Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public via Microsoft Teams
Wednesday 25 May 2022 at 10:00

Vision: Working to Improve Lives

PART ONE: MEETING HELD IN PUBLIC via Microsoft Teams
AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
	PRESENTATION West Essex Out of Hospital Model – Nicole Rich, Director of West Essex Community Physical and Mental Health Services Stephanie Rea, Associate Director West Essex Mental Health			
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 30 March 2022	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	Chief Executive Officer Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	PS	Attached	Noting
(b)	Complaints Annual Report	MS	Attached	Approval
(c)	Duty of Candour Annual Review	NH	Attached	Approval
(d)	Freedom to Speak Up Report	YM	Attached	Noting
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Standing Committees:			
	(i) Audit Committee	JW	Verbal	Noting
	(ii) Finance & Performance Committee	LL	Attached	Noting
	(iii) Quality Committee	RH	Attached	Noting
	(iv) People, Equality and Culture Committee	ML	Attached	Noting
(b)	Board Oversight Safety Group	AR-Q	Attached	Noting
9	**RISK ASSURANCE REPORTS**			
(a)	(i) COVID-19 Assurance Report	PS	Attached	Noting

10	**STRATEGIC INITIATIVES**			
(a)	Communications, Brand and Marketing Strategy	MM	Attached	Noting
11	**REGULATION AND COMPLIANCE**			
(a)	CQC Update	PS	Attached	Noting
(b)	NHS England/ Improvement Self-Certification Requirements 2021-22	DG	Attached	Approval
(c)	Safe Working of Junior Doctors Quarterly Report (Jan, Feb, Mar 2022)	MK	Attached	Noting
(d)	Safe Working of Junior Doctors Annual Report	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** 27 July 2022 **- Virtual at 10:00**			
16	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** Wednesday 28 September 2022 at 10.00am Wednesday 30 November 2022 at 10.00am			

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 30 March 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
Sean Leahy (SL)	Executive Director of People and Culture
Alex Green (AG)	Executive Chief Operating Officer
Milind Karale (MK)	Executive Medical Director
Trevor Smith (TS)	Executive Chief Finance and Resources Officer
Denver Greenhalgh (DG)	Senior Director of Corporate Governance
Janet Wood (JW)	Non-Executive Director
Alison Rose-Quirie (ARQ)	Non-Executive Director
Amanda Sherlock (AS)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director
Mateen Jiwani (MJ)	Non-Executive Director
Loy Lobo (LL)	Non-Executive Director

In Attendance:

Angela Horley	PA to Chief Executive, Chair and NEDs (minutes)
Gina Trimble	Trust Secretary Coordinator
Clare Sumner	Trust Secretary Administrator
Gill Brice	Project Director (Deputising for Nigel Leonard)
Lyn Prendergast	Associate Director, Social Care - Family Group Conference Service Presentation
Lyn Taylor	Team Leader, Family Group Conference Service
Glenn Westrop	Chief Allied Health Professional (Observing)
Inder Sahney	Consultant Psychiatrist and Clinical Director Learning Disability Services, Essex and Trust wide IAPT Services (Observing)
Kelly Gibbs	Associate Director of Human Resources
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

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

023/22 APOLOGIES FOR ABSENCE

Apologies received from Nigel Leonard, Executive Director of Major Projects and Programmes and Rufus Helm, Non-Executive Director.

Signed: …… Date: ……

024/22 DECLARATIONS OF INTEREST

There were no Declarations of Interest.

025/22 PRESENTATION: MENTAL HEALTH ADULT FAMILY GROUP CONFERENCE SERVICE (FGC)

SS welcomed LP and LT to the meeting to highlight the good work being undertaken by the Family Group Conference (FGC) service.

LP advised that the FGC consistently receives positive feedback and following each family conference, an evaluation is completed and learning implemented as a direct result of this feedback. LP shared the following as a background to the FGC:

- FGC originated from the Maori community and has a strong evidence base – the format is used in a wealth of social domains; youth crime, neighbourhood disputes, homelessness, domestic abuse and mental health.
- EPUT is the leading organisation in adult FGCs worldwide, recognised for the positive results with adult mental health.
- FGC is recognised by the Social Care Institute of Excellence as best practice for families across the UK in 2013.
- Research and feedback evidences positive experience and positive impact on dependence of services, readmission, risk management, relationships, discharge and social integration.

FGC is a family / community orientated approach to decision making when the person at the centre of the planning is vulnerable and the network around them under extreme stress. The process is collaborative; recognising the importance of collective responsibility and decision making for those with complex needs. This process strengthens networks and relationships with the entire network of support, both professional and non-professional, increasing positive outcomes. This is not a family therapy / counselling service and can be accessed and used by all people entering mental health services. This is not a restrictive process and can be done at time of crisis to address the most concerning difficulties such as domestic and financial abuse, breakdown of care arrangements etc.

A FGC in mental health is a collaborative and relational approach that can be used to address and improve risk management. Risk needs to draw on clinical judgement with concerns transparently shared and a collective responsibility for ensuring continuing safety. FGC does not rely on technical and retrospective approaches and focusses on the here and now. FCGs enable the whole community around the person to do this effectively facilitating honest dialogue to get to the heart of what matters and address this so plans are successful.

LP continued that it is important to involve families and carers to strengthen family ties and network, widen the support available, and support the entire network to become healthy and address what matters – decreasing poor outcomes for carers.

The FGC team is relatively small but covers the whole of EPUT and helps over 120 families a year. This is a sustained consistent and effective service that are engaged in national research and lead on the UK adult FGC development.

LL thanked LP and LT for this informative presentation, suggesting that as a Trust do we need a view of the whole horizon of demand to see resources as to how we achieve that. AS queried whether there was an exclusion criteria on the basis of risk and clinical condition where this may not be an appropriate model and how this dynamic might be managed. ARQ queried how we cascade and learn from this service; adding that many people are isolated and do not connect or have issues with their families and queried how we address this to get families re-engaged.

PS advised that he had been able to witness sessions in practice; stating that the sessions are co-designed with families. There is a great deal of enthusiasm for this service and how we scale and expand into other services is the challenge for us.

AG thanked LP and LT for bringing practice to life through this presentation. We see the principle of choice and control with a holistic based approach. We are excited for the roll out and development of services featured in the 2022/23 plans for mental health. We are looking at this service in the space of flow and capacity not just for mental health and this model can roll out to other services.

MK stated that this was a very valuable service and the involvement of family and carers is very important and is a key priority. NH stated that she was passionate and proud of this service. NH was supportive of expansion and the need to link to other developments in mental health care and how we learn and share skills in a care programme approach.

LP advised that time had been spent with commissioners and there had been a lot of interest and plans to take the service forward in the transformation of mental health services. We need to make sure we look at involvement with PCNs and allow earlier intervention and engagement with people with other social care difficulties. We are developing a lived experience group and there are also discussions regarding how we use this model in inpatient services. Clinicians that are engaged with and understand this model are extremely positive.

In response to AS' question, LT advised that there are not many patients that would be excluded from this service. Risk assessments are undertaken and an agreement made to talk openly and honestly enabling safe treatment for all. There is a great deal of preparation undertaken prior to FGCs, which allows service users to engage in difficult conversations in a safe environment. LT gave examples of work that had been undertaken with service users that had been homeless and isolated from their families that had resulted in building relationships and enabled contact with their children. LT continued that the service could help to resolve problematic situations if all were willing to work together and engage.

SS thanked LP and LT for their presentation which set the narrative of family and service users at the centre of discussions; stating that this service was a model of good practice. SS noted comments in the chat section had been positive and suggested that Governors would welcome a session to discuss this service further.

026/22 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 26 January 2022 were agreed as an accurate reflection of discussions held.

027/22 ACTION LOGS AND MATTERS ARISING

The action log was reviewed as follows:

- 132/21 it was noted that the Vulnerable Adult Service had been invited to present at the July 2022 Board of Directors meeting.
- 040/21 – it was noted that the engagement strategy would be socialised at the April Board Seminar session before approval at the public Board of Directors meeting in July 2022.

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

The Board discussed and approved the Action Log.

028/22 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 noted that she was delighted to have been able to visit the Linden and Crystal Centres recently to see first-hand the fantastic care being delivered in these very challenging circumstances.

The Board received and noted the Chair's Report.

029/22 CEO REPORT

PS presented the CEO report which provided a summary of key activities and information to be shared with the Board and stated that the performance report would also be discussed during this item.

PS advised the Board of a press release that had been released by the secretariat of the Essex Mental Health Independent Inquiry, the purpose of which was to encourage people to come forward and share their experiences. PS wanted to reiterate that we are helping with the Inquiry process in any way we can, in an open and transparent way. An independent director has been appointed, reporting to the Audit Committee. We acknowledge the impact on staff and continue to provide support where needed.

Operational pressures across the health and care system remain challenging with a significant increase in demand seen across MH services. PS extended thanks to all colleagues working hard and compassionately to provide care to our service users.

PS was pleased to report that CAMHS Tier 4 services were now fully open following agreement from the CQC to remove the S31 restrictions.

A wide ranging programme had been initiated to launch our refreshed vision, values and purpose. The arrival of Zephan Trent, Executive Director of Digital, Strategy and Transformation will connect high level pieces into the strategic plan which will be presented to Board in the autumn.

The Board received and noted the CEO's Report.

030/22 QUALITY AND PERFORMANCE SCORECARD

AG advised that during this sustained period of demand, a comprehensive surge plan has been in place and used to effect to manage flow and capacity across all services to maintain response to service needs.

CPA review continues to be below target, focussed actions are in place regarding the caseload with some delays relating to accuracy of the reporting window. Where there are breaches, supervision is used to ensure safety is maintained. Occupancy levels have risen and the average length of stay is outside of the national benchmark and continues to be higher for those that have been detained.

At the time of writing of the report, the ambition to reach zero out of area placements by 31 March 2022 was on trajectory; however over the past week increasing activity had resulted in a number of out of area placements. Although a recovery plan is in place, AG highlighted the potential impact this may have on the end of March ambition. Despite this increase in activity, overall we continue to benchmark favourably both regionally and nationally in OOAP and Delayed Transfers of Care.

AG acknowledged the significant work of the CAMHS Tier 4 service and the improvements made following the CQC unannounced inspection. AG added that Tier 4 capacity is not the only solution to the challenge of the care of children and young people and advised that EPUT are taking a proactive leadership role to look at the system wide approach.

Waiting times for podiatric surgery have increased during the pandemic and there have also been challenges to source adequate theatre capacity. An interim plan is in place and we are working collaboratively to look at a sustainable solution.

AS referred to the exploration of caseload review and capacity and queried whether we are looking at the transfer of patients into caseloads within the organisation – specifically access and transfer of case records; and if so, how this risk is managed. AG advised that this is down to practice and within the supervision process will ensure that practice is robust. AG would provide outside of the meeting case study examples of how this is working. AG continued that a shift away from CPA to a single care plan for all is good learning.

ARQ suggested areas of concern are the average length of stay being outside of where we would like it to be; the flow and capacity project is in its infancy and as AG previously reported, the ambition for zero out of area placements by 31 March was now under question. AG confirmed that discharge plans are in place however the ambition had been compounded by a number of issues including delays in social care and issues relating to children and young people in health based places of safety. AG advised that this is a systematic piece. Until last week the trajectory for out of area placements was on target, however recent complex issues have affected this. ARQ stated that realism around targets was important to plan expectations and give some assurance. AG responded that the regional trajectory was now under review and out to consultation. The view of the Executive Team was to continue to work towards the original trajectory for 31 March 2022 and thus far had been pleased with the progress.

JW sought a general reflection of the impact of accountability framework meetings as there were many KPIs where we are looking for an improvement on trajectories. AG responded that this was developing. There had been a light touch phase during a challenging December, January and February however the process had now been stood up and was yielding meaningful and insightful conversations.

LL noted the interdependency of KPIs and suggested that we should aim for what is the target utilisation measure and how we design our indicators and design resource. PS responded that we are looking at engagement and how we develop data to ensure actions we take have an impact. NH commented that an energised piece of review at ESOG on the treadmill of improvement had changed the reporting format and was inclusive of more objectives of safety.

TS reported that the final stages of closure of the accounts for this financial year were taking place and were on target to deliver the financial break even position. All system, regional and national deadlines had been delivered and we now prepare for final submissions.

GB reported that the vaccination team had now delivered in excess of 1.3 million vaccinations. Recently a reduction in attendance had been seen but it is anticipated that this will increase due to the booster for over 75s and the programmes for 5 – 11 year olds. Pop up vaccination clinics are also being scheduled for the Easter holidays.

In terms of workforce, SL confirmed that 93 new staff had joined the organisation this month and the time to hire had reduced to 26 days. International recruitment continues with our first cohort of international nurses in situ with wrap around support in place. The Executive Team are looking at critical issues regarding the cost of living and are putting together plans to support colleagues. SS

commented that it was pleasing to hear that the Executive Team were looking at wrap around support for our staff.

SL confirmed that we continue to encourage bank staff (in particular those that are placed long term) into substantive positions that are flexible to meet their needs. Work also continues on retention of staff. SS noted that some neighbouring organisations have implemented new starter incentives and suggested that this may impact recruitment; SL responded that we are committed to work with system partners to work effectively to manage the context of staffing in these difficult times.

The Board of Directors received and noted the report.

031/22	LEARNING FROM DEATHS – MORTALITY REVIEW SUMMARY OF QUARTERS 2 & 3 2021/22 INFORMATION

NH presented the report which included information relating to deaths in scope for mortality review for Q2 and Q3 2021/22. NH advised that there were 48 deaths which fell within the scope for mortality review in accordance with the Trust's Mortality Review Policy in Q2 and 53 in Q3; this is in line with quarters not impacted by Covid-19 in previous years. We continue to improve timeliness of reviews and NH extended thanks to clinicians for their continued engagement.

The Trust takes a systemic approach to learning and continues to ensure that identified learning from investigations and reviews lead to improvements in practice. NH shared examples of actions taken in response to learning that were outlined within the report.

SS thanked NH for the assurance in terms of learning. JW added that there were examples of some really powerful learning included and queried how this is captured in the board assurance arrangements and stated that consideration may be needed as to how we close the assurance loop. NH agreed that there is a triangulation piece to come together and engage clinicians.

LL suggested there may be a piece to establish what are the precursors leading up to an SI to find early points of detection and intervention; stating that the challenge firstly is that it is hard to represent that information. LL would be happy to be part of the conversation to resolve this issue. SS agreed that there may be an opportunity at the Board development session to dig down and do a reflective piece.

AS suggested that there was an opportunity for a comparison of the SI and PSIRF process and build this into learning. NH confirmed that internal audit had been tasked to undertake a qualitative test; NH continued that there is added value of a centralised point of learning to inform our culture of learning work.

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

032/22	VIEWS OF MEMBERS AND GOVERNORS REPORT

SS presented the report which provided details of the mechanisms in place to meet the requirement set out in the Foundation Trust Code of Governance (Section E.1.3. – E.1.4). This report provides an overview of membership / Governor Engagement that has taken place in 2021/22.

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

033/22	BOARD ASSURANCE FRAMEWORK 2021/22

PS welcomed DG in her new role as Senior Director of Corporate Governance, explaining that DG would have executive responsibility for the Board Assurance Framework as part of this role.

DG presented the report which provides the Board with the March 2022 iteration of the BAF for noting and approval of recommendations made on behalf of the Executive BAF Sub Committee. DG continued that this was the second time the Board had been presented with the refreshed BAF which is in its infancy and continues to develop. DG stated that the purpose of the BAF is to consistently assess the amount of risk held and the level of comfort we can take with that level of risk. The BAF allows us to see where risk sits and determine if this is within an allowed tolerance, and if not identify actions to reduce this risk and see continued movement as we put in place mitigations and controls.

ML noted the inter-relation between CRR11 Suicide Prevention and CRR81 Ligature – noting that the latter was scored higher and queried whether there should be more correlation between the two. MK noted this valid point, stating that death by a fixed ligature was a never event and therefore this would explain the difference in scoring. ARQ suggested that ligature risk reduction is one element of suicide prevention and therefore there may be other elements relating to suicide prevention that score differently to each other. NH agreed that the suicide prevention agenda is broad and is linked to the ICS and regional work plans.

The Board of Directors:

1. **Noted the decisions made by the Executive BAF Sub Group at its meeting in February 2022; noting the BAF dashboards in Section 2 for February and March 2022.**
2. **Noted the risks linked to Strategic Objectives.**
3. **Noted the key risks in Section 4.**
4. **Noted the Risk Movement and Milestones.**
5. **Approved the decrease in scores on corporate risks in Section 2 in relation to Risks CRR90 Management of Covid 19 and CRR85 Mass Vaccinations.**

034/22 STANDING COMMITTEES

(i) Audit Committee (for January / March)

JW noted that there had been limited assurance from internal audit on several reviews - JW confirmed that the design of controls is generally sound, however compliance to controls needs to be improved. With regards to the external audit tender process, the COG had approved EY as the Trust auditors for the next three years. JW extended thanks to the Governors that assisted in this process.

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

(ii) Finance and Performance Committee

LL confirmed that that Trust is on target to achieve a break even position at the end of the financial year. LL commended the finance team for the extraordinary effort in light of current pressures. Despite significant changes to the goalpost, the team had worked hard to land this position and extended the Board's thanks.

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

(iii) Quality Committee

AS took the opportunity to thank teams across the organisation that have kept the quality committee informed and engaged and thanked all for the diligence of their work.

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

(iv) People, Equality and Culture Committee including Terms of Reference Approval

ML noted that the PECC was a new committee that was continuing to embed. The absolute priority is the resourcing piece which will maintain the majority of the committee's focus. ML noted that time to hire had reduced significantly and thanked SL and team for this achievement.

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

(v) Board Safety Oversight Group

ARQ was pleased to see the priority given to safety improvement to give assurance of the work taking place across the Trust; much of which had previously taken place in the background. SS looked forward to the new KPI dashboard that had been developed; ARQ confirmed that this was being finalised and hoped to begin reporting in April.

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

035/22 RISK ASSURANCE REPORTS

i) Covid 19 Assurance Report

GB presented the Covid-19 reporting highlighted that the NHS remains at its highest level of emergency preparedness – Incident Level 4. We continue to follow national guidance and respond to the challenges faced. There are currently 10 reported outbreaks in the Trust which highlights the need for continued adherence to IPC guidelines. We are now beginning to focus on recovery and business as usual.

ML thanked GB for this helpful update and considered the balance between national Incident Level 4 and judgements and decisions made as a Trust to return to 'normal i.e. patient visits, staff interaction and patient interactions etc. There have been many changes implemented and ML considered how we navigate to business as usual and how this is sketched out strategically. PS noted this valid point and suggested that as we move forward to a new normal IPC is a live issue across the NHS and how we move forward but stay safe. Discussions are ongoing across the wider system; NH confirmed that local work is ongoing to review IPC procedures. NH reiterated the importance of IPC across the organisation and noted that guidance is expected imminently regarding plans going forward.

The Board of Directors:

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

036/22 NHS PEOPLE PLAN 2021/22

SL advised that the EPUT NHS People Plan 2021/22 had been devised to see through to the end of the year with the expectation that a longer term plan will be developed. SL continued that when the plan had been developed EPUT had been in a positive position and had begun to implement the plan however it was felt that this only scratched the surface of what we do as a Trust. KG advised that the plan was based on four pillars: Looking after our people, new ways of working and delivering care, belonging in the NHS and Growing for the future; with 9 work streams aligned to these pillars. There are 70 actions; currently 57 of which have been delivered and 13 in delivery.

In terms of recent key deliverables, a new disciplinary procedure that promotes just learning and restorative culture has been launched and 'Here For You' has been fully embedded within the Trust.

The absence of a long term NHS People Plan has allowed the opportunity to build something bespoke to EPUT that aligns with the strategic objectives with a focus on culture. Recruitment and retention is also key. There is further work to improve staff experience and review the long term strategy for home working. SL added that it is important to focus on working with colleagues to create a colleague charter to hold all to account and a new people strategy will be backed up by the people charter. AG advised that the Executive Team are committed to deliver and make EPUT the best place to work and the right leaders in place to lead compassionately is key to this. ARQ commented that it is acknowledged that there is a recruitment shortage in terms of the 'pool' that we recruit from and queried where the use of multi skilled professionals and using different roles fit in to this. SL responded that as an organisation this is something we focus on and how we create new roles through time to care will deliver new roles.

MJ queried how we measure culture change over time; stating that we need to ensure we have support mechanisms, innovation and the financial packet to provide this. SL commented that how we build talent without overloading bands was key, providing learning and support to enable progression.

SS noted that there were many exciting developments happening, acknowledging there was still work to do; however it was great to see progress in terms of how we look after our people. SS extended thanks to KG and team for continuing to drive through.

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

037/22 MENTAL HEALTH AND COMMUNITY HEALTH SERVICES TRANSFORMATION

AG presented the report which provided an update on transformational work that has taken place in 2021/22 and highlights of transformational plans for 2022/23. AG provided the following key headlines:

- Underpinning all community transformation work is a move to early intervention.
- What has been highlighted is that despite a significant period of sustained operational challenge, there was no pause or stop of transformation plans.
- It is a testimony to colleagues that we continued to recruit over 300 staff during this challenging period.
- New primary care model has been developed and implemented in the Thurrock area.
- The DIST model is growing and embedded in physical health services.

Over the coming year we will continue to see the place model embedded and new care models with a move away from CPA. We have the potential for Family Group Conference model to be replicated across other services. We have a MH Emergency Department model that forms the blueprint for other systems and we have taken learning from Covid in the community health space and have seen virtual wards continue to grow. Key to transformation work is the close working with primary care at place based level and the development of leadership teams.

ARQ noted the amazing work that had gone into this given and the scope of achievements given the ongoing challenge presented by Covid-19. ARG queried how we measure the difference in improvement of population health and safety and how we assure ourselves that what we are doing are the right things. AG agreed stating that we continue to develop KPIs and look at what transformation is delivering. If we do this well, we should see less people requiring specialist support

and we need to consider how we then adapt to that. A lot of transformation work is underpinned by partnership and we need to develop and build in outcome methodology.

PS agreed that there is a need to measure outcomes and understand the impact to improve and move forward and welcomed challenge and questions from NEDs.

SS agreed that strategic partnership can reach out and draw in real value and this links back to the BAF risk to demand and capacity and how we manage in a creative way.

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

038/22 TRUST CONSTITUTION

SS presented the report that confirmed that a review of the EPUT constitution had been undertaken and proposed amendments for ratification by the Board of Directors.

The Board of Directors:

1. **Noted the review process and the proposed amendments to the Constitution following routine annual review as approved by the Council of Governors at the meeting held Monday 21 March 2022. And the Council's agreement to amend reference to Monitor following the enactment of the Health and Social Care Bill without the requirement to represent for approval.**
2. **Approved the Constitution as proposed.**
3. **Approved prospectively to amend references to Monitor in the Constitution following the enactment of the Health and Social Care Bill without the requirement to represent for approval.**

039/22 SAFE WORKING OF JUNIOR DOCTORS QUARTERLY REPORT (OCT-DEC 2021)

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.

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

040/22 USE OF CORPORATE SEAL

The corporate seal had been used twice since the previous Board of Directors meeting.

1. 01 March 2022 Lease renewal Jackson Road, signed by Trevor Smith, Executive Chief Finance and Resource Office and Paul Scott, Chief Executive.
2. 07 February 2022 Transfer of Chelmsford and Essex Centre signed by Trevor Smith, Executive Chief Finance and Resource Officer and Paul Scott, Chief Executive.

041/22 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

There were no items of correspondence circulated to the Board.

042/22 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.

043/22 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

MJ welcomed this opportunity to stop and reflect on the conversation held as a Board; stating that discussions had been diverse, inclusive and had allowed all to vocalise and accept constructive challenge.

MJ reflected that the presentation from the Family Group Conference service had set the tone of the meeting regarding equality and inclusivity ensuring that family, relationships and the service user are kept at the forefront. SS agreed that discussion had been empowering, compassionate and authentic and there was a sense of a unitary Board of Directors.

044/22 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.

045/22 ANY OTHER BUSINESS

There was no other business.

046/22 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 25 May 2022, which will be held virtually via the MS Teams video conferencing facility.

047/22 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 12:31.

Appendix 1: Governors / Public / Members Query Tracker (Item 047/22)

Governor / Member / Public	Query	Response provided by the Trust
John Jones, Lead Governor	Agenda item 7a page 29. Capital Spend. Planned for £14.4m and acted £9.7m – this is a high variance, why is the forecast so out of step from the actual and does the shortfall affect key risks in patient safety and building maintenance?	TS responded that there had been a 'back end' loaded programme which had historically been the case, however we were now in a much better position regarding levels of investment. There had been an issue regarding work and supplies due to Covid, but this was now on track to be fully accounted for by year end.
Pippa Ecclestone, Governor	CEO Report Introduction. Para 5. What is meant by "Our children's services are fully up and running."? [PS] …?are all the beds in Poplar, Larkwood and Longview available? ….if not then how many EPUT CAMHS beds are in use and what is the present waiting list situation? [any news on what MH service available to under 13 yr olds?]	AG: Following the recent visit by the CQC, we have been given permission to re-open to admissions without first seeking permission from the CQC. At present, Poplar ward is fully occupied with 13 young people. Longview currently has 7 patients with capacity to admit 3 more young people. There are a further 5 beds on Longview which are closed to admissions due to ongoing building work. Larkwood PICU have 3 patients and limited ability to admit due to both the seclusion room and long term segregation room being occupied at present. CAMHS do not operate a waiting list. All referrals for admission go through to the central patient flow hub, operated by HPFT on behalf of the East of England provider collaborative. Referrals are screened by the hub and admissions prioritised on the basis of clinical presentation and risk. CAMHS beds for children under the age of 13 years are provided by Cambridge and Peterborough NHS Foundation Trust at the Ida Darwin unit in Cambridge.

Signed: …… Date: ……

In the Chair

Pippa Ecclestone, Governor	CEO Report - At the recent "New EPUT Patient and Public Forum" we had a very powerful contribution from a service user who made a strong case for help and support being available for **Adults with Eating disorders** who fail to meet the criteria for our Eating Disorder Services, who are referred to the MH Dietician……***but there isn't one in post.*** ***In light of the present increased pressure on Eating Disorder Services [not just for children]*** this seems to be a very short sited omission which means that Adults with this disorder have to get worse before they can get help and hopefully, get better. Please can we do something to rectify this gap in our services?	AG: Over the next two years the Trust will work closely with commissioners and other organisations to transform eating disorder services in Essex. We intended to significantly increase staff numbers in the Trust's Eating Disorders Service and recruiting dietitians is an important part of this plan. We have recruited one dietitian in the last year and intend to recruit more over the coming year. An important part of the transformation plan is to ensure there is a comprehensive, joined-up service to support everyone who needs it. Therefore, the Eating Disorders Service intends to work closely with other teams to provide appropriate training and support to the Mental Health dietitians in Essex. It is recognised there are service gaps in MH dietetics and a plan is indeed in place to rectify this, to recruit dietitians and to provide comprehensive coverage and support – both within the community and on the wards - for people who are not otherwise supported by the Eating Disorders Service. We know that there is a significant Dietitian shortage nationally and mental health is still seen as a specialist area for Dietitians which can exacerbate recruitment challenges. We will be taking a comprehensive approach to building a service that is attractive to work in, enables Dietetic students to be placed in and includes apprentice pathways. We are part of a stakeholder group at UEL looking at Dietetic apprenticeships and have got some innovative Dietetic student MDT placements arranged in mental health services next month.
Pippa Ecclestone, Governor	**People & Culture [7/7]** Penultimate para ……..re "I want great care" launch. Two references to % increases…..related to [1] FFT responses and [2] public attendance at the "New EPUT public forum". *Without the actual numbers of people involved this means very little [*but can sound like a lot].	The patient experience team acknowledges the need to provide numbers when reporting improvements in the future to support the percentage representation and is committed to doing this moving forward.

Signed: …… Date: ……

Pippa Ecclestone, Governor	**BOARD ASSURANCE FRAMEWORK** Section 3. Oversight framework [page 12/30] Admissions to Adult facilities of patient <16 =….."Requires Improvement" …….is this automatic if it occurs? …..how many days was the <16 at the HBPoS in the Lakes?	The client stayed on the 136 suite for the duration of the admission (14/02/22 – 12/04/22). And yes any instance of an admission will revert this RAG rating to amber due to the target being 0.
Pippa Ecclestone, Governor	"Could Alison Rose Quirie clarify something in her BSOG Group Report to the last Board Meeting". Re. Basildon Emergency Department Diversion. To me this sounds like a MH Assessment Unit….?…or is it something else? [No doubt needed I'm sure] But in what way will it "reduces the need for referrals to a GP following an emergency/crisis"? Is it not important to keep the GP in the loop?	ARQ: As I understand it the Basildon Emergency MH Diversion is the equivalent to an A&E for MH. Staff triage and assess patients then signpost them on as appropriate. This reduces the pressure on A&E and thereby unnecessary admissions and fast tracks MH patients that need immediate support. The GP is kept in the loop in the same way as they are with A&E attendance. I am copying in Richard James in case I have omitted anything? Hope this helps give you some reassurance.

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 30 March 2022)

Lead	Initials	Lead	Initials	Lead	Initials
Sean Leahy	SL				

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
March 040/21	Engagement Strategy to be reset and presented to the next Board of Directors meeting.	SL	~~May 2021~~ ~~July 2021~~ ~~November 2021~~ ~~January 2022~~ ~~March 2022~~ April 2022	Part of the HR review which will be completed in June 2021. **Update 28.07.2021**: There is a lot of work being undertaken following the HR review and therefore this action is deferred to November 2021. **January 2022:** Item deferred until March 2022 due to current upsurge in the Covid-19 pandemic. **March 2022:** The Engagement Strategy will be socialised at the next Board Seminar session in April. May '22 Update- Communications, Brand and Marketing Strategy was discussed at the April	Complete	

Minutes Red	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
				Board meeting and is on the agenda for May meeting.		

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 May 2022**

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

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

Purpose of the Report		
This report provides a summary of key headlines and information 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:

- Board of Directors Strategy and Planning Day
- Prospective Governor Workshops
- Mid and South Essex Community Collaborative Board
- Service Visits
- 15 Step Visits to Service Areas with Governors
- International Nurses Day

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

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

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

Acronyms/Terms Used in the Report			
NHSE	NHS England	NED	Non-Executive Director
ICS	Integrated Care System		

Supporting Documents and/or Further Reading
Main Report.

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

Agenda Item: 5
Board of Directors Part 1
25th May 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 Board of Directors Strategy and Planning Day

I was delighted to have the Trust Board of Directors together at Anglia Ruskin University on 27th April, where we were able to spend dedicated time reviewing Trust strategic priorities and discussing enabling strategies.

2.2 Prospective Governor Workshops

With our Governor elections taking place this summer, the Trust Secretary's Office held a series of workshops via MS Teams for people interested in finding out more about the role and nomination process. The Non-Executive Directors and I were delighted to join a number of these sessions to meet our prospective Governors.

2.3. MSE Community Collaborative Board

The collaboration between EPUT, Provide & NELFT that has been forged to transform and improve community services for the communities that we serve across Mid and South Essex, continues to gather positive momentum. I have rotated back into the Chair for the ensuing six months. We have established key performance indicators (KPSs), so that we can measure and track service improvements. Our collective ambitions remain strong.

2.4 Service Visits

As restrictions are eased, the Non-Executive Directors and I are pleased that we have been able to recommence face to face visits to services. A forward plan of visits is in development and I am looking forward to visiting Brockfield House next week alongside our Executive Director of Digital, Transformation and Strategy, Zephan Trent. Other very recent visits by Non-Executive Directors have included Rawreth Court and a virtual session with the West Essex Pain Management team.

2.5 15 Step Visits to Service Areas with Governors

These structured visits, involving Governors with Non-Executive Directors and Executive Directors, had to be halted during the course of the pandemic for reasons of safety and infection prevention and control (IPC). With the Covid-19 restrictions now consistently easing, it is intended to recommence this programme, supported by clarity of IPC guidance.

2.6 International Nurses Day

On Thursday 12th May the Trust recognised and celebrated the work of our nursing and nursing support staff for International Nurses Day. Two virtual events were held, one of which heard from our international recruitment and workforce development leads on our exciting work to expand and support our overseas nursing workforce at EPUT.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

3.1 Written Evidence Submitted by Organisations and Experts to Inform the Women's Health Strategy for England: Please see the report below published on 13 April 2022. This report summarises the written responses to the call for evidence from 436 organisations and experts in

women's health. This is an extremely useful report for the Trust as the Topics raised include the need for greater support for pregnancy loss and menopause training for clinicians. These responses will help shape the first government-led Women's Health Strategy in England as part of plans to level up health care. **For Information: Link**

3.2 **Health Management and Policy Alert:** Please see the link below for a copy of a report. It is an extremely informative report for the workforce team as it contains a range of recommendations to develop the mental health nursing workforce. It outlines eight system-wide recommendations addressing issues including career progression and encouraging nurses to remain in the profession. Each set of recommendations is broken down into action points for areas of work - analysing where and how changes can be made, to guide future policy. **For Information: Link**

3.3 **National Infection Prevention and Control Manual for England:** Please see the link below for a copy of the guidance published on 14 April 2022 that will be useful to all Trust sites. It has been produced to provide an evidence based practice manual; for use by all those involved in care provision in England and should be adopted as mandatory guidance in NHS settings or settings where NHS services are delivered and the principles should be applied in all care settings. **For Information: Link**

3.4 **Integration and Innovation in Action: Provider Collaboration:** Please see the first link below for a copy of a report published on 21 April 2022 that aims to bring together NHS providers, voluntary sector and the wider health care system to reduce mental health inequalities and may be something that the Trust is interested in pursuing. Sheffield Health and Social Care NHS Trust, Primary Care Sheffield, NHS Sheffield Clinical Commissioning Group, Sheffield City Council, Sheffield Mind and Rethink Mental Illness already has a collaboration between primary care, community and voluntary that has helped reduce inequalities. The second link explains why having a shared vision and purpose is key as it allows the network to redirect resource to where needed in the community and the third link sets out the key benefits and outcomes. **For Information: Link; Link; Link**

3.5 **Major Health Education England Review Recommends Ways to Develop The Mental Health Nursing Workforce:** The points raised could be used in helping the Trust's nurses cope with the transition and encouraging nurses to remain in the profession. Please see the link below for a copy of the recommendations that focuses on ensuring mental health nurses are supported when transitioning from student to newly registered nurse along with supporting professional development, working closely with people who have experience and identifying and promoting core skills. **For Information: Link**

3.6 **10 Year Plan for Mental Health Provides Opportunity to Shape Wider Understanding and Tackle Scale of Demand:** Please see the link below for a copy of the Mental Health and Wellbeing plan published on 12 April 2022. The NHS Confederation have been calling for a cross government plan for mental health and so the 10 year plan presents an opportunity to shape wider understanding of good mental health and ensure organisations beyond the health sector are held accountable. The second link is a copy of the updated paper published on 14 April 2022 that is open to consultation. The government is committed to improving mental health and wellbeing outcomes across the country. Its commitment to 'level up' and address unequal outcomes and life chances across the country and is developing a new plan for mental health and wellbeing. **For Information: Link; Link;**

4.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by
Angela Horley
PA to Chair, Chief Executive Office and NEDs
On behalf of
Professor Sheila Salmon, Chair

		Agenda Item No: 6
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 May 2022**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1 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	✓
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			
ESOG	Executive Safety Oversight Group	BSOG	Board Safety Oversight Group
ECOL	EPUT Culture of Learning	ESR	Electronic Staff Record
F2SU	Freedom to Speak Up	ET	Employment Tribunal

Supporting Documents and/or Further Reading

Lead
 **Paul Scott** **Chief Executive**

CEO Report

1.0 Key Issues

This report will set out key issues for the Board and provide a highlight of the progress EPUT has made since the previous Board meeting in March 2022.

Demand and Development of our Services

As has been widely predicted, demand for mental health services has increased in the aftermath of the pandemic. In response, our teams across the Trust continue to focus on our recovery, working incredibly hard to support those who need it. This means that, at times, some of our patients wait longer than we would expect to access our services. We have a range of measures in place that will alleviate this including building on the investment in our community mental health teams, enhanced specialist support to primary care, the establishment of crisis houses and a mental health emergency department.

Our ambition to be the "leading mental health and community provider" means that we need to think differently about how we support people and arrange our services. To learn more about how we can achieve our ambition, I continue to meet with patients, and their families, to understand better how it feels to be a patient in our services. It is clear from these meetings, and feedback from other stakeholders that 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 and I will continue to meet with patients and families to understand if we are having an impact on this.

As highlighted in the NHS Long Term Plan, the pandemic, alongside the rise in service demand, has demonstrated the need to embrace innovative ways of working, using digital technologies to transform the delivery of care and improve patient outcomes. The Trust continues to be an early adopter of technology and innovation to support service improvement, and I am delighted to see the reestablishment of our Virtual Wards to supplement face to face contacts with patients. We are committed to increasing our Virtual Wards throughout 2022/23, focusing particularly on the development of a Frailty Virtual Ward, and the expansion of our successful Respiratory and Heart Failure Virtual Wards.

With those suffering from crisis a priority within our Integrated Care System (ICS) and Clinical Commissioning Group (CCG) partnerships, I was delighted to see the opening of the first Crisis House in Basildon, as part of the new 24-7 Mental Health Crisis Response service via 111 option 2, providing help and support for adults experiencing a mental health crisis. These step down facilities offer an exciting solution to keeping people out of an acute psychiatric setting and within a therapeutic one, where people's needs may be better met.

Integrated Care Boards

We know, however, we will not achieve our ambition alone and working closely in partnership with our local health and care partners, the voluntary sector and our local authority colleagues will be vital in realising our future goals. Last month, the Health and Social Care Act 2022 received Royal Assent, establishing a legislative framework to formalise the ICSs and incorporating proposals to form NHS statutory Integrated Care Boards (ICBs). These ICBs will be tasked with the commissioning and oversight of NHS services across a specific geography and population, accountable to NHS England, for spending and performance. This significant change will build on existing work to join up services, increase data sharing between partners, and solidify the move away from a focus of competition to one that promotes collaboration, integrated care and addresses the wider determinants of health. The

anticipated launch of our three ICBs (Mid and South Essex, Suffolk and North East Essex and West Essex ICB) on 01 July is an exciting development and I look forward to working closely with our ICB partners to collectively plan and improve services, meeting the needs of our local population and helping our communities thrive.

Essex Mental Health Independent Inquiry

We continue to support the Essex Mental Health Independent Inquiry, which remains on track to publish its findings in April 2023. Our Project Team have been working on new requests received from the Secretariat, and we continue to do so with full transparency and an unwavering commitment to learning lessons and improving our services. In addition to staff briefings, details of the inquiry are available to staff via the Intranet and the dedicated website portal. We remain grateful to all of those who took the time to share their experiences with the Inquiry, and we encourage anyone who wishes to provide their views to come forward, making use of the wellbeing measures we have made available wherever needed.

International Nursing Day and Mental Health Awareness Week

Finally, this month saw us celebrate International Nursing Day, observed globally on 12 May each year, to mark the contributions that nurses make to society. This month also marked Mental Health Awareness Week, throughout which we held events to raise awareness of this year's theme of Loneliness, whilst last week we marked Dementia Awareness Week, illustrating the importance of developing new and innovative approaches to improve care for people living with dementia. The need to build and maintain meaningful connections with friends, family, colleagues and communities has never been more apparent, and I would therefore like to take this opportunity to thank all our staff for the extraordinary compassion, flexibility and collaboration they display to our patients, families and colleagues every day.

2.0 Performance and Operational Issues

Safety and Quality – Natalie Hammond, Executive Nurse

We continue to provide assurance on the activities relating to the Safety Strategy through our spotlight reporting into the Executive Safety Oversight Group (ESOG) and Board Safety Oversight Group (BSOG). In this period, we have successfully delivered the objectives of the Safer Staffing initiative.

Our programme of work to improve the accurate completion of patient observations, has now successfully delivered its desired outcomes. We instigated multi-disciplinary task and finish groups with membership from ward leadership teams, medical teams, AHPs, Corporate Services, Quality Services and senior Trust leadership. We implemented uniformed templates for use across the Trust, processes for the recording of observations and decision-making, clearly worded guidance that staff can easily now follow, and enhanced training for substantive, bank and agency staff. This programme of work has now transitioned to business as usual and will be managed through the local governance processes.

The serious incident themes received from the Coroner's report have been organised into six common areas; policy, training, care coordination, communication, governance and patient records. They 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 programme (ECOL) has now successfully on-boarded a Lessons Communication Business Partner. They have been instrumental in developing an infographic that is

being used already to cascade information on Learning Lessons across the Trust. Recruitment for the outstanding roles has also been successful with only the Lessons Database Manager left to recruit. This new team will drive this programme of work to embed EPUT's culture of learning ambition.

Finance – Trevor Smith, Executive Chief Finance and Resource Officer

The Trust has recently submitted its financial accounts 2021/22 for external audit; it is now working to the new financial plan for 2022/23 as agreed by the Board of Directors last month. The new financial plan includes significant efficiencies to improve our use of resources and a number of investments with £11.3m of capital planned to improve the Trust's infrastructure, estate and medical devices.

The Trust is working closely with its system partners to ensure the very best use of resources across the integrated care systems (ICS) it provides services. This includes continued support to the stewardship initiative within Mid and South Essex ICS to drive best value for our patients and population.

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 its system partners as we move forward.

Operations – Alex Green, Executive Chief Operating Officer

There have been no increases in inadequate performance for our commissioner and internal KPI's.

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.

I am pleased to report that delivery against our refreshed system out of area elimination plan is progressing. Inappropriate out of area placements are reducing bringing us closer to our EPUT ambition of zero by the end of June.

Our inpatient capacity continues to fluctuate with a small increase in average length of stay in acute adult mental health. Our inpatient care unit is about to embark on a flow coaching initiative to support improvement and we have refreshed our approach to system escalation as part of our work on purposeful admission. The number of our beds closed due to COVID is reducing with occupancy rates also slightly reduced.

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 rollout of the new MaST tool (management and supervision tool) has commenced and will enable enhanced local performance management oversight at an individual level.

The interim plan to recover wait times for Podiatric Surgery remains in place with recruitment underway along with a prioritisation strategy for new client sessions. This, along with the exploration of longer term solutions for theatre provision, is expected to recover these waits.

Major Projects – Nigel Leonard, Executive Director of Major Projects

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 1.325 million vaccinations.

Since the last report to the Board, we have seen an increase in footfall through our centres, with the delivery of the Spring Booster programme to:

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

We have also played a significant role in the delivery of the vaccination to healthy 5 – 11 year olds, who became eligible to receive the vaccine at the start of April, coinciding with the Easter holidays. We took action to ensure that the environment of the vaccination centres was appropriate and welcoming for younger children, to help them feel at ease. Feedback from parents and children has been extremely 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. As well as running sessions within the vaccination centres, we delivered a number of "pop up" sessions during the Easter holidays in other locations to ensure ease of access to the vaccination. We also offered family sessions within our vaccination centres and in the pop up sessions to enable families who had children of different age groups or any adult family members due a Spring Booster to have their vaccinations as part of one longer appointment.

Throughout this period we have also continued working with our system partners to look at innovative ways to increase vaccination opportunities for people who have yet to take up the offer of vaccination. This has included continuing the mobilisation of our vaccination buses particularly within areas of lower uptake and areas with high demand. We have also recently started to support the systems in the delivery of the Spring Booster in care homes and to those eligible who are housebound, where these cohorts are not being covered by a GP led local vaccination service (LVS).

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.

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

Workforce

Work has progressed over several months 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 the Band 4 Nurse 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. This has impacted on mandatory training compliance which has dropped by 1% and the ability to deliver some of the other professional development courses which are planned. However, the situation appears to be improving and it is hoped that the recovery plans can now be fully implemented.

Innovations in training are continuing and the Immersive Training Project is now going to be extended as a collaborative project to the MSE ICS. It is hoped that procurement can commence by July.

Staff Engagement and Wellbeing

EPUT's 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. A deeper dive into the detail of the survey results shows that the Trust has been successful particularly in looking after the Health and Wellbeing of staff.

It's important to acknowledge there is more work to be done and staff have told us there is room for improvement in areas including reward and recognition, autonomy, and feeling empowered to speak up to raise concerns. We are committed to working on making improvements in these areas and engaging with our staff directly to implement positive change. We have delivered four workshops across the trust where all staff have been invited to take part, and where we have discussed the results and begun co-creating solutions and action that our staff would like to see implemented and will form a trust wide action plan.

Recruitment

We continue to analyse the insights we receive through our staff and pulse surveys at every level to respond to what our staff have told us. Our vacancy and turnover rates remain well within the target levels, and in March alone we welcomed 133 new permanent and fixed term starters, as well as 128 new bank staff, whilst having further reduced our recruitment time to hire to 23.1 days from shortlisting through to unconditional offer. Alongside our local recruitment initiatives, we continue to welcome our international nurses and look forward to welcoming further cohorts throughout the rest of the year.

The Trust's Freedom to Speak Up (Whistleblowing) Policy and Procedure has been reviewed and agreed with staff side representatives, and we are currently is out to market to recruit for a new Principle Freedom to Speak Up Guardian.

Communications

We developed content to mark stress awareness month throughout April with a sustained campaign across all channels, including specific events. There has also been activity to mark Mental Health Awareness Week with new content and a series of events to explore this years' theme of 'loneliness'. We have also celebrated nurses across the organisation on International Nurses Day with a series of events and wider communications telling the stories of nurses from across the Trust. We continue to focus on the regular rhythm of communications with bi weekly all staff briefings, a bi weekly CEO blog and a Manager's one pager to support all managers in cascading messages to their teams. Now that the pre-election period restrictions on press releases has ended the team are focussed on generating positive news coverage as well as ongoing management of reactive media interest.

Marketing and Brand

The new Trust website went live in April with great success with the Marketing and Brand Team receiving some great feedback. The rebrand also went live in April/May, with numerous bits of collateral, signage and internal documents being updated and rolled out across the Trust's estate. The new Marketing & Brand strategy has been approved and the team looks forward to working on some exciting and innovative campaigns to really showcase the Trust as a positive place for all our service users and staff.

Volunteers

Our volunteer management system is now full digitised though Kinetic, and we currently have 185 volunteers registered, up from 110 since Aug 2021. We continue to work with our Mass Vaccination Team to bring the volunteers into our digital system, which will support the management and further cross pollination for volunteer services.

Patient experience

We continue to develop the conditions for person-centered care services through meaningful involvement with the demand for coproduction growing exponentially in all areas. Further to this we are supporting the emerging systems to embed meaningful involvement and service design across the systems. Our lived experience team is growing, although we have plans to accelerate this to support the demands both locally and across system. 'IWantGreatCare' is now live and, although uptake is still relatively low, we are looking to align with the Safety Team to raise its profile.

PALS and Complaints

The coproduction project for redesigning the complaints process is progressing well with NHS England / Improvement suggesting that if we continue as we are it will likely be recognised nationally as case study for innovation in this area.

Medical Directorate – Milind Karale, Executive Medical Officer

Medical Recruitment Fair

The Trust is holding its first ever recruitment event for doctors on Friday 17 June from 2pm to 7pm at the Crystal Centre with the aim of attracting new doctors at all levels into the organisation.
A dedicated project team has been working on this event, led by Dr Vyasa Immadisetty, which includes representatives from medical workforce, communications, marketing and the Trust project team.

The schedule for the afternoon will include an opportunity to meet with clinical directors and other colleagues with dedicated time slots to discuss roles either face to face or virtually.

The event is being published across our social media channels and a digital campaign will be launched next week targeting areas of both London and Essex, signposting viewers to the medical recruitment fair webpage where they can find more information and register to attend.

Older Adult Home Treatment Team

The new Older Adult Home Treatment Team for southwest, set up with transformation funding, also called the FIRST (Functional Intensive Response & Support Team) started functioning from this month. The team has already facilitated early discharges from the ward and are working with the CMHTs to support patients who are deteriorating in their mental health.

Medical School Report

Catering to two medical schools; Norwich Medical School, University of East Anglia (UEA) and Anglia Ruskin University (ARU), the Trust is involved with both block Teaching/campus based teaching and clinical placements for students**.** The total number of students in clinical placements from both ARU

and UEA is nearly 200 each year with positive experience ratings reported within most units, of supervisors and from on call shadowing. Trainees and Consultants have been involved in MMIs (multiple mini interviews), Medical School exams, ARU OSCE assessments, contributing to question banks and providing formative/summative assessments.

Dr Kallur Suresh has been elected to the Executive Committee of the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists.

Dr Feena Sebastian has been elected to the Old Age Faculty Executive of the Royal College of Psychiatrists.

Dr Edwin Ugoh (Trust Clinical Lead on Addiction) has signed on as an addiction tutor network clinician to improve the addiction training competencies of future psychiatrists. EPUT now has an inpatient detoxification unit based in Chelmsford, this is an important milestone in EPUT as it again firmly established the Trust position as a frontline NHS trust in the management of substance addiction and dual diagnosis.

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 May 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 – *mandatory section*		
Summary of risks highlighted in this report	All inadequate and requiring improvement indicators.	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	Continued monitoring of Trust performance through integrated quality and performance reports.	

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

Recommendations/Action Required
The Board of Directors is asked to: 1. 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 1 (April 2022) The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) have reviewed performance for April 2022. Four inadequate indicators (variance against target/ambition) have been identified at the end of April 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 April 2022 • Out of Area Placements There are no inadequate indicators in the EPUT Safer Staffing Dashboard for April 2022. There are no inadequate indicators within the CQC scorecard. As the end of April 2022; 1 (1%) individual action is in progress and not yet due for completion and there are no individual actions overdue. 7 (99%) individual actions have been completed. Within the Finance scorecard one item has been RAG rated inadequate for April. • Temporary Staffing The Trust has initiated a significant International Recruitment campaign which will assist in reducing reliance to temporary workforce. 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
April 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.

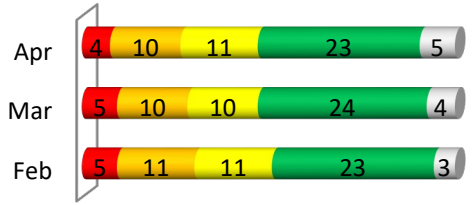
How is data presented?

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

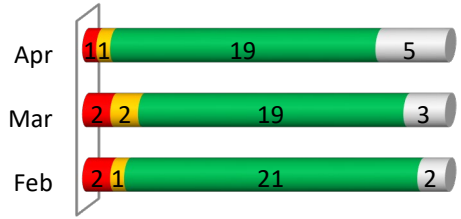


April Inadequate Performance

- 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



April Inadequate Performance

- Out of Area Placements

Summary of Safer Staffing Indicators

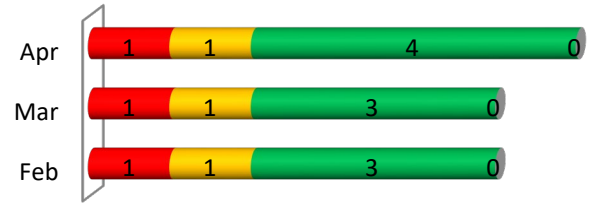
Three risks identified within the Safer Staffing section. There is currently a project underway being led by the Head of People Programmes to enhance the staffing reporting with new metrics which will enable improved monitoring and mitigation.

Summary of CQC Indicators

The CQC undertook an unannounced site re-inspection at all 3 wards on 1st March 2022, the Trust is awaiting the outcome of this.

As the end of April 2022; 1 (1%) individual action is in progress and not yet due for completion and there are no individual actions overdue. 7 (99%) individual actions have been completed.

Finance Summary



April Inadequate Performance

- Temporary Staffing

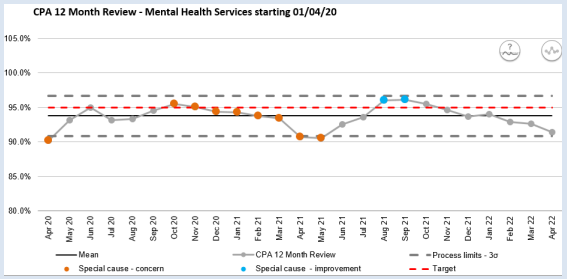
Capital Resources have now been added to the scorecard.

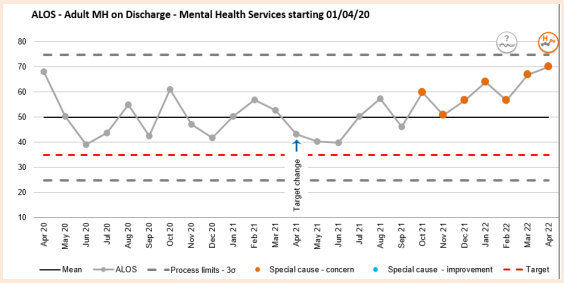
SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

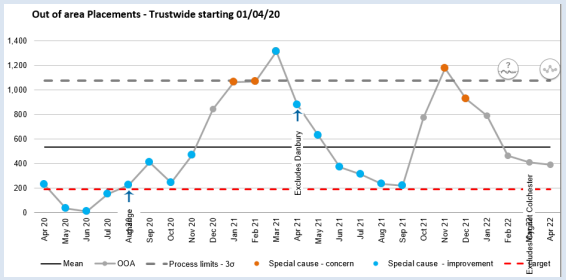
<table>
<tr><th colspan="8">Effective Indicators</th></tr>
<tr><th rowspan="2">RAG</th><th rowspan="2">Ambition / Indicator</th><th colspan="2">Position M1</th><th rowspan="2">Trend</th><th rowspan="2">Nat RAG</th><th rowspan="2">Narrative</th><th rowspan="2">Recovery Date</th></tr>
<tr><th>Perf</th><th>RAG</th></tr>
<tr><td>2.3 CPA Review

Committee: Quality
Indicator: National
Data Quality RAG: Amber</td><td colspan="7">Inadequate
CPA Reviews has been highlighted as inadequate in April, overall performance remains below target at 91.5%, this is a reduction from the position reported in March (92.7%)

Staffing levels and COVID pressures continue to impact performance. Staff 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) has also begun rollout which will enable staff to further monitor their caseloads.</td></tr>
<tr><td></td><td>People on CPA will have a formal CPA review within 12 months

Target 95%</td><td>91.5%</td><td></td><td>Above Target = Good
 
</td><td></td><td>14 Teams in the South, four Teams in Mid, three Teams in NE, two Teams in West and one Trust Wide Team below target.</td><td></td></tr>
<tr><td>2.9 Inpatient Capacity Adult & PICU MH</td><td colspan="7">Inadequate
Locality joint inpatient and community review and discharge planning meetings are now established in each locality offering senior oversight on progression to discharge and an escalation structure to support delay avoidance. Meetings are informed by Red to Green NHS E/I improvement methodology and address Ward and Trust level constraints. System DTOC are raised in weekly meetings with Health and Social Care commissioning. Discharge Coordination teams lead a monthly review of clinical information for all Adults with LOS 28+ days to ensure all have an active treatment plan, an allocated care coordinator, barriers to discharge are understood and that there is progression to discharge with escalation to Clinical Director, Service Manager and Associate Director for review if required. Monthly review consistently indicates clients with an extended LOS are in active treatment and extended inpatient admission is clinically appropriate.</td></tr>
</table>

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Indicator: Local Data Quality RAG: TBC	2.9.2 Adult Mental Health ALOS on discharge less than NHS benchmark **Target: <35** (Adult Acute Benchmark 2020 35)	69.9 days	●	Below Target = Good 	●	Consistently failing target 106 discharges in April (34 of whom were long stays (60+ days)). Adult Acute 2020 benchmark EPUT result was 31, against a National mean of 35.	TBC

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**	April has seen a further positive reduction in out of area bed days, 390 (excluding Danbury & Cygnet). Recent increases in mental health presentations to A&E and further ward closures due to COVID outbreaks had affected this indicator. The target to achieve 0 placements by the end of March has not been met and the Trust continues to discuss challenges with NHSE/I. The revised target has now been set to 0 placements by the end of June. 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. Four new clients were placed OOA (three Adult & one PICU) in April, and following the repatriation of four (Adult), there were 13 remaining (12 Adult & one PICU) OOA at the end of the month.						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA**	390 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	June 2022

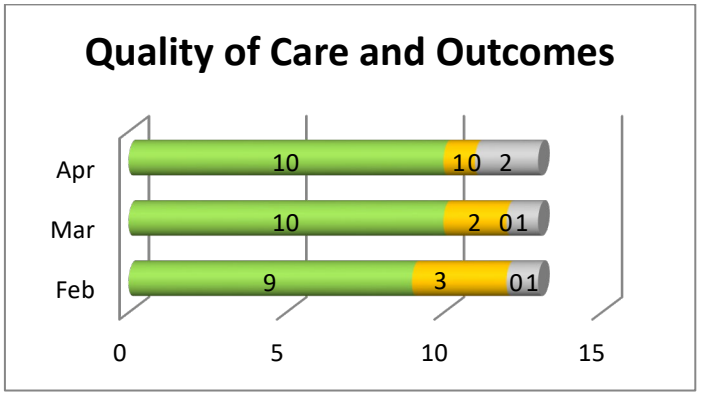
4.10 Psychology Committee: Quality Indicator: Local Data Quality RAG: **Blue**	4.10 Clients waiting on a Psychology waiting list	Development work, initiatives, and improvements continue to be made across the Adult Community Psychological Service with continued scrutiny being invested to best utilise available resource. In addition, the Trust continues its project to transfer the psychology waiting lists to the EPR systems, an initial planning meeting has taken place along with further scoping sessions. This has identified potential developments needed for both Trust systems. This development will allow more enhanced oversight, clearer reporting, and reduce the current staff pressures to maintain the manual waiting list. The Psychological Awareness Programme (PAP) continues to be the first provision of engagement, which helps service users understand their presenting problem better, and prepares them for the demands of therapeutic intervention. This has resulted in a reduction in DNAs as well as improved service user choice. It also introduces to service users the concept of change readiness, and helps them consider what barriers there may be to their ability to make the best use of therapies offered. This is the first step in any intervention, and as such forms the foundation of the intervention journey. This leads to an accessible formulation focused assessment that can support the development of a clinically informed treatment and safety plan. This results in people accepted initially being seen in a responsive timeframe, which, with recent improved investment in capacity, is reducing as the backlog of clients is addressed. The PAP set-up also supports wider MDT engagement, a robust risk management response and ensures that people are sitting in a clinical pathway confirmed as being appropriate to meet their needs, and fast-tracks treatment in groups. In South East Essex the wait times across localities have overall reduced from referral to first meaningful intervention contact (referral to PAP/formulation based assessment). Wait times for subsequent intervention sessions remain static overall, even with additional resource. This can be understood by the overall increase in referral rates. All people waiting for the next phase of therapy receive a 1 hour risk and goal review session every 12 weeks. The South East ACP has been fully staffed since the start of the year, although a small resource is currently lost due to a secondment. This underspend will be used to recruit support on bank over the summer, to bridge the gap between placement students. This ensures the robust running of the service's clinical pathway. Four DBT groups continue to run in South East. There are additionally 2 STEPPS groups running across the area. These interventions form part of the complex needs pathway. The number of referrals in all localities continue to have variability each month. Southend has the highest referral rate across ACP and Southend and Castlepoint have the highest referral rate for DBT. Within South West The wait times across localities were stable for some time before step 4 was introduced, however they are now starting to reduce. This is a positive step showing that despite no reduction in demand we are starting to reduce the backlogs in both ACP and DBT/STEPPS pathways. Resource will be allocated to manage waits and the plan is to move some resource from establishment budget in Thurrock to Basildon/Brentwood to bring more parity in wait times across the South West. It will take time for the step 4 model to embed into the system. The Head of Service is working closely with the South West CCG's and step 4 providers in both Thurrock and Basildon/Brentwood to create a data set to evaluate the effectiveness of the service. This will include the impact on ACP referral rates and wait times.

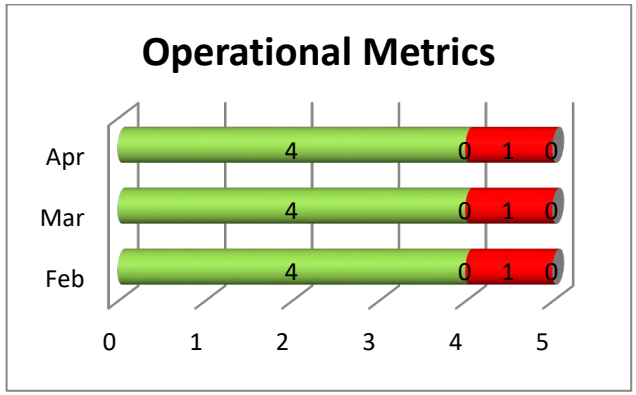
		Once the backlogs are cleared, ACP South West should be able to meet demand with the newly commissioned resource, if remaining fully resourced without vacancies, and assuming the demands do not increase substantially. We should also see system-wide access improvements through developments in ARMS, PCN and other transformation initiatives. 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 April 2022: CastlePoint: ACP Assessment to Treatment currently has the highest average wait time with an average of 9 months. There are 16 clients waiting at this stage. Rochford/Rayleigh: ACP Assessment to Treatment currently has the highest average wait time with an average of 8 months. There are 31 clients waiting at this stage. Southend: ACP Assessment to Treatment currently has the highest average wait time with an average of 12 months. There are 77 clients waiting at this stage. Thurrock: Individual DBT currently has the highest average wait time with an average of 26 months. There are 5 clients waiting at this stage. • Basildon/Brentwood: Individual therapy currently has the highest average wait time with an average of 13 months. There are 56 clients waiting at this stage.

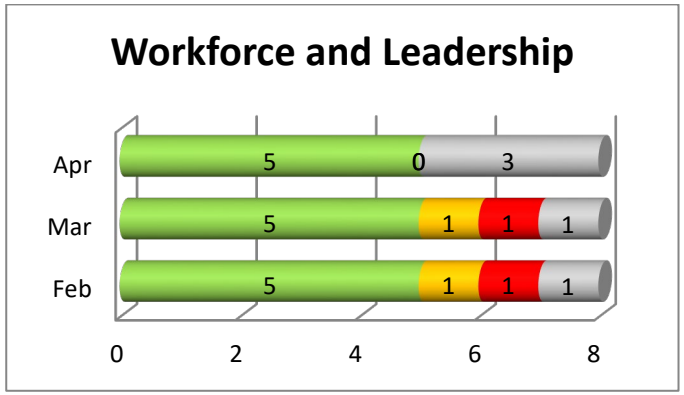
SECTION 4 - OVERSIGHT FRAMEWORK

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

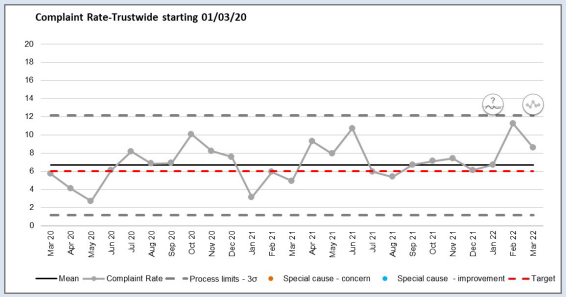
Requires Improvement

- Clients in Settled Accommodation

<table>
<tr><th colspan="8">Quality of Care and Outcomes</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M01
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td rowspan="2">5.1.1 CQC Rating

Committee: FPC
Data Quality RAG: Green</td><td>Achieve a rating of Good or better</td><td>Good</td><td>●</td><td colspan="4">The CQC has rated our CAMHS service as ‘inadequate’ in 2021. A restriction has since been imposed onto the registration for the CAMHS service.
Following improvements made and assurances provided to the CQC, the CAMHS units can take admissions.</td></tr>
<tr><td>No action plans past timescale</td><td colspan="2">●</td><td colspan="4">The CQC has undertaken an unannounced site re-inspection at all 3 wards on 1st March 2022, the Trust is awaiting the outcome of this.
67 (99%) individual actions have been completed; 1 (1%) individual actions are in progress and are not yet due for completion and there are no individual actions are overdue.</td></tr>
<tr><td>4.1.1 Complaint Rate

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

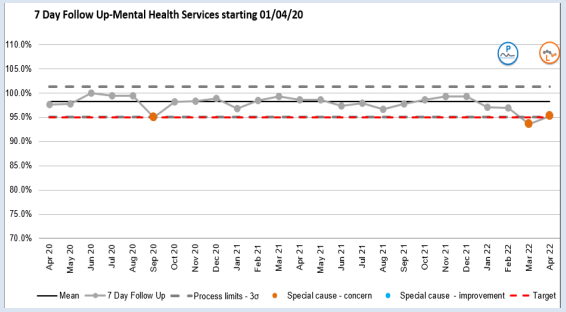
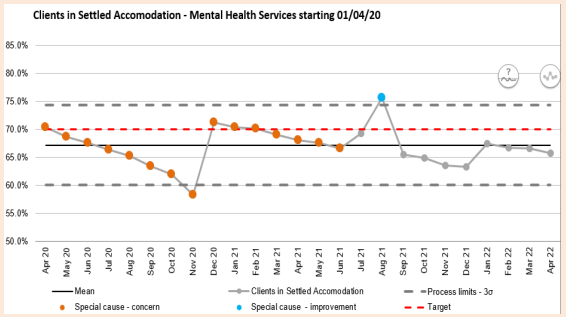
Locally defined target rate of 6 each month</td><td></td><td>●</td><td>Below Target = Good
 
</td><td>●</td><td>Awaiting complaint rate data.</td><td>N/A</td></tr>
<tr><td rowspan="2">5.6 Staff FFT

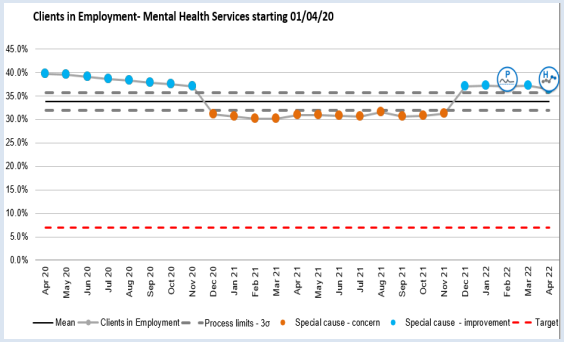
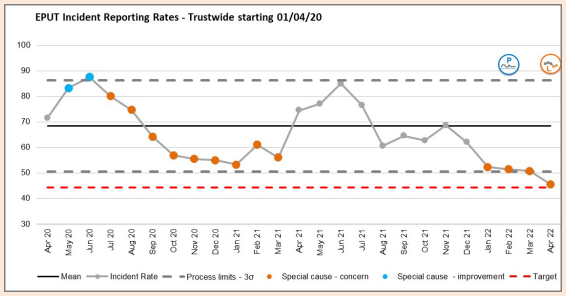
Committee: FPC
Data Quality RAG: Green</td><td>5.6.1 Staff FFT recommend the Trust as place to work

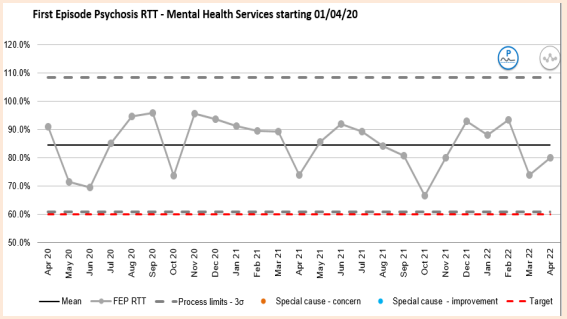
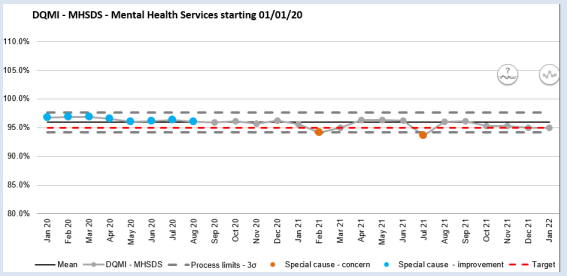
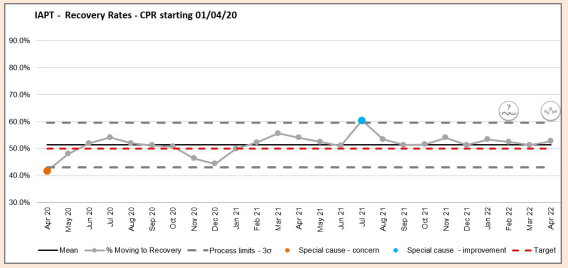
Target 63%</td><td colspan="5" rowspan="2">The Staff FFT has been replaced with the National Quarterly Pulse Survey. This launched on the 4th January and closed on the 31st January. Results will be provided once published.</td><td></td></tr>
<tr><td>5.6.2 Staff FFT recommend the Trust as a place to receive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

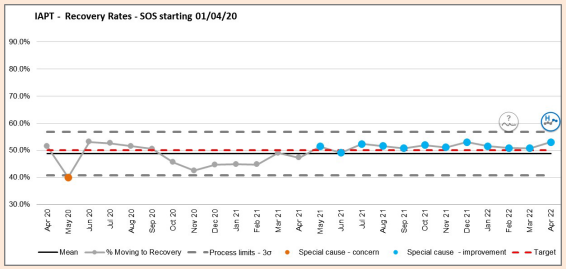
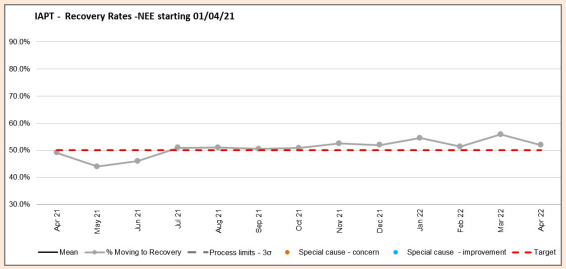
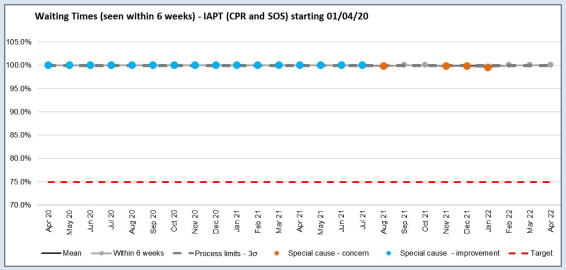
Target 74%</td><td></td></tr>
<tr><td>1.1 Never Event</td><td>0 Never Events</td><td>0</td><td>●</td><td>Year to Date 0</td><td>●</td><td></td><td>N/A</td></tr>
</table>

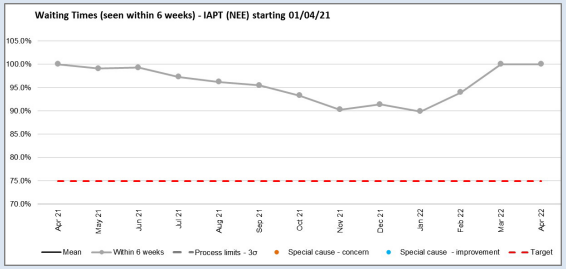
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M01**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Indicator: OF Data Quality RAG: **Blue**	**2019/20 Outturn 0**						
1.6 Safety Alerts Committee: Quality Indicator: OF Data Quality RAG: **Green**	There will be 0 Safety Alert breaches **2020/21 Outturn 0**	0	●	Year to date there have been no CAS safety alerts incomplete by deadline.	●		N/A
3.1 MH Patient Survey Committee: Quality Indicator: Oversight Framework Data Quality RAG: **Green**	Positive Results from CQC MH Patient Survey	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					
3.3 Patient FFT	3.3.1 Patient FFT MH response in line with benchmark		●		●		

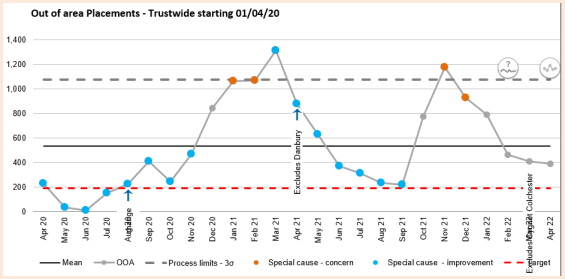
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M01**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
 Committee: Quality Data Quality RAG: **Green**	Target = 88% (Adult Acute 2020 Benchmark 88%)			I Want Great Care has been rolled out across the Trust from 23rd January 2022. We are awaiting confirmation of the FFT elements to this.		93.8% for the positive score. 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**	Mental Health Inpatients will be followed up within 7 days of discharge **Target 95%** **Benchmark 98%** (Adult Acute 2020 Benchmark 98%)	95.3%		Above Target = Good 		Discharge follow ups form part of EPUT's "10 ways to improve safety" initiative. April performance : Total 121 / 127 Adult Acute 2020 benchmark EPUT result was 92%, against a National mean of 98%	
2.4 MH Patients in Settled Accommodation  Committee: Quality Indicator: Oversight Framework Data Quality RAG **Green**	We will support patients to live in settled accommodation **Target 70% (locally set)**	65.8%		Above Target = Good 		April performance : Paris 61.6% Mobius 79.8%	N/A

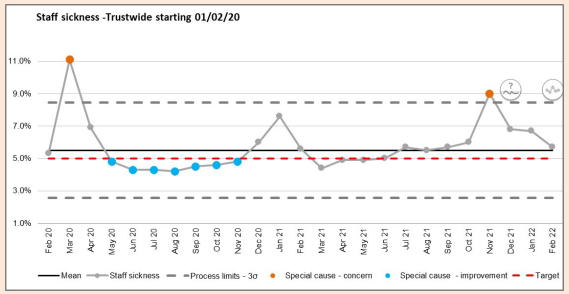
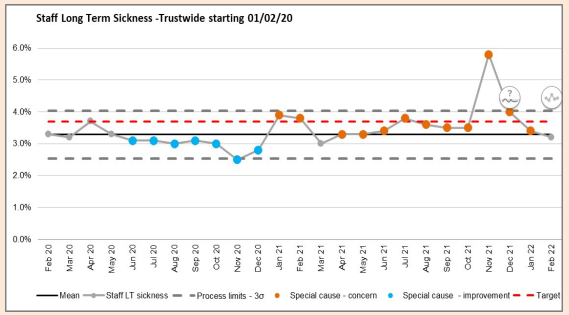
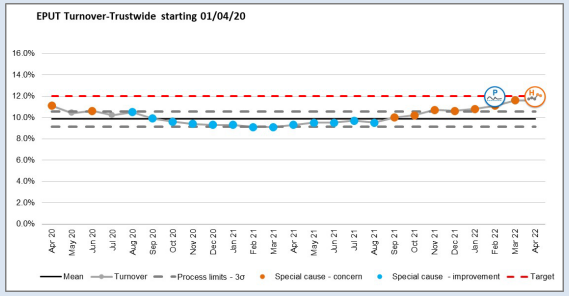
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M01**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.5 MH Patients in Employment Committee: Quality Indicator: Oversight Framework Data Quality RAG: **Green**	We will support patients into employment **Target 7% (locally set)**	36.3%	●	Above Target = Good 	●	April performance : Paris 41.9% Mobius 17.7% 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	45.5	●	Above Target = Good 	●	This is achieving target for April, with the EPUT total at 45.5. Staffing pressures are impacting on the time available for staff to sign off all incidents. This data is also extracted very early in the month due to reporting timescales and does usually improve on refresh.	
1.15 Admissions to Adult Facilities of under 16's Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	0 admissions to adult facilities of patients under 16	0	●	Zero admissions in April.	N/A		N/A

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M01**		**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%**	80.0%	●	Above Target = Good 	●	April performance represents: 20 / 25 patients.	N/A
2.2.1 Data Quality Maturity Index Committee: FPC Data Quality RAG: **Green**	2.2.1 Data Quality Maturity Index (MHSDS Score – Oversight Framework) **Target 95%**	95.0%	●	Above Target = Good 	●	Latest published figures are for January 2022	
2.16.4/5/6 IAPT Recovery Rates Committee: FPC	2.16.4 IAPT % Moving to Recovery CPR **Target 50%**	52.7%	●	Above Target = Good 	●		

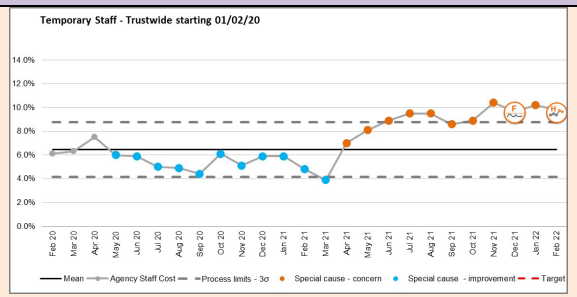
Operational Metrics							
RAG	**Ambition / Indicator**	**Position M01**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: National Data Quality RAG: **Green**	2.16.5 IAPT % Moving to Recovery SOS **Target 50%**	53.0%	●	Above Target = Good 	●		
	2.16.6 IAPT % Moving to Recovery NEE **Target 50%**	51.9%	●	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%**	100%	●	Above Target = Good 	●		

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M01**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.16.8 % Waiting Time to Begin Treatment – 6 weeks NEE **Target 75%**	100%	●	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	April has seen a further positive reduction in out of area bed days, 390 (excluding Danbury & Cygnet). Recent increases in mental health presentations to A&E and further ward closures due to COVID outbreaks had affected this indicator. The target to achieve 0 placements by the end of March has not been met and the Trust continues to discuss challenges with NHSE/I. The revised target has now been set to 0 placements by the end of June. 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.						

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M01**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: Oversight Framework Data Quality RAG: **Amber**	Four new clients were placed OOA (three Adult & one PICU) in April, and following the repatriation of four (Adult), there were 13 remaining (12 Adult & one 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**	390 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 M01**		**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%**			Below Target = Good 		Awaiting April update. The sickness figures are reported in arrears to allow for all entries on Health Roster. National data December 2021: The overall sickness absence rate for England was 6.2%. This is higher than November 2021 (5.6%) and higher than December 2020 (5.1%). Anxiety/stress/depression/other psychiatric illnesses is consistently the most reported reason for sickness absence. EPUT reported in line with the England average for this period at 6.2%.	
	5.3.2 Long Term Sickness Absence below 3.7% **Target 3.7%**			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%**	11.6%		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) No Oversight Framework Target			Below Target = Good	N/A	Awaiting data	

<table>
<tr><th colspan="7">Workforce and Leadership</th></tr>
<tr><th rowspan="2">RAG</th><th rowspan="2">Ambition / Indicator</th><th colspan="2">Position M01</th><th rowspan="2">Trend</th><th rowspan="2">Nat RAG</th><th rowspan="2">Narrative</th><th rowspan="2">Recovery Date</th></tr>
<tr><th>Perf</th><th>RAG</th></tr>
<tr><td>

Committee: FPC
Indicator: Oversight Framework Indicator
Data Quality RAG: Green</td><td></td><td></td><td></td><td> 
</td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">5.5 Staff Survey

Committee: FPC
Data Quality RAG: Green</td><td></td><td colspan="4">The 2021 Staff Survey results have now been published. The 2022 Staff Survey will launch in late September 2022.</td><td></td></tr>
<tr><td>5.5 Outcome of CQC NHS staff survey</td><td colspan="4"><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:</td><td></td></tr>
</table>

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M01**		**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 M01** **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

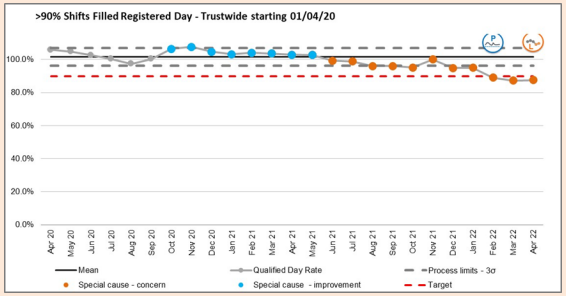
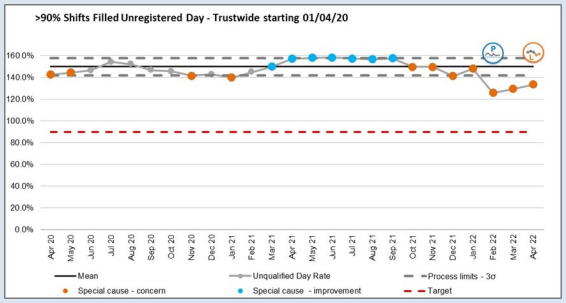
Theme: We are a team	**Score**
My immediate manager takes a positive interest in my health and wellbeing; 77.2% said agree or strongly agree In reference to the questions on line management, there is a positive message that shows that even through unprecedented circumstances and change, managers are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

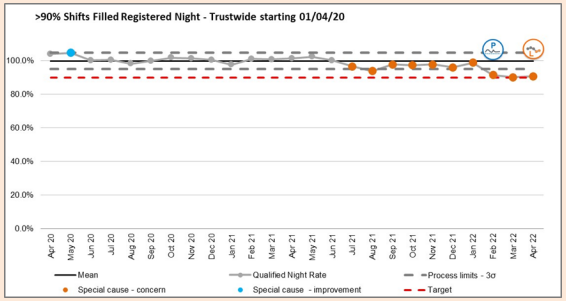
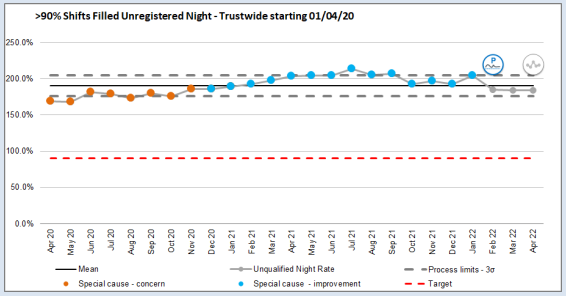
Theme: Staff Engagement	**Score**
I am enthusiastic about my job; 72% selected often/always and 2% above average. In reference to questions about motivation, here we can see that there is an opportunity for us here at the trust as despite the pressures our staff members are facing, they are still passionate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

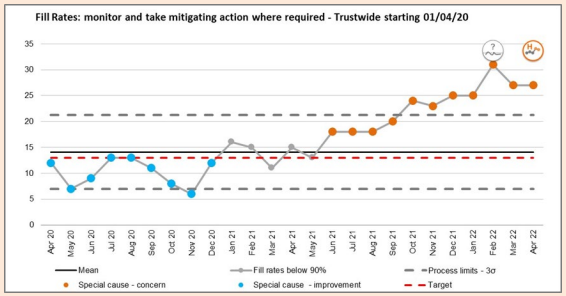
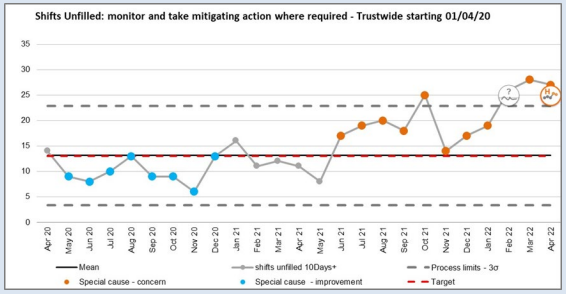
Theme: Morale	**Score**
I will probably look for a job at a new organisation in the next 12 months; 20.5% agreed/strongly agreed. In reference to questions relating to retention/ thinking about leaving, this area warrants concern as we already have staffing levels pressures.	Above Average

SECTION 5 - SAFER STAFFING SUMMARY

Click here to return to summary page

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M01**		**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 March 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 Committee.							
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	87.6%		Trend above target = good 		The following wards were below target in April: Specialist: Alpine, Aurora, Causeway, Forest, Fuji, Robin Pinto, Woodlea Adult: Cedar, Chelmer, Kelvedon, Stort, Cherrydown CAMHS: Longview, Poplar Older: Henneage, Ruby , Tower CHS: Avocet, Beech, Gibberd, Plane, Poplar Rehab: Ipswich Road PICU: Christopher Unit, Hadleigh Unit Older: Gloucester, Kitwood, Meadowview, Roding, Topaz Nursing Home: Clifton Lodge, Rawreth Court LD: Heath Close	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	133.7%		Trend above target = good 		The following wards were below target in April: Adult: Ardleigh, Cedar, Willow, Chelmer, Gosfield, Kelvedon. Stort, Cherrydown Adult Assessment: Basildon MHAU, Peter Bruff CAMHS: Longview, Larkwood, Poplar LD: Heath Close, CHS: Beech, Gibberd, Plane, Avocet Nursing Home: Clifton Lodge	N/A

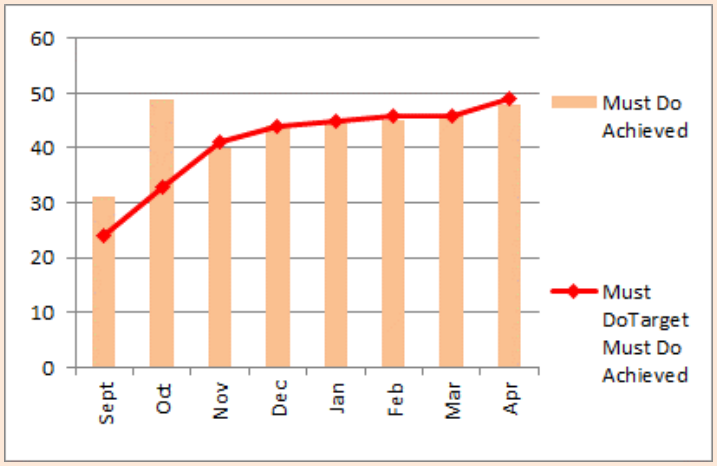
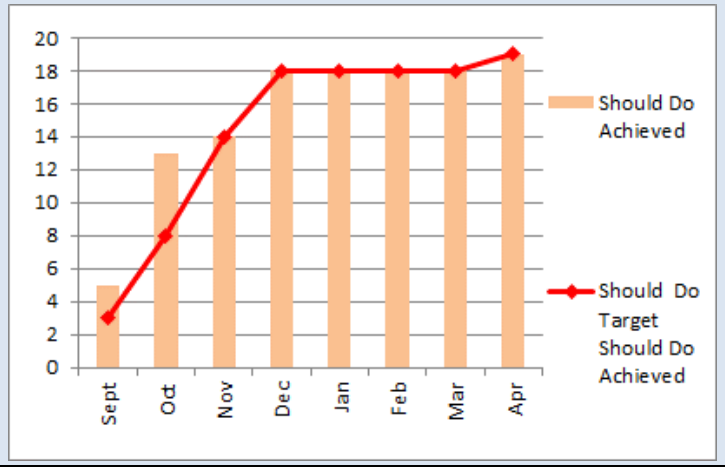
Safer Staffing							
RAG	**Ambition / Indicator**	**Position M01**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
						Older: Beech, Gloucester, Henneage, Kitwood, Meadowview, Roding, Ruby, Tower PICU: Christopher Unit, Hadleigh Unit Specialist: Alpine, Aurora, Causeway, Dune, Edward House, Forest, Lagoon, Robin Pinto, Woodlea Clinic Rehab: Ipswich Road	
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	90.8%	●	Trend above target = good 	●	The following wards were below target in April: Adult: Cedar, Willow, Finchingfield, Kelvedon, Cherrydown Adult Assessment: Basildon MHAU CHS: Beech, Poplar, Plane CAMHS: Poplar Nursing Home: Clifton Lodge Older: Beech, Gloucester, Kitwood, Meadowview, Roding, Ruby, Topaz PICU: Hadleigh Unit Rehab: Ipswich road Specialist: Alpine, Aurora, Causeway, Dune, Edward House, Forest, Fuji, Lagoon, Robin Pinto Unit, Woodlea Clinic	N/A
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts filled	184.4%	●	Trend above target = good 	●	The following wards were below target in April: Adult: Ardleigh, Cedar, Willow, Chelmer, Finchingfield, Gosfield, Kelvedon, Stort, Cherrydown Assessment: Basildon MHAU, Peter Bruff CHS: Avocet, Gibberd, Plane, Poplar CAMHS: Longview, Larkwood, Poplar Rochford	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M01**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
						LD: Heath Close Nursing Home: Rawreth Court, Clifton Lodge Older: Beech, Gloucester, Henneage, Kitwood, Meadowview, Roding, Topaz, Tower PICU: Christopher Unit, Hadleigh Unit Rehab: Ipswich Road Specialist: Alpine, Aurora, Causeway, Dune, Forest, Fuji, Lagoon, Rainbow, Robin Pinto, Woodlea	
Fill Rate	We will monitor fill rates and take mitigating action where required	27		Below Target = Good 		The following wards had fill rates of <90% in April: Adult:, Finchingfield, Galleywood, Older Adult: Topaz, Nursing Homes: Rawreth Court, Specialist: Edward House, Rainbow CHS: Beech, Cumberledge, Poplar	N/A
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	27		Below Target = Good 		The following wards had more than 10 days without shifts filled in March: Specialist: Robin Pinto	N/A

[Click here to return to summary page]

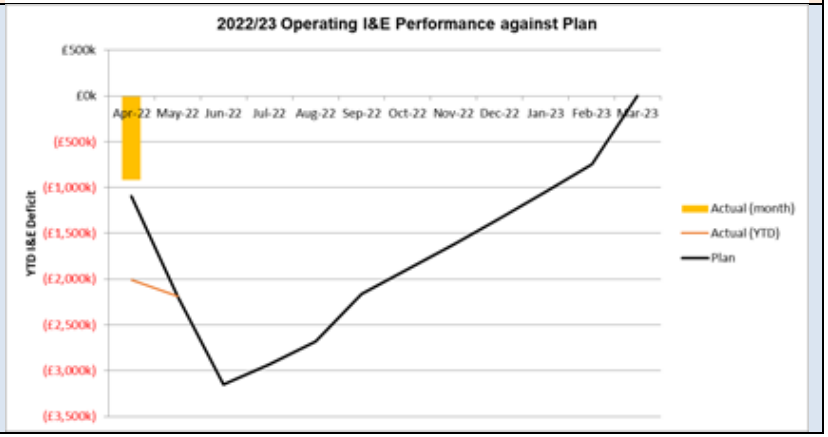
SECTION 5 – CQC

Click here to return to summary page

RAG	Ambition / Indicator	Position M1	Trend (above target = good)	Narrative
CQC Must do Actions	There will be 0 CQC Must Do actions past timescale	At the end of April 0 actions were past timescale	Achieve target = good performance 	0 CQC Must Do actions past timescale at the end of April 2022
CQC Should do Actions	There will be 0 CQC Should Do actions past timescale	At the end of April 0 actions were past timescale	Achieve target = good performance 	0 CQC Should Do actions past timescale at the end of April 2022

SECTION 6 - Finance

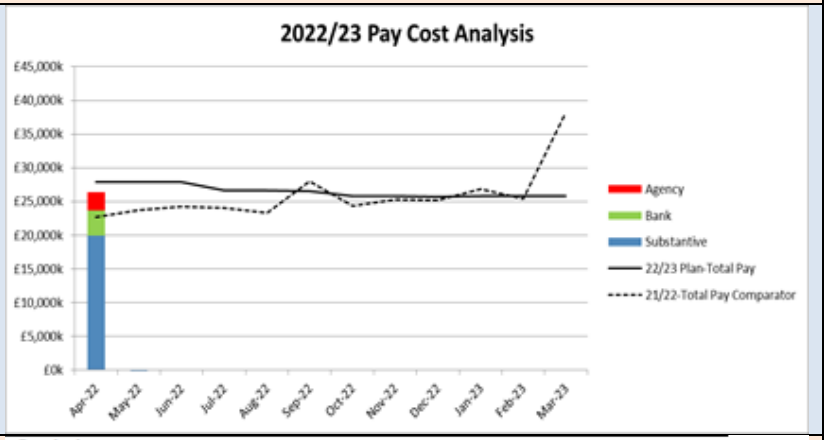
Click here to return to summary page

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). For month 1 the Trust has incurred capital expenditure of £300k against the plan of £467k.	**Capital**
Operating Income and Expenditure	Operating Income and Expenditure	The month 1 position is £914k deficit, £0.2m favourable against plan.	

	Annual Plan £000	Year to Date Plan £000	Year to Date Actual £000	Year to Date Variance £000
2021/22 Carry Forward	2,319	295	290	5
Business As Usual	3,873	5	0	5
Strategic Schemes	5,064	157	0	157
Charge against Capital Allocation	**11,256**	**457**	**290**	**167**
Critical Cybersecurity	39	0	0	0
New Leases (fleet)	877	0	0	0
PFI Residual Interest	113	10	10	0
Net CDEL	**12,285**	**467**	**300**	**167**

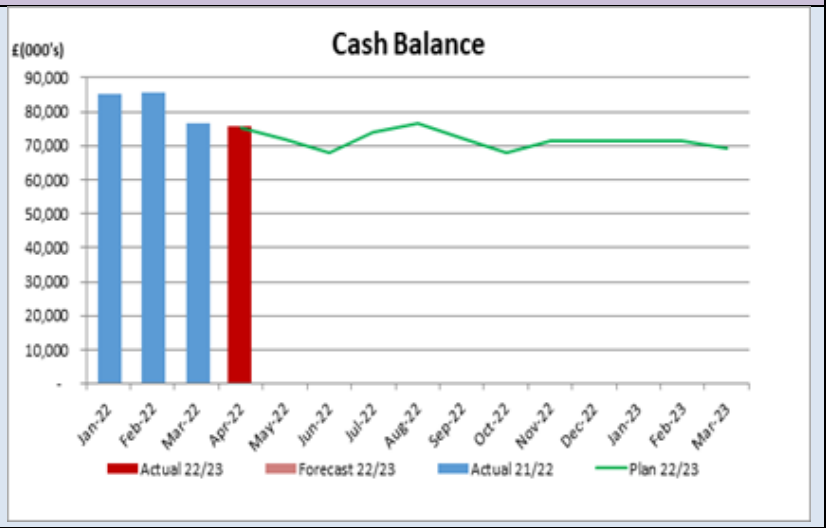
RAG	Ambition / Indicator	Position	Trend
Efficiency Programmes	Planned improvement in productivity and efficiency	In order to deliver the annual financial plan, the Trust will need to deliver £17.3m of efficiencies during the year. The month 1 reported position is £89k against the plan of £89k.	
Temporary Staffing	Level of Temporary Staffing Costs	In month temporary staffing was £6.4m; bank spend £3.7m and agency spend £2.7m. The Trust has initiated a significant International Recruitment campaign which will assist in reducing reliance to temporary workforce.	
Capital Resources	Maximising Capital Resources	The Trust plan for 22-23 is £12.3m (of which £11.3m relates to system allocation). For month 1 the Trust has incurred capital expenditure of £300k against the plan of £467k.	

	Efficiencies	YTD Plan	YTD Delivery	YTD Variance
	£000s	£000s	£000s	£000s
Indentified	6,851	89	89	0
Unidentified	10,439	0	0	0
EPUT Total	17,289	89	89	0



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	295	290	5
Business As Usual	3,873	5	0	5
Strategic Schemes	5,064	157	0	157
Charge against Capital Allocation	**11,256**	**457**	**290**	**167**
Critical Cybersecurity	39	0	0	0
New Leases (fleet)	877	0	0	0
PFI Residual Interest	113	10	10	0
Net CDEL	**12,285**	**467**	**300**	**167**

RAG	Ambition / Indicator	Position	Trend
Cash Balance	Positive Cash Balance	Cash balance as at end of M1 was £75.6m against plan of £75.4m.	

END

		Agenda Item No: 7b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 May 2022**

Report Title:	**Complaints & Compliments Annual Report 2021/22**					
Executive/ Non-Executive Lead:	Sean Leahy, Executive Director of People and Culture					
Report Author(s):	Claire Lawrence, Head of Complaints & PALS					
Report discussed previously at:	Quality Committee 12/05/22					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report

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

Purpose of the Report

This report provides the Quality Committee with a review of the overall performance of Complaints handling in EPUT as follows:

- Number of complaints received and closed during the year.
- Number of complaints referred to the Ombudsman.
- Response timescales
- Number of PALS enquiries
- Complaint themes
- Number of compliments received.

Approval	✓
Discussion	
Information	

Recommendations/Action Required

The members of the Board of Directors are asked to:

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

Summary of Key Issues

- The volume of complaints received has increased by 37% on the previous year's figure to 376.
- 92% of complaints were closed within agreed timescales, however only 59 (20%) were resolved within the 40-working day target.
- 4 complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO) which is 1.3% of the total number of complaints closed (295).
- The top category for Formal Complaints, Rapid Responses and MP complaints was "Lack of Community Support", and this was also the 4th highest PALS enquiry category.

- The number of compliments the Trust received outweighed the number of complaints about the service by over 5:1

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			
PHSO	Parliamentary & Health Services Ombudsman	PALS	Patient Advice & Liaison Service

Supporting Documents and/or Further Reading
Main Report

Lead

Sean Leahy
Executive Director of People and Culture

Essex Partnership University
NHS Foundation Trust

Complaints Annual Report

2021-2022

Contents

1.0 PURPOSE

This annual complaint report has been produced by the Head of Complaints and is based on the PALS requests, Complaints, and Compliments that have been received during the year from April 2021 to March 2022. The PALS and Complaints data has then been through a process of thematic analysis in order to find common themes and trends to which EPUT should focus their effort on improving for the year ahead. This report should be used to provide an overview of the past year and fundamentally feed into quality improvement and learning for 2022-2023.

2.0 SUMMARY

Essex Partnership University NHS Foundation Trust (EPUT) provide services to 3.2 million people living across Luton and Bedfordshire, Essex and Suffolk. We are a large employer in the East of England with more than 9000 staff working across over 200 sites. We also provide services in people's home and community settings.

The PALS and Complaints service is managed by a central team within the People and Culture Directorate and offers an extremely powerful mechanism for the Trust to receive feedback on our services and of the experiences of them for those that use them. However, it is vitally important to note that 'PALS and Complaints', whilst managed by a central team, are all of our responsibility to ensure that we provide a prompt and effective response that meets the needs of the person that has taken the time to provide feedback on their experiences of our services where reasonable. All final response letters are subject to a rigorous approval process and are seen and signed by the Chief Executive or, in his absence, a designated signatory. Although, as we move into the year ahead we want to make PALS and Complaints much more about driving quality improvement across our services, with demonstrable outcomes, and feeding into our learning culture.

The Covid-19 pandemic continued to affect EPUT last year, increasing pressure on our services as we prioritised the need to keep our patients and staff safe whilst continuing to deliver essential services within our community and inpatient settings. At times, this decision has affected our ability to respond effectively to complaints, which saddens us immensely. We had to adapt our complaints process, balancing the need to reduce the pressure on our clinical teams with continuing to provide a process to address and respond to concerns raised by our service users.

We have focussed on locally resolving complaints where we feel this would provide a quicker and more effective resolution for the person raising the complaint, and we introduced a “Rapid Response” process for responding without a formal investigation, where complaints were not complex, and the person agreed.

At the start of 2022 we launched a coproduction project to review and redesign our end-to-end complaints process. The Patient Experience team is supporting this project, and the coproduction collaborative is made up of complainants, complaint investigators, and the complaints team. We believe that this will enable us to have PALS and Complaints driving improvement and feeding into our learning culture, whilst giving the most effective outcomes for those that use our services.

Key highlights from the Annual Report:

- The volume of complaints received has increased by 37% on the previous year’s figure to 376.
- 92% of complaints were closed within agreed timescales, however only 59 (20%) were resolved within the 40-working day target.
- 4 complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO) which is 1.3% of the total number of complaints closed (295).
- The top category for Formal Complaints, Rapid Responses and MP complaints was ”Lack of Community Support”, and this was also the 4th highest PALS enquiry category.
- The number of compliments the Trust received outweighed the number of complaints about the service by over 5:1

N.B It should be noted that the figures in this report from point 3, (and those reported in the Trust’s Quality Account) do not correspond with the figures sent by the Trust to the Health and Social Care Information Centre on our national return (K041A). This is because the Trust’s internal reporting (and thus the Quality Report / Account and Annual Complaints Report) is based on the complaints closed within the period while the figures reported to the Health and Social Care Information Centre for national reporting purposes have to be based on the complaints received within this same period.

3.0 FORMAL COMPLAINTS

Number of Complaints Received

Total Complaints carried forward from 2020/21	Total Complaints Received 2021/22	Total Complaints Closed 2021/22	Total Complaints carried forward to 2022/23
59	376	295	140

376 formal complaints were received by the Trust during 2021/2022, which is an increase of 37% on the previous year's figure (275). Important to note that we do not see this increase as a negative, but as a positive because it means that more of those that use our services are taking time to provide feedback and find opportunities to improve.

Having said that, the increase in formal complaints is in part because of the following:

- The launch of the Covid vaccination programme in January 2021, which saw EPUT administer half a million vaccinations to people across Essex and Suffolk within the first 6 months (27 complaints received)

- The previous year's number of complaints was lower because of a temporary process we adopted in quarter 1 (Apr-Jun 2020). Because of the Covid-19 pandemic and the pressures that were facing our service, where right, concerns raised during this time were dealt with by PALS or responded to directly by the service, rather than being formally investigated. There were 39 complaints dealt with under this process, which would otherwise have been logged as formal complaints.

- The activity and publicity around the public enquiry has encouraged increased feedback on EPUT's services.

Received by Area

Mental Health Services saw the most significant increases, with an overall increase of 29% compared with last year.

Area	2020/21	2021/22	% change
Mid and South Essex STP	116	162	+ 40%
North East Essex STP	42	63	+ 50%
West Essex STP	22	38	+ 73%
Medical – Trust-wide	50	48	- 4%
Specialist – Trust-wide	20	12	- 40%
Total Mental Health	**250**	**323**	**+ 29%**
Community - South East Essex	16	11	- 31%
Community - West Essex	9	15	+ 67%
Total Community Health	**25**	**26**	**+ 4%**
Covid Vaccination Programme	-	27	
Grand Total Received	**275**	**376**	**+ 37%**

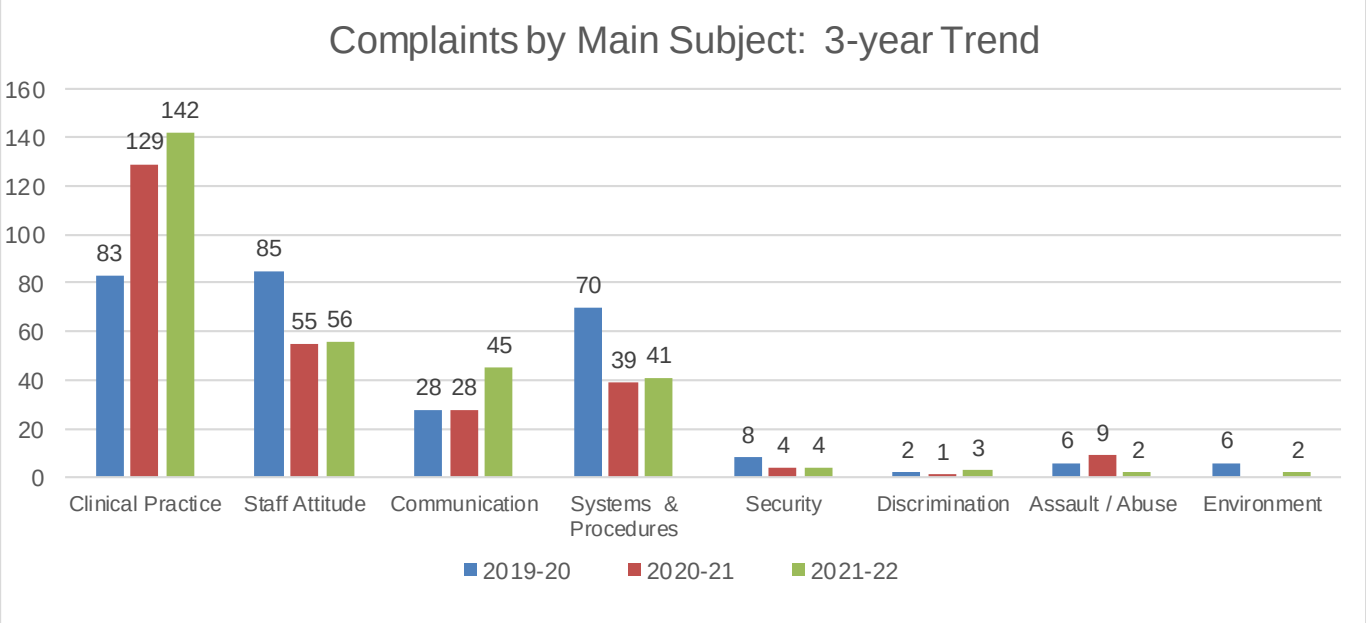
Complaint Outcomes

295 formal complaint investigations were completed and responses sent during the year, with two thirds being either upheld or partially upheld.

	Not Upheld	Upheld	Partially Upheld	Not Investigated	Withdrawn	Resolved locally	Grand Total
Mid and South Essex MH	35	13	61		3		112
North East Essex MH	15	9	27			1	52
West Essex MH	7	3	18		3		31
Medical	15	5	18	2	1		41
Specialist Services	6	1	5				12
South East Essex Community Health Services	1	3	8				12
West Essex Community Health Services	1	3	7				11
Covid Vaccination Programme	8	6	9		1		24
Grand Total	**88**	**43**	**153**	**2**	**8**	**1**	**295**
% of Total	**30%**	**15%**	**52%**	**1%**	**3%**	**0.3%**	**100%**

Complaint Themes

Closed complaints are sorted according to their category or 'theme'. The chart below shows the 3-year trend of these complaint categories.



Below are some of the trends we have seen when comparing the data across the last 3 years:

- Clinical Practice stays the highest category for the second consecutive year.
- Staff Attitude complaints are still at the same level as last year, having dropped from being the highest category in 2019-20.
- Complaints relating to Communication have increased by 61% compared to the previous 2 years.

Top ten Sub-categories of Complaint Themes

Under each Main category, there are a number of "sub-categories". The top ten sub-categories make up nearly half (48%) of the total closed complaints in 2021-21 (142 out of 295), as follows:

Main Subject	Sub-category	Number closed	% of Total Complaints
Clinical Practice	Lack of Community Support	30	10.2%
Clinical Practice	Unhappy with Treatment	14	4.7%
Clinical Practice	Assessment & Treatment	14	4.7%
Clinical Practice	Covid Vaccination	14	4.7%
Clinical Practice	Medication	13	4.4%
Staff Attitude	Unhelpful	13	4.4%
Communication	Communication breakdown with relatives	12	4.1%
Staff Attitude	Inappropriate behaviour	12	4.1%
Communication	Communication breakdown with patient	10	3.4%
Staff Attitude	Rude on telephone	10	3.4%
	Total	**142**	**48%**

Re-opened Complaints

Complainants are encouraged to let us know if they still are dissatisfied after receiving our response, so that we can try to resolve any outstanding concerns.

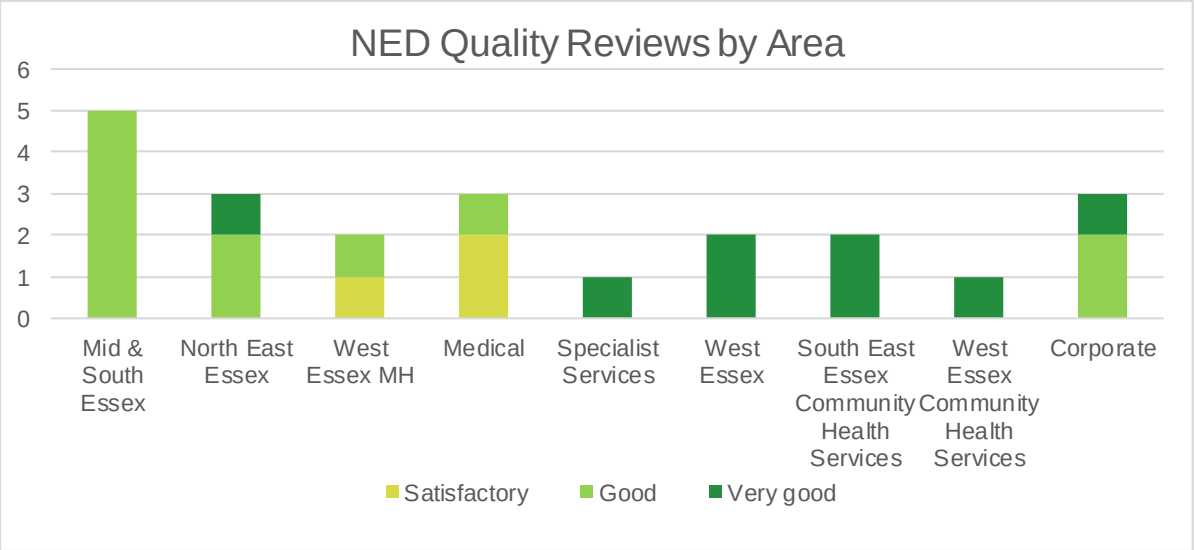
Of the 295 complaints closed in 2021/22, a total of 23 (8%) were reopened as the complainant was dissatisfied with the Trust's first response.

The reasons given for requesting the complaint to be re-opened are detailed below.

Reason for Re-opened Complaint	Number of complaints
Disagrees with response	8
Unhappy with outcome	6
New questions/ information	5
Complaint not fully addressed	2
Dissatisfied with investigation	2
Grand Total	**23**

Non-Executive Director Complaints Quality Reviews

The Trust's Non-Executive Directors (NEDs) provide an important and valuable part of the complaints process by undertaking independent quality reviews of randomly selected complaints that are marked as complete. This adds an extra level of assurance in the Trust's complaints performance. During 2021/22, 23 reviews were completed for Q1-Q3, and a further 7 complaints closed during Q4 are due for NED review. This totals 30 NED complaint reviews, which is 10% of the all closed complaints in the whole year (295). Of the complaint responses that were reviewed by the NED's, 8 were considered 'Very Good' (36%); 11 'good' (50%); and 3 were 'Satisfactory' (14%). None were considered as below 'Satisfactory'.



4.0 COMPLAINTS RAPID RESPONSE APPROACH

In 2021, we introduced a Rapid Response approach to Complaints that met specific criteria and not complicated. We recognise a complicated complaint as one spanning multiple teams, services, and often multiple organisations.

Rapid Response Complaints By Area

118 complaints received by the Trust in 2021/22 were logged as "Rapid Responses". As at year-end, 87 were resolved and 31 carried forward into 2022/23.

Rapid Responses	Received	Resolved
Mid and South Essex STP	66	51
North East Essex STP	19	16
West Essex STP	3	2
Medical – Trust-wide	8	5
Specialist – Trust-wide	5	2
Total Mental Health	**101**	**76**
Community - South East Essex	9	4
Community - West Essex	1	1
Total Community Health	**10**	**5**
Covid Vaccination Programme	7	6
Grand Total Received	**118**	**87**

Rapid Response Complaint Themes

Half of all the 87 Rapid Response complaints were logged within the top 6 sub-categories. The top sub-category was "Lack of Community Support", which was the same as the top sub-category for Formal Complaints.

Main Subject	Sub-category	Number closed	% of Total Complaints
Clinical Practice	Lack of Community Support	12	14%
Clinical Practice	Unhappy with Treatment	10	11%
Clinical Practice	Covid Vaccination	6	7%
Clinical Practice	Medication	6	7%
Clinical Practice	Poor care on ward	5	6%
Communication	Communication breakdown with patient	5	6%
		44	**50%**

5.0 MP COMPLAINTS

The Trust received 84 enquiries from MPs on behalf of their constituents, which was one more than the previous year, and the top three topics of the MP enquiries were as follows:

- Lack of Community Support (19)
- Covid Vaccination concerns (12)
- Access to Treatment (7)

6.0 LOCALLY RESOLVED COMPLAINTS

Wherever possible, all EPUT staff are encouraged to try to resolve complaints locally when they are first raised and at the earliest opportunity. The details of any complaints resolved in this way should then be passed to the Complaints Team, so that any actions taken and lessons learned can be recorded, along with the details of the complaint. This not always the case and we are aware that many issues are resolved locally without ever being recorded. On one hand this is good, as it prevents unnecessary escalation but on the other it also inhibits us from capturing and sharing lessons learned, so the team are looking at how we can make it easier for teams to self-log this activity.

There was a total of 35 locally resolved complaints recorded for 2021/22, by the following areas:

Area	Resolved Locally
Mid and South Essex MH	14
North East Essex MH	4
West Essex MH	1
Specialist Services	6
South East Essex Community Health Services	6
West Essex Community Health Services	3
Corporate Services	1
Grand Total	**35**

7.0 COMPLAINTS RESPONSE TIMES

Formal Complaints Response Times

The Trust aims to investigate and respond to formal complaints within 40 working days and where this is not achievable; we endeavour to keep the complainant updated with our investigation and planned response date. The increased operational pressure on our services caused by Covid-19 has continued to impact on our responsiveness to complaints, as investigations were delayed where we have had to prioritise immediate clinical duties.

Out of 295 complaints closed in 2021/22:

- 59 (20%) were resolved within 40 working days.
- The average time taken to respond was 75.5 working days (compared with a pre-pandemic average of 44 working days in 2019-20)
- 92% of complaints were closed within the agreed extended timescale

Based on the information above, we recognise that this means that 80% of formal complaints have not met our internal target of 40 days, with 4 out of 5 complaints delayed and timescales extended. Although we are meeting our national targets, we know that this is not good enough. This is why we have initiated a coproduction project to review and redesign the complaints process end to end, with the key objectives of improving response times and making the complaints process more user-friendly.

Rapid Response Complaints Response Times

As highlighted above, the Rapid Response process is for less complex complaints that usually just involve one area. If the complainant wishes, these types of complaint can be responded to directly by the relevant Service, without a formal investigation. We aim to resolve these complaints within 15 working days.

Out of the 87 Rapid Response complaints closed in 2021/22:

- 47 (54%) were resolved within 15 working days.
- The average time taken to respond was 23 working days

Based on the information above, generally, this approach has been effective and we will now work with teams to ensure they can meet the 15 working days target for responding.

8.0 PARLIAMENTARY & HEALTH SERVICES OMBUDSMAN (PHSO)

If a complainant is dissatisfied with the response they receive and feels that all avenues to resolve it with the Trust have been exhausted, they can ask the Parliamentary & Health Services Ombudsman (PHSO) to conduct an independent review of their complaint.

PHSO Referrals

During 2021/22 a total of 4 complaints were referred to the Parliamentary & Health Service Ombudsman (PHSO). All 4 cases are awaiting assessment by the PHSO, who will advise the Trust if they are going to proceed with an investigation. There were no new complaint cases accepted for investigation by the PHSO this year.

PHSO Investigations

A total of 4 PHSO investigations were closed during 2021/22, and all were partly upheld by the PHSO. A brief summary of these is supplied below.

ESSEX MENTAL HEALTH (NORTH EAST), Ardleigh Ward **Date of PHSO Final Report: May-21** **Final Decision: Partly Upheld**
The PHSO found a failing in the Trust not following its plans to update the complainant on his wife's progress before discharging her, and when she was in seclusion and did not give her anti-ligature clothing. The Trust's Seclusion Policy was amended in July 2019 to include the use of anti-ligature clothing together with rationales and guidance for the use of this.

ESSEX MENTAL HEALTH (MID & SOUTH), Medical (Thorpe Ward) **Date of PHSO Final Report: May-21** **Final Decision: Partly Upheld**
Complaint about the standard of care received following patient's discharge from hospital in Sep-18. PHSO partly upheld the complaint, and found there was a shortfall in ensuring that CPA processes and the patient's aftercare plan under Section 117 were properly assessed and recorded. The Trust now has a robust system in place to ensure that we capture and monitor those patients needing CPA and Section 117 aftercare, especially after a period of admission to hospital.

ESSEX MENTAL HEALTH (MID & SOUTH), Inpatient - Basildon Mental Health Unit
Date of PHSO Final Report: Aug-21
Final Decision: Partly Upheld

Patient died 3 days after being discharged, due to a heart condition. The complainant feels that the Trust missed opportunities to notice her son's deterioration and should have taken proper action. The PHSO found the care and treatment the Trust provided to the patient to be right and in line with guidance. However, failings were found in that the Trust did not update the patient's clinical record in line with its records management policy. The Trust were recommended to apologize and provide evidence explaining the steps it will take to ensure staff complete patient records in line with its records management policy.

ESSEX MENTAL HEALTH (MID & SOUTH), Inpatient – Hadleigh Unit (South)
Date of PHSO Final Report: Oct-21
Final Decision: Partly Upheld

The PHSO found that the Trust failed to refer patient for trauma therapy in 2016, and it did not take sufficient action to appropriately collaborate with her to set out her preferences for how her care should be delivered. Additionally, the Trust failed to do all the things it should have done after complainant was involved in fights with another patient. Awareness of the links and overlaps between EUPD and trauma have been raised with our clinical staff and they are able to provide Personality Disorder-specific treatments and trauma treatments. We are now more focused on negotiated goals for treatment and service user choice. £500 paid in compensation and letter of apology sent to patient.

9.0 LEARNING FROM COMPLAINTS

The Trust has a strong and developing culture of learning, and recognizes Complaints as a valuable source of feedback from which we can learn and improve our services. As part of the complaints investigation process, we always consider the actions needed to prevent errors from reoccurring, or to minimize the risk. Where learning is identified as part of a complaint investigation, the Complaints Team follow up with the relevant service to provide assurance that improvement actions have been taken forward and embedded into everyday practice. Although we know this can (and will) be strengthened during the year ahead as we work closely with the Quality Improvement and Learning Culture teams.

Lessons found are presented monthly at the Learning Oversight Committee to help Trust-wide dissemination. The Commissioners of EPUT's services also receive a report on the lessons learned from complaints for their specific geographical areas. Some examples of lessons learned from complaints over the past year are supplied below.

Examples of learning from Formal Complaints

Below are just some of the examples of learning from Formal complaints although there are many more, which are available on request.

Service: Dementia Memory Service, The King's Wood Centre	
Brief Complaint Description	**Brief Summary of Learning**
Patient's daughter complained about a letter received about her mother's diagnosis of dementia. The letter had many inaccuracies, and the diagnosis based on this inaccurate information. There is no reference in the letter to any comparison of a recent MRI to one done in 2017. The patient's daughter would like this investigated as she disputes the diagnosis.	Outcome: **UPHELD** Case explored through MDT forum and discussion in supervisions/ team meetings with memory assessment nurses. Now embedded into the process to check for any earlier scans at the point of screening referral and completing MRI safety questionnaire with patient/ family.

Service: Community Nursing (District Nurses), St Margaret's Hospital	
Brief Complaint Description	**Brief Summary of Learning**
Daughter of patient complained to West Essex CCG, she was advised the district nurses would attend her father's home to teach her how to support him and to manage his catheter, but they did not arrive. Daughter was trying to get support from physiotherapy, ulcer clinic and the memory clinic, this was not carried out either.	Outcome: **PARTIALLY UPHELD** During conversations with the complainant she suggested the creation of a leaflet in regards to catheter care, aimed at families and carers. Community services do have patient information leaflets for catheter care and all community nursing teams will be reminded to share with patients/family and carers. We are working with Princess Alexandra Hospital to improve the discharge journey for patients, family and carers with a focus on supplying correct information of what ongoing care and referrals have been made.

Service: Community Mental Health Team (CMHT), Coombewood, Rayleigh	
Brief Complaint Description	**Brief Summary of Learning**
Father of patient is complaining about the way his son has been treated by the community mental health team at Coombewood, his appointments keep getting cancelled last minute, they do not call him to advise and letters are sent out after the appointment date	Outcome: **UPHELD** More text messages will be send to patients when the notice period for an outpatient cancellation is 7 days or less.

Service: Acute Treatment Ward, The Crystal Centre	
Brief Complaint Description	**Brief Summary of Learning**
Patient's "Care and Recovery Plan" was lost. Patient has raised several concerns about other patients on the ward as she feels she is not listened to and the issues raised have not been looked into or taken seriously.	Outcome: **PARTIALLY UPHELD** Ward Manager has now introduced a new system where the "My Care and Recovery Plan" documents can *only* be handed over to ward administrators to ensure that they are uploaded on our system straightaway to prevent a similar situation from happening again.

Examples of learning from Local Resolutions (informal complaints)

Below are just some of the examples of learning from locally resolved informal complaints although there are many more, which are available on request.

Service: Therapy For You (SEE), Pride House, Laindon	
Brief Complaint Description	**Brief Summary of Learning**
Patient wanted to know why a discharge letter was sent to his GP when he missed his appointment on 27/11/20 at 3.30 when he called in explaining he had not heard his phone that day. Patient has since been booked a follow up appointment but did not receive an apology for the letter being sent.	The therapist to leave a message for the client should an appointment be missed. The therapist to wait 24 hours for contact from clients engaged in treatment missing an appointment before sending discharge letters.

Service: District Nursing Team, Rochford Hospital	
Brief Complaint Description	**Brief Summary of Learning**
Patient's daughter rang to complain her father's insulin was missed at 7am.	Following a discussion with the District Nurse, he admitted this was due to human error and he had missed the task from the day service for an early call. Matron made a follow-up phone call to the patient's daughter to explain and apologise. The night service will now check all tasks when they come on duty

Service: Specialist Community Mental Health Team, Herrick House	
Brief Complaint Description	**Brief Summary of Learning**
Patient's former care co-ordinator did not inform patient of her leaving date. Care Co told patient that she would be leaving at some point in January 2021, but patient was never informed of the date. One day on calling the service, patient was told that her care co had already left.	The importance of effective communication with patients, particularly where there are changes to the professionals involved in their care and treatment. Discussed at team meeting as case study.

10.0 TRIANGULATION OF COMPLAINTS, PSI'S AND CLAIMS

Complaints linked to Patient Safety Incidents

All complaints are logged onto the Datix reporting system and are cross-referenced with the incidents, to highlight any incidents that are connected to the complaint. Where there are complaints that are also being investigated as a Patient Safety Incident (PSI), the Complaint Investigator works collaboratively with the Patient Safety Team, ensuring that all elements of the complaint are investigated without conflict or duplication. The complainant is kept informed throughout this process.

During 2021/22, there were 24 complaints that were linked to an incident recorded on Datix. Of these, 7 were linked to a Patient Safety Incident.

A detailed root-cause analysis is undertaken for a PSI, and the final report is used to inform the complaint response. The joint learning from the serious incident and the complaint is discussed at the Learning Oversight Steering Committee.

Legal Claims related to complaints

There was 1 claim received by the Trust that related to a formal complaint this year, which is an alleged Clinical Negligence claim. A total of 2 claims were closed, with joint damages of £145,415.00.

11.0 FEEDBACK ON COMPLAINTS PROCESS

We send a survey link with our complaint responses, to gauge satisfaction with our complaints process. In 2021/22 we received 34 responses to the survey, and the results are shown below. This data has been used as part of the co-productive redesign project to understand our current position.

1. Did the investigator make contact with you at the start of the process?

	Answer Choices	Response Percent	Response Total
1	Yes	63.64%	21
2	No	36.36%	12
		answered	33
		skipped	1

2. Were all aspects of your complaint addressed?

	Answer Choices	Response Percent	Response Total
1	Very satisfied	12.12%	4
2	Fairly satisfied	15.15%	5
3	Neither satisfied nor dissatisfied	3.03%	1
4	Fairly dissatisfied	18.18%	6
5	Very dissatisfied	51.52%	17
		answered	33
		skipped	1

3. Were the reasons for the outcome of your complaint fully explained?

	Answer Choices	Response Percent	Response Total
1	Very satisfied	9.38%	3
2	Fairly satisfied	15.63%	5
3	Neither satisfied nor dissatisfied	6.25%	2
4	Fairly dissatisfied	25.00%	8
5	Very dissatisfied	43.75%	14
		answered	32
		skipped	2

4. Was your complaint dealt with in a reasonable timescale?

	Answer Choices	Response Percent	Response Total
1	Very satisfied	6.06%	2
2	Fairly satisfied	12.12%	4
3	Neither satisfied nor dissatisfied	9.09%	3
4	Fairly dissatisfied	15.15%	5
5	Very dissatisfied	57.58%	19
		answered	33
		skipped	1

5. Do you believe the complaints process is fair and would you have confidence to use it again if necessary?

	Answer Choices	Response Percent	Response Total
1	Very satisfied	12.12%	4
2	Fairly satisfied	12.12%	4
3	Neither satisfied nor dissatisfied	6.06%	2
4	Fairly dissatisfied	9.09%	3
5	Very dissatisfied	60.61%	20
		answered	33
		skipped	1

There are some themes to the survey, which we hope to resolve as part of the co-productive redesign project:

- Not meeting the expected outcome
- Perceived to be unfair therefore resulting in a lack of confidence
- General dissatisfaction with response times

12.0 COMPLAINANTS' STORIES

Story 1

Following the development and administration of the Covid-19 vaccination, EPUT received many enquiries relating to the recording of the vaccinations, through the helpline, Patient Advice and Liaison Service (PALS) and the Complaints Department.

In this instance, the complainant had received their first vaccination; however, when trying to rearrange the second vaccination this was not appearing as it should, leaving the complainant unable to rebook through the National Booking System. The complainant felt that there was insufficient information available to guide people to the correct department to enable their concerns to be heard and rectified which caused stress. EPUT recognised this as a source of frustration.

In response to the complaint, immediate contact was made by a representative of the service who explained the reason for the first vaccination not being added was due to the system being in its infancy and there was a backlog of errors. New staff were in place to rectify the issues. It was subsequently confirmed that their vaccination had been recorded; however, it would take a period of time to show correctly.

The complainant highlighted the inconvenience and frustration of having to contact several departments and they advised that there was a lack of communication despite promises of return calls. The Trust acknowledged that this was not acceptable; we require telephone calls to be returned as promised and it was disappointing that this was not facilitated. This was raised with the manager of the service for them to address directly with staff where expectations were reiterated. The complainant was advised that their feedback had allowed improvements to be made to the service to enhance the experience of future patients.

Story 2

The service user contacted their usual team expressing concern and panic about medication for addiction that was not available to collect from the pharmacy. The service users usual prescribers were absent from work on the day of the telephone call and instead they were given an alternative telephone number to call. They explained that on contacting the team they were given a date for a further appointment which would leave them without medication for 8 days leading to withdrawal and vulnerability.

Having been made aware of the situation, the prescribers acted at once to rectify the issue and arranged for provision of medication. A full investigation was completed to find what went wrong and how the risks of reoccurrence could be mitigated.

It was found that although staff did follow the correct procedure, the level of anxiety of the service user was not recognised. It would have been more proper for a return telephone call to have been made in this circumstance to gain further details and allow the service user to be heard. It was also agreed that this particular case should have been managed differently and going forwards clinicians will be approached for advice in the event that the service user makes contact.

It is important that service users feel supported and listened to, especially in instances where there is added concern about potential withdrawal due to lack of medication. Staff have been requested where possible, to call clients back, instead of asking them to call another number. This will ensure that the frustration and stress of the service user is minimised.

The staff involved were invited to attend a customer service training session. This session was also made available to all staff so that service users are placed at the centre of their care and that our staff are supported/empowered to respond on an individual needs led basis showing care and compassion.

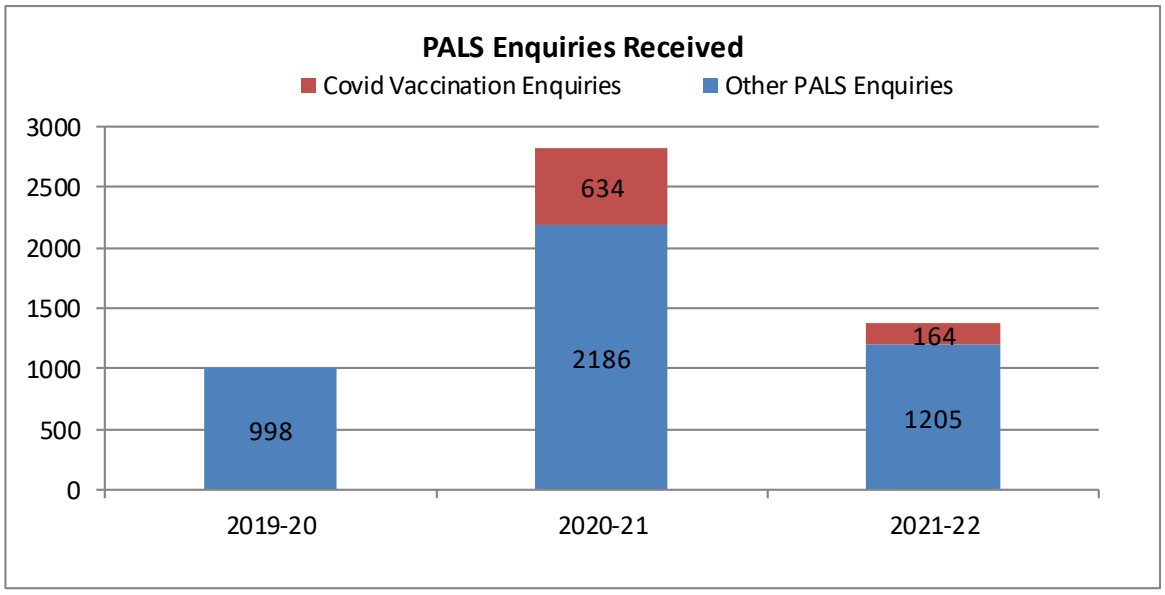
13.0 PATIENT ADVICE AND LIAISON SERVICE (PALS)

The PALS service sits alongside the Complaints Team, and serves as a first point of contact for enquiries and concerns, which are received and responded to by telephone and email. Our PALS service supplies confidential advice, support and information about all aspects of EPUT services, primarily to patients, their families and their carers.

PALS logged 1369 enquiries during the year 2021-22, which was a decrease of 51% from the previous year's total of 2820.

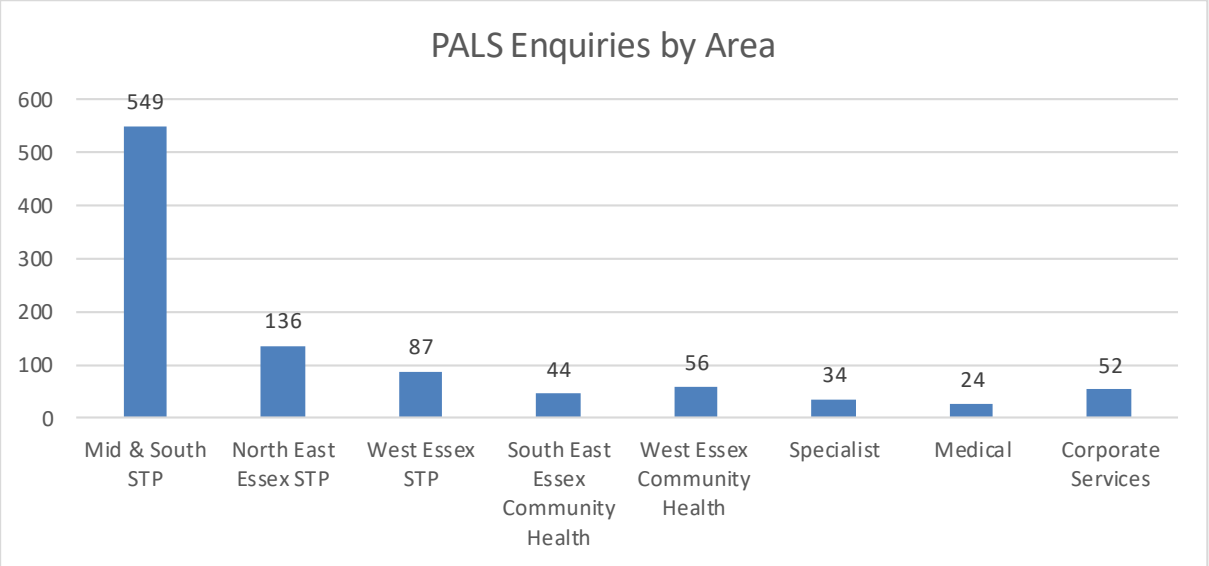
This reflects the spike in the volume of enquiries we saw in 2020-21 when the Covid Vaccination programme was first launched, and the impact the pandemic had on other services that prompted enquiries.

We continue to receive enquiries related to Covid vaccinations, however the volume of these has considerably decreased.



The majority of contacts to PALS are either resolved by the team or passed to the relevant services. If the issue requires a formal complaints investigation it is passed to the Complaints Team to action through the Trust's complaints process. A total of 17 (1.2%) were passed to the Complaints Team as formal complaints and 232 (17%) were signposted to other organisations.

The below chart shows where the PALS enquiry was referred to a specific area.



The top 10 themes for PALS enquiries in 2021/22 made up 58% of the total enquiries for the whole year (1369). These are shown in the table below as a percentage of the total number of enquiries received.

Top 10 PALS Categories	Number of Enquiries	% of Total Enquiries
Clinical Practice: Covid Vaccination	158	12%
Request for Information	158	12%
Communication breakdown with patient	117	9%
Lack of Community Support	87	6%
Unhappy with Treatment	73	5%
Communication breakdown with relatives	52	4%
Referrals / Appointments	48	4%
Access to treatment	35	3%
Medication	32	2%
Care	29	2%
TOTAL	**789**	**58%**

14.0 COMPLIMENTS

1,936 compliments were logged by the Trust in 2021/22. Services directly received 1479 compliments and 457 compliments were taken from comments made within the Friends and Family Test (FFT) feedback.

The breakdown of this was:

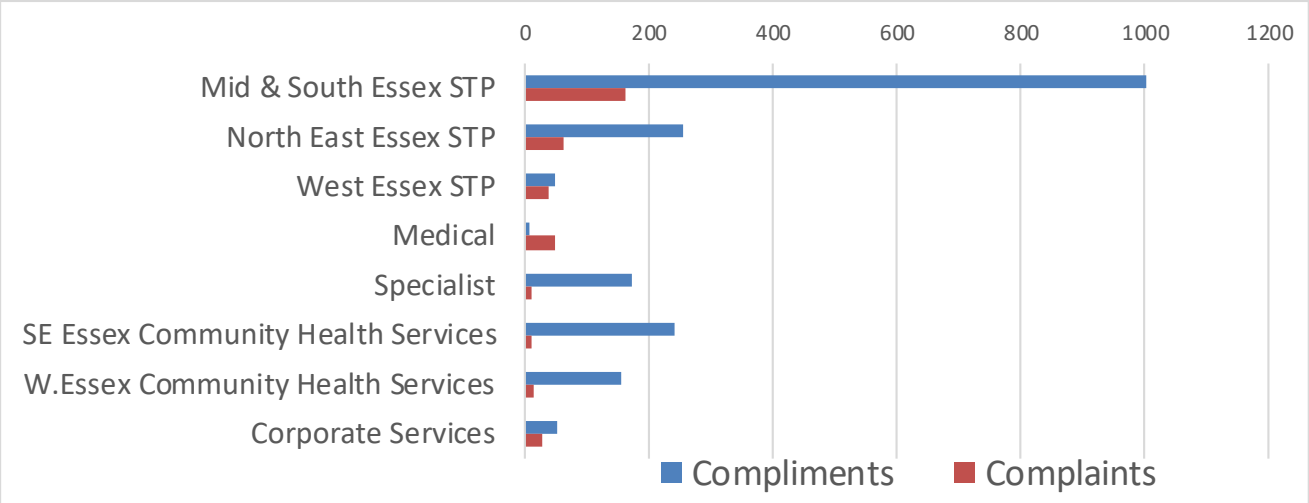
- 1487 for Mental Health Services
- 397 for Community Health Services
- 52 compliments were received for Corporate Services – mainly relating to the Covid Vaccination Programme.

Compared to last year's total figure of 1,000, the Trust has seen a significant increase in compliments received. The low figure the previous year was a direct result of the FFT being paused during the pandemic.

A selection of compliments are published regularly in our internal newsletters, and uploaded onto the website on the individual services pages. Compliments are also shared with services to discuss at their team meetings and display in their work areas.

Area	Compliments Received
Mid & South Essex STP	1004
North East Essex STP	256
West Essex STP	47
Medical	7
Specialist	173
Total Mental Health	**1487**
South East Essex Community Health Services	241
West Essex Community Health Services	156
Total Community Health	**397**
Corporate Services	52
Total	**1936**

There were over 5 times as many compliments received than complaints during the year, and this comparison is illustrated on the chart below by Area.



N.B. It is not always possible to work out when a compliment relates to the Medical Directorate, therefore these may be captured under other areas.

15.0 UPDATE ON PRIORITIES FOR 2021/22

Please find an update on the priorities set in the annual report for 2021/22 in the table below.

Priorities set for 2021/22	Status	**Action Taken**
Update our Complaints training to align with the PHSO Complaint Standards, which is a model Complaints Handling Procedure and guidance, due to be published this year	Complete	**This is incorporated within MDP Training**
Build on the work already in place to learn lessons from Complaints, ensuring that our new complaints process is robust in supporting the identification, proper sharing and embedding of lessons across the Trust.	Complete	**We have improved our process in the following ways:** • **We have a robust process for following up monthly on lessons found through complaints to ensure that actions are completed, and lessons are embedded.** • **We have included lessons found from locally resolved complaints into our monthly reporting so that these are now shared Trust-wide**
Supply support to the operational areas and improve adherence to agreed timescales by centralising the process of monitoring impending due dates and keeping complainants updated within the Complaints Team	Complete	**This process is now managed within the Complaints Team, and it has improved adherence to agreed timescales and kept us on track with updating people about their complaint.**
Develop a process to provide information of complaints and compliments made about specific staff members for inclusion in reviews and annual appraisal	Outstanding	**Carried forward.**
Explore ways to promote and publicise compliments received to the Trust.	Ongoing	**We are continuing to publicise compliments widely and have plans to work with Communications this year to promote positive stories from across all aspects of the Trust internally and externally.**

16.0 PRIORITIES FOR 2022/23

- Redesign our Complaints Process to improve satisfaction with outcomes and reduce unnecessary delays and extensions.

- Improve the way that Complaints and PALS drives learning and quality improvement across EPUT.

- Enhance PALS accessibility by creating a network of volunteers onsite within our services to provide support and advice, and proactively seek feedback from our service users.

- Improving the self-logging facilities for staff and service to log informal complaints and compliments

- Develop a process to provide information about complaints and compliments made about specific staff members for inclusion in reviews and annual appraisal

- Explore ways to promote and publicise compliments received to the Trust.

Report produced by:

Claire Lawrence
Head of Complaints and PALS

On behalf of:

Sean Leahy
Executive Director of People and Culture
May 2022

		Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 May 2022**

Report Title:	**Duty of Candour Annual Review**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Georgia Warne, Clinical Lead, Patient Safety Incident Management Team					
Report discussed previously at:	Executive Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	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*	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 annual position on Duty of Candour compliance • An updated summary of associated work streams for the year 2021/22 • An overview of the updated guidance on meeting the Duty of Candour (CQC Regulation 20)	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board is asked to:

- Note the contents of the report
- Request any further information or action
- Approve the content of the annual report

Summary of Key Issues

- The Duty of Candour actively encourages transparency and openness; the Trust has a legal and contractual obligation to ensure compliance with the standard.

- A number of areas of work are in place to support staff in encouraging an open and transparent culture. This includes a training programme, family involvement in investigations and reviews under PSIRF
- The Trust was compliant with Duty of Candour timeframes and requirements for all applicable incidents during 2021/22.

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			X
Data quality issues			
Involvement of Service Users/Healthwatch			X
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			
PSIRF	Patient Safety Incident Response Framework	PSIRP	Patient Safety Incident Response Plan
FLO	Family Liaison Officer	CQC	Care Quality Commission

Supporting Documents and/or Further Reading
Main Report

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

Agenda Item: 7c
Board of Directors Part 1
25 May 2022

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DUTY OF CANDOUR ANNUAL REPORT

1.0 PURPOSE OF REPORT

To provide the Board of Directors with an annual position on Duty of Candour compliance and an updated summary of associated work streams for the year 2021-22. The report will also provide an overview of recently updated guidance for providers on Regulation 20 – the Duty of Candour.

2.0 CQC REGULATION 20 – THE DUTY OF CANDOUR

The Duty of Candour regulation puts a legal duty on all health and social care providers to be open and transparent with people using services and their families in relation to their treatment and care. It also sets out some specific actions that providers must take when a notifiable patient safety incident occurs:

- Informing the people affected about the incident
- Offering reasonable support
- Providing truthful information and a timely apology

In March 2021, the CQC updated the guidance to make it clear what providers must to do meet the requirements of the regulation and the circumstances in which it must be applied. The updated guidance gives a more specific explanation of what is defined as a notifiable safety incident and *"makes clear that the apology required to fulfil the duty of candour does not mean accepting liability and will not affect a provider's indemnity cover".*

A notifiable safety incident **must** meet all three of the following criteria:

- It must have been unintended or unexpected.
- It must have occurred during the provision of an activity regulated by the CQC.
- In the reasonable opinion of a healthcare professional, already has, or might, result in death or severe or moderate harm to the person receiving care.

It is important to note that the presence or absence of fault on the part of a provider has no impact on whether or not something is defined as a notifiable safety incident. ***Saying sorry is not admitting fault.*** Even if something does not quality as a notifiable safety incident, there is always an overarching duty of candour to be open and transparent with people using services.

Definitions of harm:

Moderate harm
Harm that requires a moderate increase in treatment and significant, but not permanent, harm.

Severe harm
A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

Moderate increase in treatment
An unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).

Prolonged pain
Pain that a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Prolonged psychological harm
Psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Duty of Candour and PSIRF
The duty of candour requirements are referred to in the PSIRF and PSIRP. The EPUT Being Open Policy is currently under review to reflect both the implementation of PSIRF and the updated Duty of Candour guidance.

3.0 THE ROLE OF THE FAMILY LIAISON OFFICER LEADS

A review of the Patient Safety Incident Management Team establishment was recently undertaken and provided resource for an additional Family Liaison Officer. The Trust will have two dedicated Band 7 Family Liaison Officers, whose role will be separate from the Inquest Leads. Their duties will include:

- To lead and co-ordinate the role of the Family Liaison Officer across the Trust, ensuring that staff have adequate training and support to enable them to carry out their role effectively.
- To ensure that patients/families/carers are fully involved in the investigation and review processes and are adequately supported by their allocated Family Liaison Officer.
- To support the appointed Family Liaison Officers to attend inquest to accompany the family in which they have established contact with throughout the review/investigation process.
- To support the patient/families/carers to access appropriate support as and when required, fulfilling Duty of Candour principles.
- To undertake the role of Family Liaison Officer for more complex and/or sensitive cases.

Plans are in place for the role of the FLO Lead across the organisation, and this will include:

- A review of the Duty of Candour letters sent to patient/families to ensure they remain

inclusive of PSIRF principles
- Review the information sent to patients/families about the role of the FLO
- Obtain feedback from the patient/family about the role of their FLO, to strengthen the role, and incorporate their views into training programmes
- A review of the FLO training and for this to include case studies of FLO roles to aid knowledge, experience and training for new FLOs
- FLO forums to offer a reflective space for the FLOs

In addition to this, the following work streams are also in place:

- Mandatory Being Open/Duty of Candour training for staff via e-learning and within the Trust induction programme.
- Family Liaison Officers are included within all correspondence around reviews/investigations and informed of timeframes and scope in order to facilitate transparency and involvement of patients/families in the review/investigation.
- Patients/families are central to the review/investigation process as detailed in the PSIRF and the Trust's PSIRP.
- Weekly review of moderate harms and incidents for escalation to confirm if they meet Duty of Candour criteria and to identify further investigation/review required.
- Commissioning of case note reviews and monitoring via the Deceased Patients Review Group (DPRG) and presentation of learning to the Mortality Review Sub-Committee.

4.0 THE ROLE OF THE FAMILY LIAISON OFFICER

When a Family Liaison Officer has been appointed, they make contact with the patient/family to offer their apology for the incident having occurred and condolences, where appropriate. This conversation is followed up in letter form with the patient/family and this is what formalises the Duty of Candour process.

The Family Liaison Officer will:

- Provide signposting to services which can offer emotional and practical support following the incident/death
- Provide the patient/family member with updates throughout the investigation/review process
- Provide the investigator/reviewer updates of contact with the patient/family and questions which they have raised which they would like to be considered within the report
- Arrange a meeting between the patient/family and investigator/reviewer
- Offer for the report to be shared with the patient/family, and provide support after they have reviewed the report
- If the patient/family are not satisfied with some of the information within the report, or they have any questions for the investigator/reviewer, the FLO will obtain this information and share with the investigator/reviewer

At present, the Trust have 168 trained FLOs. Other organisations do not have the same model of allocation of FLO as EPUT; they often use the investigator/reviewer to act as the FLO. EPUT has been recognised as delivering a different service from neighbouring organisations and

have been asked to present the work in which we have done at external conferences.

Some feedback we have obtained from patients/families in the past year have included that they felt their voice had been heard within the investigation report; they prefer that the reports identify the patient by using their first name and not initials; and they have felt included within the investigation process by being informed of updates by their FLO. The presence of the appointed FLO at inquest has also shown to have benefits for the family and the support they receive during and after the hearing.

5.0 COMPLIANCE

The following table confirms that all applicable incidents have followed Duty of Candour requirements.

Directorate	Total applicable cases	DoC timeframe achieved	Total
Mid and South MH	32	32	**32**
South CHS	0	0	**0**
West Essex MH	14	14	**14**
West Essex CHS	2	2	**2**
North East MH	24	24	**24**
Specialist Services	1	1	**1**
EPUT TOTAL	73	73	**73**

6.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report
2. Approve the Report

Report written by:
Georgia Warne
Clinical Lead

On behalf of:
Natalie Hammond
Executive Nurse

		Agenda Item No: 7d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25th May 2022**

Report Title:	**Freedom to Speak Up Guardian Service**					
Executive/ Non-Executive Lead:	Sean Leahy, Executive Director of People and Culture					
Report Author(s):	Yogeeta Mohur, EPUT Principal Freedom to Speak Up Guardian					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	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 Trust Board of Directors with an overview of EPUT's Freedom to Speak Up Guardian Service for 2022/2023.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

Summary of Key Issues

EPUT's Freedom to Speak Up Principal and Local Guardians complement other arrangements already in place in the Trust for staff to raise concerns such as the Trust's Freedom to speak up Policy / Whistleblowing Policy and Procedure.

The Freedom to Speak Up (FSU) review led by Sir Robert Francis into whistleblowing in the NHS provided independent advice and recommendations on creating a more open and honest reporting culture in the NHS. Key elements included:

• The appointment of local FSUGs in every NHS organisation, now a requirement of the NHS Standard Contract.

• The establishment of the Care Quality Commission's National Guardian, with Dr Henrietta Hughes first National Guardian appointed in October 2016.
• An integrated policy and a common procedure for employees to raise concerns.

The FSUG role incorporates being an additional route for whistleblowing but extends well beyond, aiming at developing cultures where safety concerns are identified and addressed at an early stage. FTSU has three components: improving and protecting patient safety, improving and supporting staff experience and visually promoting learning cultures that embrace continual improvement.

No one should experience discrimination or be victimised for speaking up, but we know fear of this can prevent staff from doing so. Those who raise concerns via the Freedom to Speak Up process can expect to receive support and advice from the Trust's Freedom to Speak Up Guardian, as will managers with whom the concerns are raised. The role of the
Freedom to Speak Up Guardian is to be impartial and ensure that a fair and timely investigation into concerns takes place and that outcomes, actions and learning are shared.

The Board of Directors is committed to running the organisation in the best way possible. Our policy is in place to reassure staff that it is safe and acceptable to speak up and to enable staff to raise any concerns they may have at an early stage and in the right way. Rather than wait for proof we would prefer staff to raise the matter when it is still a concern. In so doing, we can prevent any potential harm from happening.

It is said that the Principal Freedom to Speak Up Guardian is a trusted pillar of support for NHS workers. They provide a route through which they speak up about any matter that could get in the way of delivering high-quality patient care, or that presents the workplace being the supportive caring environment that hard-working and caring staff should expect.

The National Guardian office which gathers all details has felt that over the last few years that excellent feedback that has been received from workers who have sought the support of the freedom to speak up demonstrates that the much-needed and trusted route for speaking up outside the normal line management chain has been developed. The findings of this survey emphasise the apparent correlation between highly rated organisations and the best speaking of cultures of which the guardian role is a central component.

The guardian role is not an easy role but a rewarding one. The expectation of the National Guardian Office (NGO) is high and broad, as patient safety and staff well-being is at its heart. There have been 20, 388 cases raised (1 April 2020 to 31 March 2021) nationally. The National Guardian office is proud to have recently appointed Dr Jayne Chidgey-Clark last year following the departure of Dr Henrietta Hughes who stepped down after being the National Guardian since 2016. Dr Chidgey-Clark is a clinical leader and registered nurse, with more than 30 years' experience in the NHS, higher education, voluntary and private sectors. Her most recent roles include as non-executive director at NHS Somerset Clinical Commissioning Group (CCG) where she was a Freedom to Speak Up Guardian.

The following values are upheld by Freedom to Speak Up Guardians:

 Courage … speaking truthfully and challenging appropriately
 Impartiality … remaining objective and unbiased
 Empathy … listening well and acting with sensitivity
 Learning … seeking and providing feedback and looking for opportunities to improve.

The National Guardian Office:

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015).

These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

The office leads, trains and supports a network of Freedom to Speak Up Guardians in England and conducts case reviews of organisations when it appears that speaking up has not been handled according to best practice.

There are over 700 guardians in NHS and independent sector organisations, national bodies and elsewhere that ensure workers can speak up about any issues impacting on their ability to do their job. The National Guardian's Office also provides challenge and learning to the healthcare system as a whole as part of its remit.

The National Guardian Office emphasises the importance for every Trust to have:

Fair recruitment process and banding for Freedom to Speak up Guardians.

Dedicated time for the role.
Access and support from CEO and other senior leaders.
Guardian wellbeing and resilience - support for guardians.

The General Medical Council noted an increase in the number of anonymous disclosures to them this year, because some staff were fearful of repercussions: "This shows there is still some way to go in improving a culture that supports raising and acting on concerns."
Concerns about the ability of regulators to investigate when workers remain anonymous were echoed by other healthcare regulators.

High profile cases where whistle-blowers in the health service have suffered victimisation may contribute to a fear of raising concerns openly. Addressing healthcare workers' fears of being bullied, ostracised, side-lined or dismissed for raising concerns needs constant focus. An emphasis on better listening up and better treatment of whistle-blowers will help healthcare workers have confidence that their concerns will be addressed, and that they won't suffer when they speak up to stop harm.

The overall purpose of the Guardian Service is to:

- Support the organisation in further developing a culture of openness and freedom for staff to raise concerns about patient safety and anything that gets in the way of delivering care as part of everyday practice.
- Support staff to raise concerns about patient safety directly with their line manager/supervisor.
- Work in partnership with managers where staff are unable to raise the patient safety concern themselves.
- Escalate raised concerns that are not acted upon by managers with the Chief Executive.
- Where concerns about patient safety raised by staff are not acted upon internally, the Principal Guardian is expected to take the matter externally to the National Guardian for investigation.
- Provide training across the organisation on the raising concerns agenda.

This report provides details on:

- Activity and progress.
- Concerns raised and themes noted.
- Challenges.
- Successes.
- Activities planned in 2021 and beyond.

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			N/A
Involvement of Service Users/Healthwatch			✓
Communication and consultation with stakeholders required			N/A
Service impact/health improvement gains			✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			Backfill of Principal Guardian's role
Governance implications			N/A
Impact on patient safety/quality			✓
Impact on equality and diversity			N/A
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
MDP	Management & Development Programme	TASI	Therapeutic and Safe Intervention
LD	Leadership Development.	MST	Microsoft Teams

Supporting Documents and/or Further Reading

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

Agenda Item 7d
Trust Board of Directors
25 May 2022

EPUT

FREEDOM TO SPEAK UP GUARDIAN SERVICE

1.0 PURPOSE OF REPORT

This paper outlines the activity from the Freedom to Speak Up Guardian service in 2021.

2.0 EXECUTIVE SUMMARY

2.1 EPUT's Freedom to Speak Up Guardian Service

The Trust Board of Directors will recall I was elected and commenced in the role of EPUT's Principal Guardian in November 2019, dedicating 2 days per week to role while my substantive role of community psychiatric nurse working for the Trust's Access and Assessment Team is backfilled. Here at EPUT, the profile of Freedom to speak up has risen significantly. Colleagues have been using the platform more and more and with the increased amount of activities and concerns raised, the role is now a full time role.

Since becoming the Trust's Principal Freedom to Speak Up Guardian, the profile of Freedom to speak up at EPUT has raised significantly. Staff are approaching the platform more and more. Previously staff would raise concerns through the online portal and call the dedicated Freedom to speak up number however more recently, the colleagues who are approaching the platform advised that they have been referred by someone who have approached the platform before and highly recommended the service.

EPUT's vision for Freedom to Speak Up is 'Supporting compassion, openness and empowerment'. We aim to continue to grow the number of Local Guardians in the Trust. Unfortunately due to staff turnover as well as job changes and staff not feeling able to continue to commit to be a Local Guardian we have had staff who are no longer able to be a guardian. At the time of writing this report the total number of Local Guardians is 11. We have another 2 people joining us shortly who are in the middle of completing their training as per the requirement of the National Guardian office. We continue to promote the agenda and in doing so we encourage people to consider becoming a Local Guardian.

The Freedom to Speak up Principal and Local Guardians complement other arrangements already in place in the Trust for staff to raise concerns such as the Trust's Freedom to Speak up policy /Whistleblowing Policy and Procedure. As previously noted the 'I'm Worried About' process changed in August 2019 and consequently concerns have been received by the Guardian Service which may be better addressed elsewhere. This remains the case and the Guardian Service are continuing to support, reassure and signpost to other departments as required.

Through other training programmes in the Trust, for example TASI/ personal safety, Clinical Risk and the Management Development Programme, we continue to raise awareness of Freedom to Speak up.

As the Board is aware the overall purpose of the Guardian Service is to:

- Support the organisation in further developing a culture of openness and freedom for staff to raise concerns about patient safety as part of everyday practice.
- Support staff to raise concerns about patient safety directly with their line manager/supervisor.
- Work in partnership with managers where staff are unable to raise concerns themselves.
- Escalate raised patient safety concerns that are not acted upon by managers with the Chief Executive.
- Where concerns raised by staff are not acted upon internally, the Principal Guardian is expected to take the matter externally to the National Guardian for investigation.
- Provide training across the organisation on the raising concerns agenda.

2.2 Overview of activity/progress in 2022 continuing from last year.

- Training of new Local Guardians has continued.
- Continuation of meetings with Board representatives including the Non-Executive Director and Executive Director for the Freedom to Speak Up agenda, the Chief Executive.
- Continuation of the Communications strategy to raise awareness of the agenda in 2021 and beyond.
- Continuation of visits to services and teams in the Trust to develop/increase awareness of the Freedom to Speak up process and Guardian service, particularly those highlighted as 'hotspot' areas. In the recent times these meetings have been done remotely however we are looking to have that physical visibility soon as the rules of the lockdown eases.
- Working closely with Organisational Development (OD) and Staff Engagement Teams.
- Leadership engagement representation.
- Working closely with education and training to identify gaps → closer engagement with TASI training. Due to the pandemic and with social distancing in place, it has not been possible to attend but this remains on the agenda.
- Principal Guardian attending EPUT's Learning Oversight Sub Committee.
- Working with Estates and Facilities to ensure colleagues working in this area of the Trust are aware of the agenda.
- As part of Covid-19 attending silver command to discuss with senior leaders how the Guardians can support colleagues to continue to work and improve services and work experience for staff.
- Supporting the anti-bullying ambassadors in creating a better working experience for our workers.
- We continue to reflect with colleagues from learning from serious incidents meeting.

2.3 Concerns Raised

As per the requirement of the National Guardian Office, we report data on a quarterly basis. Staff who report concerns are thanked for bringing the concerns to our attention and we give them clear guidelines as per our own Freedom to Speak up Policy and Procedure and we advise them on a clear time frame for feedback. Feedback given to the colleagues who speak up is extremely important to promote the culture of speaking up and for colleagues to be able to continue to have faith in the Freedom to Speak up platform. We have had 199 concerns raised through the Freedom to speak up Platform in 2021/22.

2.4 Number of staff who have received training is below:

The following table details training activities that have taken place in respect of the agenda in the year 2021/22.

Training Type	Approximate Number of attendees
MDP Raising Concerns Training for Managers	26
Leadership Training	51
Allied Health Profession students	83
Student Nurses: North and south South East Essex and West Community	 596 170

2.5 Emerging Themes

The following themes have been noted from the concerns raised from 1 April 2021 to end of March 22. Please note that individuals may have raised more than one issue as part of their 'raised concern':

Concern Theme	**No of concerns since April/May/June 2020**
Patient Safety/Quality	1
Staff Safety	9
Bullying/Harassment/Discrimination	15
Infrastructure/Environmental	3
Other	2
Total	**30**
	No of concerns July/Aug/Sept 2020
Patient safety	4
Staff safety	8
Bullying and harassment	24
Infrastructure/Environmental	4
other	10
Total	**50**
	No of concerns Oct/Nov/Dec 20
Patient Safety	5
Staff Safety	14
Bullying and Harassment	26
Infrastructure/Environmental	14
Other	15
Total	**74**

	Jan/Feb/March 21
Patient safety	8
Staff safety	12
Bullying and Harassment	43
Infrastructure/Environmental	6
Other	12
Total	**81**
April/ May/ June 21	
Patient safety	**5**
staff safety	**3**
Bullying and harassment	**43**
Infrastructure/ Environmental	**5**
Other	**8**
Total	**64**
July/August/September 21	
Patient safety	**9**
Staff safety	**3**
Bullying and harassment	**31**
Infrastructure/Environmental	**4**
Other	**7**
Total	**53**
Oct/Nov/Dec 21	
Patient safety	**1**
Staff safety	**4**
Bullying and harassment	**28**
Infrastructure/Environmental	**2**
Other	**2**
Total	**37**
Jan/Feb/March 22	
Patient safety	**7**
Staff safety	**2**
Bullying and harassment	**26**
Infrastructure/Environment	**2**
Other	**8**
Total	**45**

Bullying and harassment remains the top theme reported since the last report presented to the Board. The law makes clear that all employees have the right to work in a safe environment. In conjunction with Human Resources, the Guardian Service supports staff members who feel they are being bullied and harassed. Sometimes people who use the Guardian Service do not wish to take things further; however, the service has provided a platform where they feel they are being listened to. The Guardians will continue to encourage people to come forward to hear their stories so that issues get addressed and we can support each other in creating and maintaining a safe workplace, free from bullying, intimidation and harassment.

The main professional background where concerns are raised from are nurses and support workers, followed by administration staff colleagues.

Freedom to speak up training has also been delivered to our doctor colleagues. We continue to work with the training department to promote the Freedom to speak up agenda and encourage staff from different backgrounds/professions to join us and promote this agenda further. On our intranet page staff can see at a glance the list of local guardians and their

professional background as well as geographical base therefore giving staff the choice of which local guardian to approach.

With regards to the recording of those raising concerns who have protected characteristics, currently the only data collected is in respect of race and it is optional for people to do so or not. Again this is not an area showing any trends to report. Concerns reported by staff from a white background are fairly equal to that reported by the EMREN (Ethnic Minority Race Equality Network) staff members and we have been working with our colleagues from HR as well as the EMREM network to support individuals.

We have committee meetings where we look at lessons learnt and how we can do things differently. We also learn a lot from exit interviews. We encourage staff to talk about their lived experience. Where we feel that staff have suffered detriment as a result of speaking up, staff are offered support to express their feelings and escalate matters with the help of HR. We also look at the patient experience to see how we can learn from concerns raised.

Last year a new question was included in the NHS staff survey asking staff if they feel safe to speak up about anything that concerns them in their organisation.

We welcome the inclusion of this question, because Freedom to Speak Up is about more than the ability to raise concerns about patient safety. It is about being able to speak up about anything which gets in the way of doing a great job, whether that's an idea for improvement, ways of working, or behaviours.

Freedom to Speak Up is for everybody who works in health. It includes primary and secondary care, independent providers, hospices and national bodies. It goes beyond those surveyed in the NHS staff survey and to be truly inclusive needs to work for locum and agency workers, junior doctors, students, volunteers, contractors and all workers who may face additional barriers to speaking up. The National Guardian Office is continuing its work to look at the wider work group and continue to look at ways of addressing barriers to speaking up.

2.6 Challenges

As previously reported some of the challenges that exist in the Trust will not change, like the physical size of it and the task of getting around the Trust to continually increase visibility and awareness is ongoing. The pandemic certainly made face to face visibility difficult however I must state that using other means of delivering meetings (e.g. video conferencing) actually helps by capturing a bigger audience.

A continuing challenge in the process of raising concerns has been related to timings. Some managers/leaders remain very quick in responding and taking action when a concern has been raised, whilst for others it can be weeks or months before a response is received which can extend the process. As previously noted this was highlighted at a leadership event in October 2019, and is a discussion point during the MDP sessions. It is an area which will continue to be monitored. If progress is slow the sense for staff raising concerns is that nothing has or will happen, and is a major deterrent for others to speak up. The expected timeframes for managers to respond by have been added to the Raising Concerns policy and procedure. As Guardians, we are working closely with the area directors and Associate Directors in continuing to monitor matters and address them.

Culture change remains the biggest task which will be ongoing. It is noted that the majority of the concerns raised are done so anonymously which is an indication of how safe the staff feel in raising concerns. As noted reducing the time to respond to concerns will be an important aspect of tackling this. Where feedback is not being received in a timely manner, all efforts continue to be invested in following this up and escalating matters as required. The Executive Director for People and Culture is really passionate about our people listening to their stories

and making changes to our culture such whereby speaking up becomes more and more business as usual.

In health, as in all sectors, the best leaders understand the importance of listening to workers who are the eyes and ears of an organisation. But in health it is even more crucial as speaking up can be a matter of life or death. A positive environment and a supportive culture are key elements of the NHS People Plan.

The Freedom to Speak up Guardian's access to both the Executive Teams as well as the CEO gives colleagues faith that matters will continue to be raised if not acknowledged and not resolved around the normal route. Furthermore, having access to our Non- Executive Directors also supports the openness and fairness.
This evidences that we have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.

Staff have had the opportunity to use the open door policy and access the Executive Director for People and Culture as well as our CEO and spoke directly about their work experience in EPUT. Having access to our senior leaders really gives staff that feeling of worth and being valued. This also upholds our values of learning, caring and empowers colleagues. We also have live sessions open where staff can attend and ask the Executive Team questions directly. I have had a lot of colleagues who have praised this platform as this shows our senior leaders robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.

Inductions for student nurses remains firmly on our agenda as they are our future workforce. As guardians, we work with the Practice assessors and placement areas to promote this agenda from the very first port of entry.

As noted in the previous report presented to Trust Board, patient safety concerns are raised regularly during training sessions. As part of my clinical work, I have attended TASI training previously and also attended personal safety training. This is a great opportunity to meet people from different areas and have discussions around patients' safety. The aim is to continue to work with colleagues from other departments to ensure that we have this valuable opportunity to reflect on practice and learn from other people's experiences and continue to improve on the quality of service we deliver and allow our staff to express themselves and continue to promote the speaking up culture. The current pandemic does mean that we now deliver most sessions via MST and in some ways it has actually made these easier for people to attend and have a larger number of people at a time.

We are primarily here to support workers to overcome barriers that they face when they feel they need to speak up. But these barriers are often more associated with how well the worker is listened to, or whether or not they receive follow up feedback about the impact that their courage to speak up has had. Workers might speak up once. But it's the quality of the listening and following up that influences whether or not they would do it again.

To achieve excellence as a healthcare organisation, speaking up, listening up and following up well must be an integral part of everything we do, how we communicate and how we identify what needs to change.

So, in order to enable all workers at EPUT to see how integral this is to how we do things around here, we have do not just listen up when contacted by colleagues by it is the following up that most people report matters to them.

When colleagues contact the platform, it is important that they are given the time to express their feelings and look at a realistic ways of how they can be supported and sign posted accordingly. Often colleagues do not report concerns because they want to take any formal

actions (especially concerns related to bullying and harassment) but to feel listened to by someone completely impartial that they can have access to.

2.7 Successes

As noted in the report in November last year, the profile of the Freedom to Speak Up service has significantly risen through the support of the Communications Team and the concerted effort during the National Speak up month which is in October.

Last year the regional officer for Freedom to speak up was invited to the October speak up month event and presented at our CEO's live briefing and the year before we had the National Guardian officer Dr Henriette Hughes who joined us. We work very closely with the National Guardian office and welcome colleagues to come and meet our team and as the role evolves nationally, we, here at EPUT show how we continue to raise the profile of our Freedom to Speak up Platform and the numbers show that we continue to, as a Trust promote this culture of speaking up.

The Guardian will continue to have strong links with the Human Resources Team, subsequently if required the Guardian will signpost to further support systems in the Trust, these included the relevant HR process such the Grievance and Bullying and Harassment procedures.

A large number of bank workers have also been using the platform more and more. I believe that by taking part in staff group supervision, it gives great opportunity to hear about staff's experience as well as any potential challenges that they face and how we can address those. In doing so and engaging in their group supervision, staff have been able to approach us to raise concerns where they otherwise felt unable to do so.

2.9 Feedback

Feedback from people who have used the Guardian Service is critical to the Freedom to Speak Up agenda and we will have to continue to create this culture of openness. Feedback is requested at the end of each quarter from people who have raised a concern. This is also reported to the National Guardian office. For colleagues who report to us anonymously, it can be difficult to obtain feedback if they are not in touch.

The majority of comments reflected a positive experience of the service, however there were some responses from people who felt that nothing had changed for them. As noted in section 2.6 timeliness of response continues to play a huge part in staff feeling that something has changed for them as well as detailed responses from managers on how they looked into the matter and any actions taken. We will continue to survey people to continue to use feedback as a reflection and how to continuously make improvements to our services.
A number of people said that they would be happy to share their story of raising concerns. We welcome colleagues to share their experience to the board meeting to hear directly from them about their experience of using the Freedom to speak up platform and what they would like to see differently and what can we learn from their experience and improve. As a result of approaching the Freedom to Speak up Platform, a number of colleagues have also felt empowered to deal with the concern themselves after feeling empowered to do so. We ultimately want to create a culture whereby our staff feel safe to speak up about any matters that gets in the way of them provide the highest quality of care or that gets in the way of them having a good work experience.

2.9 Conclusion

As previously noted EPUT has good processes in place to manage concerns raised by staff and this service is an addition to the Freedom to Speak up /Whistleblowing Policy and Procedure. The challenge is to continue to raise awareness and understanding of the Freedom

to Speak Up process and to help staff overcome barriers to speaking up. As noted previously the key issue is culture, both of people feeling able to raise concerns and then managers to act on them in a timely manner. The crucial part is to thank the person for raising issues as unless we know of concerns, one cannot address them and have lessons learnt as a result.

The Trust continues to see areas of good practice with staff coming forward to raise issues and managers are listening and responding swiftly. We want to take the opportunity to share good practice and this learning across the organisation.

The pandemic did unfortunately slow some of our promotional work down however as we start to get back to the new normal, we will continue with our work to promote and continue to raise awareness of this important agenda.

2.9 Actions planned 2022 and beyond:

In 2022/23 the following have been identified as key items to be taken forward as part of the work plan:

1. Continue to take forward the Communications Plan to ensure awareness of the agenda at all levels with all staff Groups including greater use of social media.
2. Consider how specific training packages for all staff and managers can be rolled out.
3. Share learning from high functioning team cultures where raising a concern is everyday business.
4. Analyse the impact on patient safety by looking at other data, including employee relations.
5. Continue to learn from the F2SU Guardian network, and therefore improve and learn from best practice and case reviews.
6. Continue to work with other departments such as Training and Development, Staff Engagement and OD to increase messaging regarding the agenda.
7. Continue to build a virtual network for the Local Guardians to allow idea generation and sharing, learning, support and celebrating successes.
8. Continue to work with Teams, mainly leaders to encourage them to allow staff to thrive and continue to work not solely for their teams but for the wider organisation. This includes allowing staff to attend non mandatory training where it is identified that in doing so the staff member will benefit from this and improve quality of service we deliver.
9. Continue to work with managers to also recognise the wider organisation and the need to release staff for their involvement in networks to promote equality and fairness.
10. Continue to identify any hot spots areas so we are more aware of those and invest more time in supporting the staff from those areas.
11. Develop stronger links and relationships with the managers to promote the agenda of fairness and speaking up, encouraging a speaking up culture to be part of everyday practice.
12. Continue to be part of the exit interview process, not only to learn from constructive feedback but also positive experiences that staff have had and learn how we can continue to improve on those and reflect on areas we have not done so well and build action plans.

3.0 ACTION REQUIRED:

The Board of Directors is asked to:

1. Note the content of the report and consider recommendations for future actions.

Report prepared by:

Yogeeta Mohur, EPUT Principal Freedom to Speak Up Guardian

On behalf of:

Sean Leahy, Executive Director of People and Culture

		Agenda Item No: 8aii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 May 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	✓
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 April and May.

Performance Report

This report covers the position for month 12 (Mar-22) and month 1 (Apr-22).

In April 2022 there were 4 areas of inadequate performance (5 in March).

The Executive Director of Operations provided assurance that there have been no increases in contractual KPI's not meeting target, and the number of inadequate indicators has reduced. Topics covered by the Executive Director of Operations were those relating to CPA Reviews, Flow & Capacity, Out of Area Placements (OOA), and Ligatures.

During the April meeting the Associate Director of Flow & Operational Transformation presented the recovery plan for Surge Planning and OOA Placements.

During the May meeting the Associate Director of Flow & Operational Transformation was again in attendance to discuss the current processes in place for Delayed Transfers of Care, and the Clinical Director of Psychological Services attended to give a deep dive presentation on the historical challenges for the service and how and what measures are being taken to recover.

The Chair and Committee members thanked those who presented and gave praise for the clear picture they provided.

Draft Operating Plan 22/23

The Executive Chief Finance Officer gave information to the Committee that the Operating Plan had been refreshed to include further requested detail. These included items such as patient experience, workforce narrative, and success measures within care units. The Chair gave their support in principle and were happy with the details provided; any final comments were requested by close of business Monday with Board to be informed of any changes..

Contracting Update

The Executive Chief Finance Officer informed the Committee that extra time had been provided to the Time to Care tender to enable completion of bid submissions. Interested parties have been invited to an engagement event and the Executive Chief Finance Officer hoped to provide a verbal update on progress in the upcoming Board meeting.

The Committee thanked the Executive Chief Finance Officer for their update.

Provider Collaborative Update

An update to the Provider Collaborative was given by the Director of Commercial Finance who noted that the close of last financial year left a small surplus, the Trust started the year in a challenged position. Assurance was provided that risks are noted along with mitigations, and there are no major concerns at present.

Members of the Committee thanked the Director of Commercial Finance for all work undertaken to help detail the financial situation of the Trust.

Financial Update – Month 1 (incl. System Financial Plan)

The Director of Operational Finance reported to the committee the current positions for revenue and Capital. Revenue is currently reporting slightly better than planned and Capital is spending £0.2m less than plan. The Director of Commercial Finance also gave an update on 22/23 planning and noted an additional £1.5bn national allocation to support non-pay inflationary pressures has been announced. Further financial controls and reporting requirements were also anticipated.

The committee members thanked both Directors for their updates.

Code of Governance & FT4 Review 2021/22

The Senior Director of Governance & Corporate Affairs provided their update and recommendations on the Code of Governance and the NHS Provider Licence (FT4).
NHS Foundation Trusts are required to make annual self-certifications against the NHS Provider Licence and self-assessments to confirm the Trust complies with the provisions of the Code of Governance.

Members of the Committee confirmed approval for these items.

Policy Extension & Approval Requests

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

- CPG50 ITT Security Policy
- CP30 VPN Policy

There were no policy extension requests in May.

Any Risks or Issues

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

Any Other Business

There was no other business.

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead

Name: Loy Lobo
Job Title: Non Executive Director

Agenda Item 8aii
Board of Directors Meeting Part 1
25 May 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 12 March 2022 and month 1 April 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 12 (Mar-22) and month 1 (Apr-22).

In April 2022 there were 4 areas of inadequate performance (5 in March):

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

The Executive Director of Operations provided assurance that there have been no increases in contractual KPI's not meeting target, and the number of inadequate indicators has reduced. Topics covered by the Executive Director of Operations were those relating to CPA Reviews, Flow & Capacity, Out of Area Placements (OOA), and Ligatures.

During the April meeting the Associate Director of Flow & Operational Transformation presented the recovery plan for Surge Planning and OOA Placements. This covered current position, challenges and their mitigation, and what has been set in place to maintain our recovery trajectory. Members of the Committee shared their appreciation for the presentation and update.

During the May meeting the Associate Director of Flow & Operational Transformation was again in attendance to discuss the current processes in place for Delayed Transfers of Care and gave assurance that benefits are being realised through these new measures.
The Clinical Director of Psychological Services attended in May and gave a deep dive presentation on the historical challenges for the service and how and what measures are being taken to recover. The Committee were grateful for the assurance that recovery is being witnessed.

The Chair and Committee members thanked those who presented and gave praise for the clear picture they provided.

3.0 Draft Operating Plan 22/23

The Executive Chief Finance Officer gave information to the Committee that the Operating Plan had been refreshed to include further requested detail. These included items such as patient experience, workforce narrative, and success measures within clinical audits.

Refinements continue to be made to the document and the Executive Chief Finance Officer asked the Committee for their agreement in principal.

The Chair and Non-Executive attendance gave their approval in principal and were happy with the details provided.

4.0 Contracting

The Executive Chief Finance Officer informed the Committee that extra time had been provided to the Time to Care tender to enable completion of bid submissions. Interested parties have been invited to an engagement event and the Executive Chief Finance Officer hoped to provide a verbal update on progress in the upcoming Board meeting.

The Committee thanked the Executive Chief Finance Officer for their update.

5.0 Provider Collaborative Update

An update to the Provider Collaborative was given by the Director of Commercial Finance who noted that the close of the last financial year left a small surplus, the Trust started the year in a challenged position.

Assurance was provided that risks are noted along with mitigations, and there are no major concerns at present.

Members of the Committee thanked the Director of Commercial Finance for all work undertaken to help detail the financial situation of the Trust.

6.0 Financial Position – Month 1 (incl. System Financial Plan 22/23 & Stewardship)

The Director of Operational Finance reported to the committee that the revenue position for month 1 is a £0.9m deficit, this being £0.2m better than plan. All budgets have been aligned to the new Accountability Framework and this will be the basis of in year monitoring.
For Capital there is a £0.3m actual spend compared to £0.5m plan.

The Director of Commercial Finance also gave an update on 22/23 planning and noted an additional £1.5bn national allocation to support non pay inflationary pressures has been announced. The allocation requires organisations to re-instigate pre-Covid financial controls, in particular agency and consultancy spend controls and a requirement to demonstrate financial controls and stewardship are robust. The Trust awaits further details of its fair share of allocation upon which annual plans will be re-submitted 20 June. The report has been expanded to include Stewardship.

The committee members thanked both Directors for their updates.

7.0 Code of Governance & FT4 Review 2021/22

The Senior Director of Governance & Corporate Affairs provided their update and recommendations on the Code of Governance and the NHS Provider Licence (FT4).
NHS Foundation Trusts are required to make annual self-certifications against the NHS Provider Licence and the Senior Director of Governance & Corporate Affairs has placed forward a recommendation to

declare compliance with all the requirements. Along with this, the Committee was asked to approve the self-assessment to confirm the Trust complies with the provisions of the Code of Governance.

The Senior Director of Governance & Corporate Affairs confirmed that the Trust is required to undertake an independent review of Well Led by the end of 2023/24 for which the Trust is planning for.

Members of the Committee confirmed approval for these items.

8.0 Policy Extension Requests

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

- CPG50 ITT Security Policy
- CP30 VPN Policy

There were no policy extension requests in May.

9.0 Any risks or issues

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

10.0 Any Other Business

There was no other business.

Report prepared by:

Amy Tucker
Senior Performance Manager
On behalf of:

Loy Lobo
Chair of the Finance and Performance Committee

		Agenda Item No: 8aiii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	25 May 2022

Report Title:	**Quality Committee Assurance Report**					
Executive/ Non-Executive Lead:	Rufus Helm, Non-Executive Director					
Report Author(s):	Matt Rangué, Quality Project Lead					
Report discussed previously at:	Not previously discussed.					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues
The Quality Committee has reviewed the work of all sub-committees and all performance and quality dashboards accountable to the Quality Committee. This report is presented to the Board 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	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
Accompanying Report

Lead
Rufus Helm **Non-Executive Director** **Chair of the Quality Committee**

Agenda Item: 8aiii
Board of Directors Part 1
25 May 2022

QUALITY COMMITTEE ASSURANCE REPORT

1.0 PURPOSE OF REPORT

This report provides the Board of Directors with assurance on actions taken by sub-committees, to progress key aspects of the quality agenda.

2.0 EXECUTIVE SUMMARY

1. Minutes of previous meetings

The minutes of the Quality Committee meetings held on 14 April 2022 were approved as correct accounts of the meetings. The minutes of 12 May are awaiting approval.

Summary of discussions and issues identified as well as assurances provided at the April and May meetings:

2. Meeting held on 14 April 2022:

2.1 Quality Performance Report

The Committee received the quality performance report, identifying that 15 indicators the Committee are monitoring are performing within their target parameters.

Board members' attention is brought to three indicators that are currently performing outside of the target. These include:

- Care Plan Approach Reviews (CPA) - The rationale for the under-achievement of 92.8% is Covid-19 workforce pressures. Mitigations in place include closing of appropriate cases by the Flow and Capacity Lead and review of patient caseloads during Clinical Supervision sessions. Support is also on-going from the Operation Productivity Team.
- Inpatient Mental Health Capacity (Adult & PICU) - Performance at 55.7 is outside of the target <35 days. In addition, adult occupancy at 96.1% is outside the target of <93.4%. Mitigating actions have been taken to ensure senior oversight on progression to discharge and escalation process to avoid delays.
- Psychology Waiting Times - Mitigations continue using best utilisation of resources including transfer of psychology waiting lists to EPR.

2.2 Quality Account

The Committee received a verbal update of progress made in producing the Quality Account. The report was progressing well with the first draft ready during the week commencing 18 April. The Committee were informed the draft document would be circulated to stakeholders for comment in May, including a ballot on quality priorities for 2022/23. Assurance was given that the final draft was on track for the submission compliance target date of 30 June 2022.

2.3 Work Plan

The Committee received, discussed and approved the work plan and schedule of business for 2022/23.

2.4 Restrictive Practice Framework

The Committee received, discussed and approved the reviewed framework. The Committee were informed the framework had been renamed Reducing Restrictive Practice to reflect national terminology. Work was underway with Human Engine will produce a dashboard for more accurate monitoring and assurance.

2.5 Clinical Audit Programme 2022/23

The audit programme has been updated to include an escalation process for resourcing. The programme was reviewed and approved by the Committee.

2.6 Care Quality Commission (CQC) Exception Report

The Committee received a report highlighting the following key areas:

- 1 March CQC re-inspection of CAMHS Services. This included onsite inspection of three wards. The outcome of the inspection was pending from the CQC. However, the Trust was able to apply to have the Section 31 lifted and reopen beds, which it had done. The Committee discussed the need for on-going evidence to ensure lessons have been learnt and new practice embedded
- Following the CQC announcement to recommence inspections a preparation plan had been implemented, this included the Compliance Team testing previous action plans to assess if changes in practice have been embedded.
- New guidance/updates from CQC, including:
    - CQC Mental Health Insight
    - Restraint, Segregation and Seclusion Review: Progress Report (March 2022)
    - Monitoring the Mental Health Act in 2020/21 Report

2.7 Mortality Data and Learning Quarterly Report

This report has previously been presented to the Board in March. The report was therefore only presented to the Committee for noting.

2.8 Patient Safety Incident Response Framework (PSIRF) Annual Report

The report was received, reviewed and noted by the Committee, which included an update on the last six months activity following implementation of the framework.

The Framework had been generally well embedded in the Trust, however, the report noted that main issue facing staff was the capacity to respond to the number of investigations, requests from the Independent Enquiry and backlog of scheduled inquests. Members of the Committee noted the detailed information within the report and the engagement of families in the Patient Safety Incident Response Framework (PSIRF) process. The Committee noted being an early adopter for the PSIRF has had the reputational benefit of enabling the Trust to showcase learning at a national level.

Following implementation, local priorities have been agreed in the Patient Safety Incident Response Plan, which included:

- Suicide/suspected suicide following disengagement from mental health services
- Mental health inpatient attempted suicide of patients on leave
- Suicide/suspected suicide within 72 hours if discharge from a mental health inpatient ward
- Patient safety incident resulting in serious to severe harm/death involving internal service transition
- Near miss ligature incidents on mental health inpatient wards involving a fixed ligature point

- Patient safety incident involving a patient with psychotic illness that has been identified as a Problem in Care score of 1-3 following review
- Fall resulting in head injury requiring admission to acute hospital.

Other noteworthy points included:

- No fixed ligature near misses requiring further investigation. No suicides where patients have been on leave and no suicides within 72 hours of discharge
- Main learning themes reported over the last six months are record keeping, discharge and transfer, and involvement of family. Main learning themes reported over the last twelve months are safeguarding, dual diagnosis, patient court attendance, eating disorder deaths and suicide/suspected suicide of patients with autism.
- Approval for the recruitment of a Medical Examiner, which will enable closer liaison with the acute services mortality investigations.

2.9 Suicide Prevention Strategy Report – Review of Priority Areas and Outcomes

The report included the development of potential outcome measures, which were subsequently considered by the NHSE East of England Suicide Prevention Programme Lead and the Mortality Review Sub-Committee. The following outcome measures were agreed:

- Safety Planning for all patients in contact with mental health services – to establish adult and performance completion rates and to undertake a quality review of safety planning
- 72 hour follow-up of all patients following discharge into the community from mental health wards – establish Trust performance measure and to consider a quality review of 72 hour follow-up reviews
- Completion of a Bio-Psychosocial assessment for all patients receiving care from mental health services – to establish audit and performance completion rates
- Delivery of enhanced training of staff regularly working with patients at risk of suicide – training trajectory to monitor delivery of essential STORM based suicide prevention training

The Committee discussed and approved the outcome measures and the appointment of a lead for each outcome.

2.10 Patient Story

The Committee agreed to change the current format of receiving Patient Stories from a monthly report presented on behalf of a patient to a quarterly event where a patient is supported to present their story in person. The aim was to enable a greater impact on the Quality Committee members and provide an opportunity for richer learning. The change had been included in the Schedule of Business for 2022/23.

2.11 Deep Dive Safeguarding Report

The Committee received an in-depth report on the learning and emerging themes from the Safeguarding Lead

The key themes and learning from published reviews and from Trust investigations into reviews include:

- Policy development
- Engagement and disengagement
- Care plans
- Professional curiosity
- Discharge

- Transition
- Mental Capacity

The Multi-Agency Thematic Audit highlighted:

- The Essex Safeguarding Children Board Business Plan Priorities for 2022 would focus on working with neglect in Essex. There are 2 Child Safeguarding Practice Reviews (CSPRs) due to be published at some point in 2022, both of which contain learning and reflection on child neglect
- The impact of the pandemic will be a feature of the audit and the identification and response to neglect in light of significant adaptations to practice and how agencies work with families
- The audit commenced in February 2022 and is due to be completed by July 2022

Members of the Committee discussed and approved the report also seeking assurance that the impact of child poverty will be included as a topic for further scrutiny in the audit process.

2.12 Sexual Safety Privacy & Dignity Framework

The new framework had been developed with the Royal College of Psychiatrists to establish national guidance that organisations should implement to protect people's sexual safety. The framework was reviewed and approved by the Committee.

By adopting this framework, the Trust would identify a change in culture concerning how staff view sexual safety. The Learning Lessons Team would be engaged to support the required changes in practice.

Work was underway with Human Engine to ensure the timely development of a performance dashboard to ensure assurance that the framework becomes business as usual.

3. Meeting held on 12 May 2022:

3.1 Nursing and Allied Health Professionals (AHP) Joint Strategy

The Committee received and reviewed the new Nursing and AHP joint strategy. The document sets out a shared approach to developing and improving Trust services. The strategy puts person-centred care at the heart of what the Trust aims to do, by promoting multi-disciplinary approaches to care and ensuring the Trust recruits and retains a skilled, knowledgeable confident and supported workforce.

A co-design approach had been used to develop the strategy. Through one-to-one sessions and workshops, which included key stakeholders, priorities, themes and associated actions were identified and built into the strategy.

The Committee was assured that key deliverable outcomes and performance metrics had been included, ensuring the progress could be tracked. Members also felt the objectives were ambitious and would showcase the full potential for service delivery and workforce development. The excellent engagement of staff was also noted and congratulated.

The consensus of the Committee was that the Nursing and AHP Joint Strategy was a comprehensive, constructed document which reflects well on the Trust skilled and dedicated workforce. The Committee unequivocally endorsed the strategy.

3.2 Ligature Risk Management Year End Learning Report 2020/21

The report detaild the work undertaken over the previous financial year and was discussed and reviewed by the Committee. Approval was not given at the meeting as members made recommendations to clarify some of the report's narrative. The report would return to the next Quality Committee in June.

Key areas highlighted, included:

Independent Assurance:

- Independent Assurance: Following the Trust's internal independent auditors (BDO) audit in May 2021, the action plan is now complete with all the identified issues having been fully addressed
- In January 2022, the Care Quality Commission (CQC) produced an updated briefing guide on ligature anchor points, ligatures and other means of self-harm using fixtures and furniture for their inspection teams. Work continues to finalise an action plan, which tests the Trusts processes against the CQC criteria
- EPUT undertook peer reviews with East London Foundation Trust (ELFT) and an action plan has been developed to address the findings /recommendations and is being monitored by the Ligature Risk Reduction Group (LRRG).

Governance:

- The Trust continues to hold the Ligature Risk Review Group (LRRG) monthly chaired by the Chief Operating Officer. Quarterly Ligature reports are shared with the Trust Quality Committee and Trust Board of Directors to provide assurance reporting and risk escalation
- Ligature Environmental Risk Assessments of all Mental Health and Learning Disability wards continued in 2021/22. Regular review of the Ligature Risk Assessment Tool is undertaken to ensure learning from safety alerts and incidents is identified. Assessment includes an in-house electronic risk register system
- The Ligature Policy and Procedure is subject to continuous review as new guidance and learning is published

Learning Culture:

- The Trust aims to develop a culture of risk awareness and continuous learning when an incident happens. An essential part of developing this culture is having robust training programmes for staff.
- Ligature training is delivered via a range of courses including ligature risk awareness e-learning. Overall Trust compliance in April 2022 was 92%.
- The Trust provided the bespoke ligature risk assessment training in 2021/22 (TIDAL) and will continue to be offered in 2022/23. To date, 87 staff have been trained, 62 of which are clinical staff. The training is now available to EPUT staff who are Band 4 and above.

Innovation:

- The Trust has continued to work in partnership with technology provider Oxehealth to implement Oxevision, a digital tool that allows for contactless monitoring of vital signs and movement. To date, a total of 438 rooms have Oxevision installed.

3.3 Emergency Preparedness Resilience Response (EPRR) Annual Report

The EPRR annual report was presented to the Committee for approval. The members commended the continuous efforts made to ensure compliance and the successful achievement of the EPRR core standards. The report was approved pending a revision to the oxygen standard, which should reflect how well the Trust managed this asset during the pandemic. In addition:

- NHS England EPRR Core Standards 21/22 – Trust scored 91.8% - substantially compliant. 3 standards identified where improvements can be made and these

have been added to the EPPR work plan

- Major Incident Plan - EPUTs Major Incident Plan has been enacted throughout 2021/22 in response to Covid-19. The 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
- Business Continuity Plans (BCP), have successfully been enacted at different times in 2020/21 in response to a range of events including fuel disruption, power outage and local response to Covid-19
- Communication Plan - A well-informed public is better able to respond to an emergency and minimise the impact of the emergency on the community. The Trust has a communications plan in place to ensure that this happens in a timely manner. There are various means available including, Pando, WhatsApp, Intranet, cascade text messages
- EPPR Exercises - National Guidance sets out minimum requirements for organisations to undertake EPRR exercises. In 2021/22 EPUT undertook the following:
    - Table Top Mass Vaccination Centre security exercise led by EPUT
    - Command Post Led by EPUT – quarterly checks of physical readiness to set up an Incident Control Centre
    - Exercise Starlight – Major incident communications cascade exercise led by NHS E/I (suspended due to regional technical issues)
    - Exercise Walker led by region (suspended due to Covid-19)

3.4 Complaints and Compliment Annual Report

The Committee received the report, which provided a review of the overall performance of complaints handled as well as a review of the compliments received. Key areas highlighted included:

- The volume of complaints received has increased by 37% on the previous year's figure to 376 – this is seen as a positive as there is more opportunity to listen, learn, and improve
- The number of compliments received outweighed the number of complaints by over 5:1
- 92% of complaints were closed within agreed timescales, however only 59 (20%) were resolved within the 40-working day target
- 4 complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO) - 1.3% of the total number of complaints closed (295)
- The top category for formal complaints, rapid responses and MP complaints was "lack of community support" – this resonates with the Community Mental Health Survey and was also the 4th highest PALS enquiry category

The Committee members noted that complaints related to community support triangulates with other sources of data and should be an area for increased focus. It was commendable that senior managers were leading by meeting directly with families to address concerns.

Response times were also scrutinised by the committee with the Executive Director of Nursing leading the challenge, noting that the organisation will be judged by the public for not responding promptly to critical patient and family concerns.

The Executive Director of Nursing additionally offered the challenge that the narrative explaining the reasons for poor response times should include a critique of the impact Covid-19 has had on capacity, including what the organisation can learn about improving systems and processes to meet public expectation while under pressure. The Executive Director of Nursing stated that there cannot be any room for complacency in meeting the Trust's duty to respond to concerns, therefore the response to current performance must be robust, ambitious and innovative. A clear ambition for addressing response times must be made a priority for 2022/23.

The Committee requested further work to understand the data and reasons behind current response time performance, adding that outcomes have room for improvement and there must be a clear path to achieving better standards of compliance.

Challenge was also offered in relation to PALS performance and current position statement that 39 PALS investigations had not been investigated. The Committee requires clearer explanation for performance and actions being taken to ensure the Trust meets standards and public expectation.

The Committee Chair also commented on the launch of 'I Want Great Care' initiative, expecting compliments to increase significantly, which has not happened. Assurance was offered that plans are in place to introduce volunteers in clinical areas, to be the face of PALS and encourage feedback. The performance issue has been escalated to agree immediate responses to the committee challenge on performance.

All comments on the report were accepted and would be addressed. It was noteworthy that the standard of complaint investigations and reports was generally good and that greater effort is being made to prioritise the family/patient centred approach to investigations and addressing issues identified.

3.5 Combined Sub-Committees Assurance Report

The Committee received the Combined Sub-Committee Assurance Report. The Executive Director of Nursing offered the critical challenge that in the reports current format there is insufficient consistency in the level of assurance and information presented in the report. However, the Committee welcomed the review being undertaken by the Director of Governance and Corporate Affairs.

The Committee stressed that sub-committee leads must be involved in the review process to ensure they understand the assurance requirements of the Quality Committee and to ensure a consistent approach to data presentation and interpretation.

3.6 Draft Quality Account 2021/22

The Executive Director of Nursing presented the draft Quality Account to the Committee in advance of the final draft being presented to the Board at the end of May.

The Committee reviewed, discussed and noted the Quality Account.

3.7 Care Quality Commission (CQC) Assurance Report

The assurance report was presented to the Committee, which reviewed and noted the reports content. Members challenged and made recommendations to support improved compliance and assurance. The report highlighted the following areas:

- Section 31 application for removal was completed and submitted. CQC have responded, advising they will review the application within 14 weeks of submission
- An application has been made to the CQC to notify of a change to the registered manager for Rawreth Court. This application was approved by CQC
- CAMHS wards, previously inspected in May 2021, continue to have an open action plan following this inspection. As at 26th April 2022:
    - 67 (99%) individual actions have been completed
    - 1 (1%) individual action is in progress
- A CQC preparation plan has been initiated following CQC's announcement to recommence inspections. The plan takes a risk-based approach to prioritise focus and support, and the plan is structured as follows:
    - Areas for focus: Multiple sources of data were reviewed and key focus themes agreed which included staffing numbers and mitigation, outstanding ligature actions and training compliance

  - Ward/service focus: Multiple sources of data were reviewed and key wards/services identified for focused support
  - Ward/service self-preparation: All operational services have been asked to complete a series of CQC preparation tools including record keeping and environment tools asking 'what would an inspector find if they visited today', and a reflection prep tool to help identify and articulate successes/what works well in the service and risks with mitigations
  - Well Led preparation: Work is underway to ensure the Trust is ready for a well lead inspection
- Compliance Team continue to test action plans completed to ensure actions had been embedded. Where gaps were found, these were escalated to the appropriate Trust Committee to action.
- The Compliance Team had actively started undertaking site visits to areas where available information had identified potential risk of non-compliance. The schedule would work alongside the ward heat map indicators
- CQC Guidance / Updates
  - Feedback to CQC on Citizen Lab
  - Health and Care Bill
  - Update on our new regulatory model
  - Because We All Care Campaign (focus on carers): stakeholder toolkit

The Executive Nurse led the discussion and challenge of the CQC Assurance Report. Greater assurance was requested with additional narrative in respect of the outstanding action on the Mental Health Optimal Staffing Tool (MHOST). The Trust is expecting greater support from the national implementation team which needs to be clarified and quantified.

The Executive Nurse also expressed concern regarding the response rate to the self-preparation tool, which was disappointing and requested immediate escalation to address the issue.

Members challenge also included adding CQC preparation to the Accountability Framework agenda so that there was 'check and challenge' at that level.

The Committee requested that a second compliance visit to Rawreth Court take place as a matter of urgency to assess progress on all outstanding issues.

Mutual support had also been requested from colleagues who were currently in the process of being inspected by the CQC.

3.8 Infection Prevention and Control (IPC) Assurance Framework

The Committee received and noted the IPC Assurance Framework. Key issues included:

- The national IPC guidance was reviewed and updated on 21/12/2021, but the Mental Health Appendix was removed from the document. New guidance has now been written, however this focuses on physical acute services. The IPC are awaiting confirmation on the relevance and appropriateness of this guidance for the mental health environment.
- The Committee was informed that there are added challenges which arise when Gov.Uk guidance is issued to the general public but alignment of this for the NHS sector does not get issued concurrently.

The Committee was assured that the IPC Team are continuously monitoring guidance as it is released and will update clinical practice guidelines and policies as required.

4. Policies approved at April and May meetings:

The following policies were approved by the Committee:

- CLP85 Vagal Nerve Stimulation Policy
- CLP66 Joint Working Clinical Policy
- CPG9a Structure and Content of Healthcare Records Procedure
- CP50h Cyber Incident Response Procedure
- CLP51 Hospitality & Sponsorship – Committee approved subject to a final review and sign off is required by the Trust Counter Fraud Specialist.

5. Policy Extension Requests approved at April and May meetings:

The Committee identified no additional risk to agreeing to the extension of the following policies:

- Media Policy
- Data Quality Policy
- Procedure Section 7: Prevention and Management of TB
- Procedure Section 8: Infestations
- Procedure Section 10: Pets and Pests
- Procedure Section 11: Decontamination of Mattresses
- Mental Capacity Act & Deprivation of Liberty Standards (DoLS) Policy
- Fire Safety Policy
- Research & Development Policy (New review date: June 22)
- Communicating Patient Safety Incidents, 'Being Open' Policy (New review date: July 22)
- Emails, Intranet, Internet Access & User Procedure (New review date: July 22)
- NHS Mail Usage Procedure (New review date: July 22)

6. Reflections on Risks, Issues and Concerns at April and May meetings:

The Committee identified:

- No risks for escalation to the CRR or BAF, although it is noted that the following are identified as potential risks:
    - Rawreth Court is identified as a potential risk for a CQC visit - a further compliance visit is required to ensure progress has been made (to be escalated to the Compliance Team)
    - Reputational risk following publication of Complaints Report (to be escalated to the Communications Team)
    - Response to completion of the Self-Assessment Tool in readiness of CQC preparation (to be escalated to the Executive Committee)
- There were no issues to be raised with other standing committees, but a question to be raised with F&P Committee – how will they be tracking performance trajectory and the impact on the quality outcomes?
- There were no recommendations to the Audit Committee linked to the Internal Audit Programme

7. Reflections on areas of good practice at April and May meetings:

<u>April:</u>

- The Chair of the Quality Committee identified a number of areas of good practice, these included the detail and depth of the reports, the development of performance monitoring for assurance and the lead role the Trust is playing in the implementation of the PSIRF.

<u>May:</u>

- Nursing/AHP Strategy

3.0 RECOMMENDATIONS

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: 8aiv
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	25 April 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	
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

3 The Board requirement to note the Workforce Race Equality Standard and Workforce Disability Equality Standard data.

4 Approval for the Committee to move to a bi-monthly meeting schedule from the end of May '22.

Summary of Key Issues

The People, Equality and Culture Committee (PECC) met on the 21 April 2022 and the 19 May 2022, the meetings were quorate and the minutes of the meetings held on 24 February 2022 and 21 April 2022 were approved subject to minor amendments.

The Committee received reports on the following:

- **Engagement Update** – The Committee received a thorough update on staff engagement and the Trust benchmarked well with the nine areas covered and that there were now in place robust targets for engagement. The Committee welcomed the robust response on the actions taken on the back of feedback. Overall the report was welcome.

- **International Recruitment** – The Committee was advised of the positive feedback from NHS England on our recruitment programme and that the Trust had been given a grant to build relationships in the Caribbean for ethical recruitment. The Board is alerted to the risk associated with the potential for visa delays and the added impact of accommodation usage. An action has been taken by the non-executive directors to meet our new international recruits and understand their experience of the programme, with the potential to hold a focus group. At the meeting this month, the Executive Director of People and Culture advised that this seems to having no impact at present.

- **Mandatory Training** – The Committee were reminded of the decision taken to prioritise the training ask at the peak of the COVDI-19 pandemic. The Trust was now on a recovery journey and the plan to deliver mandatory training was presented. The Board is alerted to the risk related to the capacity to release staff to attend training against balanced with safe staffing within our service areas. The executive reported that further work was being undertaken to enable training to be rostered.

- **Values and Behavioural Toolkit** – The Committee were appraised of the development of a behavioural toolkit which would enable all staff and line managers to hold meaningful conversations and link these to the new appraisal process and 1-2-1 meetings. The Committee noted that this would hold people to account for their behaviours and will have a significant impact on our culture. An action was taken to have a presentation of the new appraisal process at a future meeting.

- **Employee Relations –** The Committee was pleased to see that early interventions were having a positive impact and the reduction in the number of disciplinary actions as a result.

- **Gender Pay Gap** – The Committee received the data and the assurance that the mandatory return was published in line with requirements, with benchmark data coming back to a future meeting when available.

- **Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)** – The Committee received the data and noted that the WRES performance had receded and the WDES had improved. The Committee welcomed the actions set out to address areas requiring improvement.

- **Policy Extensions -** The Committee approved the extensions of reviews for policies, noting that revised deadlines to be met.

- **HR Metrics** – The Committee congratulated the team on the improvement in reduced the time to hire from circa 40 days to circa 20 days.

The Chair of the meeting, along with the Executive Director of People and Culture have been reviewing the forward plan for the PEC Committee, with the support of the Senior Director of Corporate Governance. It is planned, subject to Board approval, to move to the Committee meeting on a bi-monthly basis which will enable the scheduling of business to be aligned to strategic pillars for our people and reporting twice a year on progress. This approach would provide time to move programme forward between reporting periods.

The Committee is also planning to hold a task and finish group to design and set up a PEC Committee dashboard drawing on the key performance metrics that would help oversee this function within the Trust.

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 Documents and/or Further Reading
None

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

WORKFORCE RACE EQUALITY STANDARD (WRES)

Ind.	Type	Description	Averages		EPUT WRES Scores		Progress 2020 - 2021		
			EoE 2021	National 2021	2020	2021	Org.	EoE	Nat.
1	Workforce Data	Percentage of staff in each of the National NHS Pay bands (1-9 and VSM including Executive Board members) compared with the percentage of staff in the overall workforce. ***Higher = Better***	23.9%	22.4%	26%	24.7%	Decline	Higher	Higher
2		Relative Likelihood of BAME staff being appointed from shortlisting compared to White staff across all posts ***Lower = Better***	1.69	1.61	0.91	1.59	Decline	Lower	Lower
3		Relative Likelihood of BAME staff entering formal disciplinary process compared to White staff. ***Lower = Better***	1.06	1.14	2.73	3.40	Decline	Higher	Higher
4		Relative Likelihood of BAME staff accessing non-mandatory training and CPD compared to White staff ***Lower = Better***	0.99	1.14	2.10	1.64	Improv.	Higher	Higher
5	Staff Survey Results	Percentage of BAME staff experiencing harassment, bullying or abuse from patients relatives and public in last 12 months, in comparison to White staff. ***Lower = Better***	29.8%	28.9%	39%	33%	Improv.	Higher	Higher
6		Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months, in comparison to White staff. ***Lower = Better***	28.6%	28.8%	25%	27%	Decline	Lower	Lower
7		Percentage of BAME staff believing the Trust provides equal opportunities for career progression & promotion, in comparison to White staff. ***Higher = Better***	70.4%	69.2%	74%	67%	Decline	Lower	Higher
8		In last 12 months have you personally experienced discrimination at work from Manager or Team? (In comparison to White staff) ***Lower = Better***	17.1%	16.7%	13%	18%	Decline	Higher	Higher
9	Board Membership	Difference between BAME Board membership & overall workforce ***Lower = Better***	TBC	12.6%	19.3%	0.3%	Improv.	TBC	Lower

WRES score template with comparative ranking and NHS Benchmarking

Organisation: Essex Partnership University NHS Foundation Trust (EPUT)

Person completing this report: *Gary Brisco (Equality Advisor)*

WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

Ind.	Source	Description	National Average 2021	Org. Scores		Progress: 2020 - 2021	
				WDES 2020 score	WDES 2021 Score	Org Progress	National Average Comparison
1	Workforce Data Mar 2021	Percentage of Disabled staff in the workforce **Higher = Better**	3.7%	3%	3.6%	Improvement	Lower
2		Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts. **Lower = Better**	1.11	0.95	1.17	Decline	Higher
3		Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. **Lower = Better**	1.94	1.41	2.61	Decline	Higher
4a I	Staff Survey Results Mar 2020	Percentage of Disabled staff compared to non-disabled staff experiencing harassment bullying, or abuse from patients, relatives and public. **Lower = Better**	31.9%	39%	39%	No Change	Higher
4a II		Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from managers **Lower = Better**	18.5%	20%	18%	Improvement	Lower
4a III		Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients, carers and public. **Lower = Better**	25.6%	26%	22%	Improvement	Lower
4b		Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. **Higher = Better**	49.7%	52%	52%	No Change	Higher

WDES score template with comparative ranking and NHS Benchmarking

Organisation: Essex Partnership University NHS Foundation Trust (EPUT)
Person completing this report: Gary Brisco (Equality Advisor)

WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

Ind.	Source	Description	National Average 2021	Org. Scores		Progress: 2020 - 2021	
				WDES 2020 score	WDES 2021 Score	Org Progress	National Average Comparison
5	Staff Survey Results Mar 2020	Percentage of Disabled staff compared to non-disabled staff believing the Trust provides equal opportunities for career progression or promotion. **Higher = Better**	78.4%	75%	79%	Improvement	Higher
6		Percentage of Disabled staff compared to non-disabled staff feeling pressure from their manager to come to work despite not feeling well enough to perform their duties. **Lower = Better**	31.1%	30%	32%	Decline	Higher
7		Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. **Higher = Better**	39.4%	38%	43%	Improvement	Higher
8		Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work. **Higher = Better**	76.6%	72%	78%	Improvement	Higher
9b		The staff engagement score for Disabled staff, compared to non-disabled staff. **Higher = Better**	6.68	6.5	6.8	Improvement	Higher
10	Board Membership	Difference between disabled Board membership and overall workforce **Lower = Better**	3.7%	-3%	8.9%	Improvement	Higher

WDES score template with comparative ranking and NHS Benchmarking

Organisation: Essex Partnership University NHS Foundation Trust (EPUT)
Person completing this report: Gary Brisco (Equality Advisor)

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 8b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 May 2022**

Report Title:	**Board Safety Oversight Group Assurance Report – May 2022**					
Executive/ Non-Executive Lead:	Alison Rose-Quirie, Non-Executive Director					
Report Author(s):	Richard James, Director of Transformation					
Report discussed previously at:	Executive Safety Oversight Group Board Safety Oversight Group					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	Yes/ ~~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 the Board of Directors with an update on the progress of projects and programmes linked to the safety priorities within the safety strategy. • Safe Staffing • International Recruitment • EPUT Culture of Learning • Ligature Risk Reduction • Engagement & Supportive Observations • In-patient Flow and Capacity	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

Summary of Key Issues
N/A

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

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

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

Acronyms/Terms Used in the Report			
ECOL	EPUT Culture of Learning	EPMA	Electronic Prescribing and Medicines Administration
PMO	Programme Management Office	EMIS	Egton Medical Information Systems
PID	Project Initiation Document	IELTS	International English Language Testing System
PECC	People, Equality and Culture Committee	ET	Executive Team

Supporting Documents and/or Further Reading
Main Report

Lead
Alison Rose-Quirie **Non-Executive Director** **Chair of the Board Safety Oversight Group**

Part 1 Agenda Item: 8b
Board of Directors Part
1 25 May 2022

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Board Oversight Safety Group

This report is provided as assurance to the Trust Board on the continued progress of projects and programmes that are linked to the safety priorities within the safety strategy.

Since our last report we have carried out a scheduled review of the Executive Safety Oversight Group (ESOG) agenda and as a result there have been a number of new priorities added to the meeting and a new reporting cycle proposed. Additionally, the safe staffing project has now been completed and engagement and supportive observations has transitioned to business as usual and will now be reported through internal governance processes.

An overview of the new reporting cycle is shown below:

	Theme	Agenda Items
Week 1	ESOG - Safety Priorities	Coroner/SI Themes (new) Ligature Risk EPUT Culture of Learning EPMA/EPR Patient Experience (new)
Week 2	ESOG - Staffing	Inpatient Flow Safety Strategy Update (new)
Week 3	ESOG - Performance Metrics	Safety Priorities Dashboard Key Performance Indicators (new)
Week 4	BSOG – Consolidated report	Consolidation and summary of reporting weeks 1-3. With exception reporting of material changes to any previous week's reporting

Coroner/SI Themes

This is a new safety priority being reported into ESOG and BSOG. Updates will be provided from June 2022.

Ligature Risk Reduction

An agreement was made, supported by the Senior Responsible Officers (SROs) for Ligature Risk Reduction programme to introduce a cut-off point of the 31st March 2022 for all historic environmental actions. Any new actions following this date are now being handled in accordance with established business as usual processes and governed through the Ligature Risk Reduction Group (LRRG). There are five historic actions which remain open and these will continue to be monitored and progress reported to ESOG.

As a result of the analysis of historic actions, the Transformation Team proposed the scope of the programme should be broadened to include Training and Policy as these areas account for the highest number of ligature related serious incidents. This has been agreed by the SROs.

In line with the Transformation Team's ambition to govern projects a consistent way, the Ligature Risk Reduction project has established a framework of task and finish groups who will drive progress in each identified area of need; Environment, Training and Policy. These are now being reported by the working group's leads into a newly formed project management group and will report to LRRG.

This new group has also taken forward the work instigated by the Technical Solutions Group to synchronise data between Datix and 3i using robotic process automation (RPA). The use of RPA technology is a first for the Trust and will improve accuracy and efficiency of data entry following Ligature Audits.

A list of completed environmental actions is included in Part 2 of the Trust Board meeting.

EPUT Culture of Learning (ECOL)

Following a successful recruitment campaign, we have now on-boarded the Lessons Communication Business Partner. Their role is in place to support the cascading of information about ECOL throughout the organisation. Despite only being in role a couple of months they have already been instrumental in ensuring the infographic we use to cascade information was fit for purpose and is being used across the Trust.

We have also made offers on the following roles; a Functional Lessons Analyst/Shared Head of Learning, who is responsible for the day to day operational management of the team and delivery of the culture of learning ambition. A Learning Lessons Analyst to analyse information in a thematic way, providing second line assurance, complete audits, and link the learning collaborative and learning oversight sub-committee. A Learning Lessons Facilitator to support the delivery of Patient Safety Syllabus and deliver Learning Lessons training. There now only remains the appointment of a Lessons Database Manager, this is currently advertised with a closing date of 16th May.

We are continuing discussions with our Digital colleagues on the creation of a PowerBI Safety Dashboard to focus on safety incident reports across the Trust. This will combine numerous data sources into one cohesive dashboard, allowing better insights into staff and patient safety. Additionally, we have made good progress on the development of the EPUT Lessons Identified Management System (ELIMS) which has now progressed into initiation phase.

EPMA/EPR

The EPMA project is currently paused due to EMIS confirming further delays to the release of software which is now not expected to be available until Q4 2022 earliest.

KPMG have been engaged to prepare an EPR business case for submission to the Trust Board. Given the delays from EMIS we have asked KPMG to include ePMA in the scope of their work and explore the impact, advantages/disadvantages, appetite and timelines for EPMA and EPR projects to be combined.

Patient Experience

This is a new safety priority being reported into ESOG and BSOG. Updates will be provided from June 2022.

Inpatient Flow and Capacity

Our Inpatient Flow and Capacity priority has updates under the following areas:

Out of Area Placements:
Due to a high demand in the acuity of our in-patients we have seen an increase in inappropriate placements, taking the number at the beginning of May to 14. To address this an OoAP sustainability and recovery plan has been completed and circulated with wider System partners, and NHSEI consultants have been meeting with EPUT teams to offer clinical coaching.

Purposeful admission:
Weekly inpatient and community patient review and discharge planning meetings now take place in all of our five adult acute sites. These meetings address ward and trust level Delayed Transfers of Care (DToC) escalations. In addition to this the system-level escalation calls for adult DToC's has been restructured and streamlined by merging the North and South acute adult calls.

Basildon Emergency Department Diversion/ Mental Health Emergency Department:
Analysis of data gathered from the Basildon ED Diversion service and Basildon Acute Emergency Department is taking place in order to inform key decisions for the development of the Mental Health Emergency Department (MHED). This analysis is expected to be concluded by the end of May and will then be presented to the Executive Team. Meetings have been taking place with the MSE Chief Operating Officer and Mid and South Essex Clinical Commissioning Group to ensure collaboration on the model with further stakeholder engagement being initiated with senior system leadership teams in early May.

Optimal Patient Pathways:
The Service User Network has been reviewing the Inpatient emotionally unstable personality disorder (EUPD) pathway ahead of it being shared with the patient information and plain English group. Following these reviews, the community service provisions for EUPD will be explored further.

Safety Strategy Update (new)

This is a proposed new addition to the ESOG meeting and reporting cycle. Work has started to produce an update on our progress against the plan to deliver the Safety Strategy and this will be reported to ESOG and BSOG.

Key Performance Indicators

We have drafted and presented a set of key performance indicators, which are aligned, to our safety priorities. As a next step, we will work alongside KPMG (external organisation) to develop these further as part of their Business Intelligence Strategy programme of work. In addition to this, we will ensure that any key performance indicators proposed are in line with those reported through the Accountability Framework meetings and other committees to ensure there is no duplication and consistency of reporting across the Trust.

International Recruitment

The project is now progressing well and has moved from red to amber status in the past month. This is due to the achievements of the entire team in shortlisting, interviewing and recruiting a large number of nurses.

During April we interviewed 118 Nurses making offers to 93 candidates and received 77 acceptances. 26 Nurses are due to arrive in May with accommodation secured in both Chelmsford and Billericay.

Seven of our 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 in Epping. The three remaining nurses who arrived in this cohort will sit their first attempt OSCE on the 18th May 2022.

In April a team of nurses from EPUT visited Botswana alongside NEU Professionals (a specialist healthcare recruitment agency) to interview nurses. As a result we have made 65 offers of employment and these candidates now need to complete their eight-week International English Language Testing System (IELTS) course before completing a computer based test (CBT) and a visa application. These nurses are predicted to arrive in the UK at the end of this year.

Preparations continue at Swan Housing in Chelmsford & Colchester and Mountnessing Court in Billericay for Nurse arrivals in May. This includes ensuring accommodation, technology and sundries are all ready and at the required standards.

We have successfully secured an additional £101k from NHS England to go towards two projects which will accelerate the arrival of nurses as part of a National Mental Health innovation fund initiative. £35,000 is to be used to support nurses in their home country to complete their International English Language Test (IELTS) and £66k will be used for an in-country recruitment campaign conducted by a team of nurses and EPUT professionals.

In future, this programme will be governed and reported into People, Equality and Culture Committee (PECC) and the Executive Team (ET).

Engagement & Supportive Observations

The Engagement & Supportive Observations programme has now transitioned into business as usual and will no longer be reported through ESOG and BSOG. Further information on the outcomes of the programme of work are detailed in the Chief Executive report.

Report Produced by
Richard James
Director of Transformation

On behalf of
Alison Rose Quirie
Non-Executive Director
Chair of the Board Safety Oversight Group

		Agenda Item No: 9ai
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 May 2022**

Report Title:	**Covid 19 Assurance Report**					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Nicola Jones, Director of Risk and Compliance					
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	Move to use of General workplace risk assessments to include Covid risks Ongoing management at incident level 4	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	✓
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

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

Recommendations/Action Required

The Board of Directors are asked to note the content of the report and to remit oversight to the Executive Team with the caveat that reporting be re-instated if there is a further surge.

Summary of Key Issues

The NHS 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 Trusts arrangements for managing COVID-19 remain effective and in line with national guidance.

For the NHS Covid-19 restrictions remain in place and as such we continue to monitor prevalence amongst our patients and staff and respond promptly to guidance as and when provided. Restrictions have been reduced removing the requirement for 2 meter distancing.

We continue to develop our recovery plans incorporating learning, the decision benefits and impacts which were used to identify the key areas for recovery

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

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

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

Acronyms/Terms Used in the Report			
NHSE/I	NHS England and Improvement	IPC	Infection Prevention and Control
COVID RR	Covid Risk Register	CCG	Clinical Commissioning Group
CPNS	Covid-19 Patient Notification System	UKHSA	UK Health Security Agency
GWPRA	General Workplace Risk Assessment	PCR	Polymerase Chain Reaction

Supporting Documents and/or Further Reading
Covid Assurance Report Covid Risk Register Summary (Appendix 1)

Lead

Paul Scott
Chief Executive

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

COVID 19 ASSURANCE REPORT

1. Purpose of Report

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

2. Background

The country continues to deal with the corona virus pandemic and the NHS remains at its highest level of emergency preparedness being an Incident Level 4 up to 19 May 2022 at which time the incident level was reduced to Level 3.

The Trust's arrangements continue to be working effectively and are regularly reviewed in line with any national or regional guidance received. For the NHS the Covid-19 restrictions remain in place and as such we continue to monitor prevalence amongst our patients and staff and respond promptly to guidance as and when provided.

3. Command Structure

The separate Gold, Silver and Bronze command structures remain in place and continue to be held separately once a week. This frequency remains flexible in regards to reducing/ increasing meetings dependent on need. Bronze command meetings continue to mirror the Silver and Gold commands to ensure decisions and information received continues to cascade through the organisation at pace, and that we are responsive to any changes required.

The (virtual) Incident Control room remains operational 7 days a week 8am until 6pm in line with the East of England Operational Centre. This continues to be covered by the Compliance and Assurance Directorate with the additional help at the weekends from the Directorate and a bank Band 6 Emergency Planning Support Officer.

The regular sit rep submissions required by the Centre continue, with 2 daily sit reps the National COVID daily sitrep and Community discharge daily sit rep as well as the regular Lateral Flow Testing numbers and Long Covid activity submissions.

The number of national and regional information / guidance received via the incident control inbox continues to decrease, however the continued monitoring of the inbox remains in place to ensure that should anything of urgency come through we are able to remain responsive. All national/ regional guidance, information and/or requests continue to be cascaded to the appropriate Directors and through discussion at the Command meeting for information and consideration of the actions required with a timely response.

The equalities network leads continue to have a presence at the command meetings to ensure that issues are captured and a reflection on risks and impact is undertaken to safeguard that no staff group is adversely affected by decisions made.

The ethics committee remains in place with a Non-Executive Director as Chair for oversight of any ethical decisions that may be required as a result of our response to dealing with the pandemic and ability to review the impact of these decisions.

4. Impact to Date

Since last reporting in March 2022 there has been a decrease in our reporting of COVID-19 positive cases. At time of writing, we currently have 2 COVID-19 confirmed patients within our services (previously 25) and a total of 30 staff off sick not working due to Covid-19 related illness which is a significant decrease from 167 of last report.

There have not been any further Covid-19 related deaths to report onto the Covid-19 Patient Notification System (CPNS). These are reportable for patients having tested positive in the proceeding 28 days prior to their death.

Since last reporting, we currently have 4 outbreaks declared to UK Health Security Agency (UKHSA) formerly known as Public Health England, this is a reduction from the 10 at last reporting period. The 4 open outbreaks relate to 3 Mental Health Service wards and 1 Specialist Service ward for which we continue with consistent monitoring and reporting. To note an outbreak is classified when there are 2 or more cases in one area at a period of time, which was the threshold met in each of the teams where the outbreaks have occurred.

It should be noted that whilst the number of outbreaks has deceased we continue to ensure learning from each episode and that the necessary processes are followed as advised through joint meetings with operational teams, NHSE/I, CCG's and UKHSA.

5. Trust wide Response

As we move back to business as usual we continue to develop the recovery plan and the work being undertaken on the agreed key impacts under the following 4 themes;

- Workforce Resilience
- Inpatient Capacity and Flow – MH
- Mandatory/ Essential Training, Supervision and Appraisal compliance rates
- Community patient experience – waiting times and face to face activity; Dementia Diagnosis

The Health and Safety Executive requirement for separate COVID secure risk assessments to be undertaken for our buildings has now been removed and replaced with the requirement to risk assess COVID. We have agreed as a Trust that we will cover COVID risk assessments as part of our General Workplace Risk Assessments (GWPRA). To achieve this the GWPRA has been updated and covers identified risk areas. The social distance posters are being removed, with exception of areas where there remains the need for the 2 meter social distancing such as break rooms.

6. Communication

Decisions made through Command meetings and any changes in guidance continue to be communicated to all staff through bronze command, the regular production of the Live briefings, the Wednesday Weekly publication and on the intranet.

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

7. Risks

The Trust's COVID Risk Register (Appendix 1), remains a live document. There are 5 open stand-alone COVID risks made up of 1 extreme, 3 high and 1 medium.

In addition there are 3 risks on the Corporate Risk Register (CRR) relevant to COVID-19, made up of 2 high risks and 1 medium.

8. Learning

Learning continues to be a key part of the Trust response to COVID-19 and a number of activities as reported previously are continuing to take place, alongside some new initiatives and additional incentives to support our staff.

The importance of compliance with personal protective equipment is a consistent feature at command meetings and further cascades, highlighting the importance of the named Covid Marshals to challenge any non-compliance with staff and/or visitors in real time.

The NHS remained at Level 4 incident up to the 19 May 2022. We continue to develop our recovery plans incorporating learning, the decision benefits and impacts which were used to identify the key areas for recovery.

9. Action Required

The Board of Directors are asked to note the content of the report and to remit oversight to the Executive Team with the caveat that reporting be re-instated if there is a further surge.

Report compiled by
Nicola Jones
Director of Risk and Compliance

On Behalf of
Paul Scott
Chief Executive

SUMMARY COVID RISK REGISTER 2021/22

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

Note: SR1 Safety SR2 People SR3 Systems and Processes/ Infrastructure and SR4 Demand and Capacity all have Covid-19 as part of their context

Table 1 – Stand-alone Covid-19 risks

Risk and Objective ID	Summary	Potential Risk	Key Controls	Key Assurances	Key Gaps/Actions
Strategic Objective 1 We will deliver safe, high quality integrated care services					
CVG19 SO1 Lead: NH Committee: Quality	**Infection and Prevention Control** 12 12 12 Current Risk score 4 x 3 = 12 Risk score Target 4 x 2 = 8 Ongoing	If EPUT does not manage Infection and Prevention Control (IPC) during COVID19 then infections may increase resulting in a negative impact on the pandemic	• Assurance visits being undertaken and clinically held action plans • IPC Board Assurance Framework (national document) updated bi-monthly • New guidance reviewed and implemented through Command structure as received • National recommendations derived from other organisations during C19 are reviewed against EPUT measures • C19 secure procedures are in line with IPC guidance • IPC Dashboard developed to monitor potential risk areas • Live event w/c 18 October to mitigate risk • Undertaking patient risk assessment and follow isolation flow chart on inpatient areas	Level 1: assurance visits Command meetings Level 2: Covid Dashboard	• Reiterate compliance with current guidance • Covid Ward dashboard indicating not doing monthly assurance audits on Tendable in a timely manner and Not swabbing patients as per the frequency guidelines • Challenging staffing levels on wards • Included question about risk assessments on admission • EPUT still has outbreaks but learning is being shared and slides to be cascaded (it is most likely that the introduction of the new testing regime may result in a reduction in outbreaks)

Risk and Objective ID	Summary	Potential Risk	Key Controls	Key Assurances	Key Gaps/Actions
			• IPC BAF updated March 22 and submitted to Quality Committee 10 March 22 • Silver Command monitoring of Outbreaks • New Government guidance issued and implemented		
CVG10 SO1 Lead: TS Committee: F&PC	**Capital Programme** 9 9 9 Current risk score 3 x 3 = 9 Ongoing Target 3 x 2 = 6	If EPUT is unable to maintain its planned capital programme through lack of contractor access then delays or deferments may occur resulting in increased pressure on the capital programme in recovery	• Capital projects continuously under review • Building contractors have returned to BAU • No delay identified and no significant risk to future programme • Situation continues to be managed including managing contractors on care home sites	Level 1: Capital Group ESOG Level 2: F&P	• Contractors working within social distancing guidelines still an issue • Consider for closure once there are no outbreaks
CVG55 SO1 Lead: AG Committee: Quality	**Outbreaks** 10 10 10 Score increased to 5 x 3 = 15 by Silver Jan 22 Risk score 5 x 2 = 10 at threshold<br ~~June 21~~<br ~~March~~ June 22 Target 5 x 2 = 10	If EPUT continues to experience ward closures due to Covid19 outbreaks then availability of beds to acutely ill patients may diminish resulting in additional community/ virtual support and potential harm to patients	• Mitigation in place for swabbing, lateral flow testing on wards • ICP Dashboard developed to help identify wards at potential risk • Daily sit reps provide information on any Covid positive patients/Staff • Outbreak management process in place • Extend completion date in line with national lockdown easing	Level 1: Bronze Command and Surge Plans Ward Assurance Level 2: Silver Command and IPC function	• Continue to revisit this risk following lifting of restrictions • Jan 22 – 15 outbreaks with the potential to increase again • 10 March 22 - 10 outbreaks and 1 emerging outbreak. • Increase being seen in staff numbers testing positive w/c 7 March • Improving position
Strategic Objective 2 We will enable each other to be the best that we can					

Risk and Objective ID	Summary	Potential Risk	Key Controls	Key Assurances	Key Gaps/Actions
CVS30 SO2 Lead: SL Committee: PECC	**Fatigue and burnout** 12 → 12 → 16 Risk score increased Dec 21 to 4 x 4 = 16 Ongoing Target 4 x 2 = 8	If EPUT does not manage the levels of fatigue within the organisation then burnout and sickness levels may rise resulting in a failure to deliver services in a safe way and compromised wellbeing of staff	• Wobble rooms where practicable • Take a break initiative promoted • Annual leave guidance updated • Wellbeing events and mindfulness • Wellbeing Festival Summer 21 • Rest nest sessions • PULSE survey to be reinitiated August 21 • Discussions at Senior Leadership Team • Refocus on the environmental factors that are affecting staff stress levels e.g. excessive workloads and demands • Focus on recruitment to vacancies • Wellbeing incentives and support on offer promoted in Wednesday weekly – includes resilience and mental health webinars	Level 1: Command	• Continue to encourage staff to take up offers of online support • Senior and local leaders to address environmental factors affecting staff morale and wellbeing through discussion focus • Commitment to transfer bank and agency staff to permanent posts • Full establishment review **Comments** • Silver Command Jan 22 approved increased score to 16 – seeing increases in staff sickness plus change in self-certification process • March 22 sickness absence decreased Covid absence below 1% and general sickness below 5%. Self cert process has been reinstated for all absence > 7 days • NHS Covid sickness and isolation pay to continue for both substantive and bank staff until further notice

Risk and Objective ID	Summary	Potential Risk	Key Controls	Key Assurances	Key Gaps/Actions
CVS32 SO2 Lead: SL Committee: PECC	**Staffing Pressures** 20 20 20 New risk Dec 21 Initial risk score 5 x 4 = 20 Target date and score March 22 5 x 2 = 10	If EPUT is unable to manage staff absence and availability of flexible and corporate clinical workforce during Omicron wave then BCPs and surge plans are significantly affected resulting in compromised service delivery and breaches in working time regulations	• Incentives being offered to bank staff – undertake three shifts and receive pay for a fourth shift • Incentives offered to substantive staff over New Year period • Corporate clinical staff redeployments to clinical areas • Surge Plans in place	Level 1: Bronze Command / ward staffing sit reps and oversight huddle Level 2: Silver Command and ESOG	• Breaches in working time regulations by staff working additional hours to cover absentees • Easter incentive package to be agreed at Gold Command • Use of safe care model to identify areas of risk – escalation flow chart around staff and staffing strategies being implemented trust wide using time to care

Table 2 – Extract from the current Corporate Risk Register of all Covid-19 related risks.

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
CRR45 SO2 Lead SL PECC	**Mandatory training** 16 16 16 Initial Risk Score 4 x 3 = 12 Current Risk Score 4 x 4 = 16 Target March 22 4 x 2 = 8	If EPUT does not achieve mandatory training policy requirements then patient and staff safety may be compromised resulting in additional scrutiny by regulators and not meeting the IG Toolkit requirements	Training frequencies extended over Covid-19 pandemic leaving need for recovery	Local trajectory in place for safety focused and IG mandatory training as a priority Monthly reporting to ET National OLM issue resolved	Developing detailed recovery plan	Level 1: Compliance under Covid arrangements 89% Level 2: Level 3: IG DSPT	Risk materialised on meeting the Information Governance Toolkit requirements – further work to be done in 2021/22 TASI main area of concern
CRR85 SO4 Lead	**Mass Vaccination** 8 8 8	If EPUT does not effectively direct and implement the entire mass vaccination	Covid-19 pandemic Mass Vaccination programme is nationally driven	A risk register set up specifically related to the Mass Vaccination programme to strengthen	Maintain watching brief on variable vaccine supply and impact on programme	Level 1: Programme Board and Risk Register Level 2: Quality Reports for SNEE	None identified

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
NL Quality Committee	Current risk score decreased to threshold subject to EBAF approval 4 x 2 = 8 Mar 22 Initial Risk Score 5 x 4 = 20 Target Ongoing 4 x 2 = 8	programme during challenging times then it may not meet ~~level 4~~ deliverables and timescales resulting in a compromise to the programme		governance around the project New BCPs developed for vaccination centres Working in partnership, with Local Resilience Forums, Local Authorities and other providers to deliver the programme Clinical oversight and governance in place at all vaccination centres discussed daily All costs passing through NHSE and laptop costs supported by skill mix work Robust communication in place with vaccination centres Pre-assessment model developed by EPUT now approved by Region Managing alternative models for vaccination delivery including pop ups and large trailer, drive through pilot and buses Maintaining workforce at vaccination centres (and other delivery centres) with forward planning to identify workforce challenges Maintaining vigilance and awareness on security and potential criminal activity at vaccine sites Mirrored on Covid-19 and Mass Vaccs risk register 12-15 age group School Immunisation Teams now delivering vaccines mainly through school environments Delivery of phase 3 booster programme commenced on	Assessment of recently published national security guidance to draw out any actions (Pfizer/ Cominarty) Maintain watching brief with national uncertainty about extension of vaccination programme Monitor situation in relation to further cohorts coming on stream due to the Omicron variant JCVI Directive is that all over 18's to receive boosters by 31 Jan 22 Project team working on covering off pre-assessments on behalf of other systems Contractual discussions with staff – some contracted to end June 22 and there will still be a programme to cover Creation of an integrated vaccination service for Essex and Suffolk in early stage discussion Outstanding cohorts 5-11 vaccinations scheduled for clinically extremely vulnerable, primarily GP led offer but vaccination centres filling gaps in provision High level plans in place but no formal indication from the centre about when and how	and MSE Quality Groups Level 3: over 1,350,000 vaccinations delivered	

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
				20 September via a range of delivery models including GP led, Community pharmacies and large scale vaccination centres Standing up temporary vaccination centre in Chelmsford and working with system to maximise resources Expanded 12-15 age group appointments Workforce stable Security risk at threshold	Changes to vaccination programme expected – healthy 5-11 year cohort from April, plus vulnerable and over 75 age group boosters – expected to be a 10-12 week programme Prepare plans for a booster programme in the autumn of 2022 for cohorts 1-6		
CRR90 SO4 Lead NL Quality Committee	**Management of Covid-19** 10 10 10 Initial Risk Score 5 x 3 = 15 Current risk score decreased Mar 22 to 5 x 2 = 10 Target March 22 5 x 2 = 10	If EPUT does not manage Covid-19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements	Covid-19 pandemic	• BCPs • Command structure • Sit rep daily monitoring • Covid-19 intranet page and range of staff training in place • Covid-19 dashboard issued weekly to monitor prevalence • NED and Executive Lead for Emergency Planning agreed (NL) • Demonstrating lessons learnt from Covid-19 through bi-monthly Trust Board reports and EPRR quarterly report • Action Plan completed	• Prepare for Covid-19 Statutory Inquiry due to start work Spring 22 with first public hearings in 2023 • Review emergency planning processes in light of Covid-19 experience • Hold internal emergency planning exercise	Level 1: Action plan completed Level 2: EPRR Team / IPC Team Level 3: EPRR Standards	• Covid-19 IPC risk increased in score and escalated

Table 3 – Heat Map against 5 x 5 scoring matrix

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2				CRR85	CVG55 CRR90
	3			CVG10	CVG19	
	4				CRR45 CVG59	CVS32
	5					

		Agenda Item No: 10a
SUMMARY REPORT	**BOARD REPORT PART 1**	**25 May 2022**

Report Title:	**Communications, Brand and Marketing Strategy**					
Executive/Non-Executive Lead:	Sean Leahy, Executive Director of People & Culture					
Report Author(s):	Martine Munby, Communications Director					
Report discussed previously at:	Board of Directors Part 2 27 April 2022					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report		
This report provides an overview of the proposed strategy for Communications and Marketing	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to

1. Note the content of the Communications and Marketing Strategy

Summary of Key Issues

While the Communications and Brand and Marketing Teams are organisationally separate there is extensive collaboration and integration between the two.

Consequently 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.

It is a strategy that also seeks to manage EPUT's corporate reputation and to give all who work for the Trust a sense of pride and belonging, while giving those who rely on our services a sense of reassurance that their needs and care are at the heart of everything that we do.

The strategy is at an early stage of socialisation and given the role of The Board in setting strategy we are seeking early consultation and engagement before going through the usual governance processes.

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

Acronyms/Terms Used in the Report			
NHS	National Health Service		
EPUT	Essex Partnership University Trust		

Supporting Documents and/or Further Reading
Communications, Brand and Marketing Strategy

Lead

Sean Leahy
Executive Director – People & Culture

Communications, Brand and Marketing Strategy

1 Purpose of Report

1.1 The purpose of this report is to provide The Board with a summary and next steps in relation to Communications, Brand and Marketing Strategy, as presented at the Board Seminar on 27 April 2022.

2 Board Summary

2.1 The Communications, Brand and Marketing Strategy sets out the 3 year objectives and strategy to deliver effective internal and external communications to ensure that EPUT can achieve its vision, purpose and strategic objectives.

2.2 The paper has been shared for early socialisation with The Board, given their responsibilities in setting the EPUT strategy and the paper is for information.

2.3 The final, completed and fully costed strategy will be shared with The Board at a future date.

3 Objectives

3.1 Communications Objectives

- To create innovative and engaging content so that all audiences understand the focus and strategic direction of EPUT
- To develop effective tactics and channels of communications focussed on reaching all audiences which are measurable and provide data to allow continuous improvement
- To create a compelling external narrative so that press and external stakeholders understand the positive work across the Trust and to tell the story of the EPUT family in a clear rhythm of positive news
- To manage crisis communications so that we minimise negative impact on the Trust's reputation internally and externally – through effective media management, preparation and insight into future risks and issues via horizon scanning.

3.2 Brand and Marketing Objectives

- Create innovative and informative marketing campaigns to promote EPUT as the leading health and wellbeing service in the provision of mental health and community care – from charities to football clubs - and utilise the good work NHS E&I already do within the provision of Mental Health.
- Work collaboratively with our internal and external stakeholders to showcase the positive work and projects happening on a regular basis.
- Build engagement across all of our social media channels, and create compelling work to drive traffic to our new EPUT website.
- Secure EPUT's reputation as a place that delivers safe, high quality integrated care services as well as a place people want to come and work, and promote its success beyond the boundaries of Suffolk and Essex.

4 Audience Segmentation

Key audience groupings have been identified as follows:

External Stakeholders:

- Patients and the public
- People who use local health services and their carers
- Our governors
- Patient Participation Groups (PPGs)
- Our residents across Essex, Suffolk and Luton & Bedfordshire
- Local authorities
- Local academic institutions
- Research partners
- Interest groups and campaigners
- Voluntary, community and third sector organisations
- Organisations representing the armed forces and veterans
- Charitable organisations
- Suffolk and Essex Healthwatch
- Media, print, social, broadcast, digital

Elected representatives

- Politicians: local MPs
- Suffolk and Essex County Councils
- District and Borough councils
- County, Borough, and District councillors
- Suffolk and Essex Health and Wellbeing Boards) Health Overview and Scrutiny Committees (Suffolk and Essex)
- Town and Parish Councils

NHS/Partners

- Department of Health and Social Care
- NHS England/NHS Improvement
- NHS Providers
- Care Quality Commission
- Commissioning Support Units (CSU)
- Other NHS provider Trusts and CCGs (and Integrated Care Boards when created), particularly in Suffolk and Essex
- GPs and primary care, dentists and pharmacists
- Out of hours providers and NHS 111
- Private and voluntary sector providers
- Local Professional Committees
- East of England Ambulance Service

6 Communications – 3 year focus

6.1 Year One

Internal Communications:

- Establish a rhythm of tactics and channels of two way communication with a focus on continuous improvement and driving participation and engagement
- Develop new tactics targeted at hard to reach or off line audiences
- Develop consistent messaging which speaks to the achievements of the past few years but looks forward to the next stage in the evolution of EPUT with the focus on achieving the new strategy, vision and purpose
- Focus on two way communications – you said/we did
- Working with the staff engagement and well-being teams to support staff as we move forward post COVID-19 with a recovery plan and against the back ground of the independent inquiry

- Support key projects e.g. International recruitment, MHED, launch of new services etc. – by telling the story of the people involved and creating a compelling picture of the benefits they bring.
- Deliver the Quality Awards and EPUT birthday celebrations – building engagement and a sense of celebrating our people and their achievements
- Celebrate our people and what they do via marking the calendar of awareness days through the year

External Communications

- Focus on establishing external relationships so that we have a right to have a voice that better influences the external narrative.
- Effective management of crisis communications through planning, responsiveness and effective media handling – coupled with horizon scanning and identifying future risks.

Channel	Audience	Purpose	Metrics
Press releases (3 per week target)	Press and media	Promote EPUT and the achievement of our people	Coverage
Stakeholder emails/briefings	Governors, MPs, Councillors, service partners	Build advocacy and awareness	Stakeholder reaction
Parliamentary Awards sponsorship	MPs	Build advocacy and awareness	Stakeholder reaction
Stakeholder Events	Various	Drop in and virtual events as part of campaigns and launch of new services eg Westminster drop in sessions	Attendance

6.2 Year Two

Internal Communications

- Use metrics to inform the way in which we develop our tactics so that we use human centred design.
- Create a suite of tactics that means we can engage with all colleagues from the driver delivering stock to the Matron of an inpatient ward and those working in the community.

This will include:

- Continue refining and improving the channels we have – making them easier to use and developing the content and frequency in line with audience feedback
- Develop new channels as needed e.g. workplace app
- Stopping things that don't work anymore
- Improve two way communications through workplace social – e.g. yammer

- Getting the messaging right – refine the narrative tone so that what we say resonates with people and that everyone can understand the role that they have to play in delivering the EPUT vision

External Communications

To build on work in year one to further develop:

- Stakeholder relationships with MPs, councillors and pressure groups etc
- Create a regular drum beat of positive news coverage building on activity in year one – look at collaborative work with key local and national papers – "day in the life of a community support worker" – going further that issuing a press release and providing interesting opportunities for features
- Annual plan for awards entry to maximise reputational benefits
- Plan of speaking opportunities for key members of staff – having an expert voice

6.3 Year Three

Internal communications

- Develop a suite of communications available for staff to tailor to their needs
- Each colleague would in effect have the equivalent of a tailored news feed via their lap top, the intranet or a work place app – where the home screen reflects where they work and their interests.
- This would rest on a mixture of digital innovation and a culture that had moved away from command and control to one of trust where an individual is given personal accountability
- The same suite of channels and messaging would exist – the difference is the option to pick and choose and personalise what each member of staff sees and the way they see it.
- Of course there are mandatory and "need to Know" communications but these would be available in a variety of channels with clear metrics to record staff engagement with the content and proof of communication.

External Communications

Continuing and building on the work of years one and two:

- Strategic partnerships with charities and pressure groups – Local branches of Mind, Age UK etc. so that we have a clear voice in policy direction and a position as the experts in key areas
- Mature relationship with press where we are working collaboratively to build awareness of the issues that we face in the services we provide and a chance to celebrate the work that our people do
- Engaging with the local community and stakeholders at various events and speaking opportunities

7 Brand and Marketing – key areas of focus

7.1 Digital communications

- To grow the audiences of our social media channels, respond to any interactions in a timely manner and engage positively in digital conversations.
- Create and implement an annual social media content planner with exciting, positive stories to promote the EPUT brand as a digitally engaging organisation.
- To report on each of our digital activities to ensure we're being as effective and efficient as we can across all activities.
- To provide staff, patients and other audiences with any immediate information on a situation that may constantly change or be urgent
- Create two or more positive social posts and news articles on the website per week
- Improve statistics across our social media channels through engagement with our audiences
- Improve followers across all social media platforms. We currently have 3,480 followers on Facebook, 3,480 followers on Twitter and 4,374 followers on LinkedIn.
- Drive more traffic to our new external facing EPUT website. We currently drive anywhere between 45,000 and 81,000 users per month (based on old website figures).

7.2 External Advertising

- To raise the profile of EPUT and positively promote its work and reputation.
- To proactively promote EPUT as a place to both work and to receive quality care.
- To make sure patients and other stakeholders receive timely, relevant and accurate information about EPUT.
- To understand the needs of our stakeholders and adapt how we communicate to suit their needs and views.
- Ensure all of our marketing activities are in line with the accessibility needs of all of our users and stakeholders.

7.3 Key campaigns for 2022/23

	Q1	**Q2**	**Q3**	**Q4**
Service	General Mental Health services	EPUT Brand Campaign	General Mental Health services	CAHMs
Campaign Idea	Mental Health Awareness Week		Mini campaigns	Ongoing
Date	9 – 15th May	Jul – Sept	Oct – Dec	Jan – Mar '23
Subject	Mental Health	EPUT is a positive place	Vaccinations, celebrate achievements, Men's Mental Health	
Ideas	Promote therapy for you, talking therapy and work with local and national	Video about EPUT, services, staff, patient experience (spotlight on Patient	Work with local football teams and charities on a large scale men's mental health month	Hampshire NHS CAHMS Campaign 'Hear Me' – get schools involved to

	Q1	Q2	Q3	Q4
	charities including Samaritans, Age UK Work with service lead on community projects including Celebrating International nurse's day (12th May) – tie in with recruitment campaigns.	Feedback?) – 'Welcome to EPUT' video Charitable funds – what we've done with funds (therapy gardens, equipment, extra care etc.) and what we could do with more NHS Birthday – 5th July – 74 years old (4th July, thank you day for NHS) – patient video messages to staff – staff video and why they love working for the NHS (repurpose for recruitment).	campaign – promoting ways to improve mental health in males and the services we offer. Team up with a national spokesperson and advocate for mental health. Promote through social media and other channels. Utilise NHS E&I campaign for flu vaccinations/COVID19 vaccinations through marketing channels.	create responses to 'Hear me'. We could hold an event in collaboration with a charity (Samaritans, Mind UK) – art therapy, a coffee morning, in a community space.
BAU	• Promote Governor Elections, Your Voice, workshops, forums etc. • Ongoing social media campaigns in line with the social media content strategy and website updates. Promotion of new services, EPUT updates etc. • Patient Safety – on going promotion through all channels. • Recruitment – general, mini campaigns and international recruitment. Will carefully tie-in with any awareness campaigns. • Promote The Green Plan throughout the year - effective content as a short animation detailing achievements which can then embed on webpage.			

8 Conclusion

Costings and next steps are currently being developed in line with feedback from The Board at the Board seminar on 27 April. In the meantime the Communications and Brand and Marketing teams continue to focus on immediate priorities for 22/23.

9 Next Steps

9.1 Discussions are taking place with Finance around budget to support the strategy and further updates and a final proposal will be shared with The Board at a future meeting

10 Action required

The Board is asked to note the update relating to the development of The Communications, Brand and Marketing Strategy

Report prepared by:

Martine Munby
Communications Director
25 May 2022

		Agenda Item No: 11a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	25th May 2022

Report Title:	CQC Compliance Update					
Executive/Non-Executive Lead:	Denver Greenhalgh, Senior Director of Corporate Governance					
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	
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 fundamental standards of care.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to note the contents of the report

Summary of Key Issues

EPUT is fully registered with the CQC and currently has restrictions imposed on registration with regards to CAMHS.

The Trust, on advice of the CQC team, have applied to remove the Section 31 restriction imposed on registration for CAMHS. The Section 31 application for removal was completed and submitted on the 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 5 April 2022.

The CQC undertook and unannounced inspection of the CAMHS Wards on 1 March 2022. At the time of report writing, the draft report for factual accuracy is awaited.

The CQC have undertaken 6 Mental Health Act (MHA) inspections in April 2022.

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

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
PICU	Psychiatric Intensive Care Unit	CCG	Clinical Commissioning Groups
BAU	Business As Usual		

Supporting Documents and/or Further Reading

Lead

Denver Greenhalgh
Senior Director of Corporate Governance

Agenda Item 11a
Board of Directors
25th May 2022

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Compliance Update

1. Introduction

The purpose of this report is to provide an update and assurance on the key Care Quality Commission (CQC) related activities that are being undertaken within the Trust.

2. Meeting Registration Requirements

EPUT is fully registered with the CQC and currently has restrictions imposed on registration with regards to the Children and Mental Health Services (CAMHS).

An application was made to the CQC to notify of a change to the registered manager for Rawreth Court to Philippa Crocket, this was approved and confirmed in writing by the CQC on 5 April 2022.

3. CQC Inspections

3.1 CAMHS March 2022

The CQC have undertaken a new inspection of the Children and Mental Health Service Wards on 01 March 2022. This involved unannounced site inspections at all 3 wards and follow up information request, which has been submitted.

The outcome of the inspection is awaited from the CQC. Upon receipt of the draft CQC inspection report, an operational group will meet to complete Factual Accuracy and review any recommendations made.

3.2 CAMHS May 2021

The CAMHS wards have an open action plan following the CQC inspection report from September 2021.The action plan addressed 22 areas of improvement (from 13 ‘Must Do’, 9 ‘Should Do’ recommendations)

The CQC has confirmed that the Trust can admit children and young people whilst the application to remove the Section 31 is being processed as they are mindful of the pressures on the CAMHS system in the East of England. The Section 31 application for removal was completed and submitted on the 30 March 2022. The CQC have responded, advising they will review the application within 14 weeks of submission (circa 8 July 2022). The Trust must continue to submit the fortnightly observation reports to the CQC until the Section 31 and registration conditions have been lifted.

As at April 2022, the action plan status was:

- 67 (99%) individual actions have been completed
- 1 (1%) individual action is ongoing associated with undertaking establishment reviews using MHOST.

The CAMHS Intensive Support Group (set up in response to the improvement needed), agreed at the meeting held on the 25 March 2022 to close the Group with the service moving to business as usual, with ongoing support from the compliance and corporate service teams.

The outstanding actions within the CQC Action Plan will be monitored via other committees with assurance being provided to the Compliance Team. This group will be re-established once the CQC inspection findings are published to take forward any action required.

3.3 CQC Mental Health Act (MHA)

The CQC have undertaken 6 MHA inspections in April 2022. Following each inspection a monitoring report is received with recommendations for improvement. All develop action plans to address these recommendations are supported by the MHA Office. The MHA Office review all reports to identify areas for ongoing monitoring. These include:

- Use of agency staff
- Discharge planning
- Section 132 Rights

4. CQC Inspection Preparation Programme 2022

As previously reported, the Trust annual CQC preparation plan has been developed and initiated for 2022. The 2022 plan takes a risk based approach to prioritise focus and support, including:

4.1 Areas for Focus

- Utilising service heat maps (derived from multisource data) to enact early support from the compliance team where identified. All areas identified to date, have been visited by the team and plans in place to support improvement.
- 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 in ligature reduction actions.
- Promotion of good clinical record keeping – both written and electronic.
- Delivery of the recovery plan for mandatory training.
- Collating the supporting information for a Well-led CQC review and ensuring all relevant senior staff are prepared for interviews on leadership and governance.

4.2 Ward / Service Self Preparation

Key to success at inspection is ownership of local standards of care and adherence to policies and procedures. To empower our operational services to continuously meet these standards there are a series of CQC preparation tools (including record keeping and environment assessment) to guide local managers and staff to celebrate and to check their professional practice.

Sharing of the completed preparation tools enable thematic review on which to base further support from the compliance team.

5. 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 fundamental standards

The Trust compliance team have undertaken a mixture of virtual and onsite visits to a range of wards and services to test compliance with the CQC fundamental standards of care. Following each visit recommendations are made for areas of improvement and the ward/service develops an action plan to address these with support from the Compliance Team. Visits are also an opportunity to identify areas of good practice for sharing.

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 where improvement is needed. The heat map was last presented to ESOG in March 2022 and is now being shared with the Care units via accountability meetings.

Where support is identified a range of options are considered with the service including support visits, data deep dives and establishment of Intensive Clinical Support Groups. There are currently 5 services receiving additional support.

5.3 Action Plan Testing

The Compliance Team have continued a programme of action assurance, testing to ensure actions are fully embedded. The programme will be reviewed with the ongoing development of Tendable which provides routine assurance on a number of areas previously part of compliance team testing.

6. CQC Guidance / Updates

Feedback to the CQC on Citizen Lab
The CQC is asking for feedback on the CQC's future regulatory mode, you can share your thoughts with the CQC by using the link below

The link can be found at Project • An update on CQC's new regulatory model (citizenlab.co)

Health and Care Bill
A Bill has been put forward, to make provision about health and social care.

The CQC are expecting new responsibilities under the Health and Care Bill relating to Local Authority assurance and oversight of Integrated Care Systems. The CQC have released their latest briefing, in which Deputy Chief Inspectors Rob Assall and Ann Ford outline the new responsibilities they are expecting under the Health and Care Bill.

The video can be found at Developing our approach to system oversight - YouTube

The CQC are expecting new responsibilities related to Local Authority assurance through the Health and Care Bill from April 2023 and are asking for input, via a survey.

The survey can be found at Project: CQC and system oversight (citizenlab.co)

The Bill can be found at Health and Care Bill - Parliamentary Bills - UK Parliament

The Government have released a factsheet, covering the Bill, which can be found at Health and Care Bill factsheets - GOV.UK (www.gov.uk)

Update on new regulatory model
Since the CQC launched their new strategy in May 2021 they have been working with health & social care providers and professionals to develop their new regulatory model. A video has been released, where Dave James, Head of Policy, updates on this work and shares the latest on what the new model will look like.

The vide can be found at CQC's future regulatory model: where we are and next steps | Explainer video - YouTube

The CQC have released a blog from Chris Day, Director of Engagement at CQC, where he talks about the approaches the CQC are taking to implement their new strategy and transform how they will regulate.
The blog can be found at Shaping our future in partnership with stakeholders | by Care Quality Commission | Apr, 2022 | Medium

Because we all care campaign (focus on careers): stakeholder toolkit
The CQC is partnering with Carers UK to launch a 4 week campaign to focus on carers, ending 12th April 2022

More information on this campaign can be found at Because we all care campaign (focus on carers): stakeholder toolkit | Care Quality Commission (cqc.org.uk)

7. Recommendations and Action Required

The Board of Directors is asked to note the content 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

		Agenda Item No: 11b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 May 2022**

Report Title:	**NHS England/ Improvement Self-Certification Requirements 2021-22**					
Executive/Non-Executive Lead:	Denver Greenhalgh, Senior Director of Governance					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Executive Team 10 May 2022 Finance & Performance Committee 19 May 2022					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber-Attack	
Does this report mitigate the Strategic risk(s)?	N/A	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	N/A	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report provides the Board with the self-assessment documentation.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required
The Board of Directors is asked to: • Approve the detailed review of Trust compliance against the Provider Licence and therefore confirm compliance and publication of certificates on to the Website as per requirements.

Summary of Key Issues

On an annual basis NHS foundation trusts are required to self-certify the following NHS provider license conditions after the financial year end.

- **Foundation Trust Condition 4 (FT4) -** the Trust has complied with required governance arrangements. A breakdown and narrative of our position is provided. The statement on governor training will be reviewed and approved by the Council of Governors.

  Within the report is noted the following actions:

  - Between now and the end of 2023/24 the requirement to have had an independent review of well led for leadership an governance
  - The continuation of COVID-19 command and control structure until the NHS steps the level 4 down
  - To continue to embed the accountability framework
  - Conclude the process with the CQC to remove the section 31 conditions on the CAMHS service. And noting that the latest inspection report is pending.

- **Continuity of Service Condition 7 (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 is also included for review.

The Finance and Performance Committee reviewed the attached at its meeting on the 19 May 2022 and recommend the Board to approve, and confirm that the Trust select 'confirm' compliance on all statements, noting with the CoS7being subject to external audit confirmation.

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 Documents and/or Further Reading
Appendix 1: G6 and CoS7 Self-Assessment Appendix 2: FT4 Self-Assessment

Lead
 Denver Greenhalgh Senior Director of Governance

APPENDIX 1

EPUT REVIEW OF COMPLIANCE AGAINST THE PROVIDER LICENCE 2021/22 AS AT APRIL 2022

Objective: As EPUT is required to comply with the terms of the provider licence, it is essential that it ensures there is ongoing compliance with the licence conditions and areas identified to strengthen maintenance of compliance.

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
SECTION 1: GENERAL CONDITIONS				
G1	**Provision of Information** Obligation to provide NHSE/I with any information it requires for its licensing functions within required timeframe and format ensuring that such reports and information are accurate, complete and not misleading, and is a true copy of the document requested	The Licensee shall furnish to NHSE/I such information and documents, and shall prepare or procure and furnish to NHSE/I such reports, as NHSE/I may require for any of the purposes set out in section 96(2) of the 2012 Act	Compliant	• Systems and processes in place to identify and respond to routine and ad hoc requests • EPUT submits all documents, reports and declarations in accordance with all relevant statutory and regulatory requirements in force from time to time • Any submissions required are made by the Finance Directorate and retained • Copies of all documents to NHSE/I are retained
G2	**Publication of Information** Obligation to publish such information as NHSE/I may require including making available to the public	The Licensee shall comply with any direction from NHSE/I for any of the purposes set out in section 96(2) of the 2012 Act to publish information about health care services	Compliant	• Compliance with Annual Report/Quality reporting guidance (ARM) and EPUT Constitution • Annual Report and Accounts, Quality account/Report, etc. on EPUT website • EPUT's publication scheme • Register of interests •
G3	**Payment of fees to NHSE/I** Gives NHSE/I the ability to charge fees and obligation for licensees to pay them	The Licensee shall pay fees to NHSE/I in each financial year of such amount as NHSE/I may determine	Compliant	• There have been no plans publicised to charge a fee to licensees
G4	**Fit and proper persons as Governors and Directors** Prevents licensees from allowing unfit persons to	G4.1 The Licensee shall ensure that no person who is an unfit person may become or continue as a Governor, except with the approval in writing of	Compliant	• FPP policy and procedure in place at recruitment and ongoing. • Disqualification criteria set out in EPUT Constitution • Requirement of both Directors and Governors

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
	become or continue as a Governor or Director except with NHSE/I approval	NHSE/I. G4.2 The Licensee shall not appoint as a Director any 'person who is an unfit person, except with the approval in writing of NHSE/I G4.3 The Licensee shall ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee shall ensure that it enforces that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of NHSE/I		mirrored in Code of Conducts • Directors and Governors sign declarations as part of recruitment and nominations processes • Condition of appointment: relevant checks undertaken by Trust Secretary's Office and HR • Responsibility of Board Directors and Governors to notify in-year changes • Annual declaration received by the Board • Board Director contracts include provision permitting summary termination in the event of the Director becoming/being 'unfit' • There has been no requirement for NHSE/I to allow a Director or Governor to remain in post • Conflict of interest policy and procedural guidelines in place with implementation plan. **Action:** Explore self-enrolment of DBS by all Directors which has a rolling checking and alert process.
G5	**NHSE/I Guidance** Obligation to have regard to guidance issued by NHSE/I. A licence holder is required to advise NHSE/I if it decides not to follow such guidance giving reasons	The Licensee shall at all times have regard to guidance issued by NHS Improvement for any of the purposes set out in section 96(2) of the Health and Social Care Act 2012	Compliant	• Systems and processes in place to ensure EPUT responds to/meets guidance issued by NHSE/I • Submissions and information provided to NHSE/I are approved through relevant and appropriate authorisation processes • Monthly Legal Update Report presented to Executive Team • Bi-Monthly Chair's Report to Board including Governance • Full reviews of NHSE/I guidance is undertaken by relevant teams including Compliance Team, Trust Secretary, Legal Team, Finance Team, etc.
G6	**Systems for compliance with licence conditions and related obligations** Obligation to take reasonable	G6.1 The Licensee shall take all reasonable precautions against the risk of failure to comply with: (a) the Conditions of this Licence,	Compliant	• Risk management Assurance Framework in place support the identification and management of risk across the business. Annual review of compliance with the terms of the provider licence undertaken, with

Commented [GD(EP1]: This should be the Remuneration & Nominations Committee as would be confidential.

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
	precautions against risk of failure to comply with the licence including the establishment and implementation of processes and systems to identify and manage risks, and the regular review of these processes and systems to ensure implementation and effectiveness	(b) any requirements imposed on it under the NHS Acts (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS G6.2 The Licensee must take the following steps pursuant to G6.1: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence (b) regular review of whether those processes and systems have been implemented and of their effectiveness G6.3 Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to NHSE/I (by end May) a certificate to the effect that, following a review for the purpose of G6.1.2(b) The Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition G6.4 The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to NHSE/I (by end June) in such manner as is likely to bring it to the		actions to address areas for improvement. • Compliance declarations made by the Board of Directors within required timeframe (note NHSE/I no longer require these to be submitted) • Annual self-certification information included in Board papers and published on EPUT's website

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		attention of such persons who reasonably can be expected to have an interest in it		
G7	**Registration with the Care Quality Commission** Obligation to be registered with the CQC and to notify NHSE/I if their registration is cancelled	The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able lawfully to provide the services authorised to be provided by this Licence.	Compliant	• EPUT has in place CQC registration
G8	**Patient eligibility and selection criteria** Obligation to set transparent eligibility and selection criteria for patients and apply these in a transparent manner	The Licensee shall: (a) set transparent eligibility and selection criteria (b) apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee (c) publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them	Compliant	• Patients' eligibility criteria agreed with commissioners in line with relevant guidance and documented in commissioning contracts within individual service specifications: available on request • Commissioning contracts are subject to regular reviews and service specifications are generally reviewed annually • EPUT website includes its service provision by geography and service type, and contact details. There is limited eligibility criteria included
G9	**Application of Section 5 (Continuity of Services)** Sets out the conditions under which a service will be designated as a CRS (Commissioner Requested Service)	See section 5 below	N/A	• Covers all services which EPUT has contracted with a Commissioner to provide as a CRS (see CoS1 below) • See section 5 below
SECTION 2: PRICING				
P1	**Recording of Information** Obligation to record information and be transparent particularly about	If required in writing by NHSE/I, and only in relation to the period from the date of that requirement, the Licensee shall: (a) obtain, record and maintain sufficient	Compliant	• EPUT maintains a costing system that utilises information from the general ledger to calculate planned and fully absorbed costs of providing services. These costs are published on an annual

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
	costs/pricing	information about the costs which it expends in the course of providing services (b) establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with this Condition.		basis • Information can be provided to NHSE/I as required
P2	**Provision of Information** Obligation to submit the above to NHSE/I	The Licensee shall furnish to NHSE/I such information and documents, and shall prepare or procure and furnish to NHSE/I such reports, as NHSE/I may require for the purpose of Chapter 4 in Part 3 of the Health and Social Care Act 2012 (Pricing)	Compliant	• EPUT submits to NHSE/I all documents, reports and declarations in accordance with all relevant statutory and regulatory requirements in force from time to time in respect of pricing • Information provided is approved through the relevant and appropriate authorisation processes • Copies of all documents are submitted to NHSE/I and retained by the Finance Directorate and/or Trust Secretary
P3	**Assurance report on submissions to NHSE/I** Obligation to submit an assurance report confirming that the information provided above is accurate	If required in writing by NHSE/I, the Licensee shall, as soon as reasonably practicable, obtain and submit to NHSE/I an assurance report in relation to pricing/costing	Compliant	• Internal audit could review the costing and pricing processes within EPUT as part of the internal audit programme, and this assurance could be provided to NHSE/I as required
P4	**Compliance with the National Tariff** Obligation to charge for NHS health care services in line with national tariff	Except as approved in writing by NHSE/I, the Licensee shall only provide health care services for the purpose of the NHS at prices which comply with, or are determined in accordance with, the national tariff published by NHSE/I, in accordance with section 116 of the Health and Social Care Act 2012 and shall comply with the rules, and apply the methods, concerning charging for the	Compliant	• All NHS Foundation Trusts continued to operate under the adapted financial regime during 2021/22 which has been operational since the onset of the pandemic in March 2020. The Trust has been paid on the basis of block contract payments for 1st April 2021 to 31st March 2022.

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		provision of health care services for the purposes of the NHS contained in the national tariff published by NHSE/I in accordance with, section 116 of the Health and Social Care Act 2012, wherever applicable		
P5	**Constructive engagement concerning local tariff modifications** Obligation to engage constructively with Commissioners and to reach agreement locally before applying to NHSE/I for a modification	The Licensee shall engage constructively with Commissioners, with a view to reaching agreement as provided in section 124 of the Health and Social Care Act 2012, in any case in which it is of the view that the price payable for the provision of a service for the purposes of the NHS in certain circumstances or areas should be the price determined in accordance with the national tariff for that service subject to modifications	Compliant	• On 26 March 2020 revised arrangements for NHS contracting and payment during the Covid19 pandemic were issued by NHSE/I which remained in place during 2021/22. • For 2022/23, there is a return towards pre-Covid arrangements and the Trust is negotiating aligned incentive contracts with the majority of the Trust income being received via block monthly payments.
SECTION 3: CHOICE OF COMPETITION				
C1	**The right of patients to make choices** Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. Restricts providers on giving benefits in kind/pecuniary or other advantages as inducements to refer patients or commission services	Subsequent to a person becoming a patient of the Licensee and for as long as he or she remains such a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, he or she is notified of that choice and told where information about that choice can be found	Compliant	• EPUT has in place a service directory on the website setting out the services available • Commissioners monitor EPUT's compliance with the legal right of choice as part of contract Monitoring in line with NHS Standard Contract requirements • Conflicts of Interest policy and procedure in place for all staff (clinical and non-clinical)
C2	**Competition oversight** Prevents licensees from entering into or maintaining	The Licensee shall not: (a) enter into or maintain any agreement or other arrangement which has the	Compliant	• EPUT is aware of the requirements of competition in the health sector and would seek legal and/or specialist advice should the Board decide to consider

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
	agreements that have the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users	object or which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS (b) engage in any other conduct which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS to the extent that it is against the interests of people who use health care services.		any significant changes such as mergers or joint ventures or when entering into agreements • The Finance and Performance Committee terms of reference includes responsibility for ensuring adoption and best practice in terms of decision-making in line with guidance issued by NHSE/I and CMA in relation to investments (including potential acquisitions and mergers) and the Health and Social Care Act 2012 in respect of mergers, acquisitions and significant transactions • There are no anti-competitive proceedings against EPUT • Current work on new models of care is a Commissioner initiative for collaborative procurement meaning suppliers including all public and private suppliers will be able to supply but with a changed commissioning route. It is in the interest of health care users and not restricting or distorting competition to the extent that it is against the interests of health care users.
INTEGRATED CARE				
IC1	**Provision of integrated care** Obligation to act in the interests of people who use healthcare services by facilitating the development and maintenance of integrated services	The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS: • to be integrated with the provision of such services by others • to be integrated with the provision of health-related services or social care services by others • to co-operate with other providers of health care services	Compliant	• EPUT utilises integrated care models to provide a range of healthcare services. • EPUT actively works with its partners through both formal and informal mechanisms to foster and enable integrated care • Collaborative working (for example: Essex Mid & South Collaborative.) Various collaboration agreements with commissioners and other providers, e.g. section 75 agreements, joint service provision agreements, etc. • EPUT is actively involved in three Integrated Care Systems • Some services are provided through partnership working with other local stakeholders (e.g. Essex

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
				Learning Disabilities services, work with Samaritans, etc.) • EPUT has representation on local partnership boards feeding into system wide working and planning • Stakeholders are involved in managing key shared risks through well-established contract management and partnership committee structures that oversee the operational delivery of and potential threats to services delivered in partnership • Consultations carried out with services users, carers and members of public when required.
CONTINUITY OF SERVICES				
CoS1	**Continuing provision of Commissioner Requested Services (CRS)** Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners	The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with this Condition	Compliant	• All decisions around services are agreed with commissioners as part of the contract negotiations • All changes to services provided by EPUT implemented through the relevant Contract Variations agreed jointly with the commissioners in the standard format issued by NHS England • See P4 and P5 above
CoS2	**Restriction on the disposal of assets** Obligation to keep an up-to-date register of relevant assets used in CRS and to seek NHSE/I's consent before disposing of these assets if NHSE/I has concerns about the licensee continuing as a going concern	The Licensee shall establish, maintain and keep up to date, an asset register which complies with this Condition and guidance as may be issued from time to time by NHSE/I regarding: (a) the manner in which asset registers should be established, maintained and updated, and (b) property including buildings, interests in land, intellectual property rights and equipment, without which a licence holder's ability to provide Commissioner Requested Services should be regarded as materially	Compliant	• The Finance Directorate maintain an asset register of all capitalised assets in line with accounting and NHSE/I guidance. This is subject to external audit on and would include both relevant and non-relevant assets that are owned (or have had tenant improvements where leasehold) • EPUT is only required to seek NHSE/I's consent for disposal of assets if NHSE/I had a concern about its ability to continue as a going concern (currently does not apply). EPUT has a procedure on asset disposals which includes NHSE/I's requirement for relevant and non-relevant assets • Estates retains an asset register for leasehold assets in line with the Asset Register and Disposal of Assets

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		prejudiced. The Licensee shall not dispose of, or relinquish control over, any relevant asset except with the consent in writing of NHSE/I, and in accordance with this Condition if NHSE/I has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern		Guidance for Providers of Commissioner Requested Services guidance
CoS3	**Standards of corporate governance and financial management** Obligation to adopt and apply systems and standards of corporate governance and management that would be seen as appropriate for a provider of NHS services and enable EPUT to continue as a going concern	The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as: (a) suitable for a provider of the Commissioner Requested Services provided by the Licensee (b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern	Compliant	• EPUT has robust and comprehensive corporate and financial governance arrangements, systems and processes in place; these are updated according to changes in guidance/requirements • Compliance with the *Code of Governance* reviewed annually • Annual review of EPUT's constitution, SFIs, SoRD and DSoD against regulation and NHSE/I guidance • Annual review of Board standing committees' terms of reference against regulation, NHSE/I guidance and good practice • Well led self-assessment and independent review completed in 2019/20 Trust undertakes independent review of governance every 3 -5 years in line with NHSI guidance. • Committee effectiveness review completed as part of establishment of command structure during the Covid-19 pandemic. • Annual financial plan and operational plan. • Monthly monitoring of performance, quality and finance by Finance and Performance Committee with quarterly review of governance arrangements (Board Governance Framework) and considered at each Board meeting • Executive Operational Sub-Committee weekly

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
				meetings. • Board / Executive Safety Oversight Group in place. • Risk management programme in place monitored through Finance and Performance Committee and considered at each Board meeting
CoS4	**Undertaking from the ultimate controller** Obligation to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause EPUT to breach its licensing conditions	The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHSE/I	N/A	• Not applicable
CoS5	**Risk pool levy** Obligation to contribute to the funding of the 'risk pool' (insurance mechanism to pay for vital services if a provider fails)	The Licensee shall pay to NHSE/I any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the Health and Social Care Act 2012, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid	N/A	• No payment requests received from NHSE/I; any payment required would be made in accordance with licence conditions
CoS6	**Co-operation in the event of financial stress** Applies when a licensee fails a test of sound finances and obliges the licensee to cooperate with NHSE/I	When NHSE/I has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern, the Licensee shall: (a) provide such information as NHSE/I may direct to Commissioners and to such other persons as NHSE/I may direct (b) allow such persons as NHSE/I may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on	N/A	• EPUT would co-operate should the situation arise

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		them (c) co-operate with such persons as NHSE/I may appoint to assist in the management of the Licensee's affairs, business and property		
CoS7	**Availability of resources** Obligation to act in a way that secures or has access to the required resources to operate Commissioner Requested Services (CRS)	The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHSE/I a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate in the form set out in this Condition and a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate. This statement shall be approved by a resolution of the Board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution. The Licensee shall publish each certificate in such a manner as will enable any person having an interest in it	Compliant	• EPUT submits certificates/statements as required by NHSE/I • Operational Plan developed for 2022/23. • Annual financial plan sets out details of resource requirements and efficiencies • EPUT has robust processes and systems in place to ensure it has the resources necessary to deliver its services • Predicted segmentation rating of 2 at end of March 2022 • EPUT's adjusted financial performance was a £38k surplus as at end March 2022, and a reported deficit of £4,184k.

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		to have ready access to it		
NHS FOUNDATION TRUST CONDITIONS				
FT1	**Information to update the register of NHS FTs** Obligations to provide information to NHSE/I	The Licensee shall ensure that NHSE/I has available to it written and electronic copies of the following documents: (a) the current version of Licensee's constitution (b) the Licensee's most recently published annual accounts and any report of the auditor on them (c) the Licensee's most recently published annual report and for that purpose shall provide to NHSE/I written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted or being published. The Licensee shall comply with any direction issued by NHSE/I concerning the format in which electronic copies of documents are to be made available or provided	Compliant	• EPUT provides NHSE/I with all information it requires taking account of the requirements under this provision
FT2	**Payment to NHSE/I in respect of registration and related costs** Obligation to pay any fees set by NHSE/I/ NHSE/I	Whenever NHSE/I determines in accordance with section 50 of the NHS Act 2006 that the Licensee must pay to NHSE/I a fee in respect of NHSE/I's exercise of its functions under sections 39 and 39A of that Act the Licensee shall pay that fee to NHSE/I within 28 days of the fee being notified to the Licensee by NHSE/I in writing	Compliant	• NHSE/I has undertaken not to levy any registration fees on FTs without further consultation • All payments made are documented in the ledger with details of the date of invoice and date payment made. To date no payments in respect of licence fees have been requested
FT3	**Provision of information to advisory panel** Obligation to provide	The Licensee shall comply with any request for information or advice made of it under Section 39A(5) of the NHS Act	N/A	• NHSE/I disbanded the panel in 2016/17 • EPUT has not received any such requests in relation to questions being referred to the advisory panel

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
	information requested by the advisory panel set up to consider questions brought by Governors	2006		
FT4	**NHS foundation trust governance arrangements** Provides NHSE/I continued oversight of FTs' governance. Obligation to ensure: • Effective Board and committee structures • Clear responsibilities for Board and committees • Clear reporting lines and accountabilities in EPUT • Establish and implement effective processes/systems	The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS in line with NHSE/I's guidance and this Condition	Compliant	• EPUT has sound corporate governance systems and processes in place • Deloitte carried out an independent well-led assessment in March 2019 • CQC carried out a well-led assessment in July/August 2019 and an overall 'Good' rating was achieved with 'Good' for the well-led domain • The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of EPUT, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically • EPUT has carried out a comprehensive self-assessment against Corporate Governance related to this licence condition
		FT4.4 The Licensee shall establish and implement: (a) effective board and committee structures (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees (c) clear reporting lines and accountabilities throughout its organisation	Compliant	• Established an effective Board and committee structure with appropriate terms of reference • Effectiveness reviews of Board and its committees with recommendations implemented. This was not completed in 2020/21 as a result of the Covid-19 pandemic in relation to establishing a command structure. • Board committee governance structure chart maintained by Trust Secretary • Scheme of Reservation and Delegation sets out the powers reserved to the Board and those that the Board has delegated, i.e. the schedule of matters reserved to the Board. This is reviewed annually and reflects delegation derived from the constitution,

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
				accounting officer memorandum, standing orders, SFIs, NHSE/I *Code of Governance* and Board *Code of Conduct* • Reviews of the corporate governance systems included in internal audit annual work programme • Review of Tier 2 Standing Committees took place in 2018. This is now being undertaken for 2022/23
		FT4.5 The Licensee shall establish and effectively implement systems and/or processes: (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern) (e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making (f) to identify and manage (including but	Compliant	• Minutes of Board meetings • Minutes of standing committees, sub-committees and sub-groups • Board reports covering quality, performance, finance, corporate governance, clinical governance, information governance and compliance (see also CoS3 above) • Board Assurance Framework • Corporate Risk Register • Compliance with *Code of Governance* annual review • Annual review of compliance with provider licence • Annual Governance Statement • Annual / operational plan developed each year in line with NHSE/I requirements • Regular monitoring of progress with objectives set out in the operational plan. • Resources allocated to provision of internal legal services team and to secure appropriate legal advice when necessary

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence (g) to generate and NHSE/I delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery (h) to ensure compliance with all applicable legal requirements		
		FT4.6 The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: (a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided (b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations (c) the collection of accurate, comprehensive, timely and up to date information on quality of care (d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care (e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account	Compliant	• The Board complete an annual appraisal process, including review of skills and meeting of objectives. This is monitored by the Board of Director Remunerating and Nomination Committee and Council of Governors respectively. • Quality Committee as a standing committee of the Board oversees quality of care considerations for any planning and decision-making processes and reports to the Board of Directors. • Accurate, timely and up to date information on the quality of care provided by the Quality and Performance Scorecards and other reports to the Board of Directors. • Governors and members of the public attend Board meetings and can query any information provided to the Board of Directors, including any relating to the quality of care. • Engagement Strategy in place underpinning how the Trust will engage with patients, staff and other key stakeholders.

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		as appropriate views and information from these sources (f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate		
		FT4.7 The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence	Compliant	• Safe staffing reports to Finance and Performance Committee, Quality Committee and Board included in performance, quality and finance reports • Robust HR recruitment processes and selection criteria and information provided to the Board via the Quality and Performance scorecard. • Fit and Proper Persons Requirements incorporated in employment contracts, contracts and appointing letters • Fit and Proper Persons policy and procedure in place. • Regular appraisals in place to ensure individuals are appropriately qualified. • Board skills and experience review undertaken.
		FT4.8 The Licensee shall submit to NHSE/I within three months of the end of each financial year: (a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it	Compliant	• All certification requirements signed on behalf of the Board by the Chair and CEO were met (note that NHSE/I no longer require submission of the self-certification) • Submissions reviewed by Executive Team and Finance and Performance Committee before final approval by Board

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		proposes to take to manage such risks (b) if required in writing by NHSE/I, a statement from its auditors either: (i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or (ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year		• NHSE/I have not required such statements

Appendix 2

EPUT

SELF-CERTIFICATION JUNE 2022 - CONDITION FT4
SELF-ASSESSMENT AGAINST CORPORATE GOVERNANCE STATEMENT

Corporate Governance Statement	Lead Executive	Evidence of Compliance	Potential Gaps/Risks/ Further improvement actions	Response (confirmed/ not confirmed)
1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	CEO	• The principles, systems and standards utilised in the Trust demonstrate good corporate governance. This is evidenced in the Trust Annual Report through a declaration of compliance with the Code of Governance Annual Statement, both subject to External Audit. These are made following a detailed review of evidence demonstrating continued compliance. *(*see additional paper on code of governance)* • In addition, an independent well-led assessment was completed in 2019, which provided an outcome of satisfactory governance arrangements, with no significant issues identified. The CQC also completed a well-led inspection in 2019, which achieved the outcome of "Good" for well-led and "Good" rating overall for the Trust.	• No material risks identified • To commission an independently facilitated well led review between 2022 and 2024.	Confirmed
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement/ England from time to time.	CEO	• All guidance is receipted and responded to as and when issued, by NHS Improvement / England, with Executive review and sign off. • As a consequence of COVID-19 the Trust set up support to receive guidance documents which were issued out of hours. • The Chair produces a monthly report to the Board of Directors which contains a Governance update, identifying any new guidance as required.	• No material risks identified	Confirmed

3. The Board is satisfied that the Licensee has established and implements: (a) effective Board and Committee structures (b) clear responsibilities for its Board, for Committees reporting to the Board and for staff reporting to the Board and those Committees	CEO	• The Trust operates an effective Board supported by a range of Standing Committees. This is supported by Standing Orders setting-out the operation of the Board. • The Standing Committees (Audit, Charitable Funds, Finance & Performance, People, Equality & Culture, and Quality) are chaired by a Non-Executive Director and have members of the Board of Directors (Executive and Non-Executive) as members. The role and remit of the Committees are provided in clear Terms of Reference, approved by the Board on an annual basis. • The Committee activities are reported to the Board via regular reports and referenced in other Board reports as required. • The Standing Committees are supported by a number of sub-committees which report on a regular basis. • The Scheme of Reservation and Delegation and Standing Financial Instructions provide clear details of delegated authority from the Board to the Standing Committees. • Executive portfolios in place together with organisational structure focussed on transformation with clear reporting lines and schedules. • The Trust established a clear command structure during the Covid-19 pandemic, with outcomes and decisions reported via the Executive Team.	• No material risks identified • *Covid-19 command structure to continue in place until level 4 incident is stood down for the NHS.*	Confirmed
(c) clear reporting lines and accountabilities throughout its organisation	CEO	• The Trust has a clear committee and report structure in place, with terms of reference for Standing Committees. • Executive portfolios are in place which provide clear areas of responsibility and reporting lines via structure charts. • The Trust has developed an Accountability Framework to ensure clinicians are at the heart of decision making and there are clear lines of accountability.	• No material risks identified • *To continue to embed the accountability framework in 2022/23*	Confirmed
4. The Board is satisfied that it has established and effectively implements systems and/or processes: (a) to	CEO	• Evidence as 3(a) and (b) above • The Trust system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of EPUT, to evaluate the likelihood of those	• No other material risks identified	Confirmed

ensure compliance with the duty to operate efficiently, economically and effectively		risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically • The Executive Team has responsibility for overseeing the day-to-day operations of EPUT and for ensuring that resources are being used economically, efficiently and effectively		
(b) for timely and effective scrutiny and oversight by the Board of the operations	CEO	• The Board of Directors meets on a bi-monthly basis and holds extra-ordinary meetings where time sensitive items are considered. The meetings receive reports, information and data relating to finance, performance and quality allowing scrutiny and challenge. • The CEO holds biweekly briefing sessions with the Non-Executive Directors where topics / risks and issues can be discussed and other information disseminated. • The Board of Directors receives the Board Assurance Framework which contains the Trusts most significant and future potential risks. The framework is owned and scrutinised by Executive Directors. The Board Assurance Framework is supported by action plans and Corporate Risk Registers, with progress updates provided regularly to the Board. • The structure of Standing Committees beneath the Board provide a layered approach to monitoring, scrutiny and challenge. The Committees meet on a monthly basis (except Charitable Funds).	• No material risks identified	Confirmed
(c) to ensure compliance with health care standards binding on the Trust including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory	Executive Nurse and Executive Medical Director	• The Trust has a clinical governance structure in place to manage health standards compliance. • Clinical care provision is underpinned by policies, procedures and clinical guidelines based in NICE and best practice guidance. • The Trust has an internal compliance team that supports clinical teams to assess and where required addressed quality standards delivery.	• CQC inspection of CAMHS Inpatient - Section 31 notice issued by the CQC June 2021. Action plan delivered, with services re-opening for admission. Risk to sustainability. Re-	Confirmed

regulators of health care professions		• The Trust has a range of subject matter experts who provide guidance and advice in their professional areas; including an Executive Nurse and Executive Medical Director. • The Trust staff are members of relevant networks and work collaborative with system partners. • Regular reports are presented to the Board of Directors providing updates on CQC related activity, guidance and progress with action plans following inspections. • The Trust currently maintains a "Good" CQC rating. • The Trust has a Clinical Audit programme in place audit clinical standards and to drive-up quality standards. • Junior doctors work plan and rota gaps reported monthly with an Annual Report that is also included in the Quality Account • Professional registration for clinical staff is closely monitored and revalidation is carried out in line with regulations for health care professionals	inspection by the CQC awaiting report. • No other material risks identified • *Application to remove section 31 to be finalised.*	
(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the trust ability to continue as a going concern)	Executive Director of Finance & Resources	• The Trust has a Finance function, underpinned by policies and procedures and overseen by the Executive Director of Finance and Resources. • The Board receive regular updates relating to Finance and financial accounts are incorporated into the annual report. • The Trust has an operational and financial plan, which is discussed by the Board before final approval. • The Trust has a Scheme of Reservation and Delegation and Standing Financial Instructions which provide clear limits on financial decision making, including when Board approval is required for significant financial decisions. • The Trust has an internal audit programme aligned to key areas of potential financial and operational risk, which is overseen by the Audit Committee. • The Trust Constitution requires the Council of Governors to approve any significant transactions as defined by the constitution. The Council also receive a learning session with the Executive Director of Finance and Resources to	• No material risks identified	Confirmed

		explain the annual accounts, which allows scrutiny by the Council via the Non-Executive Directors. • The Trust met its control total in 2021/22 (subject to audit).		
(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making	Executive Director of Finance & Resources	• The Trust has a business analysis reporting function which links into all data systems to provide comprehensive reporting to the Finance and Performance Committee, Executive Team and the Board of Directors. • The Trust has other electronic systems in place, such as patient electronic systems, incident report system etc. which allows other data to be presented to the Standing Committees and Board of Directors. • EPUT's ability to have timely and effective monitoring reports, using complete data, is recognised as a fundamental requirement in order for EPUT to deliver safe, high quality care.	• No material risks identified	Confirmed
(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of the Licence	CEO	• The Trust has in place a risk management framework which underpins the identification, risk assessment and mitigation of risks to all out operations (including compliance with the FT provider licence). • Risks are managed at the appropriate level of the organisation and significant risks are assigned to an executive director. • Significant current and future potential risks are managed through the Corporate Risk Register and the Board Assurance Framework.	• No material risk identified	Confirmed
(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery	CEO	• The Trust has developed strategic objectives, which inform our annual business plan. The achievement of the objectives are monitored to support the delivery of services. • The operational and financial plan for the Trust is developed and approved by the Board of Directors and delivered by management. • The Trust participates in system-wide working arrangements and collaborative working. Any plans	• No other material risks identified	Confirmed

		developed as part of this process are scrutinised internally and externally by partners. • The Trust developed a surge plan during the Covid-19 pandemic which identified any situations during the level 4 incident where service delivery would need to be altered to maintain safety. This was overseen by the command structure.		
(h) to ensure compliance with all applicable legal requirements	CEO	• The Trust has a number of corporate functions that ensure on-going compliance with all applicable legal requirements, led by the Executive Team. The Executive Director portfolios contain a range of activities relating to legal requirements, such as legal, Mental Health Act, information governance etc. • The Trust has a Legal Team in place and an update is provided to the Executive Team on a monthly basis. • Legal advice has been sought when required and a resource is available when legal advice is necessary. • The Trust has a Mental Health Act administrative team in place to ensure all aspects of the Mental Health Act are complied with.	• No material risks identified	Confirmed
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure (a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided	CEO	• The Executive Team consists of Executive Directors with relevant capabilities within their respective portfolios. This includes the Medical Director and Executive Nurse being registered clinicians and the Executive Director of Finance and Resources being a qualified accountant. • The Non-Executive Directors are appointed using a skills matrix and framework. Reports are presented to the Council of Governors providing details of the skills and capabilities of the Trust Board to ensure any Non-Executive Director re-appointments strengthen the Boards capability. • Appointments to the Board are overseen by the Board of Directors Remuneration and Nomination Committee (Executive Directors) and Council of Governors (Non-Executive Directors) to ensure sufficient capability of any new appointments.	• No material risks identified	Confirmed

		• The Board of Directors complete annual appraisals which focuses on key objectives due for completion. Any underperformance would be addressed.		
(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations	Executive Nurse	• Quality Impact Assessments are completed in relation to decision-making processes and particularly in relation to Cost Improvement Programmes. • The Quality Committee obtains assurance that high standards of care are provided by EPUT and that adequate governance processes and controls are in place to promote safety and excellence. This includes identifying, prioritising and managing risks. The Quality Committee reports into the Board of Directors. • The Quality Committee is supported by a range sub-committees considering specific areas relating to the quality of care. • The Trust developed a surge plan during the Covid-19 pandemic to ensure any actions taken as a result of the level 4 incident to ensure the safety of inpatient units had as minimal affect as possible on the quality of services. • Details of the Trust's approach to the quality of care is provided in the annual Quality Account.	• No material risks identified	Confirmed
(c) the collection of accurate, comprehensive, timely and up-to-date information on quality of care	Executive Nurse	• As 3(b) above • The Board of Directors receives a regular Quality and Performance Dashboard which contains a number of key performance indicators measuring the quality of care provided by the Trust.	• No material risks identified	Confirmed
(d) that the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care				Confirmed
(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and	Executive Director People	• The Trust has an Engagement Strategy in place which sets-out its approach to engaging with patients, staff and other relevant stakeholders.	• No material risks identified	Confirmed

other relevant stakeholders and takes into account as appropriate views and information from these sources	and Culture	• The Trust participates in the national Patient and Staff Surveys with the results reported to the Board of Directors and action taken to address any issues identified. • The Trust utilises the Friends and Family Test to gain the views of patients and relatives on the quality of services provided. This is supported by Patient Forums and a range of other feedback mechanisms (You Said, We Did, co-production etc. • The Trust holds Board meetings in public, where members of the public are able to attend and ask questions as a standing agenda item. • The Council of Governors have a statutory requirement to represent the views of members and members of the public. The Trust holds Your Voice public meetings where members of the public can attend hear about Trust services and ask questions of any members of the Board of Directors / Council of Governors present.		
(f) that there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate	Executive Nurse	• As 5(e) above • The Executive Director of Nursing is the lead for Quality on the Board of Directors.	• No material risks identified	Confirmed
6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately	CEO	• The Board of Directors Remuneration and Nomination Committee (Executive Directors) and Council of Governors (Non-Executive Directors) oversee the recruitment processes to the Board to ensure sufficient personnel is in place. The Trust Constitution sets-out the required composition of the Board, including statutory Executive Director roles. • The Executive Director of People and Culture is responsible for ensuring sufficient personnel is in place	• No material risks identified	Confirmed

qualified to ensure compliance with the conditions of its NHS Licence		throughout the organisation and this is undertaken through the Human Resources function in their portfolio. • The Chief Executive Officer Report and Quality and Performance Scorecards provide the Board of Directors with pertinent Human Resources information, including details of joiners / leavers and recruitment processes. • The Trust has revalidation processes to ensure clinical staff maintain their professional registration. • The Trust has a recruitment process in place, which includes checking qualifications. The Trust has Mandatory Training processes to ensure staff are trained in specific Trust processes. • The Trust undertakes a review of establishments for clinical services and complies with national safer staffing requirements.		

		Agenda Item No: 11c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 May 2022**

Report Title:	**Safe Working of Junior Doctors Quarterly Report**					
Executive/ Non-Executive Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr Sethi, Consultant Psychiatrist					
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	Junior doctors should be rostered safely and that their working hours are complaint within the parameters of their contract	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
Assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the Terms and Conditions of Service.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to note the content of the report.

Summary of Key Issues

1. Refurbishment work at Basildon and Rochford Doctor's room is still pending, work at other sites have been completed.
2. Trainees are awaiting Stepping down policy and the pay rate when they have to step down. Until the policy is approved a rate of £60/hour is agreed by HR and the managers.
3. There are 5 Exception Reports raised by trainees
4. No fines were issued in this quarter
5. There are gaps in the on call rota which are filled by MTI and LAS doctors

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			
MTI	Medical Training Initiative	Foundation	A doctor at Foundation level of training
LAS	Locum Appointed for Service (NHS Locum)		

Supporting Documents and/or Further Reading
Safe Working of Junior Doctors Quarterly Report (Jan, Feb, Mar 2022)

Lead
Name Dr Milind Karale **Job Title Executive Medical Director**

Part 1 Agenda Item: 11c
Board of Directors Part 1
25 May 2022

Quarterly Report on Safe Working of Junior Doctors

1 Purpose of Report

The purpose of this report is to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.

2 Executive Summary

This is the nineteenth quarterly report submitted to the Board on safe working of junior doctors for the period 1 January to the 31st March 22. The Trust has established robust processes to monitor safe working of junior doctors and report any exceptions to their terms and conditions.

Exception Reporting: (5 Exception reports in this quarter)

18/01/2022: Trainee worked extra 1 hour to complete ward duties as other doctors were off due to COVID. Time off in lieu was offered

20/01/2022: Trainee worked extra 1 hour to complete ward duties as other doctors were off due to COVID. Time off in lieu was offered

2nd/3rd/4th Feb 22: New ST4 is a less than full-time trainee and came in on her non-working days to attend induction and training. Time off in lieu was offered

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on the 2nd February 2022

Doctors in Training Data

Total number of posts	137
Number of doctors in training posts (total inclusive of GP and Foundation)	118
Number of doctors in psychiatry training on 2016 Terms and Conditions	72
Total number of vacancies	19
Total vacancies covered LAS/ MTI/Agency	7
Total gaps	12

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	170	170	0	1927.5	1927.5
Total	170	170	0	1927.5	1927.5

Actions taken to resolve issues:

The Trust has taken the following steps to resolve the gaps in the rota:

1. Rolling adverts on NHS jobs. Few International doctors who were appointed have started their posts.

2. Emails are sent to former GP and FY trainees if they would like to join the bank to do on-calls, this is now part of the termination process for GP's and FY's so they can express an interest in covering extra shifts when they leave EPUT.

Fines: None

Issues Arising:

1. Trainees are stepping down during their on-calls (although not frequently), trainees wanted clarification on their pay rate in these circumstances. Human Resources are aware and we are awaiting on the final stepping down Policy.

2. Trainees were urged to spend the money funded by Health Education England in the next few months.

3 Action Required

The Board of Directors is asked to:

1 Note the contents of the report

Report prepared by

Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours
March 2022

		Agenda Item No: 11d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	25 May 2022

Report Title:	**Safe Working of Junior Doctors Annual Report**					
Executive/ Non-Executive Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr Prabha Sethi, Consultant Psychiatrist					
Report discussed previously at:	NA					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Purpose of the Report		
This report provides the Board of Directors with assurance that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

2 Consider assurances provided by the Guardian.

Summary of Key Issues

Issues arising

- Gaps in rota at CT level are filled with internal doctors who are paid an internal locum rate. The gaps on the rota at ST level are unfilled. There are no particular reasons or patterns observed in these gaps, national recruitment seems to be the issue but these have improved in the last 6 months.

- Trainees raised concerns on lack of facilities in doctor's room and on-call rooms across all sites of the Trust.
- Trainees raised concerns on difficulty in finding supervisors to complete short cases in psychology which is part of their ARCP requirements and to gain competency.
- Trainees had to step down during their on-call days occasionally, hence they requested for clarity on payment in these circumstances and on stepping down policy.
- Health Education England granted £30,000 to our Junior Doctors, money was spent (based on Junior Doctors' choice) on purchasing items for Junior Doctors Room and on call rooms. Some money that was kept aside for team building events which were on hold due to COVID-19 pandemic is now being used by the trainees.

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	x
2: We learn	x
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			
FY1/FY2	Foundation Doctor	MTI	Medical Training Initiative
CT	Core Trainee	ARCP	Annual Review of Competence Progression
ST	Specialty Registrar 4-6 level		

Supporting Documents and/or Further Reading
Annual Board Report 21/22
Appendix 1 Board Report Apr to June 21
Appendix 2 Board Report July to Sept 21
Appendix 3 Board Report Oct to Dec 21
Appendix 4 Board Report Jan to Mar 22

Appendix 5 Monthly Breakdown of Vacancies 21-22
Appendix 6 Exceptions Apr 21 to March 22

Lead

Name Dr Milind Karale
Job Title: Executive Medical Director

Part 1 Agenda Item: 11d
Board of Directors Part 1
25 May 2022

Annual Report on Safe Working of Junior Doctors (April 2021 – March 2022)

1 Purpose of Report

The purpose of this annual report is to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.

2 Executive Summary

Quarterly Board reports were submitted from 1st April 2021 to the 31st March 2022 (Appendices 1 to 4)

Doctors in Training Data:

Number of doctors in training (average total inclusive of GP and FY1 & FY2)	132
Number of doctors in psychiatry training on 2016 Terms and Conditions (average)	69
Total number of vacancies (average over reporting period)	18
Total vacancies covered by LAS and MTI (average over reporting period)	10.75

Annual data summary:

Trainees within the Trust

Specialty	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average WTE)
Psychiatry	CT1-3	32	41	41	42	8.25
Psychiatry	ST4-6	26	32	32	30	7.0
Total		58	73	73	72	7.63

Trainees outside the Trust overseen by the LET guardian

Specialty	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average WTE)
GP trainees	ST1	19	19	16	16	1.5
Foundation	FY1	12	13	13	14	1
Foundation	FY2	15	14	15	16	0.25

Please refer to Appendix 5 for monthly breakdown of uncovered shifts

Agency Usage:

The Trust does not use agency workers and relies on the medical workforce to cover the out of hours i.e. 5pm to 8:30am at internal locum rates. There are varied reasons for covering out of hours ranging from sickness, the additional out of hours that less-than full time trainees can't contractually cover and vacant posts. One of the main factors for an increase in shifts requiring cover was due to COVID absence.

The total number of shifts covered in reporting period:

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
Vacancies/Mat Leave/Sickness/ LTFT cover/COVID	563	563	0	6406.5	6406.5
Total	563	563	0	6406.5	6406.5

Exception Reports:

A total of 21 exception reports were raised by trainees via the Allocate reporting system from April 2021 to March 2022.

Please refer to appendix 6 for details on Exception Reports.

Issues Arising:

1. Gaps in rota are detailed in Appendix 5 with a monthly breakdown of vacancies. The gaps at CT level are filled with internal doctors who are paid an internal locum rate. The gaps at ST level are unfilled; The Trust does not use agency locums.
   There are no particular reasons or patterns observed in these gaps, National recruitment seems to be the issue but these have improved in the last 6 months.

2. Trainees raised concerns on lack of facilities in doctor's room and on-call rooms across all sites of the Trust.

3. Trainees raised concerns on difficulty in finding supervisors to complete short cases in psychology which is part of their ARCP requirements and to gain competency.

4. Trainees had to step down during their on-call days occasionally, hence they requested for clarity on payment in these circumstances and on stepping down policy.

5. Health Education England granted £30,000 to our Junior Doctors, money was spent (based on Junior Doctors' choice) on purchasing items for Junior Doctors Room and on call rooms. Some money that was kept aside for team building events which were on hold due to COVID-19 pandemic is now being used by the trainees.

Actions taken to resolve issues:

1. Rolling Adverts on NHS jobs are in place, the Trust has recruited a number of MTI and LAS doctors who are covering the gaps in the rota.

GPs and FY2s are given an opportunity to express an interest to join the bank to do on-calls when they leave EPUT.

2. Refurbishment work at Doctor's room and on-call room at Chelmsford, Colchester and Harlow are now complete and trainees are satisfied with the outcome. Refurbishment work at Basildon and Rochford site is underway.

3. The issue on trainees having difficulty in finding the supervisors for psychology cases were escalated to relevant Clinical leads and the matter is now resolved.

4. The issue on Step down policy was escalated at JLNC. The members of JLNC are in the final stage of approving the stepping down policy. Meanwhile an agreed rate of £60 per hour in these circumstances have been agreed by HR and Managers.

5. Trainees have been urged to spend their money funded by Health Education England in the next few months.

Key issues from host organisations and actions taken:

There are no specific key issues within the Trust with regard to vacancy rates. There is a National recruitment issue. This has improved in the last 6 months and the number of gaps in the rota is less compared to last year.

At the bi-monthly Junior Doctors Forum, trainees raised the following issues:

1. Lack of facilities in on-call and doctors' room.

2. Difficulty in finding the supervisors for psychology cases

3. Difficulty in spending all the money funded by Health Education England due to several restrictions on team building activities due to COVID19 pandemic.

All the above issues have been addressed and resolved, the on-call rooms and doctor's room at Basildon and Rochford site is still outstanding but Estate department is aware.

Summary

There are ongoing issues with vacancy rates resulting in rota gaps at ST and CT level across the Trust. There are total gaps of 18 (average in the reporting period). The gaps are less as compared to the previous year.
The rota gaps at CT level are filled in by existing trainees who are paid NHS locum rates. The gaps at ST level are usually unfilled; The Trust has LAS and MTI doctors who have also filled in the gaps for rota and service provision. There are Physician Associates who also contribute in service provision. The Trust has recruited 5 doctors via the EPUT Advanced Fellowship route.

The Trust does not use Agency Locums.

The Board to note that there are no specific issues within the Trust on these vacancy rates and there is a National issue in terms of recruitment. It is important to highlight that the number of recruitments at CT and ST level in our Trust is far better compared to last year, resulting in less gaps in the rota.

Facilities at Doctors rooms and on call rooms have been addressed and trainees are satisfied with the outcome. There is outstanding work at Rochford and Basildon sites.

There were 21 Exception Reports (Appendix 6) raised by the Junior Doctors between April 2019 and March 2020, all have been addressed.

Junior Doctors Forum is held bi-monthly, all the issues addressed by the doctors are escalated timely to the relevant managers/supervisors and the issues are addressed.

3 Action Required

The Board of Directors is asked to:

1 Note the contents of the report

2 Consider assurances provided by the Guardian

Report prepared by
Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours