be significant cost and workforce shortfalls resulting in a challenge to delivering future programmes and potential reputational damage	Start date for EPUT booster programme unknown (costs involved for days not in programme)	Internal plan to reduce direct and indirect costs	Level 1: Mass Vaccination Team Level 2: Project Board	Awaiting for guidance from JCVI around autumn programme. Uncertainty on financial budget that EPUT will have to operate the programme, creating a financial and operational risk in delivery of the autumn programme Other providers shares of vaccine delivery may impact on us Contract implications for EPUT and how financial risk will transfer to providers Vaccine position unknown	1. Working with each system to develop system plans and joint vaccination programme 2. Reviewing delivery models and associated costs

Executive Chief Operating Officer

NHS
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NHS Foundation Trust

Ref	Summary	Potential Risk	Context	Key Controls that mitigate the risk	Controls Assurance	Gaps in Controls	Actions
CRR94 Observation and Engagement **Objective: SO1** **Lead: AG** **Standing Committee: Quality Committee**	Engagement and Supportive Observations Initial Risk Score 4 x 4 = 16 Current Risk Score 5 x 4 = 20 Target March 22 4 x 2 = 8 Risk Movement 20 → 20 → 20	If EPUT does not manage supportive observation and engagement then patients may not receive the prescribed levels resulting in undermining our Safety First, Safety Always Strategy	CQC found observation learning not embedded	Resources • Engagement and Supportive Observation project (Complete) Policy • Revised Obs and Engagement Policy (Jan 22) • Recording forms rolled out to MH and SS through policy revision Innovation • Weekly ward huddles and discussing Tendable reports • ADs undertaking 15 leadership steps each week • Electronic obs recording tool (in trial stage) • Intensive Clinical Support Groups have reviewed guidelines relating to observation and engagement Training • Training videos implemented • Innovation / Technology Detection • Comprehensive audits using Tendable	Level 1: • Tendable Audits Level 2 • CG&QC, Accountability, Quality Committee Tendable Audit Ward HeatMap for May showing • 23 wards scoring 100% • 7 wards scoring 90% or above • 1 ward below 90% (Basildon MHAU) • 10 wards did not complete	• Tendable audit results not reported anywhere • Some areas without Oxehealth	• Annual audit using data from Tendable • Follow up clinical audit in Q2 • Share findings of e-observation pilot with ESOG • Enhance with planned staffing improvements enabled by digital tools, engagement with AHPs and improved oversight through the accountability framework • On line training being reviewed by Deputy Director of Quality Transformation

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07 – Risk Movement

July 2022

EPUT

Risk Movement and Milestones

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Strategic Risk Movement

Risk ID	Initial Score	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Risk ID
SR1	20															New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR1
SR2	20															New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR2
SR3	15															New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR3
SR4	20															New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR4
SR5	20				New	20	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR5
SR6	12	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	15↑	15↔	15↔	15↔	15↔	15↔	15↔	SR6
SR7																									New	SR7
SR8																									New	SR8

Strategic Risk Milestones

Risk ID	Initial Score	Time on SR/ old BAF	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 22	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Risk ID
SR1	20	>6 months															New	20								SR1
SR2	20	>6 months															New	20								SR2
SR3	15	>6 months															New	15								SR3
SR4	20	>6 months															New	20								SR4
SR5 (BAF 5.1)	20	>1 year				New	20					15↓						SR								SR5 (BAF 5.1)
SR6 (CRR 1)	12	>2 years																	CRR	15						SR6 (CRR 1)
SR7	20																								New	SR7
SR8	15																								New	SR8

Risk Movement and Milestones

NHS
Essex Partnership University
NHS Foundation Trust

Corporate Risk Movement

Risk ID	Initial Score	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Risk ID
CRR11	16	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	8↓	12↑	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	CRR11
CRR34	9	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	15↑	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR34
CRR40	12	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	SR								CRR40
CRR45	12	16↑	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR45
CRR48	20	20	20	20	16↓	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	DRR						CRR48
CRR53	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	De-esc							CRR53
CRR68	16	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	De-esc							CRR68
CRR72	12			New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	De-esc								CRR72
CRR74	15				New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	DRR						CRR74
CRR76	20							New	20	20↔	15↓	15↔	15↔	15↔	10↓	10↔	10↔	Closed								CRR76
CRR77	16								New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR77
CRR78	9												New	9	9↔	9↔	9↔	Closed								CRR78
CRR79	16													New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	Close	CRR79
CRR80	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	De-esc								CRR80
CRR81	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR81
CRR82	16										New	16	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	Close	CRR82
CRR83	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	Close	CRR83
CRR84	15										New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	DRR						CRR84
CRR85	20			New	20	20↔	20↔	15↓	15↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	20↑	12↓	12↔	8↓	8↓	8↓	8↓	Close	CRR85
CRR86	16															New	16	20↑	Merged							CRR86
CRR87	20															New	20	16↓	16↓	Close						CRR87
CRR88	20															New	20	De-esc								CRR88
CRR89	15															New	15	Closed								CRR89
CRR90	15	15↔	15↔	15↔	10↓	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	20↑	20↔	20↔	10↓	10↔	10↔	10↔	Close	CRR90
CRR91	20												New	20	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	Close	CRR91
CRR92	20							New	20	20↔	16↓	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	CRR92
CRR93	15								New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR93
CRR94	16												New	16	16↔	16↔	16↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	CRR94
CRR95	20																								15	CRR95
Risk ID	Initial Score	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Risk ID

Risk Movement and Milestones

NHS
Essex Partnership University
NHS Foundation Trust

Corporate Risk Milestones

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

NHS
Essex Partnership University
NHS Foundation Trust

08 – Useful Information

July 2022

EPUT

Executive Lead Dashboard

NHS
Essex Partnership University
NHS Foundation Trust

Director of Governance and Corporate Affairs	Executive Director of People and Culture	Executive Medical Director	Executive Director of Major Projects and Programmes
Nil	1 Strategic Risk 2 Corporate Risks • SR2 People (Risk Score 20 no change) ↔ • CRR45 Mandatory training (Risk Score 16) ↔ • CRR92 Addressing inequalities (Risk Score 12) ↔	0 Strategic Risks 2 Corporate Risks • CRR11 Suicide Prevention (Risk Score 12) ↔ • CRR34 Suicide Prevention – training (Risk Score 15) ↔	1 Strategic Risk 1 Corporate Risk (New) 2 Risk Closing (Corporate) • SR5 Independent Inquiry (Risk Score 15) ↔ • CRR95 Delivery of new vaccination programme (Risk Score 15) NEW • CRR85 Mass Vaccination Programme - to close • CRR90 Management of Covid-19 - to close

Executive Director of Nursing	Executive Chief Finance Officer	Executive Director of Strategy and Transformation	Executive Chief Operating Officer
1 Strategic Risk 2 Corporate Risk 1 Risk Closing (Corporate) • SR1 Safety (Risk Score 20) ↔ • CRR93 Continuous Learning (Risk Score 15) ↔ • CRR77 Medical Devices (Risk Score 16) ↔ • CRR79 Seasonal flu ↓ to close	3 Strategic Risks (2 new) 1 Corporate Risk 2 Risks to Close (Corporate) • SR3 Systems & Processes/ Infrastructure (Risk Score 15) ↔ • CRR81 Ligature (Risk Score 15) ↔ • SR7 Capital (Risk Score 20) NEW • SR8 Revenue (Risk Score 15) NEW • CRR83 Financial Plan ↔ to close • CRR82 Efficiencies 21/22 ↔ to close	1 Strategic Objective SR6 Cyber Attack (Risk Score 15) ↔ Work ongoing in relation to setting up risk registers for strategy, and transformation as well as an EPUT Digital risk register	1 Strategic Risk 1 Corporate Risk 1 Risk Closing (Corporate) • SR4 Demand and Capacity (Risk Score 20) ↔ • CRR94 Engagement and supportive Observation (Risk Score 20) ↔ • CRR91 CAMHS Tier 4 system bed pressures ↔ to close

Strategic Objectives

OBJECTIVE 1	We will deliver safe, high quality integrated care services	Owner	Natalie Hammond	Risk Summary	4 Risks with a Score of 20+ 9 Risks with a Score of <20 2 Risks for Closure

There are 15 risks (two earmarked for closure and two new), including CRR risks, currently identified against the achievement of Objective 1:

- SR1 Safety, risk score 5x4=20. No risk score changes in last 3 months.
- SR2 People, risk score 5x4=20. No risk score changes in last 3 months.
- SR3 Systems and Processes/ Infrastructure 5x3=15. No risk score changes in last 3 months.
- SR4 Demand and Capacity, risk score 5x4=20. No risk score changes in last 3 months.
- SR5 Independent Inquiry, risk score 5x3=15. No risk score changes in last 3 months. Managed by Special Projects Team
- SR6 Cyber-attack, risk score 5x3=15. No risk score changes for 3 months. Change of Executive Lead
- CRR11 Suicide prevention, risk score 4x3=12. Risk score unchanged in last 3 months
- CRR77 Medical devices, risk score 4x4=16. No risk score changes in last 3 months.
- CRR81 Ligature reduction, risk score 4x3=12. No risk score changes in last 3 months. De-escalated from SRR. Safety strategy work stream
- CRR82 Efficiencies, risk score 4x3=12. No risk score changes in last 3 months. De-escalated from SRR. Recommended to close
- CRR83 Covid-19 Financial Plan, risk score 4x3=12. No risk score changes in last 3 months. Recommended to close
- CRR93 Continuous Learning, risk score 5x3=15. No risk score changes in last 3 months. Safety strategy work stream
- CRR94 Engagement and Supportive Observation, risk score 5x4=20. No risk score changes in last 3 months. Safety strategy work stream
- SR7 Capital – new risk 5x4=20
- SR8 Revenue – new risk 5x3=15

Strategic Objectives

OBJECTIVE 2	We will enable each other to be the best that we can	Owner	Sean Leahy	Risk Summary	3 Risks with a Score of 20+ 4 Risks with a Score of <20 1 Risk for Closure

There are 8 risks (one earmarked for closure and two new), including CRR risks currently identified against the achievement of Objective 2:

- SR2 People, risk score 5x4=20. No risk score changes in last 3 months.
- SR4 Demand and Capacity, risk score 5x4=20. No risk score changes in last 3 months.
- CRR34 Suicide prevention – training, risk score 5x3=15. No risk score changes in last 3 months.
- CRR45 Mandatory training, risk score 4x4=16. No risk score changes in last 3 months.
- CRR79 Seasonal flu, risk score 4x4=16. No risk score changes in last 3 months. Recommended to close
- CRR92 Addressing Inequalities, risk score 4x3=12. No risk score changes last 3 months. Being managed by Equality and Inclusion Sub Committee and monitored using EDS2 scores
- SR7 Capital – new risk 5x4=20
- SR8 Revenue – new risk 5x3=15

OBJECTIVE 3	We will work together with our partners to make our services better	Owner	Alex Green	Risk Summary	3 Risks with a Score of 20+ 1 Risks with a Score of <20 1 Risk for Closure

There are 5 risks (one earmarked for closure and two new) currently identified against the achievement of Objective 3:

- SR2 People, risk score 5x4=20. No risk score changes in last 3 months.
- SR4 Demand and Capacity, risk score 5x4=20. No risk score changes in last 3 months.
- CRR91 CAMHS Tier 4 System Bed Pressures, risk score 5x3=15. No risk score changes in last 3 months. Being managed by CAMHS Intensive Support Group overseen by ESOG. Recommended to close
- SR7 Capital – new risk 5x4=20
- SR8 Revenue – new risk 5x3=15

Strategic Objectives

OBJECTIVE 4	We will help our communities thrive	Owner	Paul Scott	Risk Summary	3 Risks with a Score of 20+ 2 Risks with a Score of <20 2 Risks for Closure

There are 7 risks (two earmarked for closure and two new) currently identified against the achievement of Objective 4:

- SR2 People, risk score 5x4=20. No risk score changes in last 3 months.
- SR4 Demand and Capacity, risk score 5x4=20. No risk score changes in last 3 months.
- CRR85 Mass Vaccination Programme, risk score 4x2=8. No risk score changes in last 3 months. Managed by Mass Vaccination Project. Recommended to close
- CRR90 Management of Covid-19, risk score increased in last 3 months. Managed by Command Structure overseen by Executive Team. Recommended to close
- SR7 Capital – new risk 5x4=20
- SR8 Revenue – new risk 5x3=15
- CRR95 Delivery of new vaccination programme 5x3=15

Acronyms

Essex Partnership University NHS Foundation Trust

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

Agenda Item No: 8bi

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	27 July 2022

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

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues
The report details two meetings held since the last Board of Directors meeting: **Meeting held on the 26 May 2022 covered the following areas:** • Accountability Framework • Internal Audit • LCFS • External Audit • Risk Management and Assurance Annual Report • Conflict of Interest • Losses and Special Payments • Waiver of Standing Orders • Statement of Financial Position Write Offs/Impaired Debt Write Offs **Meeting held on the 7 July 2022 covered the following areas:** • Internal Audit • LCFS • External Audit • Governance Update • Sustainability Assurance and Commission (IS014001) • Losses and Special Payments • Waiver of Standing Orders • Cyber Security – Alert Monitoring and Assurance • Outcome of Audit Committee Effectiveness Review 2022 Further details is included in the attached report.

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

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

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

Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**~~YES~~/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report

Lead

Janet Wood
Non-Executive Director
Chair of the Audit Committee

Agenda Item: 8bi
Board of Directors Part 1
27 July 2022

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

AUDIT COMMITTEE REPORT

1.0 PURPOSE OF REPORT

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

2.0 EXECUTIVE SUMMARY

Audit Committee Meeting 26 May 2022 & 7 July 2022

The Audit Committee met on the 26 May 2022 and the 7 July 2022. At the meeting held on the 26 May 2022 the minutes were approved of the 18 March 2022. At the meeting held on the 7 July 2022 the minutes were approved of the 26 May 2022 subject to minor amendments. These minutes are available to Board members on request.

At the meeting held on 26 May 2022 the following matters were discussed:

1. **Accountability Framework**

   An update was provided to the Committee regarding the Accountability Framework and the introduction of Phase 2. It was noted that the second phase would include a monthly expanded Executive Team meeting to consider themes, key issues and to share learning from the Accountability Framework meetings.

2. **Internal Audit**

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

- Serious Incidents Investigations
- Key Financial Systems (Purchase Cards)
- Data Security Protection Toolkit

Internal Audit and Annual Report and Annual Statement of Assurance
The above report was issued with 'moderate' assurance.

Internal Audit Plan 2022/23
The above plan and terms of reference are due to be presented to the Executive Operational Committee in June 2022, for approval.

Local Counter Fraud Service Progress Report

- **Referrals:** The Committee received an update on the current investigations/referrals.
- **Counter Fraud Services Annual Report & Counter Fraud Functional Return** The above report was approved and submitted.

3. **External Audit**

Progress Report
Audits are in the process of being undertaken and are on track.

4. **Risk Management and Assurance Annual Report 2021/22**
The above was approved by the Committee.

5. **Conflict of Interest**
Annual assurance report to be presented to the Committee.

6. **Losses and Special Payments**
At the end of the financial year, the Trust is reporting losses and special payments of £24k.

7. **Waiver of Standing Orders**
During the period 1 March 2022 to 30 April 2022 competitive quotations were waived on twenty six occasions totalling £846k (including VAT). Of these, one item relates to the mass vaccination programme (£18k).

For the same period five competitive tenders was waived which totalled £1,284k.

From 1 April 2022 retrospective waivers will be recorded. In this period there have been four retrospective waivers identified.

Value of waivers for 2022/23 are lower than at the same time in 2021/22.

8. **Statement of Financial Position Write Offs/Write Backs/Impaired Debts Write Offs**
There were no write offs.

9 **Directors Expenses**
For the 2021/22 financial year a total of £4,958 has been claimed by nine members of the Board of Directors. For the previous year £2,497 was claimed by 13 Board members.

At the meeting held on 7 July 2022 the following matters were discussed

1. **Internal Audit**

Internal Audit Progress Report 2021/22
The following report has been issued in draft:

- SFIs and Waivers

2022/23 Internal Audit Plan
Draft terms of reference to be presented to the EOC on the 19 July 2022, for approval.

Local Counter Fraud Service Progress Report
- **Referrals:** The Committee received an update on the current investigations/referrals.

2. **External Audit**

EPUT Auditors Annual Report – Year Ended 31 March 2022
The above report was presented and noted.

3 **Governance Update**
A presentation was provided to the Committee which was discussed and noted.

4. **Sustainability Assurance & Commission (ISO14001)**
The above was discussed and noted.

5. **Losses and Special Payments**
As at the end of Month 2, the Trust is reporting losses and special payments of £32,215.

6. **Waiver of Standing Orders**

During the period from 01 May 2022 to 31 May 2022 competitive quotations were waived on ten occasions totalling £418k (including VAT). Of these, two items relates to the mass vaccination programme (£29k).

For the same period in 2021/22 five competitive quotations were waived which totalled £701k.

From 1 April 2022 retrospective waivers are now being recorded. In this period there have been three retrospective waivers. Two have been received from the Mass Vaccination Programme, and one from the Nursing Directorate.

7. **Cyber Security – Alert Monitoring & Assurance**
The Committee were assured that the Trust has the appropriate protection and controls from theft or damage via electronic means in place to secure data, devices, services and networks.

The report was discussed and noted.

8. **Outcome of the Audit Committee Effectiveness Review 2022**
It was noted that the Audit Committee received positive feedback following the above review.

3.0 MANAGEMENT OF RISK

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

4.0 NEW RISKS

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

5.0 ACTION REQUIRED

The Board of Directors are asked to:

1. Note the summary of the meeting held on 26 May 2022 and the 7 July 2022.
2. Confirm acceptance of assurance given in respect of risk.
3. Request further action/information as required.

Report prepared by:
Carol Riley
Audit Committee Secretary

On behalf of:

Janet Wood
Non-Executive Director
Chair of the Audit Committee

		Agenda Item No: 8bii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 July 2022**

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

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	Listed in BAF report	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Board of Directors • That the 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. Assurance to the Board of Directors that the Finance and	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

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

Performance Report

This report covers the position for month 2 (May-22) and month 3 (Jun-22).

In June 2022 there were 4 areas of inadequate performance (4 in May).

The Executive Director of Operations provided assurance on contractual performance and the number of inadequate indicators advising that performance is stable. In addition to the four inadequate indicators, discussions also covered the podiatry waiting list and what measures are being taken to reduce this.

During the June meeting the Director of Community Delivery & Partnerships in North East Essex provided an update on CPA reviews, including the contributors to reduced performance, and the plans and mitigating actions that are in place to continue work on this. In addition the Director of MH Inpatient & Urgent Care attended to discuss restrictive practice, capacity & demand, and out of area placements.

During the July meeting the Director of Community Delivery & Partnerships in North East Essex attended to provide a further update on CPA review performance advising the factors which continue to impact this and the increased demand the services are witnessing.

Contracting

In June the Director of Contracting noted there had been a positive outcome for the tender of the Time to Care project. An evaluation has been undertaken and resulted in a recommendation to Deloitte, who scored higher than other bidders. This was approved by delegation of the Board.
The Trust is also bidding with processes underway for a bridging contract in West Essex with Essex County Council.
The School Aged Immunisation Service and the Lighthouse project were also discussed.

Whilst presenting in the July meeting the Director of Contracting gave a further update advising that the Time to Care project is now live and work has begun.

The Director of Contracting also advised the Trust is proposing to bid again this year for the Veterans Mental Health service.

The Committee and Director of Contracting and have agreed that a Lessons Learnt piece on the Lighthouse contract will still be provided in the September Committee meeting.

Financial Update – Month 3

The Director of Finance gave an update as to the month 3 financial position for the Trust.
Revenue reports a YTD deficit of £2.6m, £0.5m better than planned expectations. This favourable position relates to over-delivery against the Trust's efficiency programme.
There is a current Capital underspend of £1m associated with mobilisation of schemes with recovery expected in future months. Clinical and operational engagement are to agree priority associated with ward refurbishments.

Improvement in receivables position with longstanding debt with a neighbouring Provider has been resolved.
Efficiency shows improvement in level of identified efficiency schemes but residual unidentified schemes of £2m-£3m remain. Care Units are due to run workshops to identify residual efficiencies.

Feedback from the Capital Projects Programme Group

The Director of Finance provided feedback from the Capital committee and proposed approval for the reprioritised capital plan in order that refurbishments to a number of wards can commence during 2022/23. As well as this the committee discussed updates on the MH ED funding and the MH Urgent Care bid.

Following discussions the Director of Finance has agreed to meet with clinicians to ascertain if one area is preferred for improvement refurbishments above others and whether any schemes can be moved to allow progression.

MSE ICB Finance Strategy

The Director if Commercial Finance highlighted that the system is in a challenging financial position, looking at projections the Trust predicts that this will stretch out further over a 4 to 5 year period.
The Trust is looking to address this through various ways, including the need to become a clinically led system to give local empowerment to transform services and by developing existing staff and future leaders to build bridges through community and systems.

Members of the committee noted how key the governance and reporting will be in this, which is in development with the ICB.

Estates & Facilities Q1 Update

The Q1 update was presented by the Director of Estates & Facilities and covered PFI, support to the LRRG, ISO 9001 & ISO 14001, the New Ways of Working Group, and the Capital Group.
It was also noted that there is currently a restructure taking place within Estes to deliver a split between Estates & Facilities sections.

Updated Planning Submission

In June the Director of Commercial Finance informed the committee of a non-pay allocation of £1.5m with providers having break even plans in place. The Trust has used this funding to reduce its risk profile.

The Executive Chief Finance Officer thanked Finance colleagues for their work on this challenge and delivering this so well for EPUT.
Committee members mirrored this praise.

National Cost Collection Pre-Submission Report

During the June meeting the Director of Commercial Finance provided an update on National Cost Collection, for which there is a national obligation to collect data for. If was noted there is a plan in place to deliver the information and this will be submitted over the summer months.

A further report will be provided to the committee with more detail as this progresses. Members of the committee have agreed to provide their approval and assurance.

BAF Quarterly Update

The Interim Director of Risk and Compliance assured the committee in June that the BAF project review is underway and a new format had been shared which will evolve further as the work progresses.

Policies

The Interim Director of Risk and Compliance attended the July meeting to apply for committee approval of changes made to the CP8 Purchasing Policy and to approve an extension of the ITT policy.

Both of these were granted approval by the committee.

Any Risks or Issues

There were no risks identified as requiring addition to the risk register in June or July.

Any Other Business

There was no other business.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead

Name: Loy Lobo
Job Title: Non Executive Director

Agenda Item 8bii
Board of Directors Meeting Part 1
27th July 2022

FINANCE AND PERFORMANCE COMMITTEE ASSURANCE REPORT

1.0 Purpose of Report

This report is provided by the Chair of the Finance and Performance Committee, Loy Lobo to provide assurance to Board members that the performance operational, financial and governance as at month 2 May 2022 and month 3 June 2022.

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

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

2.0 Quality and Performance Report

This report covers the position for month 2 (May-22) and month 3 (Jun-22).

In June 2022 there were 4 areas of inadequate performance (4 in May):

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

The Executive Director of Operations provided assurance on contractual performance and the number of inadequate indicators advising that performance is stable. In addition to the four inadequate indicators above, discussions also covered the podiatry waiting list and what measures are being taken to reduce this.

During the June meeting the Director of Community Delivery & Partnerships in North East Essex provided an update on CPA reviews, including the contributors to reduced performance, and the plans and mitigating actions that are in place to continue work on this. In addition the Director of MH Inpatient & Urgent Care attended to discuss restrictive practice, capacity & demand, and out of area placements.

During the July meeting the Director of Community Delivery & Partnerships in North East Essex attend to provide a further update on CPA review performance advising that this further decline in performance for June is closely linked with vacancies and sickness. It was also noted that referrals have increased, in contradiction to previous years which witnessed a reduction during summer months.

The Chair thanked those who attended to present an update on their respective areas.

3.0 Contracting

In June the Director of Contracting noted there had been a positive outcome for the tender of the Time to Care project. An evaluation has been undertaken and resulted in a recommendation to Deloitte, who scored higher than other bidders. This was approved by delegation of the Board and presented to the L50 group which was well received.

The Trust is also bidding with processes underway for a bridging contract in West Essex with Essex County Council.
The School Aged Immunisation Service and the Lighthouse project were also discussed.
Committee members asked that a lessons learnt process is undertaken following the September review on the Lighthouse project. It was noted that early indications from patients are very positive of the service we are providing.

Whilst presenting in the July meeting the Director of Contracting gave a further update advising that the Time to Care project is now live and work has begun. This will become a standing item at the committee for monitoring.

The Director of Contracting also advised the Trust is proposing to bid again this year for the Veterans Mental Health service as part of the Collaborative, and as a sub contract with St Andrews.

The Committee thanked the Director of Contracting for their update and have agreed that a Lessons Learnt piece on the Lighthouse contract will still be provided in the September Committee meeting.

4.0 Financial Update M3

The Director of Finance gave an update as to the month 3 financial position for the Trust.
Revenue reports a YTD deficit of £2.6m, £0.5m better than planned expectations. This favourable position relates to over-delivery against the Trust's efficiency programme.
There is a current Capital underspend of £1m associated with mobilisation of schemes with recovery expected in future months. Clinical and operational engagement are to agree priority associated with ward refurbishments.
Improvement in receivables position with longstanding debt with a neighbouring Provider has been resolved.
Efficiency shows improvement in level of identified efficiency schemes but residual unidentified schemes of £2m-£3m remain. Care Units are due to run workshops to identify residual efficiencies.

Other matters:

- National pay award announcement - Systems to receive allocations in August followed by a distribution process.

- Trust has submitted MH ED OBC to Regional office to assist in securing capital resource. Revenue consequences being discussed with CCGs.

- Following clinical and operational review / capital prioritisation recommendation that programme of ward refurbishment/improvement is commenced.

- Updated purchasing policy approved.

- MSE / ICB finance strategy shared for Information.

5.0 Feedback from the Capital Projects Programme Group

The Director of Finance provided feedback from the Capital committee and proposed approval for the reprioritised capital plan in order that refurbishments to Woodlea, Hadleigh, and Christopher Unit can commence during 2022/23.
As well as this the committee discussed updates on the MH ED funding and the MH Urgent Care bid.

The Chair of the committee thanked the Director of Finance for their update and the Director of Finance has agreed to meet with clinicians to ascertain if one area is preferred for improvement refurbishments above others and whether any schemes can be moved to allow progression.

6.0 MSE ICB Finance Strategy

The Director of Commercial Finance highlighted that the system is in a challenging financial position, looking at projections the Trust predicts that this will stretch out further over a 4 to 5 year period.
The Trust is looking to address this through various ways, including the need to become a clinically led system to give local empowerment to transform services and by developing existing staff and future leaders to build bridges through community and systems.

Members of the committee noted how key the governance and reporting will be in this, which is in development with the ICB.

7.0 Estates & Facilities Q1 Update

The Q1 update was presented by the Director of Estates & Facilities and gave comprehensive feedback on the implementation of current and systemic changes.
The Director of Estates & Facilities advised that the PFI has been held to account within Q1 to deliver as per the contract.
The team continue to support the Trust ligature risk management programme with effective environmental audits and focussed technical support.

It was also noted that there is currently a restructure taking place within Estes to deliver a split between Estates & Facilities sections.

In addition to the above, further updates were provided on ISO 9001 & ISO 14001, the New Ways of Working Group, and the Capital Group.

The Chair of the committee thanked the Director of Estates & Facilities for their update.

8.0 Updated Planning Submission

In June the Director of Commercial Finance informed the committee of a non-pay allocation of £1.5m with providers having break even plans in place. The Trust has used this funding to reduce its risk profile.

The Executive Chief Finance Officer thanked Finance colleagues for their work on this challenge and delivering this so well for EPUT.
Committee members mirrored this praise.

9.0 National Cost Collection Pre-Submission Report

During the June meeting the Director of Commercial Finance provided an update on National Cost Collection, for which there is a national obligation to collect data for. If was noted there is a plan in place to deliver the information and this will be submitted over the summer months. The Trust meets most standards and is compliant, with just a couple areas of focus for next year.

A further report will be provided to the committee with more detail as this progresses. Members of the committee have agreed to provide their approval and assurance.

10.0 BAF Quarterly Update

The Interim Director of Risk and Compliance assured the committee in June that the BAF project review is underway and a new format had been shared which will evolve further as the work progresses.

Two corporate risks have been closed, and four risks remain open.

The Chair of the committee thanked the Interim Director of Risk and Compliance for their progress update.

11.0 Policies

The Interim Director of Risk and Compliance attended the July meeting to apply for committee approval of changes made to the CP8 Purchasing Policy and to approve an extension of the ITT policy.

Both of these were granted approval by the committee.

12.0 Any risks or issues

There were no risks identified as requiring addition to the risk register in June or July.

13.0 Any Other Business

There was no other business.

Report prepared by:

Amy Tucker
Senior Performance Manager

On behalf of:

Loy Lobo
Chair of the Finance and Performance Committee

		Agenda Item No: 8biii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 July 2022**

Report Title:	**Quality Committee Report**					
Executive/ Non-Executive Lead:	Rufus Helm, Non-Executive Director / Chair of the Quality Committee					
Report Author(s):	Matt Rangué, Quality Project Lead					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues
The Quality Committee has reviewed the work of the sub-committees and all performance and quality dashboards accountable to the Committee. This report is presented to the Board of Directors as assurance of the review and challenge initiated. This report confirms that the Quality Committee has received assurance that all work streams are in place and actions are being taken to mitigate risks.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report

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

Agenda Item:8biii
Board of Directors Meeting Part 1
27 July 2022

QUALITY COMMITTEE REPORT

1.0 PURPOSE OF REPORT

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

2.0 EXECUTIVE SUMMARY

Summary of discussions and issues identified as well as assurances provided at the June and July meetings:

2.1 COMMITTEE MEETING HELD ON 09 JUNE 2022

2.1.1 Quality Performance Report

The Committee received the Quality Performance Report, identifying that 15 indicators continue performing within the target parameters.

Board members attention was brought to 3 indicators that are currently performing outside of the target:

- Care Plan Approach (CPA): In April performance declined to 91.5%, reduced from 92.7% in March. North East & West services are currently performing at 94% and Mid & South services are performing at 88.9%. Both Specialist and Trust wide services are achieving the target at 100%. Performance continues to be affected by staffing levels and COVID pressures. Mitigation in place includes closing of appropriate cases by the Flow and Capacity Lead and review of patient caseloads during Clinical Supervision sessions.

  The Committee Chair challenged the actions in place to improve performance, requesting evidence that these were effective. In mitigation, use of the Management and Supervision Tool (MaST) tool was offered as a robust intervention that will have a positive impact going forward.

  Impact of psychology waiting times on CPA performance was noted and discussed and it was agreed that performance for CPA should be separately reported as psychology and non-psychology CPA.

- Inpatient MH Capacity (Adults & Psychiatric Intensive Care Unit (PICU)): In April, adult average length of stay (LOS) continued to fall outside the benchmark of <35 with performance at 69.9, this is a small increase on 66.9 in March. There were 106 discharges in April 34 of whom were long stays (60+ days). Adult occupancy rates have reduced slightly to 96.4% in April, which also remains outside the benchmark of <93.4%.

- Psychology Wait Times. Remains outside of the target timescales. Mitigations continue using best utilisation of resources including transfer of psychology waiting lists to Electronic Patient Record (EPR).

It was noted that despite interventions to improve flow, the average length of stay has increased and assurance was given that the Purposeful Admission Group is actively looking at

solutions, which will tackle delayed discharges – a more individualised approach to setting the Estimated Date of Discharge (EDD), including a red to green assessment will be ready to deploy soon.

Committee members noted the following positive trends:

- Sustained reduction in pressure ulcers
- Prone restrictive practice remains below the monthly threshold, although the current trend is for an increasing number of incidents.

2.1.2. CQC Exception Report

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

- CQC have confirmed that the Trust may start to admit children and young people with immediate effect, whilst the application to remove the Section 31 is being processed.
- Trust annual CQC Preparation Plan has been developed and initiated for 2022 which takes a risk based approach to prioritise focus and support. The first phase is complete and hotspot areas have been visited by the Compliance Team. Next stage will be looking at emerging themes and well led preparation
- Compliance Team is continuing their programme of work with one new intensive support group open for older adults following incident on Gloucester Ward
- New guidance released:
    - Smiling Matters: Oral Health Care in Care Homes
    - CQC upgraded website is now live
    - Recruitment Guidance and Best Practice

Committee members noted that a Clinical Intensive Support Group had been commissioned for older adults to bring together the multidisciplinary Team to better understand the model of care and support employed for those with physical and mental health needs, citing the risks and benefits of profiling beds in maintaining health while presenting a ligature risk.

It was also noted that the Mental Health Act (MHA) CQC visits are becoming more frequent and thorough and now include an assessment of staffing, family engagement and the Care Plan Approach (CPA), and now form a greater part of the overall intelligence being used for rating Trust compliance with CQC standards.

2.1.3 Operational Procedure Assurance

The Committee received and discussed the Mental Health Act Operational Procedure, which identified functions within the Mental Health Act Administration service and processes involved to complete these functions. The Mental Health Act Team have administration checklists in place and these are used to ensure that processes are followed correctly.

Since the introduction of the procedure, functions and processes of Mental Health Act Administration are monitored through 'Situation Reports' which take place twice daily over Microsoft Teams with members of the Mental Health Act Administration Team. There has been no highlighted identified issues during the last three months regarding practice as defined in the procedure.

Assurance was sought that future updates and escalations will be brought to this Committee, and it was confirmed that this will be reported as part of the Mental Health Act & Safeguarding Sub-Committee bi-monthly assurance reporting.

2.1.4 Mortality Data and Learning Quarterly Report

The Committee received and discussed the Mortality Data and Learning Quarterly Report. In summary there were 55 deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in Q4. These are in line with quarters not impacted by COVID-19 in previous years. Of the 55 deaths, 9 were inpatient deaths and 6 were nursing home deaths. 5 of the 9 inpatient deaths and all 6 of the nursing homes deaths have been confirmed as due to natural causes. The remaining causes of death, with the exception of 1, are currently under determination. There was one inpatient death which was due to unexpected unnatural causes and this death is subject to a comprehensive Patient Safety Incident Response Framework (PSIRF) investigation.

It was noted that the Patient Safety Incident Response Framework (PSIRF) was helping with case reviews and enabling more immediate feedback of learning.

Assurance was sought that that the Trust is learning from these reviews, and it was confirmed that system improvement plans are being developed, and these can be shared with the Committee and all relevant stakeholders.

Assurance was also sought that Regulation 28 Notices from the Coroner are being embedded, and it was confirmed that ESOG monitor and have oversight of these as well as a position statement on patient safety incidents being presented weekly to the Executive Committee. .

It was agreed that consideration would be given as to future reporting to this Committee in respect of Regulation 28 Notices and Patient Safety Incidents.

2.1.5. Board Assurance Framework

The Committee received the Board Assurance Framework Report and noted that as part of the new project, risk assessments have been undertaken against the new strategic objectives and a new style document has been developed and which was presented to the Board of Directors in January 2022.

The Committee noted there are currently 2 strategic risks and 9 corporate risk open relevant to this Committee and that there has been no significant change to these risks and no new risks added. It was further noted that 1 risk had been closed – Seasonal Flu, as this risk has now become a whole system target.

2.1.6. Patient Story

Following agreement at a previous Quality Committee meeting, a new format for presenting patient stories by video was shown to Committee members.

The video offered a previous patient from the Linden Centre the opportunity to discuss her experience as a patient under the care of EPUT. Overall the patient's experience was positive and commended the support and care received from staff.

Constructive comments on where services could be improved including:

- Continuity of consultant
- Access to Community Pharmacy for patients restricted to seven day supply of medication.

It was agreed that these videos invigorate the patient story agenda and give a greater impact allowing the Trust to learn more about an individual's personal experience and

that additional benefit will be gained by sharing the video wider.

2.1.7. Deep Dive Restrictive Practice Report

The Committee received and discussed the Deep Dive Restrictive Practice Report, which evidenced that there has been an overall increase in all areas of restrictive practice with the exception of prone restraint, which appears to be in line with the national picture supported by NHS Benchmarking data. A number of actions are scheduled for the coming 12 months, which will be subject to monitoring via the Quality Committee.

It was noted that due to the enactment of the Use of Force Act in March 2022, Trust Boards are required to receive an annual report on restrictive practice, and Therapeutic and Safe intervention De-Escalation (TASID) training refresher courses must be undertaken every 12 months to maintain Accreditation of Certified Training along with the TASID Policy being reviewed annually.

2.1.8. Clinical Audit Annual Report

The Committee received and noted the Clinical Audit Annual Report, which confirmed that during 2021/22 the Trust undertook an extensive programme of clinical audit across clinical services.

It was noted that processes are in place to ensure that clinical audit is integral to the Trust's quality improvement and assurance agenda and can inform the Trust's clinical governance requirements in a robust and timely manner.

2.1.9. Reflections on Risks, Issues and Concerns

The Committee identified:

- No risks for escalation to the Corporate Risk Register (CRR) or Board Assurance Framework (BAF) were identified
- Issues to be raised with other standing committees:
  Finance & Performance Committee – Flow & Capacity. Quality Committee would like a summary on what is being undertaken currently so there is no repeat cycle of conversation and to ensure everyone is sighted on progress, impact and projector
- There were no recommendations to the Audit Committee linked to the Internal Audit Programme however it was noted by members that the internal audit programme included some items following previous discussions held at this Committee

Reflections on good practice:

- Improvement in prone restraint
- New approach to the patient story agenda

2.2 <u>COMMITTEE MEETING HELD IN JULY 2022</u>

2.2.1 Combined Sub-Committees Assurance Report

The Committee received assurance reports from the following Sub-Committees:

- Mortality Review Sub-Committee
- Mental Health Act and Safeguarding Sub-Committee
- Health Safety and Security Sub-Committee
- End of Life Group
- Restrictive Practice Group
- Research and Innovation Group
- Learning Oversite Sub-Committee

It was noted that those Sub-Committees who reported are delivering against agreed action plans and schedules of business, positive progress continues in core areas of delivery and corporate teams are focusing their efforts on supporting operational teams with both frontline service delivery and in reducing risk. Sub-Committee agenda risks have also been identified

For those Sub-Committees who did not provide a report, it was noted that the Equality and Inclusion Sub-Committee is due hold their first meeting on 13th July, the Quality Improvement and Innovation Sub-Committee is to be disbanded as this work is now led within the Transformation Team, and the Patient Experience and Carer Sub-Committee has not met since 2021

Committee members identified that as a committed 'patient first organisation', the Patient Experience and Carer Sub-Committee must be re-established as a matter of urgency as it provides a valuable platform for organisational learning and openness. Committee members were assured that plans are in pace to reinstate this group and an update will be provided on progress at the next meeting.

The following noteworthy exceptions from the combined sub-committees report are brought to the attention of the Board:

- Mental Health Act and Safeguarding Sub-Committee:
  Continues to experience pressures to meet investigation timescales because of continuing workforce capacity. The number of referrals remains higher than expected
- End of Life Sub-Committee:
  No issues for escalation, however the sub-committee is to be commended for contributing to shared learning at a national level emphasising the developing learning culture of the Trust
- Mortality Review Sub-Committee:
  Capacity within the Patient Safety Team to meet investigation timescales continues to be a challenge
- Health Safety and Security Committee:
  No issues for escalation
- Restrictive Practice Group:
  Meeting the compliance target for TASID training continues to be challenging, this is related to the workforce capacity issues noted to be impacting on a number of areas of clinical governance

2.2.2 CQC Assurance Report

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

- Section 31 issued for Child and Adolescent Mental Health Services (CAMHS) has been lifted by the CQC. The improvements to service undertaken by the Trust now meet the CQC's recommendations.
- Draft report for the CAMHS inspection was received on the 20th June 2022. Factual accuracy checking has been undertaken and a response sent back to the CQC.
- CQC have undertaken four MHA inspections in May 2022. Recommendations from the visits have been developed into individual ward action plans. Examples of the actions being taken include:
  - Ensure patients feel safe on the ward
  - Ensure patients have enough one to one support time with the nursing staff
  - Continue safer staffing work to address staff vacancies and the use of agency staff
  - Avoid blanket restrictions including access to the garden
  - Ensure robust MHA scrutiny process

- CQC Insight Report has been received and highlighted some areas in performance which, when benchmarked nationally, identify potential workforce concerns:
    - Proportion of Staff Doing Paid Overtime (%) Increased to 33.75% (Worse than National average 26.52%)
    - Proportion staff appraised 78.73% (national average of 84.18%)
    - Recognised and rewarded 6.2 (Much Worse than expected / National average is 6.4)
    - High rates of restrictive interventions Increased to 3.4 (National average is 0.2).
    - Morale 6.3 ("much worse" than expected / National average 6.1)
    - Proportion staff believe the provider is adequately staffed (%) Decreased 32.05% (worse than expected / National average of 30.69%)

Committee members noted the on-going work with the Trust workforce who are experiencing greater pressures following Covid-19, workforce capacity, increased patient acuity and cost of living increases, and it was agreed that consideration would be given to the benefits of a buddy system between well performing clinical areas and those struggling. .

Committee members felt that the Insight Report may not be reflecting the views of all staff which does raise important issues which needs to be continuously monitored and where possible, remedial actions taken to support the Trust workforce.

2.2.3 Update on progress made against the Learning Disability Improvement Standards

The Committee received the update report and noted that progress continues to be made against the implementation of the Learning Disability Improvement Standards. The Trust has established some areas of good practice, including meeting the challenges of improving engagement.

It was also noted that progress has been made to deliver better outcomes for people living with a learning disability. The Chief Allied Health Professional will continue updating the Committee with progress every six months.

2.2.4 Health Safety and Security Annual Report 2021-22

The Committee received the annual report, which gave a comprehensive update on the activity of the Health, Safety and Security Team from 1 April 2021 to 31 March 2022 and provided assurance that there are satisfactory governance arrangements in place for managing health, safety and security across the organisation.

Committee members noted the content of the report and hard work undertaken by the team to deliver the Trust's statutory obligations and protect the well-being of patients and staff.

2.2.5 Mental Health Act Annual Report

The Committee received the annual report which provided an overview of its activities in 2021/22 and the outcomes of its deliberations, and developments and challenges anticipated in 2022/23. The Mental Health Act and Safeguarding Sub-Committee ensures the organisation it is working within the legal requirements of the Mental Health Act.

Committee members noted the work undertaken by the team and thanked them for their efforts. It is of particular note that the team are sharing MHA expertise with acute providers within the Integrated Care System (ICS).

2.2.6 Tendable App

The Committee received an update on Tendable, which is a quality inspection app and platform used in health and care settings, making quality inspections easier and more effective. The Trust has signed a further three-year contract (renewal).

Committee members noted that the app allows audits to be aligned to existing Trust audits, and that results from these audits will be reported into this meeting for assurance on environmental clinical safety.

2.2.7 System Partnership and Engagement Project Scoping

The Committee received the project initiation document for the implementation of the System Partnership and Engagement Project. The project is based on the EPUT and MSE Executive Nurses innovation idea to improve the experience and health outcomes of people living with a mental illness, who use acute and mental health services within the ICS. The project aims to develop a culture of clinical cooperation between EPUT and MSE.

The project will encourage and embed clinical practice that delivers sustainable good mental healthcare in the physical health space and good physical care in the mental health space. Staff will be empowered to work without organisational boundaries, sharing their skills and expertise and share complimentary pathways of care.

It was noted that the project includes a delivery plan and recommendations for monitoring benefit realisation and measures of success and that delivery will be aligned to both trusts transformation programmes.

Members of the Committee agreed the project fits within the wider mental health transformation process and the development of the Integrated Care System and requested that consideration should be given to include patients with lived experience as part of the oversight of the project implementation.

2.2.8 Service User Survey Update

The Committee received a verbal update and it was noted that the survey is currently capturing data as below expectation, and this tool is also being used by the CQC to monitor the Trust's performance. The Director of Patient Experience has offered a challenge to the current survey and advised that other trusts are starting to switch from the survey to measures, which more effectively reveal patient experience.

Committee members discussed the opportunity to look at other organisations to see if any of the methodologies being used could be applied to the Trust.

2.2.9 Ligature Risk Management Annual Report

The Ligature Risk and Management annual report was presented which provided assurance that the Trust is undertaking continuous improvement to systems and processes that reduce risk of harm to patients. The report describes robust risk identification and management, the carrying out of patient safety improvement works and the establishment of a 'risk aware' learning culture.

Committee members noted the development of a ligature risk aware culture within the Trust through training and environmental assessment. Learning from incidents is used as a method of embedding improvements to clinical practice.

Also commendable is the Trust approach to using assistive technology to provide early warning of patient deterioration following a ligature incident and the use of door alarms. These alarms are also a tool for early warning when a potential ligature incident is taking place.

Committee members thanked the team for their hard work and the presentation of a comprehensive review of the previous years' work.

2.2.10 Infection Prevention and Control Annual Report

The Committee received the annual report and noted that the Infection Prevention and Control Team have continued to work through unprecedented demand during 2021/22 due to the continued Covid-19 pandemic.
During the pandemic the IPCT continued core governance and clinical safety functions

It was noted that team met the challenge of the Covid-19 pandemic head on and worked long hours to keep patients and staff as safe as possible. It is evident that the team showed exemplary leadership qualities under the guidance of the Executive Nurse and DIPC, and members thanked the team for all their hard work.

2.2.11 Infection Prevention and Control (IPC) Board Assurance Framework

The IPC Board Assurance Framework Template update was presented and Committee members noted:

- There are no new gaps in provision to report.
- There are no new gaps in provision to report for Estates and Facilities who are undertaking a review of the Environmental Cleaning Policy to align with national standards for cleanliness with IPC support
- There are no gaps in provision within the latest version of the Visitors Policy
- There are no gaps in provision to report with regards to the use of PPE - guidelines were reviewed to align with changes in national guidelines
- The control and command structure stood down during June 2022 to reflect reduced requirement for decision making in relation to Covid 19

2.2.12 Reflections on Risks, Issues and Concerns

The Committee identified:

- No risks for escalation to the CRR or BAF were identified
- No issues to be raised with other standing committees:
- No recommendations to the Audit Committee

Reflections on good practice:

- End of Life Care
- Members thanked Val Evans, Associate Hospital Manager Chair for all her hard work and welcomed Phil Barlow as the new Associate Hospital Manager Chair

3.0 POLICIES

3.1 Policies approved at the June and July meetings:

The following policies were approved by the Committee:

- CP3/CPG3 Adverse Incident Reporting Policy/Procedure
- CPG50D Information Governance Incident Reporting Procedure

- RM08 First Aid Policy
- CP82 Reward and Recognition for Lived Experience Policy and Procedure
- RM02 Fire Safety Policy & Procedure
- RM04 COSHH Policy & Procedure
- CP14 Spiritual and Pastoral Care Policy

3.2 Policy extension requests approved at the June and July meetings:

The Committee received requests to extend the review dates for the following policies:

- CLP1 - Consent to Examination or Treatment Policy
- CLP34 - Missing Persons Policy
- CP14 - Spiritual and Pastoral Care Policy
- CP55 - Data Quality Policy
- CP61 - Paper & Electronic Corporate Records Policy
- CP74 - Passwords Policy
- CP76 - Anti-virus Policy
- CP77 - Firewall Policy
- CP78 - Patch Management Policy
- ICPG1 - Section 7 – Prevention and Management of TB
- ICPG1 - Section 8 – Infestations
- ICPG1 - Section 10 – Pets and Pests
- ICPG1 - Section 11 – Decontamination of Mattresses
- MCP2 - Mental Capacity Act and Deprivation of Liberty Standards Policy
- MHA20 -Section 136 Policy
- RM02 - Fire Safety Policy
- RM12 - Assured Safe Catering Policy
- CP41 – Dress Code Policy
- CLP19 – Research and innovation Policy
- CP21 – ITT purchasing Policy
- CP55 – Data Quality Policy & Procedure
- HR21 – Induction, Mandatory and Essential Training Policy & Procedure

Committee members raised concerns regarding the number of requests to extend policies due for review. It was confirmed that there would no further extensions granted going forward and that there is push back and challenge on every request to extend a policy past its expiry date.

It was noted that there were no risks identified with the extension of the above policies.

4.0 RECOMMENDATIONS / ACTION REQUIRED

The Board of Directors is asked to:

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

Report prepared by:
Matt Rangué, Quality Project Lead

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

		Agenda Item No: 8biv
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	27 July 2022

Report Title:	**People, Equality and Culture Committee**					
Executive/Non-Executive Lead:	Manny Lewis, Chair of the People Equalities and Culture Committee					
Report Author(s):	Denver Greenhalgh Senior Director of Corporate Governance					
Report discussed previously at:	Not previously discussed.					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber-Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	N/A	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	N/A	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report provides the Board of Directors with details that the People Equality and Culture Committee (PECC) is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objectives are being managed effectively.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: 1 Receive and note the contents of the report 2 Accept the Assurance provided

Summary of Key Issues

The People, Equality and Culture Committee (PECC) met on the 21 July 2022, the meeting was quorate by means of delegated membership and the minutes of the meetings held on 19 May 2022 were approved subject to minor amendments on meeting presence.

The Committee received reports on the following:

- **People Plan** – The Committee received an overview of the progress to date across the 9 9 work streams, noting that against the 70 actions across the domains of Belonging to the NHS; Looking after our people; New ways of working; and Growing for the future to be delivered in 2021/22, it was reported that 58 actions had been completed.

  Further to this the Committee received an outline of the People Strategy noting whilst this plan needed to dovetail with the wider corporate strategy to help drive the key priorities for the Trust, there were some key areas which would be relevant to progress now in the area of recruitment & retention; wellbeing & experience; organisational development; and transformation.

  The Committee heard that learning and development would be captured in a separate standalone strategy. And equality, diversity and inclusion would be integral to the whole People Strategy. The committee asked for a 'compact' to be reflected in the new strategy that would set out the good employer 'promises' to our staff and the expectations of our staff.

- **Engagement Champion Review and Relaunch** – The Committee was provided with an update on both the background and the refresh of the Engagement Champions work. The refresh had been underpinned by seeking feedback from the champions which has led to work to confirm their roles, merged the different champion roles under one grouping, and put in place a support package to enable the champions to fulfil their role.

  The Committee heard positive feedback on executive engagement with the champions through the monthly forum and that in the current national quarterly pulse survey our response rate already exceeded previous levels. It was reassuring that staff are being engaged to give feedback.

  The section was concluded with a short video – 'Why I became an engagement champion' highlighting the value of the role within the Trust.

- **Policy Extensions and Approvals -** The Committee approved the extension of the review of the Induction & Mandatory training policy, noting that this delay would not have implications for delivery. It was reassuring that the number of requests for extension is low in month. The committee also approved the Reimbursement of Governor out of pocket expenses policy.

- The Committee received reports on employee relations, the annual MH workforce plan, and a medical workforce update.

The focus for the next Committee meeting is Training and Development. And the non-executive directors have a planned focus group in August to meet a cohort of international recruits to understand their experience of the process and working for EPUT.

The Board is asked to note that there were no significant issues to report from this meeting.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
None

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

		Agenda Item No: 8c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 July 2022**

Report Title:	**Board Safety Oversight Group Report – July 2022**					
Executive/ Non-Executive Lead:	Alison Rose-Quirie, Chair of the Board Safety Oversight Group					
Report Author(s):	Richard James, Director of Transformation					
Report discussed previously at:	Executive Safety Oversight Group Board Safety Oversight Group					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Board of Directors with an update on the progress of projects and programmes linked to the safety priorities within the safety strategy.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The accompanying report provides an update on the following projects and programmes linked to the safety priorities within the safety strategy:

- Ligature Risk Reduction
- EPUT Culture of Learning

- Patient Experience
- Mental Health Urgent Care Department
- International Recruitment

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report Appendix A: Safety First, Safety Always – A Deep Dive Into Leadership

Lead

Alison Rose-Quirie
Non-Executive Director
Chair of the Board Safety Oversight Group

Agenda Item 8c
Board of Directors Part 1
27 July 2022

BOARD SAFETY OVERSIGHT GROUP REPORT JULY 2022

1.0 PURPOSE OF REPORT

This report provides the Board of Directors with an update on the progress of projects and programmes linked to the safety priorities within the safety strategy.

2.0 LIGATURE RISK REDUCTION

Following agreement by the Senior Responsible Officers (SROs) to expand the scope of the project, the Transformation Team have worked with colleagues to establish leads and working groups for the three key areas of focus: Training, Policy & Procedure and Environment.

The Training Working Group has completed a gap analysis of all ligature-related training provided by the Trust and identified an opportunity to reduce duplication and bring training in-house. They are currently working on a proposal for the training content and will share this with clinical, operational and estates colleagues for comment before sharing with the Ligature Risk Reduction Group for approval in August.

The Policy & Procedure Working Group are currently focused on a review of all ligature-related policies, which will be followed up with the creation of a 'policy on a page', aimed at summarising the key elements of a policy on one page, to be displayed in staff areas.

Work continues on establishing robotic process automation (RPA) to synchronise data between DATIX and 3i. This is the first implementation of RPA technology within the Trust and when completed will be a major step forward in ensuring that two of our key systems for risk reporting and estates management are in sync. The Trust have been supported by ESNEFT in this endeavour, with hopes to go live by August.

3.0 EPUT CULTURE OF LEARNING (ECOL)

Following a successful recruitment campaign, the ECOL Learning Lessons Team has now been fully recruited and all individuals have commenced their posts. The team is comprised of a Lessons Communication Business Partner, a Shared Head of Learning/Functional Lessons Analyst, a Learning Lessons Analyst and a Lessons Database Manager, who will support the organisation in transforming the Trust's culture of learning.

Working with the Director of Safety and Patient Safety Specialist, the Transformation Team have reviewed the projects within the ECOL programme and created a proposal for a revised scope, which was presented to the ECOL Steering Group on 6 July, receiving approval on 14 July.

The proposal will see the Learning Lessons Team taking project management ownership of the projects which fall within the 'business as usual' function; Learning Lessons Team Training and Upskilling; Wider Team Training and Upskilling; Information Sharing; Quality and Safety Network Champion; and Learning Governance Structure. The Transformation Team will continue to support the Learning Lessons Documentation and Management project (previously known as ELIMS) and the Patient Safety Incident Review Framework

(PSIRF) Process Review project, working alongside the Patient Safety Incident Management Team to deliver the latter.

Discussions continue with Trust Marque to build the PowerBI Safety Dashboard which will combine multiple data sources into one dashboard, allowing better insights into staff and patient safety. The Digital PMO will continue to support this project in line with the work they are currently undertaking on the wider Trust reporting.

4.0 PATIENT EXPERIENCE

The Patient Experience and Culture of Learning teams have been working together to scope the role of the Patient Safety Partner (PSP). A working group has been setup with the four newly recruited PSPs, the Lead Safety Specialist and the Patient Experience team, to drive forward how this role looks and works.

The uptake of the I Want Great Care (IWGC) feedback tool remains low across services (currently only 9% of services are using this). A meeting is scheduled to take place with senior leaders to work together to agree the approach to promote and amplify the message. Additionally, it has been suggested that technology be available on the wards to increase the response rate as part of the discharge process.

Two new safety specific questions are to be included in the Friends and Family Test. These will act as a lever to increase adoption rate of IWGC across our services and these questions will be going live in the coming months.

5.0 MENTAL HEALTH URGENT CARE DEPARTMENT

The Mental Health Urgent Care Department project will deliver a specifically designed and built department at the Basildon MHAU site to support the increasing System and local A&E demand and pressures.

This extension of the ‘Core 24’ model, will build on EPUT’s existing urgent care pathway and enhance the urgent care provision as well as providing a self-referral “front door” to mental health services. This will act as an additional gatekeeping step for and subsequent reduction of MHAU and inpatient admissions.

Similar services in the UK, Camden, Islington and Leicester NHS Trusts, have seen a diversion of up to 60% of patients attending local A&E’s alongside numerous other benefits such as improved patient experience, a significant reduction in patient admissions and a reduction patient in wait time. We have consulted with colleagues both within our Trust and the wider systems to learn and build from their experiences of Camden, Islington and Leicester NHS Trusts.

The Mental Health Urgent Care team will triage and assess patients in one of five assessment rooms using a multidisciplinary team approach which includes a consultant, nurses, social care and support staff.

Lived experience workshops have begun to ensure patient input into shaping the service, estates planning work is progressing, and initial plans have been signed off alongside a review and costing of initial staff and service model.

There are Urgent and Emergency Care capital monies available to support a significant amount of the estate’s costs, and a bid submission to NHSE to align this will be submitted. Additional costs to EPUT and the System are being detailed within the business case along with other financial avenues of support.

This project is System led and key stakeholders from MSE, EPUT and the Ambulance service, alongside various commissioners are participating in discussions to drive and shape the project to become a national model of mental health crisis care supported by the core 24 services.

6.0 INTERNATIONAL RECRUITMENT

Our International recruitment of Nurses project continues to progress at pace. We successfully on-boarded a further 43 nurses, 25 at the end of June and a further 18 week commencing 11 July.

All of the first cohort of international nurses who arrived in December 2021 have now successfully passed their Objective Structured Clinical Examination (OSCE) and are working on our wards as Staff Nurses.

To ensure we are set up for success to deliver the best possible experience for our international nurses and following good project practice, we have recently completed a review of the current status of the project and our readiness for future cohorts. As a result, we made the decision to temporarily pause arrivals of international nurses until the autumn. This allowed us to successfully on-board our June/July cohorts, and successfully plan future cohorts. We remain on track to on board 195 nurses by the end of December 2022.

7.0 SAFETY STRATEGY UPDATE (SEE APPENDIX A)

Work is underway to review our progress, provide further assurance that the initiatives proposed in the “Safety First, Safety Always” strategy are all being fully addressed and show our achievements to date.

The strategy is split into seven priorities: leadership, culture, continuous learning, wellbeing, innovation, enhancing environments, and governance and information. A mapping exercise of all initiatives contained in the Safety Strategy and the progress/status has been completed alongside the identification of other initiatives linked to our safety agenda. This was presented to the BSOG on the 21 June 2022.

Report produced by:

Richard James
Director of Transformation

On behalf of:
Alison Rose Quirie
Non Executive Director
Chair of the Board Safety Oversight Group

NHS
Essex Partnership University
NHS Foundation Trust

SAFETY FIRST, SAFETY ALWAYS

A DEEP DIVE INTO LEADERSHIP

EPUT

CONTENTS.

01

OUR APPROACH

We are reviewing the progress against our Safety Strategy to ensure that all planned initiatives have been addressed.

The Safety Strategy is split into seven priorities, so we have approached this by planning a deep dive into each of these over the next 7 months.

The deep dives will focus on the commitments that were made in the Safety Strategy. In addition, we will identify other initiatives both delivered and in progress which contribute to our safety improvement work.

This pack will include examples of the achievements and ongoing work focussed on our leadership priority.

SAFETY PRIORITIES

- LEADERSHIP
- CULTURE
- CONTINUOUS LEARNING
- WELLBEING
- INNOVATION
- ENHANCING ENVIRONMENTS
- GOVERNANCE AND INFORMATION

EPUT

02

HIGHLIGHT ACHEIVMENTS

WE CARE.
WE LEARN.
WE EMPOWER.

TARGET OPERATING MODEL

Objective

The core objective is to drive a transition towards distributed leadership and create the conditions required to become the leading health and wellbeing service. We will provide dedicated leadership for our inpatient adult mental health and emergency care services while integrating leadership for community, physical and mental health services.

The care units will be made up of multi-disciplinary teams for clinical operational services, empowered to make local decisions with the support of the dedicated business units: People and Culture, Finance and Information.

Progress

The care units are in place. All of the operational roles have been appointed. The "medical" and "quality and safety" director roles are currently being filled with two appointed so far.

Corporate alignment is currently underway to better integrate the dedicated business units with the care units.

INTERNATIONAL RECRUITMENT

10 Nurses who arrived in 2021 have now passed their OSCE exam and are fulfilling substantive roles on our wards as Staff Nurses.

A further 73 nurses have arrived in the UK this year and are currently completing their training in preparation to take their OSCE exams.

We remain on track to have recruited 195 nurses by the end of December 2022.

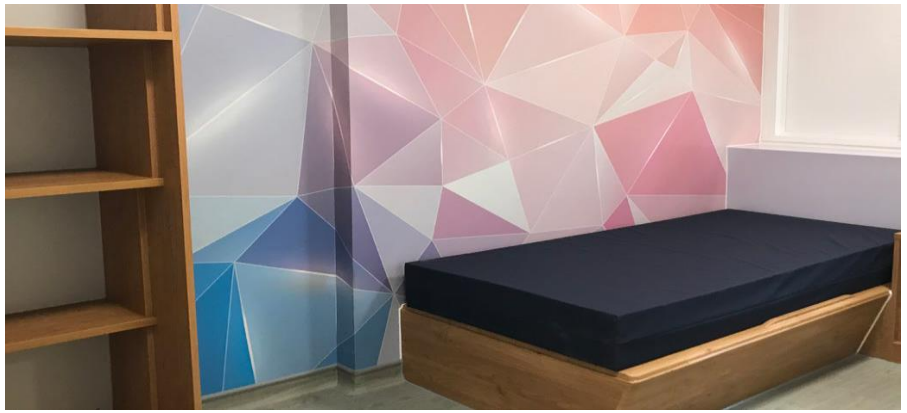
ENHANCING ENVIRONMENTS

Our patients are telling us how much of a difference the new ward environments are making.

"I feel so much safer already knowing I have my own room. Not having to share with other people will make such a difference to me and my recovery"

"This is the best ward I have been to; it is like a hotel. I would be happy to pay for my stay here. The ward environment is therapeutic"

"This will make such a difference. Previously I shared with someone who liked the light on and it meant I couldn't sleep properly."



LEADERSHIP THROUGHOUT THE PANDEMIC

SAFETY FIRST,

SAFETY ALWAYS

The Safety Strategy was formed during the COVID-19 pandemic.

Our compassionate leadership focussed on meeting the core needs of staff, ensuring their wellbeing and sustained motivation to help them deal with the rapidly changing crisis.

Some of the initiatives EPUT implemented:

- Gold, Silver and Bronze Command
- CEO Live Brief
- Schwartz rounds
- Wellbeing Sessions
- Managing Anxiety
- Here for You
- Long COVID Support
- Vaccination Outreach and Support

EPUT

03

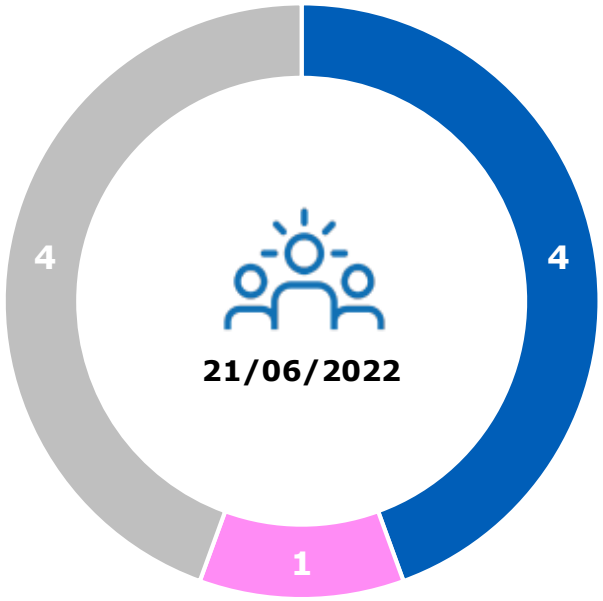
LEADERSHIP OVERVIEW

WE CARE.
WE LEARN.
WE EMPOWER.

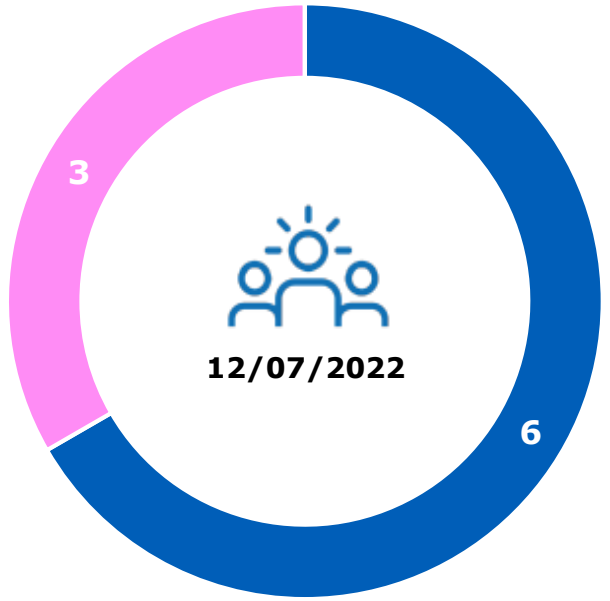
OVERVIEW OF LEADERSHIP

WHAT HAVE WE LEARNT FROM THE DEEP DIVE?

INITIAL ANALYSIS



AFTER DEEP DIVE



KEY

Complete

In progress

Unknown or not started

EPUT

04

STATUS UPDATES

ACCOUNTABILITY FRAMEWORK

COMPLETE
JANUARY 2021 – JANUARY 2022

Objective

The Accountability Framework intended to introduce integrated oversight of EPUT's delivery. Allowing us to centrally monitor 5 domains for the purposes of decision making:

- Quality and safety
- Performance
- Workforce and culture
- Finance
- External relations

A key principle of the accountability framework is ensuring decisions can be made as locally as possible. This is achieved by making the most relevant information available to the appropriate individuals.

Progress

Since September 2021, Monthly Accountability Framework Meetings have been held with the leadership of each Care Unit and the Executive Team.

This gives each Care Unit an opportunity to work through risks and issues with Executive support. Through this approach, we have been able to respond more quickly to emerging risks using this faster escalation pathway and more informed decision making.

Future Enhancements

Additional work is planned to further embed the Accountability Framework including:

- Enhanced attendance for the monthly meetings
- Further refinement of the KPIs used
- Development of Trust performance reporting

ORGANISATIONAL DEVELOPMENT FRAMEWORK

IN PROGRESS NOVEMBER 2020 – PRESENT

Objective

A need was identified for a new framework that would set out the direction for the organisation.

As part of this framework, there will be a push towards alignment with the Care Units.

Marcus Riddell was appointed as the Senior Director of Organisational Development in May 2022.

Progress

A high level brief of objectives for this framework is being formed and is to be agreed upon at the end of July, broadly covering the following areas:

- Culture – focus on civility and respect, and ensuring accountability around behaviour
- Strategic organisational development – including workforce specific commitments on the back of organisations new strategy
- Organisational design – how People and Culture is set up to help EPUT achieve overarching ambitions
- Review and refresh of leadership development – evaluation of L&D offer, including potential reconfiguration of leadership programmes
- Resource requirements – identifying what skills need to be brought into organisation to support aforementioned work

WORKFORCE FRAMEWORK

IN PROGRESS NOVEMBER 2020 – PRESENT

Objective

The Workforce Framework intends to deliver in four areas as documented in the NHS People Plan:

- Ensuring staff are safe and healthy
- Exploring new ways of working and care delivery
- Pushing for inclusivity, compassionate leadership and empowerment of staff
- Driving growth through recruitment and retention

Progress

The current Workforce Framework has expired and is awaiting the overarching Trust strategy refresh before redevelopment.

Whilst this is in progress, EPUT is following the National NHS People Plan to ensure that momentum on this work isn't lost. This produced 70 actions for 2021 - 2022 with 57 of these already complete.

People and Culture is also taking this opportunity to restructure with appointments being made into HR Development roles which will be aligned with the Care Units.

PSIRF EARLY ADOPTION

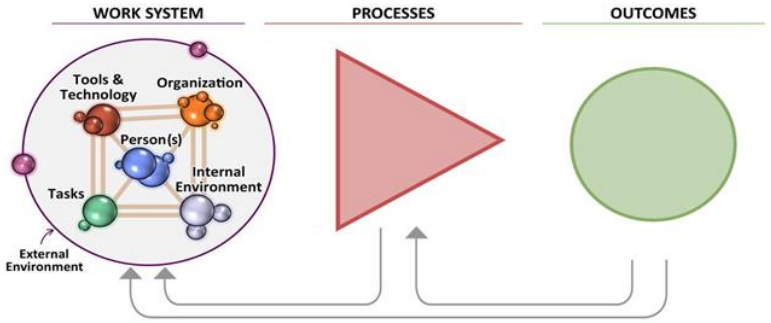
COMPLETE MARCH 2020 – MAY 2021

Objective

EPUT participated in the early adoption of the Patient Safety Incident Response Framework (PSIRF).

PSIRF replaces the Serious Incident (SI) Framework 2015 and was developed as a result of the 2018 engagement programme.

It intends to reduce the likelihood of similar incidents recurring compared to SI Framework.



PSIRF acknowledges that outcomes are most impacted by processes and systems, the investigation therefore focuses on these areas.

Progress

PSIRF was implemented and early adopter status was achieved in May 2021. EPUT is currently supporting other NHS Trusts with their adoption of PSIRF.

We have received positive feedback from NHS England and Improvement. In a case where the coroner reviewed a report developed by us using PSIRF it was described as "exemplary".

Family and carers have also reflected positively on the new process in comparison to the SI Framework.

Future Enhancements

The PSIRF process will be further evaluated as part of ECOL to ensure that its been implemented as robustly as possible and to ensure issues from the SI Framework have been mitigated.

APPOINTMENT OF SENIOR SAFETY SPECIALIST

COMPLETE

OCTOBER 2020 – MAY 2021

Objective

As part of the NHS Patient Safety Strategy, Patient Safety Specialists were made a requirement for all NHS organisations.

Patient Safety Specialists are asked to prioritise the local implementation of national priorities documented in the NHS safety strategy including Just Culture, PSIRF and improving the quality of incident reporting.

Progress

Moriam Adekunle was appointed as Director of Patient Safety and Patient Safety Specialist.

Moriam is an Advanced Nurse Practitioner and Florence Nightingale Scholar, with over 25 years of experience working in different specialisms within community, learning disability and mental health services.

The Director of Patient safety has been heavily involved in implementing the national priorities. ECOL has become the overarching programme to address incident reporting, just culture and improved incident reporting and lessons learning.

QUALITY IMPROVEMENT

IN PROGRESS

FEBRUARY 2021 – PRESENT

DIAGNOSTIC WORK

From February to May 2021, Newton performed diagnostic work for EPUT to understand where we should be focussing our improvement efforts.

They walked in the shoes of our clinicians and our employees within inpatient services and committed to providing feedback to all involved.

They split the organisation into three key areas that affected quality and patient care: Patient Pathways, Safety and Staffing.

The output of their work was recommendations for improvement in each of the key areas. With a key recommendation being the implementation of a trust-wide continuous improvement cycle.

NEWTON

TIME TO CARE

Following the diagnostic work with Newton, we initiated an invitation to tender to find an appropriate consultancy to build on this work and continue our quality improvement efforts. This resulted in Deloitte being appointed.

Deloitte is providing a team with significant experience in the health and social sector, including individuals with specific mental health, nursing, process improvement and digital expertise.

The work is planned to start in July 2022 and finish in June 2023.

Deloitte.

SAFETY WALKROUNDS AND HUDDLES

COMPLETE IN CONTINUOUS IMPROVEMENT

Objective

Safety WalkRounds were proposed as a new system for ensuring safety, aligned with the Safety Strategy and Just Culture. A core principle of this approach is recognising safety as a constant topic rather than something to be addressed by one-off audits.

Safety Huddles are an opportunity for the ward staff to come together locally and raise safety concerns and consider potential mitigations.

Progress

Non Executive Directors conduct safety WalkRounds using the 15 step model.

Matrons have developed a spreadsheet for this but it isn't fully aligned with the Safety WalkRound model.

This initiative has been limited by the pandemic but WalkRounds and Huddles continued to be held virtually throughout the entire period.

Future Enhancements

Further work is required to ensure that all Safety WalkRounds are conducted in line with the 15 step model.

To introduce further structure to Safety WalkRounds and Huddles with increased involvement from patient safety partners.

EXISTING INITATIVES

LEADERSHIP DEVELOPMENT PATHWAYS

The Leadership Development Pathways were identified as an existing initiative in the Safety Strategy.

Developing our managers into effective leaders is essential in ensuring safety for our patients and staff.

Nicky Reeves is currently the Acting Head of Organisational Development.

EPUT has produced a sizeable portfolio of leadership development pathways for middle managers and junior staff.

Future Enhancements

EPUT are investigating potential improvement pathways designed for the most senior leaders.

CHIEF EXECUTIVE LIVE SESSIONS

The CEO live sessions were held fortnightly throughout the pandemic with the Executives Direct reports. They provide an opportunity for all of the Executives collectively to meet with SMEs and focus on safety topics.

These meetings have strong backing from the Exec and when required have been as often as twice a week.

These sessions are an invaluable tool in ensuring that our services remain available and safe throughout the COVID-19 Pandemic.

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Agenda Item No: 10a

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	27 July 2022

Report Title:	**Transformation Update Report**					
Executive/ Non-Executive Lead:	Alex Green, Executive Chief Operating Officer Dr Milind Karale, Executive Medical Director					
Report Author(s):	Mark Travella, Associate Director Service Improvement and Business Development					
Report discussed previously at:	Service Directors and operational leads/Transformation Project Managers as required					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	Workforce remains the biggest challenge to delivery of transformational change. There is a national shortage of all clinical professional groups. This is mitigated by national and international recruitment campaigns, working alongside VCSE organisations as colleagues, apprentiships and development and support for peer support workers and unqualified staff.	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	Yes. The transformation programme seeks to use local system resources more effectively and more efficiently.	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report provides the Board of Directors with an update on the transformation programmes and projects progress across mental health and community services of Essex.	**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

- Mental health and community services transformation has progressed at pace over the last two years despite the restrictions with covid-19 and associated staffing challenges.
- EPUT clinical services took the approach that they would be needed more than ever because of covid-19 and services adapted and continued to develop despite it. For example the Mental Health 24/7 111 crisis services were launched in April 2020 and have continued to develop ever since when many areas of the UK paused their plans. Similarly, older people's community MH services and the Out of Hospital transformation plans adapted but did not stop.
- Local people have continued to receive a high quality service, and are beginning to experience even safer and more responsive services as transformational capability is improved.
- EPUT as a major local partnership provider of health and social care services is providing leadership in the integration of care pathways.
- New operational capability through transformed services as local system integrated care pathways is beginning to realise benefits including;
    - Faster access to services
    - Less duplication and less gaps and therefore less exclusion in service provision
    - Better quality
    - Safer services
    - Improved customer satisfaction.
    - Essex is delivering many exemplar services and informing the rest of the UK on good practice examples and supporting other regional and national systems to improve.
    - Some transformed services are beginning to deliver best in UK examples of high quality services and learning is being shared and spread to ensure there is consistency for all the people of Essex.
- This report summarises many of these examples.

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

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

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

Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**NO**	**If YES, EIA Score**	N/A

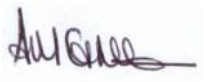
Acronyms/Terms Used in the Report			
EEAST	East of England Ambulance Service NHS Trust	PD&CN	Personality Disorder and Complex Need
ICB	Integrated Care Board		
EUPD	Emotionally Unstable Personality disorder		

Supporting Reports/ Appendices /or further reading

Main Report
Appendix 1: Mid and South Essex Mental Health Crisis Support – Crisis Alternatives

Lead

Alex Green
Executive Chief Operating Officer



Dr Milind Karale
Executive Medical Director

Agenda Item: 10a
Board of Directors Part 1
27 July 2022

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

TRANSFORMATION UPDATE REPORT JULY 2022

1.0 PURPOSE OF THE REPORT

This report provides the Board of Directors with an update on the transformation programmes and projects progress across mental health and community services of Essex.

2.0 EXECUTIVE SUMMARY

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

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

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

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

- The NHS Long Term Plan that set the ambition for 'new and integrated models of primary and community care' for both mental health and community health services.
- The Community Mental Health Framework that set out a vision to provide 'place based community mental health delivered at PCN level and also announced 12 Early Implementer Sites, West Essex being one of them.
- The Aging Well programme with the aim to develop patient centred services that enable people to age well.
- Essex Local Alliance Strategy that seeks to bring local organisations together to better use their resources to deliver evidence based high quality care.

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

3.0 MENTAL HEALTH SERVICES ACROSS ESSEX

Essex has three Integrated Care Boards (ICBs) formed from 7 Clinical Care Groups (CCGs), three local authorities and a large number of Voluntary, Community & Social Enterprise (VCSE) organisations trying to align their strategic aims to review and redesign clinical services together. Around 300 EPUT mental health posts have been recruited to in the last year to deliver these transformed services, itself an enormous task for busy operational colleagues and the support services that work along-side them. Local systems have employed many more staff.

Transformational work is broadly organised against an Essex programme portfolio of work comprising three main programmes delivered though a number of projects. These programmes are;

1. **Urgent and Emergency Care Programme;**
    - Crisis Resolution Services (24/7 – 111/2) development
    - Home Treatment Team development
    - Emergency Department Mental Health Liaison Service development
    - Pilot of a new VCSE & EPUT collaboration that has opened a Mid and South Essex Mental health Crisis House April 2022 with an evaluation in Q4 to inform the future potential of this model in MSE and possibly other parts of Essex
    - Pilot of a new Essex Mental Health Diversion Team at Basildon Hospital with a view to a full service for Essex in Q4 2023
    - VCSE provided Sanctuaries (5 across Essex) that link in with and are supported with EPUT Urgent & Emergency Care pathways
    - Street Triage Services and their links with Police, Ambulance, and Essex Urgent & Emergency Care services
    - A new Functional Intensive Response and Support Team (FIRST) which had a soft launch in April in the South West of Essex. Roll out across Mid & South Essex will take place later this year and into next year.
    - A new VCSE/EPUT collaboration to introduce an Admission Prevention and Early Discharge (APED) service. This service integrates a VCSE and peer support workforce into EPUT Mental Health teams and connects up care pathways ensuring that where additional support is required to achieve early discharge or more support is required to prevent admission this workforce can be called upon to help. Case study 4 in appendix 1 demonstrates how APED alongside other local services are connecting up care pathways to manage need.

    Highlights for noting

    - The Mid & South Essex Mental Crisis House pilot, also known as Sanctuary Plus, is live and has so far been a success. This service is an extension of the Sanctuaries that provide both telephone support and referred drop-ins to people in crisis. EPUT services such as the Commissioner Requested Services (CRS), Home Treatment Team (HTTs) and Eating Disorder Mental Health Liaison (ED MH) can refer to these services. These services together are taking pressure off the wards, ED and providing high quality and effective support and care for local people in crisis. Appendix 1 contains some case studies of both the sanctuaries and sanctuary plus (crisis house).
    - The Mental Health Emergency Department Diversion project will set up a new service at Basildon Mental Health unit to support the system and local A&E pressures. This extension of the 'Core 24' model, will build on EPUT's existing urgent care pathway and enhance the urgent care provision as well as providing a self-referral "front door" to mental health services which will act as an additional gatekeeping step for assessment unit and inpatient admissions. Patients attending the mental health Urgent Care Department will be triaged and assessed in one of the 5 assessment rooms by a multidisciplinary team which will include a consultant, nurses, social care staff and support staff. Lived experience workshops have begun to ensure these support shaping the service, estates planning work is progressing well and initial plans have been signed off and the initial staffing and service model are being reviewed and costed and will be submitted imminently in the business case. Similar services in the UK have seen a diversion of up to 60% of patients attending local A&E's alongside numerous other benefits such as improved patient experience, a significant reduction in patient admissions and a reduction patient in wait time. This is planned for January 2023.
    - The FIRST team is gatekeeping all functional older people admissions, providing support to other services and is already preventing admissions and Mid & South Essex now have created bed vacancies since launch. This service is a flagship

service that links in with the frailty virtual wards and achieves parity of Mental Health and Physical health care delivery.

2. **Integrated Primary and Community Care (IPCC) Mental Health Transformation.**
   - A new Primary Care Nurse (PCN) facing integrated primary and community Mental Health care model is being implemented. This brings together local mental health, social care and VSCE staff and the organisations they represent as one, to deliver timely integrated needs led care. Across Essex most PCNs now have a Mental Health presence, while many have introduced integrated team working.
   - A programme of work to transform community mental health teams into a multi provider pathway that brings local systems together to meet the complex needs of local people and also introduces a new care plan to provide collaborative care planning, shared decision making to empower services users and carers, objective outcome measures, service user networks, and peer support workers. These services will replace the Care Programme Approach in 2023.
     West Essex continues its transformation as an early implementer site and is advanced in its work to transform the secondary care model into a comprehensive place based mental health service seamlessly linking to its PCNs. In particular it is focussing on;
     - Community Pharmacy
     - 18-25 pathways
     - Personality Disorder
     - Eating Disorders community model.
   - A sustainable offer for psychological services for people with Severe Mental Illness. This provides an additional layer of integrated (multi organisational) staff providing a range of therapies to address long waiting lists and bridge the gap between primary and secondary care.
   - At Risk Mental State (ARMS) and Early Intervention in Psychosis services development. This includes stricter maximum waiting times of two weeks. These services are developing against national standards and greatly improve the outcomes for people with a serious mental illness.
   - Health Checks for people with serious mental health problems. This supports PCN targets of achieving 60% of people on an SMI register having a physical health check. Essex has some of the UKs highest rates of achievement.
   - Perinatal Service development across Essex continues at pace with Essex having one of the most developed perinatal mental health services in the UK. Recruitment has been excellent, and access has increased. The service is on track to achieve and surpass the national performance 2022/23 targets.
   - A personality disorders steering group oversees the development of an integrated personality disorders service. This reflects three business cases and a more recent major piece of work with in-patient services to improve the care pathway for people with personality disorder.
   - The EPUT Executive Team have just approved the establishment of eight new permanent Multidisciplinary Approved/Responsible Clinician roles at EPUT. This is part of a national programme of non-medical clinician development and retention. The Multidisciplinary Approved Clinician (AC) / Responsible Clinician (RC) Trainees will need to complete training in 18 months. Each trainee will be allocated a Consultant Psychiatrist Mentor. They will also be provided with Structured Clinical Management training, and clinical supervision training. They will receive intensive professional supervision in both areas.
     Once approved by panel they will then become Multidisciplinary AC/RC Consultants, focusing 40% of their job role on cases relevant to Mental Health Act and work and 60% of their time as senior responsible clinicians within the Complex Needs pathway. This will maintain oversight of our most complex Emotionally Unstable Personality Disorder (EUPD) and Complex Needs patients, with a focus on safe transitioning out of in-patient services into the community. They will be aligned to community and in-patient services in each locality area,

and supported within the Personality Disorder (PD) & Complex Needs (CN) Transitioning Team.

- A pioneering MSE Neuromodulation service that is providing treatment alternatives to people with treatment resistant depression.
- North East Essex older people's transformation is ongoing as a complex piece of work that incorporates the re-provision plans of Clacton Hospital. A local system steering group has been set up to oversee this work and its relationship with other clinical services as part of the north east Essex health and wellbeing alliance.

Highlights for noting

- Thurrock has completed the PCN facing Mental Health integrated team implementation with psychiatrists joining the team in June. Waiting lists for psychological services are falling, access to Mental Health services has significantly improved against the national 28 target aiming to achieve less than a week, with same day to three day assessments now common place. This model will roll out across Essex. A video link describing the change process and impact is here: https://f.io/IyIVXgXu
- North East Essex are developing a new Mental Health maternity service and commencing a review redesign and implementation phase.
- Essex is exploring the development of an electronic Patient Rated Outcome Measure (PROM) called the Recovering Quality of Life Questionnaire. The EPUT Information Management & Technology (IM&T) team are working with Sheffield University and NHS England to develop what to date has been a paper format that is copied into patient records. If successful EPUT will see the first national electronic use of this (we think any) outcome measure that can be sent to service user devices, completed and returned into the patient record creating clinical dashboards and information to inform care planning and measuring improvement.

3. **Essex Accommodation Steering Group**
   This steering group comprises a number of projects to understand and improve accommodation related issues for Essex ranging from in-patient beds to independent housing. The projects include;
   - 3 x Essex projects to review and procure a new range of Mental Health Supported Accommodation
   - Dormitories restructure/Review of inpatient bed-base
   - Complex Psychosis Task & Finish group/Locked rehab
   - 439 Ipswich Road Rehabilitation service review
   - Discharge to Assess beds
   - MSE Crisis House
   - Host Families
   - Step Down Beds

4.0 SOUTH EAST ESSEX COMMUNITY HEALTH SERVICES (SEECHS) TRANSFORMATION

A new South East Essex joint Director is in post, which covers both Mental Health community services and Community Health services. This will support whole systems strategy, planning and maximising the opportunities for integration of physical health and mental health services. There are a number of major transformation workstreams in south-east Essex community services. These include;

- Considerable work and support to develop the Mid and South Essex Community (Provider) Collaborative has taken place over the last year. The collaborative sees the coming together of the Mid and South Essex community providers (EPUT, NELFT and PROVIDE CIC), to work together to plan, deliver and transform services. By working together effectively at scale, the collaborative is providing opportunities to tackle unwarranted variation, make improvements and deliver the best care for patients and communities across Mid and South Essex. An example is the Urgent

Community Response Team (UCRT) and EPUT hosted Mid and South Essex Single Point of Access: - Accelerated by pandemic and a key NHS Long Term Plan priority, the senior team at SEECHS have directed and overseen the development of a standardised UCRT (2 hour community response) across the collaborative.

- Community Coordination Centre (Admission Avoidance and Discharge to Assess): SEECHS streamlined its (patient and professional) urgent access and improved overall care coordination through the development of its Community Coordination centre (CCC) operational since Dec 2020. The new CCC benefits from improved call handling and telephony functioning and triage including UCRT, unplanned nursing and intermediate care (supporting acute discharge)
- Community Beds (intermediate Care and Stroke): The Mid and South Essex Community Collaborative (MSE CC) is overseeing a consultation process that will determine the future Mid and South Essex community bed configuration for both Intermediate care and stroke beds.
- Children's' Services Expansion (The Lighthouse): On 1st March 2022, EPUT took on a new Children's' contract, and expansion to its offer for children and families in SEE, when the 'Lighthouse' (Children's neuro-development assessment and treatment service) transferred from MSE FT. This is an exciting opportunity to create a comprehensive integrated consultant-led children's community services in the SEE place.
- Focus on 'Frailty' (including Virtual Wards): SEECHS is developing a comprehensive community offer for frailty in SEE. The offer includes a Frailty Care Coordination Centre and development of a MSE Frailty Register
- Frailty Virtual Ward – Under development as a 2022/23 Operational Plan priority. Successful implementation will be reliant on business case and investment being developed across MSE.
- Primary Care Networks (supporting Virtual Surgeries): SEECHS is working alongside emerging PCNs to integrate our services into their population-health focused 'virtual surgeries'. Two PCNs are fully operational – Benfleet PCN and SS9 PCN. Excellent integrated working between EPUT Community Nurses and PCN Nurses with Social Care and Mental Health to jointly manage complex patients at neighbourhood level to prevent further deterioration.
- Community Nursing: SEECHS is fully engaged in this Community Collaborative priority work stream with overall aim to deliver equitable standardised offer across MSE. Comprehensive audit and benchmarking exercises completed which has informed the development of the first national safer staffing tool for community nursing.
- Aligned to this work stream is the development of exciting innovations, in both catheter care and wound care, which have been piloted and tested, by community nursing and wound care teams in South East Essex.
- Work underway to review South East Essex Community Nursing Service to be fit for the future. Multi-agency workshops planned to develop plans around workforce, operational practice, digital technology and finance. This will feed into the Community Collaborative Community Nursing Programme.
- Palliative Care Services: The SEECHS Community and Palliative Care service offer is unique in its coverage and outcomes. We have developed a team of nurse specialists aligned to PCNs with strong integration with acute palliative care consultants. The service also host an End of Life register for South East Essex, which sees comprehensive reporting on patient outcomes in the provision of end of life care. The model is being adopted across the Mid and South Essex Integrated Care System.
- Respiratory Care: Given the significant focus on respiratory care linked to pandemic and subsequent impact on acute our dedicated respiratory team SEECHS is undergoing comprehensive transformation. We have created a single Respiratory team that provides a range of elements including; Respiratory Virtual Wards (supporting admission avoidance and rapid discharge), delivery of timely Spirometry Assessments with greater choice of local venues including Clinicabin (this is a mobile

unit, at Rochford, to be used for Oxygen service for Spirometry for patients with COPD), training staff all staff to complete Association for Respiratory Technology & Physiology (ARTP) accreditation, enhanced case management of patients with complex Chronic Obstructive Pulmonary Disease (COPD) and the delivery of Community Respiratory Diagnostic Hubs.

5.0 WEST ESSEX COMMUNITY HEALTH SERVICES (WECHS) TRANSFORMATION

There are a number of major transformation workstream related to the Out of Hospital Strategy in west Essex community services. These include;

- Care Coordination Centre (CCC) – Phase 2: - Initiate Interim Operating Model commenced 1st May 2022 with a focus on
    - Implementation of a full pilot to test the proof of concept for both discharge and community pathway processes.
    - Scoping of digital and technology solutions with a focus on three main priority areas: system wide patient journey tracker that supports patient flow, implementation of single electronic referrals in preparation for further interoperability and implementation of a capacity dashboard which will enable forecasting of community health and care capacity provision to inform anticipatory decision making.
    - Embedding system assurance and resilience functions within the CCC to allow a standardised collection of system data enabling comparison across and outside of the system, a single system-wide view of performance and pressure, current, retrospective and forward view, early identification and resolution of system issues, integrated leadership of system responses.
    - Collaboration with East of England Ambulance Services (EEAST) to directly access category 3 and 4 999 ambulance calls in order to deploy appropriate community responses to support the prevention of unnecessary ambulance conveyances and prevention of admission.
    - Review of the current SPA workforce roles and responsibilities in order to meet the CCC Interim Operational Model workforce structure and modelling.
    - Development of community pathways alongside the digital team and mapping these against discharge pathways to identify gaps.
    - Specification of future Business Intelligence requirement for the CCC to meet its information sharing vision for frequent users and patient trends / pressures / demands to inform commissioners and Planning Ahead for Care and Treatment (PACTs)
    - Production of a Business Plan to progress to phase 3, for the full implementation of the Interim Operating Model
- Under development as a 2022/23 Operational Plan priority. West Essex ICB has committed to developing a fully integrated virtual hospital with the ambition of providing health and care based on individual adults needs by delivering admission avoidance and early discharge to adults that are supported in their own home. Detailed plans and finance template based on ambition, national requirements and creation of additional virtual capacity have been submitted via HWE ICS to NHSE, awaiting feedback. Successful implementation will be reliant on business case and investment being developed across HWE.
- Successful two week pilot taking suitable patients directly from the EEAST stack, via CCC giving referral to most appropriate team for an urgent visit. This stopped an ambulance being despatched, patients not attending ED and a better all-round experience for the patient. This is a soft launch of the Haris/cleric project which is a national must do by September.
- Development and implementation of An Electronic Palliative Care Co-ordination System (EPaCCS) which forms a register of those identified as end of life.

- Catheter Clinics have resumed in West Essex and we are working towards undertaking Trial without Catheters (TWOC) in the community Clinics. This will greatly improve the patient pathway and experience.
- West Essex Community services are preparing to launch the wound assessment app this enables image capturing and semi-automatic in-app measurements via a smartphone camera. The system aims to scan wounds with a dedicated app, the images are then normalised and shared on a secure digital portal which can be viewed by tissue viability nurses, district nurses and GPs ensuring timely and appropriate wound care for our patients

6.0 RISKS

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

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

7.0 SUMMARY

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

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

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

8.0 RECOMMENDATIONS / ACTION REQUIRED

The Board of Directors is asked to:

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

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

On behalf of;
Alex Green
Executive Chief Operating Officer

Dr Milind Karale
Executive Medical Director

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Mid and South Essex Mental Health Crisis Support

Crisis Alternatives

‘In my own words’
An evening in the South West MH Crisis Sanctuary and MH Crisis House – Sanctuary Plus

MH Crisis Sanctuary

www.midandsouthessex.ics.nhs.uk

Sanctuary Case Study 1

I took an Initial call whilst on duty for a male service user who had been in a domestic abuse relationship which he had left the year before and had moved in with a family member. He had concerns regarding his children and felt like he was not being listened to. On this night he had driven to take the children home after a weekend visit with them, when he arrived his children became upset and did not want him to take them home. This made his ex-wife agitated and she allegedly attacked the children once in the house; the children then left the property, and he took them in his car and returned to where he was living to get the children into a place of safety from there, he called the police and then began to panic.

I took the crisis call; he was upset and very distressed, frightened of his ex-partner and what may happen to him for taking the children. I spent a long time with him on the phone. We talked things through, we regulated his emotions, supported him and gained his trust. From there a safeguarding was put into place, a social worker was allocated, we helped him to arrange the court order for court, we helped with the housing situation as him and his 4 children were all sleeping on a family member's floor. We put him in touch with men's domestic abuse services to open some doors to help find support from other victims, we referred his eldest to EWMHS for counselling and support.

He was referred over to our Community Link Worker who interacted with him helping to find other services within his community for single fathers and form filling services for housing and benefit support.

He was so overwhelmed by the help and support he had received from the Crisis Sanctuary at different times by different members of the team that he asked to come in to meet the team members that had supported him face to face to thank them. We arranged this for him and he got to say thank to each one of us which he was grateful for and stated how we had given him the strength and courage to fight a system that he thought had failed him and that how we had helped to make him realise that he had nothing to be ashamed of because he was a man in domestic abuse, and that there sadly were other men who had not yet had the courage and strength he had shown that day on his first call to us by opening up and telling us what he had been through. He stated once he was settled in his new home with the children, he would like to volunteer in men's domestic abuse to spread awareness.

Sanctuary Case Study 2

We supported the service user through a crisis call and they felt regulated and supported, their emotions had been very erratic, they declined a face-to-face visit to the sanctuary asking for phone calls only due to their heightened anxiety. We arranged an outreach call for 2 evenings later. When the peer worker contacted the service user, they were very distressed and emotional, the service user had been drinking in excess due to overwhelming feelings, the service user was threatening to harm themselves and the peer worker was concerned. The peer worker texted me to alert me to a high-risk situation, I took over the call and supported the service user for over 1 hour and half whilst emailing updates to my Senior on duty, she was on the phone to the police and ambulance service. Due to the risk assessment I had performed it was clear that the service user who was continuing to drink alcohol was unable to regulate their emotions and was becoming more distressed.

The service user was refusing to give me their location, so while we were talking, I read through their old notes and noticed that their address was a block of flats. I started to add random questions to our conversation to ascertain their location which worked and they answered the questions indicating they were in the flats where they lived, we were now able to deploy the police and ambulance service. The service user was actively cutting their arms while speaking to me and had told me they had planned to cut their throat and listen to music. They stated they had the knife and now wanted to go to sleep, and I was preventing them from laying down. I was growing more concerned for their safety, and they were becoming agitated, shouting at me and very distressed. It was then I heard the police at the door the service user ended the call with me.

I had an update from the police afterwards who stated that the service user did have a knife and was a danger to themselves and the crew on scene. They confirmed they had been cutting themselves and had try to abscond on the arrival of the police. The police then had to section them under a 136 and admit them to hospital for their own safety. The police and ambulance service praised us for our hard work, and we discussed the service that the Crisis Sanctuary provides.

Sanctuary Case Study 3

During an evening shift, we supported a service user who was in crisis by phone as she declined video contact. She expressed low mood with 'life spiralling out of control', history of severe domestic abuse, recent suicide attempt by hanging, and abuse of painkillers to cope. At the end of the call, she was calmer and better able to cope and manage her mood.

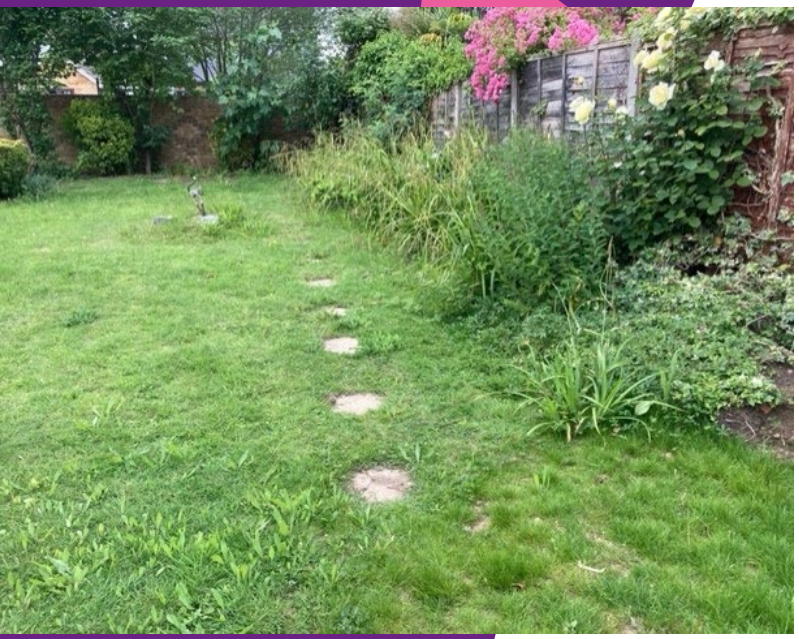
When the service user did not attend her follow up face to face outreach support, we made several attempts to contact her and informed CRS 24/7 of our concern. An hour later than scheduled, the service user came to the log cabin accompanied by her mum (both were distressed and agitated) and were supported by our team. The service user stated that she had taken an overdose but was very reluctant to attend hospital.

The ambulance service refused to attend as they were 'too busy'. CRS 24/7 stated they could not support as service user needed to be 'medically fit' before they could assess/assist.

We established that the service user was reluctant to go to A&E due to anxiety, as she thought that she would need to go in on her own. As her mum had agreed to take her, we contacted A&E who gave permission for the service user to be accompanied by her mum. Our team provided phone support until she received the medical intervention at A&E. Then following discharge from A&E, we had daily contact until she had a structured drug rehabilitation plan in place.

The service user and her mum thanked us for all of our support and help through a distressing and challenging time and are relieved that she now has a plan in place and the help she needs.

MH Crisis Sanctuary Plus



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Sanctuary Plus Case Study 4

A male who alleges he has been subjected to 30 years in a 'controlling' relationship which breaks down and he is forced to leave the marital home; turns to his stepchild for accommodation.

Allegedly stepchild takes S/U money, forces him to sleep on floor, sofa or in doorway of shops opposite if he is not let into the property. Is not allowed to shower or wash clothes and has jam on toast 3 times per day.

Diagnosed with BPAD, no formal learning disability diagnosis; unable to read and write.

During June 2022, had engaged with **CRS** who referred to the **Crisis Sanctuary SW.** **Police** who brought him to **A&E.** **MHLT** who referred to **HTT,** difficult to support S/U in stepchild's home environment.

27/6 S/U assessed by **MHLT**, due to presenting via the **police** after reportedly being at a bridge with the thoughts and plan to jump to end his life. **MHLT** conducts assessment and in consultation with **CRS** referral is agreed to **Crisis House Sanctuary Plus**.

S/U arrives at house in unkempt state with one set of spare clothes that were soiled, and glasses were broken.

Crisis House staff worked with S/U to create a wellbeing plan based on 'what matters to me' and the five ways of wellbeing. They liaised with **Basildon Council Emergency Housing Team, Peabody, Social Services**, **GP** for medication, appointment with V**ision Express**.

S/U's stay; Well rested, regulated his emotions, engaging with other S/Us and staff, watching TV and laughing at comedy, was able to assist with making meals and learnt some new games that he could play e.g. solitaire when he was on his own.

Housing offered a hotel in Barking. The appeal was initially unsuccessful, and if the Barking hotel was refused he would be taken off the list. The S/U became extremely distressed as he knew no one in Barking. A further night was offered in the house.

The offer of a **Thurrock and Brentwood Mind** room was made for the 56-day assessment period to identify suitable accommodation was eventually agreed by housing due to risk of financial abuse and other vulnerabilities.

Referral made to **APED** team to provide support in the community to prepare S/U to live as independently as possible.

Referral made to **Thurrock Advocacy Service** to support S/U to understand the care and support available.

The collaborative approach has diverted a potential re-admission onto the assessment unit with a successful outcome for the service user.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Your name

Your email

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		Agenda Item No: 11a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 July 2022**

Report Title:	**CQC Compliance Update**					
Executive/Non-Executive Lead:	Denver Greenhalgh, Senior Director of Corporate Governance and Affairs					
Report Author(s):	Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Executive Safety Oversight Group Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	Maintaining ongoing compliance with CQC registration requirements	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and requirements.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

Summary of Key Issues

The report summarises the key activities

- EPUT is registered with the Care Quality Commission (CQC).
- The CQC has removed its restrictions on Child and Adolescent Mental Health Services (CAMHS) services and issued a new registration certificate.

- CQC undertook an unannounced inspection of CAMHS wards in March and April 2022. The Trust received a draft inspection report and has undertaken factual accuracy checks. The final report and rating is awaited.
- Improvement plan from the CAMHS inspection (May 2021) is now complete and has been closed by Executive Safety Oversight Committee (ESOG).
- CQC have undertaken 4 Mental Health Act inspections in May 2022. The Mental Health Act Office have oversight and monitor reports to identify improvement themes.
- Progress continues with the annual plan to promote and monitor adherence to the fundamental standards of care (CQC registration requirements).
- Site visits by the Compliance Team continue to support services to sustain high standards and to take action where improvements are required.
- Changes to key metrics held by the CQC within the EPUT Insight Report are highlighted along with actions taken.

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

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

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	NoD	Notice of Decision
CAMHS	Child and Adolescent Mental Health Service	CICC	Cumberlege Intermediate Care Centre
BAU	Business As Usual		

Supporting Documents and/or Further Reading
CQC Update Compliance Report Appendix 1 – CQC Certificate of Registration

Lead
Denver Greenhalgh, **Senior Director of Corporate Governance and Affairs**

Agenda Item 11a
Board of Directors Part 1
27 July 2022

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC COMPLIANCE UPDATE

1.0 INTRODUCTION

The purpose of this report is to provide an update and assurance on the key Care Quality Commission (CQC) registration requirement related activities within the Trust. The report also provides details of guidance/updates that have been received since the previous full reporting beginning of June 2022.

2.0 MEETING REGISTRATION REQUIREMENTS

EPUT is registered with the Care Quality Commission (CQC).

As previously reported an application to remove S31 restrictions for Child and Adolescent Mental Health Services (CAMHS) services was made to the CQC in March 2022 following significant improvements made to the safety our CAMHS services. As a result, the CQC has removed its restrictions and issued a new registration certificate (copy attached).

A group of leaders and experts from across the Trust worked together to put improvements in place which met the CQC's recommendations. Improvements included investment in estates, technology, staff training and staffing levels. This has been achieved with the support of staff and system partners enabling us to improve the service for our patients and communities.

3.0 CQC INSPECTION

3.1 CAMHS May 2021

The previous inspection of CAMHS wards (May 2021) and resultant action plan has continued to be monitored. The Board is asked to note that the Executive Safety Oversight Group (ESOG) closed the action plan on the 31 May 2022 subject to the outstanding action - 'Establishment review using MHOST (Mental Health Optimal Staffing Tool), which as a trust wide initiative, continues to be monitored via the Inpatient Clinical Support Group.

3.2 CAMHS March 2022

As previously reported the CQC have undertaken a new inspection of the CAMHS Wards in March and April 2022. This involved unannounced site inspections at all 3 wards, virtual interviews and follow up information requests.

The draft inspection report was received on the 20 June 2022. Factual accuracy checking has been undertaken and a response sent back to the CQC. At the time of writing this report the final report and rating is awaited.

3.3 CQC Mental Health Act (MHA)

The CQC have undertaken 4 MHA inspections in May 2022. Following each inspection a monitoring report is received by the ward with recommendations for improvement. All wards develop action plans to address these recommendations supported and monitored by the Mental Health Act Office.

4.0 ANNUAL PROGRAMME 2022

As previously reported, the Trust annual plan to promote and monitor adherence to the fundamental standards of care (CQC registration requirements) has been developed and initiated for 2022/23. The plan takes a risk based approach to prioritise focus and is structured into 4 key work areas (see sections 4.1-4.4).

The following key activity has taken place in June 2022:

4.1. Themes for Focus

The Compliance Team have continued to use analysis from a range of data sources to identify what key themes will be focused on in this period. The following areas have been identified for focus:

- Testing of embedding actions following previous recommendations. Compliance Team tools have been reviewed to enable focus on embedding of actions for the next set of ward/service visits.

- Continued focus on daily staffing numbers and mitigations. Most importantly that staff are able to explain what actions are taken at a service level and how clinical risk is proactively managed. The project on safe staffing continues trust wide.

- Continued focus on ligature reduction actions. Work continues between the Risk Management Team and Estates Team to complete ligature actions.

- Promotion of good clinical record keeping – both written and electronic through compliance team visits

- Delivery of the recovery plan for mandatory training post COVID.

- Expanding analysis to look at areas highlighted in compliance team visits and service self-assessment tools.

4.2 Ward / Service Focus

The internal ward heat map document which reviews multiple sources of data has been used to identify key wards/services for focused support. There are 4 scoring categories used:

- Level 1 (score 0-11) : Review for good practice

- Level 2 (score 12-15) : Ward Review via Accountability Meetings

- Level 3 (score 16-19) : Compliance Team to visit and consider deep dive

- Level 4 (score 20+) : Compliance Team to visit and consider Rapid Response

In this period there are no wards currently scoring at level 4. There is one ward scoring at level 3 which will be visited by the Compliance Team. There are 16 wards scoring at level 2 and 29 wards scoring at level 1. The Compliance Team have put a visit schedule in place to ensure all identified areas have been visited or reviewed. Wards will receive an onsite visit and community areas will have a mix of site visits and virtual review. This is being reviewed on a fortnightly basis and any new areas identified added to the visit schedule.

The visits are focused on what the data is telling us alongside the CQC key lines of enquiry (KLOE's) and an action plan is agreed with the area to address any gaps found. Work is now underway to analyse the visit outcomes to identify any new hot spot areas for focus.

There are currently 5 services receiving additional support.

4.3 Ward / Service Self Preparation

Key to successful meeting of fundamental standards of care is ownership of local standards of care and adherence to policies and procedures. To empower our operational services to continuously meet these standards for the safety of both our patients and staff, there is a series of preparation tools (including record keeping and environment assessment) to guide local managers and staff to assess their professional practice and encourage celebration of good practice.

4.4 Well Led preparation

Collating the supporting information for a Well-led review and ensuring all relevant senior staff are prepared for interviews on leadership and governance.

5.0 TRUST COMPLIANCE PROGRAMME

The Compliance Team have focused in this period on setting up the annual preparation plan as outlined above. In addition, the team has been focusing work on the following areas:

5.1 Ongoing programme of ward/service visits to test CQC compliance

In June 2022, the Compliance Team completed 12 site visits. Following each visit a report is provided highlighting good practice found and recommendations for areas of improvement. An action plan is developed by the service and monitored by the Compliance Team until complete.

Information from the visits is analysed to identify any key themes emerging and this feeds into the preparation plan and inform areas for focus.

Examples of good practice:

Safe

- Kitwood Ward Staff adapted well to the working environment during the refurbishment and were supporting patients.

- Henneage and Hadleigh wards induction for bank/agency staff was in place and repeated if a bank/agency staff member had not worked on the ward for three months (this was learning from the CAMHS CQC visit)

- Multiple wards observed to have clean, tidy and well organised clinic rooms (this was learning from the CAMHS CQC visit)

- Hadleigh Unit patients had access to a garden supported by staff presence.

Effective

- Ipswich road had a comprehensive timetable of activities clearly displayed, including the 'music man' attending once a fortnight and each Friday there being a movie night.

Caring

- Staff were observed to be caring and compassionate to patients.

Responsive

- Wards hold regular community meetings with 'you said we did' feedback clearly displayed.

- Kelvedon Ward had clear arrangements in place for visiting and now have access to shared room with Cherrydown Ward. Staff were observed interacting with patients; playing games and responding to patient's needs.

Well Led

- Henneage Ward review of staff meeting minutes contained information about lessons learnt, health & safety, infection prevention & control, documentation and other standard headings, which displays good governance at ward level.

5.2 Ongoing development of the Ward Heat Map

The heat maps represent a series of metrics from available data to give a picture (map) of adherence to standards. These indicators provide an internal insight framework and are used to celebrate areas that are performing well and support improvement. The heat maps are now shared with the Care units via accountability meetings.

Further work to look at the metrics used in the heat maps is underway with a plan to incorporate more qualitative information from Tendable and more incident data and to better align these with the CQC fundamental standards.

5.3 Action Plan Testing

Action plan testing identified insufficient evidence of embedding actions following the completion of the CQC action plan and action is being taken to address these areas.

6.0 CQC GUIDANCE / UPDATES

6.1 CQC Mental Health Insight

The CQC published the Mental Health Services Insight Report for EPUT on the 16 May 2022. The document provides an update on the data currently held by the CQC in relation to the Trust and develops a profile, which may be used to target any inspections or instigate an inspection if a risk is seen to be emerging.

Since the last report in Feb 2022, there has been 6 key changes:

Indicator	Change	Action
Proportion of Staff Doing Paid Overtime (%) – Data source: Staff Survey	Increased from 27.81% (during Sep20 – Oct20) to 33.75% (during Sep21 – Dec21) Noted as worse than national average of 26.52%	Workforce resilience and wellbeing has been part of recovery group actions. Key actions taken include: Safer staffing project – complete and moved to BAU International recruitment drive – ongoing Initiation of safety huddles Awareness raising of wellbeing support offer Restorative supervision
Proportion staff appraised (%) – Data source: Staff Survey	78.73% compared to national average of 84.18%	Action to increase appraisal compliance is included in Recovery Plan. Incremental improvements are being made.

Indicator	Change	Action
Recognised and rewarded – Data source: Staff Survey	Score identified as 6.2 (this is scored as "much worse" than expected). National average is 6.4	Workforce resilience and wellbeing has been part of recovery group actions. Key actions taken include: Awareness raising of wellbeing support offer Restorative supervision Staff engagement champions Staff incentives
High rates of restrictive interventions - Data Source: NHS Digital - NHS Digital - MHSDS monthly Restrictive Interventions (14 Apr 2022)	0.9 in Jan 21, increased to 3.4 in Jan 22. National average is 0.2	Safety First, Safety Always Strategy Restrictive practice group A deep dive has been commissioned into these figures.
Morale – Data source: Staff Survey	Score identified as 6.1 during Sep21 – Dec21, which is a decrease to the Sep20 – Dec20 score, which was 6.3. According to the guidance a score >3 shows as "much worse" than expected. The National average is 6.1 (Sep21 – Dec21)	Workforce resilience and wellbeing has been part of recovery group actions. Key actions taken include: Awareness raising of wellbeing support offer Restorative supervision Staff engagement champions Staff incentives
Proportion staff believe the provider is adequately staffed (%) - Data source: Staff Survey	Decreased from 42.80% (during Sep20 – Dec20) to 32.05% (during Sep21 – Dec21) noted as worse than National average of 30.69%	Workforce resilience and wellbeing has been part of recovery group actions. Key actions taken include: Safer staffing project – complete and moved to BAU International recruitment drive – ongoing Initiation of safety huddles Awareness raising of wellbeing support offer Restorative supervision

7.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the contents of this report

Report prepared by:

Nicola Jones
Director of Risk and Compliance

On behalf of:
Denver Greenhalgh
Senior Director of Corporate Governance and Affairs

Certificate of Registration

This is to certify the following service provider has been registered by the Care Quality Commission under the Health and Social Care Act 2008

Certificate number: CRT1-13501331572
Certificate date: 06/07/2022
Provider ID: R1L

Section 1 **Service Provider details**

Name of service provider: Essex Partnership University NHS Foundation Trust

Address of service provider: Trust Head Office, The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

Date of Registration: 01/04/2017

Signed

Ian Trenholm
Chief Executive

You can email CQC at: enquiries@cqc.org.uk
You can contact CQC on telephone number: 03000 616161
You can write to CQC at: CQC National Correspondence, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA

Section 2

Essex Partnership University NHS Foundation Trust is registered in respect of Regulated Activity: **Accommodation for persons who require nursing or personal care**

For Regulated Activity **Accommodation for persons who require nursing or personal care** the Nominated Individual (where applicable) is:
Paul Scott

Conditions of registration that apply to:
Essex Partnership University NHS Foundation Trust for **Accommodation for persons who require nursing or personal care**

1. The registered provider must ensure that the regulated activity Accommodation for persons who require nursing or personal care is managed by an individual who is registered as a manager in respect of that activity at Clifton Lodge and Rawreth Court.
2. This Regulated Activity may only be carried on at or from the following locations:

Location Name and address	Clifton Lodge Balmoral Road Westcliff On Sea Essex SS0 7DB
Location ID	R1LJ3
Additional conditions that apply at this location	**1.** The registered provider must only accommodate a maximum of 35 service users at Clifton Lodge.

Location Name and address	Rawreth Court Rawreth Lane Rayleigh Essex SS6 9RN
Location ID	R1LJ2
Additional conditions that apply at this location	**1.** The registered provider must only accommodate a maximum of 35 service users at Rawreth Court.

Essex Partnership University NHS Foundation Trust is registered in respect of Regulated Activity: **Assessment or medical treatment for persons detained under the Mental Health Act 1983**

For Regulated Activity **Assessment or medical treatment for persons detained under the Mental Health Act 1983** the Nominated Individual (where applicable) is:
Paul Scott

Conditions of registration that apply to:
Essex Partnership University NHS Foundation Trust for **Assessment or medical treatment for persons detained under the Mental Health Act 1983**

1. This Regulated Activity may only be carried on at or from the following locations:

Location Name and address	439 Ipswich Road 439 Ipswich Road Colchester Essex CO4 0HF
Location ID	R1LX7
Additional conditions that apply at this location	

Location Name and address	Basildon Mental Health Unit Nethermayne Basildon Essex SS16 5NL
Location ID	R1L40
Additional conditions that apply at this location	

Location Name and address	Brockfield House Kemble Way Runwell Wickford Essex SS11 7FE
Location ID	R1LK9
Additional conditions that apply at this location	

Location Name and address	Broomfield Hospital Mental Health Wards Puddings Wood Drive Broomfield Chelmsford Essex CM1 7LF
Location ID	R1LZ1
Additional conditions that apply at this location	

Location Name and address	Chelmer & Stort Mental Health Wards Derwent Centre, Princess Alexandra Hospital Hamstel Road Harlow Essex CM20 1QX
Location ID	R1LPA
Additional conditions that apply at this location	

Location Name and address	Colchester Hospital Mental Health Wards The Lakes Turner Road Colchester Essex CO4 5JL
Location ID	R1LK3
Additional conditions that apply at this location	

Location Name and address	Heath Close Unit 2-5 Heath Close Billericay Essex CM12 9NW
Location ID	R1LA4
Additional conditions that apply at this location	

Location Name and address	Landermere Centre Mental Health Wards Tower Road Clacton On Sea Essex CO15 1LH
Location ID	R1LG7
Additional conditions that apply at this location	

Location Name and address	Robin Pinto Unit Calnwood Road Luton Bedfordshire LU4 0FB
Location ID	R1L31
Additional conditions that apply at this location	

Location Name and address	Rochford Hospital Union Lane Rochford Essex SS4 1RB
Location ID	R1L10
Additional conditions that apply at this location	

Location Name and address	St Margaret's Community Hospital The Plain Epping Essex CM16 6TY
Location ID	R1LT1
Additional conditions that apply at this location	

Location Name and address	The St Aubyn Centre Severalls Hospital Colchester Essex CO4 5HG
Location ID	R1L22
Additional conditions that apply at this location	

Location Name and address	Thurrock Hospital Thurrock Community Hospital Grays Essex RM16 2PX
Location ID	R1L50
Additional conditions that apply at this location	

Location Name and address	Wood Lea Clinic 2-5 The Glades Northampton Road, Bromham Bedford Bedfordshire MK43 8HJ
Location ID	R1LL8
Additional conditions that apply at this location	

Essex Partnership University NHS Foundation Trust is registered in respect of Regulated Activity: **Diagnostic and screening procedures**

For Regulated Activity **Diagnostic and screening procedures** the Nominated Individual (where applicable) is:
Paul Scott

Conditions of registration that apply to:
Essex Partnership University NHS Foundation Trust for **Diagnostic and screening procedures**

1. This Regulated Activity may only be carried on at or from the following locations:

Location Name and address	St Margaret's Community Hospital The Plain Epping Essex CM16 6TY
Location ID	R1LT1
Additional conditions that apply at this location	

Location Name and address	Trust Head Office The Lodge Lodge Approach Wickford Essex SS11 7XX
Location ID	R1LZ8
Additional conditions that apply at this location	

Essex Partnership University NHS Foundation Trust is registered in respect of Regulated Activity: **Family planning**

For Regulated Activity **Family planning** the Nominated Individual (where applicable) is: **Paul Scott**

Conditions of registration that apply to:
Essex Partnership University NHS Foundation Trust for **Family planning**

1. This Regulated Activity may only be carried on at or from the following locations:

Location Name and address	Trust Head Office The Lodge Lodge Approach Wickford Essex SS11 7XX
Location ID	R1LZ8
Additional conditions that apply at this location	

Essex Partnership University NHS Foundation Trust is registered in respect of Regulated Activity: **Surgical procedures**

For Regulated Activity **Surgical procedures** the Nominated Individual (where applicable) is: **Paul Scott**

Conditions of registration that apply to:
Essex Partnership University NHS Foundation Trust for **Surgical procedures**

1. This Regulated Activity may only be carried on at or from the following locations:

Location Name and address	Trust Head Office The Lodge Lodge Approach Wickford Essex SS11 7XX
Location ID	R1LZ8
Additional conditions that apply at this location	

Essex Partnership University NHS Foundation Trust is registered in respect of Regulated Activity: **Treatment of disease, disorder or injury**

For Regulated Activity **Treatment of disease, disorder or injury** the Nominated Individual (where applicable) is:
Paul Scott

Conditions of registration that apply to:
Essex Partnership University NHS Foundation Trust for **Treatment of disease, disorder or injury**

1. This Regulated Activity may only be carried on at or from the following locations:

Location Name and address	439 Ipswich Road 439 Ipswich Road Colchester Essex CO4 0HF
Location ID	R1LX7
Additional conditions that apply at this location	

Location Name and address	Basildon Mental Health Unit Nethermayne Basildon Essex SS16 5NL
Location ID	R1L40
Additional conditions that apply at this location	

Location Name and address	Brockfield House Kemble Way Runwell Wickford Essex SS11 7FE
Location ID	R1LK9
Additional conditions that apply at this location	

Location Name and address	Broomfield Hospital Mental Health Wards Puddings Wood Drive Broomfield Chelmsford Essex CM1 7LF
Location ID	R1LZ1
Additional conditions that apply at this location	

Location Name and address	Chelmer & Stort Mental Health Wards Derwent Centre, Princess Alexandra Hospital Hamstel Road Harlow Essex CM20 1QX
Location ID	R1LPA
Additional conditions that apply at this location	

Location Name and address	Clifton Lodge Balmoral Road Westcliff On Sea Essex SS0 7DB
Location ID	R1LJ3
Additional conditions that apply at this location	

Location Name and address	Colchester Hospital Mental Health Wards The Lakes Turner Road Colchester Essex CO4 5JL
Location ID	R1LK3
Additional conditions that apply at this location	

Location Name and address	Heath Close Unit 2-5 Heath Close Billericay Essex CM12 9NW
Location ID	R1LA4
Additional conditions that apply at this location	

Location Name and address	Landermere Centre Mental Health Wards Tower Road Clacton On Sea Essex CO15 1LH
Location ID	R1LG7
Additional conditions that apply at this location	

Location Name and address	Mountnessing Court 240 Mountnessing Road Billericay Essex CM12 0EH
Location ID	R1L65
Additional conditions that apply at this location	

Location Name and address	Rawreth Court Rawreth Lane Rayleigh Essex SS6 9RN
Location ID	R1LJ2
Additional conditions that apply at this location	

Location Name and address	Robin Pinto Unit Calnwood Road Luton Bedfordshire LU4 0FB
Location ID	R1L31
Additional conditions that apply at this location	

Location Name and address	Rochford Hospital Union Lane Rochford Essex SS4 1RB
Location ID	R1L10
Additional conditions that apply at this location	

Location Name and address	Saffron Walden Community Hospital Radwinter Road Saffron Walden Essex CB11 3HY
Location ID	R1LTH
Additional conditions that apply at this location	

Location Name and address	St Margaret's Community Hospital The Plain Epping Essex CM16 6TY
Location ID	R1LT1
Additional conditions that apply at this location	

Location Name and address	St. Helen's Street 70-74 St. Helens Street Ipswich IP4 2LA
Location ID	R1LXD
Additional conditions that apply at this location	

Location Name and address	The St Aubyn Centre Severalls Hospital Colchester Essex CO4 5HG
Location ID	R1L22
Additional conditions that apply at this location	

Location Name and address	Thurrock Hospital Thurrock Community Hospital Grays Essex RM16 2PX
Location ID	R1L50
Additional conditions that apply at this location	

Location Name and address	Trust Head Office The Lodge Lodge Approach Wickford Essex SS11 7XX
Location ID	R1LZ8
Additional conditions that apply at this location	

Location Name and address	Wood Lea Clinic 2-5 The Glades Northampton Road, Bromham Bedford Bedfordshire MK43 8HJ
Location ID	R1LL8
Additional conditions that apply at this location	

End of certificate

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Agenda Item No: 11b

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	27 July 2022

Report Title:	**Safe Working of Junior Doctors Quarterly Report (April, May, June)**					
Executive/ Non-Executive Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr Sethi, Consultant Psychiatrist					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk	Trainees escalate any issues to their supervisor, Clinical Tutor. If unresolved they escalate at Junior Doctors Forum, any unresolved issues is further escalated to Dr Karale.	

Purpose of the Report		
This report provides the Board of Directors with assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the Terms and Conditions of the Service.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: • Receive and note the content of the report.

Summary of Key Issues

The Board of Directors should note the following areas detailed in the report:

- There were 9 Exception Report raised by trainees. All the issues have been resolved.
- No fines were issued in this quarter.
- There were gaps in the on call rota, which were filled by Medical Training Imitative (MTI) and Locum Appointment Service (LAS) doctors.
- Refurbishment work at Basildon and Rochford Doctor's room is still pending. Estates are aware.
- Trainees are awaiting the final Stepping down policy.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report

Lead

Dr Milind Karale
Executive Medical Director

Part 1 Agenda Item: 11b
Board of Directors Part 1
27 July 2022

QUARTERLY REPORT ON SAFE WORKING OF JUNIOR DOCTORS

1.0 PURPOSE OF THE REPORT

This report provides the Board of Directors with assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the Terms and Conditions of the Service.

2.0 EXECUTIVE SUMMARY

This is the twentieth quarterly report submitted to the Board on safe working of junior doctors for the period 1 April 2022 to the 30 June 2022. The Trust has established robust processes to monitor safe working of junior doctors and report any exceptions to their terms and conditions.

Exception Reporting: (Exception reports in this quarter)

A trainee raised 4 exception reports on doing non-urgent blood tests on a ward during on-call, for four different patients. The Trainee was advised to consolidate all into a single report, but was unable to do this after submission of the report. The Clinical Tutor and Matron were informed and the matter is now resolved.

Two exception reports for working longer hours were submitted and time off in lieu was offered.

A trainee raised 3 exception reports regarding poor staffing levels on the ward during the bank holiday. Time off in lieu was given. A core trainee post is being filled in August 2022 at the Rainbow Unit (where the exception report were raised, this will help trainees manage the ward duties better.

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on the 6th April 2022.

Doctors in Training Data

Total number of posts	134
Number of doctors in training posts (total inclusive of GP and Foundation)	115
Number of doctors in psychiatry training on 2016 Terms and Conditions	71
Total number of vacancies	19
Total vacancies covered LAS/ MTI/Agency	9
Total gaps	10

Agency

The Trust did not use any agency locums during this reporting period but relies on the medical workforce to cover at internal locum rates as follows

Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy/Maternity/ sick/COVID	133	133	0	1560.5	1560.5
Total	133	133	0	1560.5	1560.5

Actions taken to resolve issues:

The Trust has taken the following steps to resolve the gaps in the rota:

1. Rolling adverts on NHS jobs. Few International doctors who were appointed have started their posts.
2. Emails are sent to former GP and FY trainees if they would like to join the bank to do on-calls, this is now part of the termination process for GP's and FY's so they can express an interest in covering extra shifts when they leave EPUT.
3. 11 Fellows under the EPUT Advanced Fellowship programme have been appointed last year.
4. Almost all CT/ST posts will be filled up in August 2022 rotation, except for few due to Inter Deanery transfers and last minute withdrawals/deferrals etc.

Fines: None

Issues Arising:

1. The stepping down policy to be presented at the July Joint Local Negotiating Committee (JLNC)
2. Doctors' room at Basildon and Rochford is awaiting refurbishment.
3. Trainees still have money left to spend from HEE funding, they have been urged to spend the money at the earliest.

3 Action Required

The Board of Directors is asked to:

- Receive and note the content of the report.

Report prepared by

Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours
July 2022