Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public
Wednesday 28 July 2021 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 **Here for You** **Dr Judith Friedman, Consultant Clinical Psychologist**			
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 26 May 2021	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	CEO Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	PS	Attached	Noting
(b)	Board Champions – NED and Exec Leads Requirements	SS	Attached	Noting
(c)	Infection Prevention and Control Annual Report 2020/2021	NH	Attached	Noting
(d)	Learning from Deaths Mortality Review Q4 Report 2020/21 Information	NH	Attached	Noting
(e)	Duty of Candour Annual Review	NH	Attached	Noting
(f)	Emergency Preparedness, Resilience and Response Annual Report	NL	Attached	Noting
(g)	Disciplinary (Conduct) Policy and Procedure	SL	Attached	Approval
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework 2020/21	PS	Attached	Approval
(b)	Standing Committees:			
	(i) Audit Committee	JW	Attached	Noting

	(ii) Finance & Performance Committee	ML	Attached	Noting
	(iii) Quality Committee	AS	Attached	Noting
9	**RISK ASSURANCE REPORTS**			
	(i) COVID-19 Assurance Report	PS	Attached	Approval
	(ii) EU Exit	NL	Attached	Noting
10	**STRATEGIC INITIATIVES**			
(a)	Digital Strategy Refresh	JL	Attached	Noting
11	**REGULATION AND COMPLIANCE**			
(a)	CQC Compliance Update	PS	Attached	Noting
(b)	Safe Working of Junior Doctors Quarterly Report (Apr-Jun 2021)	MK	Attached	Noting
12	**OTHER**			
(a)	Use of Corporate Seal	PS	Not Used	Noting
(b)	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
(c)	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
(d)	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
(e)	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
13	**ANY OTHER BUSINESS** Board Safety Oversight Group	NH/ARQ	Attached	Approval
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 29 September 2021 at10:00 (Venue or virtual tbc)			
16	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** Wednesday 24 November 2021 at 10.00			

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 26 May 2021
Held Virtually via MS Teams Video Conferencing

Attendees:

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

In Attendance:

Angela Horley	PA to Chief Executive, Chair and NEDs (minutes)
James Day	Interim Trust Secretary
Tina Bixby	Assistant Trust Secretary
Chris Jennings	Assistant Trust Secretary
Clare Sumner	Trust Secretary Administrator
Dr Ellen Auty (EA)	Clinical Lead and Consultant Clinical Psychologist
Jared Davis	Governor
Anabelle Vipond	Staff Member
John Jones	Governor
Stuart Scrivener	Governor
Pam Madison	Governor
Greg Wood (GW)	Clinical Director of Psychological Services
Pippa Ecclestone	Governor
Yogeeta Mohur	Freedom to Speak Up Guardian (item 0059/21)
Judith Wooley	Governor
Dianne Collins	Governor
Paul Walker	Governor
Phil Gayle	Observer
Clare Lawrence (CL)	Head of Complaints (item 060/21)
Kate Shilling	Governor
Nicola Jones (NJ)	Director of Risk and Compliance (Interim) (items 064/21 and 066/021)

SS welcomed Board members, Governors and members of the public that had joined this virtual meeting.

The meeting commenced at 10:01

050/21 APOLOGIES FOR ABSENCE

Apologies were received from Paul Scott, Chief Executive Officer and Alex Green, Executive Chief Operating Officer.

051/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

052/21 PRESENTATION: PARENT INFANT MENTAL HEALTH SERVICE AND FAMILY GROUP CONFERENCING

Dr Auty (EA) advised that the EPUT Infant Mental Health (IMH) service had been commissioned in January 2019 and had been operational since September 2019 and was an Essex wide service.

IMH is important as this time provides an important window of opportunity during a child's most rapid time of growth. The relationship between parent and infant grows the brain structure needed to regulate emotions and build social and emotional wellbeing. It is shown that those who are nurtured best, survive best and there is a vital need of attachment. Our service is dedicated to the growth of a child's mental health and is important for the future. The team support both the infant and the parent and foster the necessary attachment for the baby and their parent. The service is designed to shift trajectory and support many born into difficult situations. Things from the past can affect parental experience and it is acknowledged that adverse childhood experiences such as poverty, drug abuse and mental health issues are contributing factors.

The IMH team is small and receives referrals from the Early Years System (health visitors, midwives, GPs etc). Referring issues will be around the relationship between the infant and the parent(s). The team see people through pregnancy until two years post-natal. The service has recently been evaluated as part of a joint project with the Parent Infant Foundation and the Big Lottery. A short video that had been developed was shown, highlighting the achievements of the team and the experience of service users.

SS thanked Dr Auty for the powerful presentation and video. MK congratulated the success of the team stating that this was a very important service that made a difference in many lives. MK queried how we expand and ensure the service becomes integrated into perinatal and wider MH services. EA confirmed that a plan is in place to extend the parent and infant offer into the perinatal service. EA confirmed that the team work with the wider community, not just Mental Health services, and so having both services compliments each other and widens the cohort of people who can be seen. EA advised that there are currently only 30 teams such as this across the UK. Together with Baby is in its second year and it was important to present data and impress on commissioners the importance of the service.

ARQ thanked EA and team for the important work that was taking place. ARQ advised that she had visited the perinatal service and had been impressed by the passion of the team. The work and success was evidenced by the video. It was important to share and acknowledged the amazing work in turning children and parent's lives around for the future. In response to ARQ's query regarding the scope of demand for the service, EA advised that research evidence showed that 10-15% experience a difficult birth role in Essex which equates to circa 23,000 people. Not all would require specialist services and so the ambition is to work with the wider system in a step care approach, working with those involved in infant health (midwives, health visitors etc) to offer infant mental health interventions and arrange further referrals if needed.

NH thanked EA for the informative presentation and appreciated the passion and commitment; NH queried whether given the current situation with the ongoing pandemic, whether consideration had been given to the potential effects this could have on child development. EA confirmed that this had

been considered and stated that it was harder to observe an infant via virtual means (video calls etc) However, the team had continued to engage with parents during the pandemic. Two reports have been issued regarding the effects of the pandemic on different groups and all services are anticipating a surge in mental health needs. Discussions are ongoing with partner agencies on how to identify families in need and arrangements put in place to provide support where needed.

RH queried what research had been undertaken previously to show the benefit of the service, including the longer term benefits. EA advised that funding is being utilised to do further evaluation 18 months on to see the longevity of gain by the family. The service continues to work with the Parent Information Foundation and feed into research along with other teams across the country.

EA was thanked for her presentation and left the meeting

053/21 MINUTES OF PREVIOUS MEETINGS

JD noted that PE had advised a small number of errors and confirmed that these would be addressed, however he did not believe these changed the essence of the minutes.

The Minutes of the meeting held on 26 May 2021 were agreed as an accurate record.

054/21 ACTION LOGS AND MATTERS ARISING

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

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

The Board discussed and approved the Action Log.

055/21 CHAIRS REPORT INCLUDING GOVERNANCE UPDATE

The Chair presented a report providing the Board of Directors with a summary of key activities and an update of governance developments within the Trust. SS advised that collaboration with system partners is forging ahead and thanked the Executive Directors and Non-Executive Directors for their support with developing ICS structures across the county.

SS noted that we have been informed that the Essex Mental Health Independent Inquiry has been established and will today launch a six-week consultation inviting families and others affected to give their views on what they would like to be considered as part the inquiry. This will inform the draft terms of reference with a further opportunity for families and the public to comment before they are finalised. A news release has been issued by the inquiry, which is being posted on the Trust website shortly. SS reiterated that Safety is our absolute priority – the Trust welcomed the independent inquiry as an opportunity to learn lessons to ensure the safest care possible for our patients and the Trust will be cooperating fully. As Board members are aware, this follows a Government announcement earlier this year giving details of the inquiry. It is being chaired by Dr Geraldine Strathdee and will review mental health inpatient deaths from 01 January 2000 to 31 December 2020 at both the former North Essex Partnership University NHS Foundation Trust (NEP), the former South Essex Partnership University NHS Foundation Trust (SEPT) and EPUT following merger in 2017.

The Board received and noted the Chair's Report.

056/21 CEO REPORT

On behalf of the Board of Directors, TS extended continued thanks to all teams both clinical and corporate for their continued efforts in these unprecedented times.

In terms of the Safety Strategy Implementation, NH advised that Moriam Adekunle had joined the Trust as Director of Safety and Patient Safety Specialist. Moriam is engaging with teams across the Trust and her insight is already being well received. Newton Diagnostics, our safety partner in the diagnostic phase of the implementation of the strategy have now concluded their initial diagnostic work and are now reaching conclusions and resulting recommendations. Using this insight, we will begin to identify initiatives to ensure our services are effective and which will be open and transparent across the organisation

The Trust continues to work with post graduate students from Cambridge University looking at how we manage ligature risk and this is gaining momentum. This will be a key presentation to the Mental Health Safety Improvement Programme national programme on how we, in collaboration, will utilise quality improvement methodology, reduce self-harm and suicide.

NH confirmed that we have prioritised resources to support the implementation of the Safety Strategy and advised that the rollout of the Oxehealth system is progressing to plan with 15 wards across the Trust now live. A Project Management Office (PMO) has also been established to ensure that we have the right level of project governance, controls and assurance for our projects and programmes. Over the coming weeks we will be expanding the PMO to support all of our key project activity and are producing an overall plan of projects and programmes planned for the next 24 months to enable us to plan, prioritise and resource our teams more effectively in the future.

The Board received and noted the CEO's Report.

057/21 QUALITY AND PERFORMANCE SCORECARD

Our operational performance has remained stable, and there were 24 performance and quality indicators within target. The five areas of inadequate performance remain the same but there has been a significant improvement in the numbers of patients not seen within 12 months. There are waiting list clearance plans in place for Psychology. The pressure on inpatient adult mental health beds has continued, resulting in a further increase in out of area bed days. Topaz ward is now operational and admitting patients with a phased approach. Social distancing caps on occupancy have also been reviewed, and with support from Infection Prevention and Control, have largely now been removed. We are repatriating patients and have an action plan in place to reduce out of area placements by September 2021.

Our Tier 4 CAMHS pressures have been sustained and we have been working with our system colleagues to develop a plan for the implementation of two 72 hour admission beds to support better flow and capacity and improved outcomes for young people as well as working with regional colleagues on a number of medium term schemes.

AS requested further information regarding the plan to reduce out of area placements by September 2021 in light of significant national MH pressures; NH advised that this will be a multi-faceted approach which includes the opening of Topaz ward and the phased approach to admissions. Alongside flow and capacity work, we have a strong usage of out of area placements which the Trust needs to repatriate as soon as possible. NH reiterated that this was a multi-faceted approach with appropriate resources in place to facilitate.

AS queried what monitoring took place with regards to length of stay and benchmarking. NH confirmed that monitoring was taking place alongside work undertaken by Newton to look at the data. ARQ acknowledged the vast amount of work taking place and queried what measurement strategies were in place to demonstrate the impact of the safety strategy. NH responded that outcome measures are being agreed, for example, reducing restrictive practice. Detailed data will be analysed and progress monitored through multiple quality metrics. These will be shared with the Board of Directors. MK added that with regard to the reduction of out of area placements, work is taking place on purposeful admissions which was being led by clinicians and operational services. The Trust is also strengthening the pathway for patients to have a minimum stay on wards. There are numerous strands to this work, including strengthening community and outpatient services.

RH suggested that length of stay is calculated at the point the patient is discharged, and therefore a small number of patients with a longer stay can distort the figures, and it may therefore be better to look at length of stay at a point in time for a more accurate analysis. NH agreed that there was a need to look at length of stay data and performance and to look at length of stay for particular areas to determine if practice in that unit or patient profile needs analysis for a true expected length of stay. LL agreed that looking at data and predictive analysis can help to forward plan the right care for our patients.

GW stated that as a consequence of looking at length of stay there was an agreement to develop new roles and analysis of data which can predict a shortening of length of stay.

MK advised that a new ADHD service has been approved by commissioners in North East and West Essex and we are now in the process of recruiting staff in order for the service to commence. The Executive Team have also approved a new pathway for treatment resistant depression and work is now taking place with commissioners. Four overseas Clinical Fellowship positions have been appointed to, and the first of the doctors should be ready to start work in June. The Trust will be running another recruitment campaign to attract more overseas Fellows to join the Trust, with the expectation that with support and further training, these doctors will join our consultant workforce within the next few years.

SL commented that there is a tremendous amount of work taking place across the Trust with over 200 new staff recruited. The attrition rate remains under target with the majority of staff leaving positions due to promotion. A new appraisal process is to be launched which will enable us to identify core talent in the organisation. A review of the HR function with a view to modernise and transform the function to support staff across the organisation is also planned. ML welcomed the review of HR services, acknowledging the diligent work of the team. ML noted that three employment tribunals were identified within the report and sought clarity as to whether leaning or outcomes were included within assurance reports. ML suggested consideration be given to where this update could be received. SL agreed and reported that the number of grievances had also reduced as a result of intervention and local resolution. SL stated that the culture of the organisation was changing and the Trust encouraged an open and transparent approach.

SL reported the tremendous success seen by the Kickstart programme which was an initiative to encourage 18-20 year olds into the workplace. So far 130 people had signed up to this initiative and this was a good opportunity to show EPUT as a supportive employer and encourage apprenticeships.

LL was pleased to hear of the shift in culture and the uptake in morale and queried what more could be done to retain staff. SL advised that this was under consideration with a new appraisal process which identified core talent and how to support our staff.

ARQ suggested that the staff survey results should provide rich data; SL agreed, stating that data was currently being collated and would be fed back to the Board of Directors when available.

The Board of Directors received and noted the report.

058/21 NHSI SELF CERTIFICATION

JD advised that NHS Foundation Trusts are required to make annual self-certifications to NHS Improvement under the NHS Provider Licence, CQC Assessment Framework and the Health and Social Care Act 2012, in addition to those made as part of the annual plan submission. Four self-certifications are required (one is not applicable to EPUT in relation to Joint Ventures and Academic Health Science Centres). The Finance and Performance Committee considered compliance with the provider licence requirements at its meeting on 20 May 2021 and agreed to recommend to the Board of Directors that the declaration stated within the report was made.

The Board of Directors:

1. **Noted the contents of the report;**
2. **Approved the recommendation from the Finance and Performance Committee to make a declaration to NHSE/I as detailed in the report.**

059/21 FREEDOM TO SPEAK UP REPORT 2021

YM advised that from April 2020 to March 2021, 235 concerns were raised with the Guardian Service with 83.3% stating that they would speak up again and 100% stating that they would recommend the service to colleagues. AV shared her experience of using the F2SU platform during a time where she did not feel her working environment was safe during the COVID-19 pandemic. By raising concerns with the F2SU Guardian, support and meetings were facilitated with the manager and service manager. AV experienced a positive outcome in terms of her concerns and extended thanks to the service and stated that she would use this service again and recommend to colleagues.

ML welcomed the report and acknowledged the importance of this service. ML noted that there were 18 patient safety cases, and given the Trust's priority and focus on safety, queried how this was followed through and linked to the safety strategy. YM advised that the F2SU service works closely with NH and the Nursing Directorate, as well as working closely with HR.

RH noted that the number of concerns had varied and raised each quarter noting that this demonstrated that people were more comfortable with voicing concerns; RH queried how this aligned with other metrics. SL confirmed that all concerns raised via various channels across the organisation are triangulated and analysed for themes and trends.

ARQ, as F2SU champion, thanked YM and the local guardians for their continued work. A growth in confidence had been seen due to the work that YM and the F2SU champions undertake. ARQ stated that more champions were needed and efforts continue to raise the profile of this worthy service. In terms of the number of concerns increasing, ARQ sought clarity as to how this had been impacted by the pandemic and whether there was any anticipation that this may reduce. YM advised that during the first wave of the pandemic there had been an increase in concerns regarding availability of PPE and social distancing.

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

060/21 COMPLAINTS ANNUAL REPORT 2020/21

CL presented the complaints annual report, advising that during the COVID-19 pandemic first wave, the formal complaints process had been paused and an adapted process put in place, 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 were able to resume formal investigations by the beginning of quarter 2. However, we have retained the focus of locally resolving complaints where it is felt this would provide a more efficient resolution for the complainant.

A total of 275 complaints were received during the year with a total of 265 closed. 63% of complaints were upheld or partially upheld. 59 complaints remain active at year end. 92.5% of complaints were answered within agreed timescales with 9 complaints referred to the Ombudsman and 35 complaints were reopened.

The top three complaint categories for complaints closed in 2020/21 were Clinical Practice, Staff Attitude and Systems and Procedures.

A high volume of PALS queries were received (2820). The PALS team were the central point of contact for Mass Vaccination Centre queries and the increase in queries is therefore attributed to this.

1000 compliments were received during this time period.

SL stated that there is a need to give equal focus on complaints and compliments and the lessons to be learned from both.

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

061/21 EQUALITY AND INCLUSION REPORT ANNUAL REPORT 2020/21

SL presented the annual update on the progress of the Trust's Equality and Inclusion responsibilities as well as key achievements. During this unprecedented time, the Trust has forged extremely strong relationships and continued to build on the Equality and Inclusion agenda. SL was pleased to note the approval of a Director position reporting to SL to act as a system wide advisor in terms of Equality & Inclusion. SL felt that EPUT were leading the way and were now supporting the system with the direction of travel.

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

062/21 LEARNING FROM DEATHS – MORTALITY REVIEW SUMMARY OF Q3 2020/21

NH presented the Mortality Review Summary which provided information relating to deaths in scope for mortality review for Q3 2020/21. There were 60 deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy. This is broadly consistent with the same quarter in 2019/20 and with other quarterly figures for periods not impacted by COVID-19. Of the 60 deaths, 15 were inpatient deaths and 6 were nursing home deaths. 11 of the 15 inpatient deaths and all of the 6 nursing home deaths have been confirmed as due to natural causes. Three causes of death are currently under determination and one has been determined as unknown. It is anticipated that the next report will be impacted by the pandemic as during the height of the pandemic EPUT repurposed facilities to support the COVID-19 response.

Detailed information on learning from serious incident investigations and other individual mortality reviews is presented and considered at the Learning Oversight Sub Committee and Quality Committee to ensure actions are being taken. The Trust actively ensures that learning identified from the reviews leads to improvements in practices and actions taken in response to learning identified from individual mortality review include:

- Regular lunchtime learning sessions held via MS Teams which focus on specific learning from SI deaths and are attended by high numbers of clinicians;
- Clinical Intervention Support Groups established;
- Themes emerging from individual mortality reviews were directly used to shape the Trust's focus under the newly implemented Patient Safety Incident Response Framework (PSIRF).

AS confirmed that the Quality Committed had continued to interrogate reports on mortality and safety over the past year. SS commented on the importance of a robust process for learning and noted the Quality Committee overview.

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

063/21 PATIENT LED ASSESSMENTS AND THE CARE ENVIRONMENT (PLACE)

TS presented the report to inform the Board of Directors of the reactive estates and facilities actions taken to address any identified areas of improvement in the 2019/20 Patient Led Assessment of the Care Environment (PLACE). Due to the impact of the COVID-19 pandemic, NHS Improvement took the decision to cancel PLACE Assessments for 2020/21 In the absence of formal place assessments, the Trust has taken the decision to conduct an internal PLACE Lite assessment using a similar formula, which will be undertaken in early August 2021. It is intended that the assessments will be undertaken by Service Users, Volunteers and Governors.

SS was encouraged by the decision to move to our own assessment process noting the importance of continuing to move forward in a diagnostic way.

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

064/21 BOARD ASSURANCE FRAMEWORK

NJ presented the BAF assurance report which contained an overview of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) 2021/22 as at 26 May 2021. The report covers two months of reporting to the Executive Team BAF Sub Group.

This sub group was established in January 2021 and undertakes detailed review of the BAF and CRR. In view of the work progressing at Board and Executive level around governance, structure and accountability, the BAF, CRR and Directorate Risk Registers continue to roll over until the Board approves the Strategic Objectives for 2021/22.

There are 18 risks on the BAF, with no new risks identified since the last report. Recommendations within the paper identified one risk recommended for closure (BAF43) with appropriate mitigations in place. There has been a great deal of work to make sure mitigations are robust and understood.

JW confirmed that the Risk Management Assurance Report had been discussed and approved at the Audit Committee and confirmed that a monthly meeting was taking place with the Head of Compliance around the process to keep a watching brief.

NJ advised that BAF64 had been discussed in detail at the ESOG due to the ongoing challenging national, regional and local pressures in CAMHS. All services have seen an emergence of demand following the pandemic and Children and Young People services capacity was now a national concern. NJ confirmed that EPUT were working proactively with the system to take a holistic approach to supporting children and young people. It was recommended that the risk score be reduced and a change in wording to reflect Cause, Event and Effect. Additional mitigations and actions had also been identified. ARQ suggested that given the importance of this issue the score

should not be reduced at this time. NH confirmed that the Trust is putting in proactive work and is continuing to monitor and review the risk and score. MK added that services have been compelled to admit against clinical best practice levels and accordingly the Trust was leading to a process where it was not being compelled to admit against the advice of clinicians, and would have interventions in place. It was agreed that the score would not be reduced at this time.

SS noted that the BAF felt more dynamic and this was reflective of our approach to manage risk and escalate / de-escalate as situations progress.

The Board of Directors:

1. **Reviewed the risk identified in the BAF 2021/22 May summary and approved the risk scores including recommended changes, taking account of actions taken by EOC at its April meeting; however the Board did not agree to the reduction in score of BAF64.**
2. **Approved the BAF risk escalations, closures and amendments iterated in key issues below.**
3. **Noted the Q4 Key Performance Indicators for April.**
4. **Noted the CRR May summary table including actions taken by EOSC at its April meeting.**
5. **Approved the CRR risk escalations, closures and amendments iterated.**
6. **Did not identify any further risks for escalation to the BAF, CRR or Directorate Risk Registers.**

065/21 STANDING COMMITTEES

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

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

(iii) Quality Committee
AS thanked EOL services for an inspiring presentation given at the last Quality Committee.
The Board received and noted the report and confirmed acceptance of assurance provided.

(iv) People Innovation and Transformation (PIT) Committee
ARQ advised that Governor Keith Bobbin had attended and observed the PIT committee which had been welcomed.
The Board received and noted the report and confirmed acceptance of assurance provided.

066/21 RISK ASSURANCE REPORTS

i) COVID-19 Assurance Report
NJ advised that EPUT continued to operate under a Gold/Silver/Bronze command structure during the pandemic and arrangements are working effectively. A further decrease in the prevalence of the virus had been seen across the county and the country. However, a new variant had been identified, and this would continue to be monitored. If appropriate, a decision will be made to step the command structures up or down. NJ confirmed that there had been no further outbreaks of COVID-19 within EPUT

services and regular lateral flow testing of both patients and asymptomatic patient facing staff continues across the Trust.

During the pandemic two wards in West Essex had been repurposed to support the pandemic response. However, with the agreement of our system partners and approval by Gold command, these wards have returned to their original functions with the opportunity to step up once again if needed.

The Trust held a live MS Teams event marking one year on from the first day of the national lockdown. This has led to further reflection and understanding of the benefits and challenges of the new ways of working during the pandemic.

The Board of Directors:

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

ii) EU Exit

NL presented an update on EPUT's position in regard to the EU Exit, advising that the Trust's preparations for the end of the transition period and post transition have been taking place alongside our response to COVID-19 and winter pressures. The Trust's EU Exit Task and Finish Group continues to meet on a monthly basis alongside monthly admin meetings. There will still be changes post transition, and the Task and Finish Group will continue to meet to discuss and monitor any requirements that are relevant to the Trust and our services.

The EU Settlement Scheme will allow EU Nationals to continue to live and work in the UK beyond June 2021, and the Trust continues to encourage and assist staff to apply to this scheme.

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

iii) Ligature Risk Management Year End Learning Report 2020/21

NJ presented the year end learning report which provided an update and assurance of actions undertaken in 2020/21 to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate. The Trust is committed to improving systems and process that facilitate robust risk identification and management and is committed to continuous learning going forward. BDO, the Trust's internal independent auditors, carried out testing of the Trusts implementation of its ligature risk management policy and procedures in 2020 and reviewed of the effectiveness of the controls in place at the Trust to give assurance. It was agreed to expand the audit to test how that policy and procedure was being implemented at ward level. This expanded audit will cover 19 wards and is planned to take place in 2021.

EPUT has been working with East London Foundation Trust (ELFT) to undertake peer reviews to identify improvements that could be made and to share learning. The review was undertaken with onsite ward visits to assess environments and compare processes. The outcome report from ELFT is awaited and visits to ELFT are to be arranged to ensure that learning can be identified by comparison.

The Executive Chief Operating Officer was appointed as chair of the Ligature Risk Reduction Group and had brought new challenge and integration to the group drawing focus to the Safety First, Safety Always Strategy.

During 2020/21 there were 16 Safety Alerts relating to ligature risks identified and issued to inpatient areas across the Trust. Actions have been taken where required and monitored via the LRRG.

A review of serious incidents due to ligature has been undertaken to identify if there were any key themes, and to review learning. The number of inpatient incidents meeting the current SI criteria is small and it was difficult to draw any common themes. However, the review found a number of changes had been made following SIs including changes to Trust environmental standards for collapsible bins and changes to garden management. A ligature incident dashboard on Datix had been developed and rolled out to all MH, LD and specialist service ward managers to provide live data.

In response to a query from ML, NH confirmed that feedback following the ELFT peer review would be shared with the LRRG and Quality Committee to learn from and reflect on the findings. RH noted that ELFT are renowned for their approach to culture and quality and suggested there may be potential to extend the scope of the review to include a cultural aspect. NJ thanked RH for this suggestion and confirmed that the visit of EPUT to ELFT would provide an opportunity to observe and learn, stating that the intention of the exercise was for shared learning.

In response to a query with regard to the expanded audit testing of 19 wards, NJ confirmed that an outcome report is expected by June. This report will then be presented to the Audit Committee who had commissioned this extended audit.

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

067/21 STRATEGIC INITIATIVES

i) Mental Health and Community Health Services Transformation

GW advised that due to the COVID-19 pandemic, Trust and system staff had paused some transformational work to support operational services concentrating on business as usual. The Trust, together with local commissioners and other stakeholders, are now adjusting to the second national lockdown and resetting clinical services and transformation activities. The planning for the MH Transformation Programme for 2021/23 is currently in progress with local commissioners. Significant investment across Essex to develop EPUT led local systems and integrated care offers was anticipated, focussing on four key areas:

1. Urgent and Emergency Care
2. Personality Disorder and Complex Needs
3. Older People and Dementia
4. Community (Primary Care) IPCC

SS noted that huge amount of work taking place in regard to transformation and was conscious that this was in addition to the surge in demand as a result of the pandemic. On behalf of the Board, SS extended thanks to the teams for their commitment and willingness to integrate with system partners to improve services for those that we serve.

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

068/21 REGULATION AND COMPLIANCE

i) CQC Update

NJ advised that a project has been initiated to ensure appropriate preparation has been undertaken in the Trust for future CQC visits. This includes support visits undertaken to all inpatient areas and self-assessment of inpatient areas. The learning from both is being collated into a report for consideration. Staff engagement is underway with a number of reflective sessions held and future sessions planned, as well as staff resources being updated including the issuing of new Quality Stars posters for each ward. In addition to this, revised action cards and a new handbook and quality folder are in development.

An unannounced visit was made to CAMHS services recently and the findings from this visit are awaited.

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

ii) Safe Working of Junior Doctors Annual Report Covering 01 April 2020 – 31 March 2021

MK presented the Safe Working of Junior Doctors report and noted that the Trust had moved away from the use of agency workers to cover out of hours and relied on the medical workforce to do so. Significant work had been undertaken to improve the facilities for doctors across the Trust and following feedback from junior doctors, appropriate clinical supervisors have been identified at certain inpatient units where there was no substantive consultant post.

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

069/21 USE OF CORPORATE SEAL

The corporate seal had not been used since the previous Board of Directors meeting.

070/21 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

There were no items of correspondence circulated to the Board.

071/21 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

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

072/21 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

AS reflected that the Trust demonstrated an ongoing commitment to equality and noted the progress made around the equality agenda and noted that conversations held were open and transparent.

073/21 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

It was noted that the following Board members had briefly left the meeting as follows:

- Natalie Hammond absent from 11:51 – 11:53
- Alison Rose-Quirie absent from 11:33 – 11:39
- Loy Lobo absent from 12:00 – 12:33

JD confirmed that the Board of Directors had remained quorate at all times throughout the meeting.

074/21 ANY OTHER BUSINESS

There was no other business.

075/21 DATE AND TIME OF NEXT MEETING

SS thanked all for joining the live broadcast.

The next meeting of the Board of Directors is to be held on Wednesday 28 July 2021, 10:00am, at the Lodge, Lodge Approach, Wickford, Essex, SS11 7XX.

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

076/21 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 12:48.

Appendix 1: Governors / Public / Members Query Tracker (Item 076/21)

Governor / Member / Public	Query	Response provided by the Trust
John Jones	With regards to Out of Area Placements – given a target to reduce by September, are there plans for Board to look at progress in July.	SS confirmed that this is the case. ML advised that Finance and Performance Committed will review and monitor performance against the trajectory and an update would be included within the F&P assurance report at the next meeting.
John Jones	BAF Appendix 2 shows KPIs – what are they and what is the effect of this being red?	KPIs in relation to the Board Assurance Framework were a new initiative for 2020/21. The targets set may have been somewhat aspirational, however, we do feel that in 2021/22 we should be able to turn these green. This has to be in conjunction with the Executive Team. Since the inception of a dedicated ET BAF Sub-Group there is more engagement on ownership, collective responsibility and discussion on risks and as such we have seen an improvement in the % of increased risks, which turned green at the end of Q3. The % of stagnant risks is fairly reflective of the amount of work that needs to be done to get movement in the right direction on these risks. Examples are HSE and Independent Inquiry risks where we will expect to see movement following the sentencing and progress on the Inquiry respectively. Work is being done on whether some long-term risks such as Fire Safety should be on the BAF – whilst there is always a risk, in actual fact we have not had a major fire incident. Focus on this risk will be around fire marshals and drills. Whilst stagnant risks spiked in April 21 movement in May was in the right direction. Decreases in risk scores was much improved in May despite still being red. This is expected to continue throughout 2021/22. Recent Amberwing training for the senior leadership team and the Board of Directors has proved very useful and given the leadership team and Board better skills to manage risks. Work with Amberwing will continue in 2021/22 to ensure we articulate the correct risks against the strategic objectives and corporate objectives respectively. We will agenda a discussion in the next BAF ET Sub-Group as to whether our KPI percentages are too high in the first instance but at the same time strive to make considerably improvements against KPI2, and 2b and maintain the green rating on 2a.

Signed: …… Date: ……

In the Chair

	• Healthwatch Southend applauds the openness of the Trust in publishing such a detailed report, which is a model of good practice for other Trusts. We note your commitment to improving on response times The commitment to learning is apparent through the report. How is the Board assured that this learning is embedded so that complaints on similar themes reduce or do not reappear? • The report analyses complaints by the ethnicity of the patient. This section could be strengthened by including data about the overall ethnicity of the patients whom EPUT services – what proportion of its patient do not identify as being white-British and is this reflected in the rates of complaints? Acknowledging that there may be cultural issues, are patients given sufficient support where they may have concerns to raise? Whilst we are all increasing working in systems, data under Mid and South Essex covers a significant population, is it possible to show this by the	• The Complaints Team has recently implemented improved measures for following up on all Lessons Learned and promised actions after a complaint. Approximately 4-6 weeks after the complaint is closed we email the Service Manager and request details of how the lessons learned and/or any actions were implemented and the relevant dates. We share Trust-wide lessons at the Learning Oversight sub-Committee and monitor themes to identify and address recurring issues. • This is something we are looking into. We will include this information and any actions taken in future quarterly reports to the Equality & Inclusion sub-committee

	constituent local authority, which will mean more to the lay reader and possibly more importantly allow more local oversight of issues?	• This is not possible at the moment as complaints are not captured in this way when they are logged. We are currently reviewing our reports, and looking at how to better report on locality.
Owen Richards	Page 6/11 Adult acute MH readmissions ".....spike relating to 11 readmissions. Statistical control analysis indicates no cause for concern"	
	Is this because patients transferring for Acute Hospital treatment are counted as "discharged", even though they will then return to EPUT services for acute MH hospital treatment?	Yes that's correct, we have to count these like this because it is the national definition.
	What we need to know is how many of these patients are being readmitted within 28 days of discharge into the community?	The May readmissions were 11 out of 107 discharges, but we do not have the breakdown of the discharge destination of those 11. We have included this detail in the June report (Junes readmissions).
	Page 10 of 'Integrated Quality and Performance Scorecards' charts 4.9.3 & 4.9.4	
	'Ambition Indicator' is different from wording in the chart	This chart was temporary until enough data was present for SPCs, which are being used in the June Report, we will check the chart wording to be the same as the column descriptor.
	Please could we have numbers of patients as well as %?	The numbers for these are:- • 4.9.3 = 2892 out of 5653 (51.2%) • 4.9.4 = 355 out of 4844 (7.3%)
	Why is there such a big difference between the figures for North and South?	We have amended the calculation in the June report as planned, to bring these indicators in line with the medical caseloads (4.9.1 / 4.9.2), and have seen the

		numbers outstanding reduce for South Essex. Data quality is a difference between the two areas, changes to service teams through transformation in south should see this gap closed as validation of the caseloads is undertaken by the end of July as part of the change.
Dianne Collins	One question regarding the transformation of Mental Health Services I would like an answer to is this:- With the integration of services is the intention that the areas outside of Essex that currently have services provided by EPUT will be hived off to their County provider making us a provider for just Essex including Thurrock and Southend?	No that will not be the case – we continue to provide a number of services outside of Essex and there are currently no plans in place to change this. Where these services are part of specialist services, i.e secure services – these form part of the specialist services provider collaborative.
Paula Grayson (Question from March 2021 Board Meeting)	F&P: What financial and/or clinical issues might arise from the two Contract Performance Notices please?	There is only one Contract Performance Notice currently but not being discussed by commissioners as we have not returned to normal contractual performance monitoring at this time. This KPI is currently performing better and will probably come out of contract performance notice when the contractual process returns.
John Jones	There is no report regarding restrictive practice, given the ambition to reduce to zero and the significant progress seen will a report be available in July?	NH confirmed this will be the case. The pandemic has brought with it an increase in restrictive practices and so the report will indicate this however we have seen a half year effect from the rapid response collaboration. Further detail will be available in the Quality Account.

Signed: …… Date: ……

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 26 May 2021)

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

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
March 033/21	People Plan to be updated to include: 1. Review of the recruitment process to ensure staff can be recruited into post more quickly. 2. Details of the plans to introduce the role of Associate Practitioner.	SL	July 2021	This action has formed part of the HR review which is due for completion in June 2021.	Open	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
March 035/21	Refreshed Board Assurance Framework To be presented to the Board of Directors in July 2021 in line with refreshed Strategic Objectives.	PS	~~July 2021~~ Sept 2021	BAF refresh unable to take place until TB have approved strategic objectives. Timescale for strategic objectives is presentation to TB in July 2021. Therefore BAF refresh will aim for September TB. Work is underway on refresh using draft objectives and taking into account learning from Amberwing sessions.	Open	
March 040/21	Engagement Strategy to be reset and presented to the next Board of Directors meeting.	SL	~~May 2021~~ July 2021	Part of the HR review which will be completed in June 2021.	Open	
March 037/21 (ii)	EU Exit - Provide assurance that staff members that had not applied for the EU Settlement Scheme had been engaged and provide details of what happens if by June those staff had not been through the process.	SL	May 2021	We have 4 permanent staff who we have tried to make contact with in terms of status and have not been able to establish contact and they have not returned messages etc. – these are being followed up with their managers in terms of ensuring they are aware if the scheme and how to apply – however please see below individuals do not have to inform us of their status and legally we do not have to obtain this to continue to employ them beyond 30th June. We have 29 bank/locum workers who we have tried to make contact with re status and have not been able to establish contact with. I have attached the full breakdown report that I did provide however not sure if this was provided alongside the narrative. Home office guidance states that the onus on applying for settlement status rest on the individual and not the employer and the following is set out for existing employed staff • there is no legal obligation for employers to communicate the EU Settlement Scheme, however, we may wish to direct employees to the information that the government is providing.	Complete	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
				• it is the responsibility of the individual to make an application to the EU Settlement Scheme. There is no requirement for the individual to inform their employer, that they have applied or the outcome of their application. Likewise, you should not check that an employee has applied. The purpose of the communication we have been carrying out is awareness of the scheme and to support individuals with applications if they were struggling. The purpose was not to check up on if individuals have applied or not applied – Individuals do not need to share outcome of settlement status with us this is entirely their decision to do so we are lucky that many of our staff have engaged with this process and have willingly shared their status with us following application We do not need to do anything come 30th June – if individuals do not apply for settlement status then we will have a statutory excuse for their continued employment and will not be liable for any legal action if the individual has failed to obtain settlement status		
September 117/20 (1)	Workforce Disability Equality Standard (WDES) Update on Action Plan to be presented to BOD in January 2021	SL	~~January 2021~~ March 2021	Report being presented at Board	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
May 064/20 (1)	Freedom to Speak Up Report NHS England and NHS Improvement Self Review: review two actions agreed to bring the Trust into compliance with the self-review tool at a future Board Seminar Session.	SL	September	Due to time constraints (Covid-19) the report received from the National Guardian Office along with accompanying slides was circulated to the Board outside of the Seminar session. SL also discussed the report at the August People, Innovation and Transformation Committee.	Completed	
July 092/20 (1)	Review of BAF41 wording and mitigation in light of recent conversations held at F&P Committee, where challenges in delivering recurrent CIPs were discussed.	TS	September	Wording updated.	Completed	
July 094/20 (1)	Phase 3 Reset and Recovery Planning to be included on agenda for Board Development Session for discussion.	TS	September 2020	Added to the Board Seminar Agenda for November 2020	Completed	

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 July 2021**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The report attached provides information in respect of:

- Safety update
- Safety strategy implementation oversight
- HSJ Patient Safety Award Shortlisting
- Tower Ward GSF Accreditation
- Service Visits
- NHS 73rd Birthday
- Staff Wellbeing

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

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
Accompanying Report

Lead
Professor Sheila Salmon **Chair**

Agenda Item: 5
Board of Directors
28 July 2021

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Safety update

Board members will be aware that following prosecution by the Health and Safety Executive (HSE), the Trust was recently sentenced at Chelmsford Crown Court. In November last year the Trust entered a guilty plea to a single charge under the Health and Safety at Work Act following a HSE investigation into how one of EPUT's predecessor trusts managed risks from fixed potential ligature points in inpatient wards between October 2004 and March 2015. Since joining the Trust as Chief Executive, Paul Scott has strongly emphasised safety as being at the forefront of everything we do. Safety is and must remain our absolute priority. The Trust Board has fully embraced and collectively owns the "safety first, safety always" strategy. A resourcing plan has been agreed and advanced. Work is in train to continue driving forward improvements to our services and this year alone the Trust plans to spend an additional £10 million on ward safety as we continue in our endeavour to provide the safest possible care for the people who use our services. To underpin Board assurance through an enhanced level of overview and scrutiny, a Non-Executive Director will chair a safety strategy implementation review meeting on a monthly basis that will report directly to the Board of Directors. Terms of Reference will be agreed and enacted forthwith.

2.2 HSJ Patient Safety Award Shortlisting

I am delighted that our remote clinical assessment initiative, which is part of EPUT's vaccination programme has been shortlisted as a finalist for the highly prestigious HSJ Patient Safety Awards. This initiative allows people who have booked a Covid 19 vaccination to fill in medical questions remotely ahead of their appointment saving precious time to ensure maximum vaccination appointments are available. This initiative has been so successful that other NHS Trust vaccination programmes have adopted it. Well done to the vaccination programme team!

2.3 Tower Ward GSF Accreditation

I extend our sincerest congratulations to Tower Ward on achieving the Gold Standard Framework Accreditation for end of life care. They are the first mental health unit in the country to achieve this accreditation which is an incredible achievement. This outstanding attainment reflects years of exemplary concerted work and unfailing effort by all those involved.

2.4 Service Visits

With the easing of national restrictions, I am delighted to report that I and the Non-Executive Directors have recommenced our much missed visits to our services across the organisation. Our findings are being captured in a consistent, structured way that can provide contemporaneous feedback to service leads and teams. A programme of visits both virtual and face to face are scheduled.

During this month I have visited the CAMHS service at the St Aubyn Centre (with Alex Green) and the Linden and Crystal Centres (with Doreen Mhone). At my

invitation, we were delighted to be accompanied by Professor Stephen Heppell who is a renowned global expert on the creation of healthier spaces and learning innovations. We aim to extend this analysis and guided development as we strive to improve our physical therapeutic environments to achieve enhanced outcomes for our service recipients and better places to be and work for our staff.

2.5 NHS 73rd Birthday

This has been a year like no other and on the year of the NHS' 73rd Birthday, I would like to once again extend thanks to each and every one of our dedicated staff for their continued hard work and commitment. As you will know, the Queen awarded the NHS the George Cross for 73 years of service and the exemplary response to the Covid pandemic. This is an amazing honour and I am so incredibly proud of each and every one of the NHS staff in EPUT and indeed across the whole of the UK.

2.6 Staff Wellbeing

The wellbeing of our staff is vitally important, even more so during these unprecedented and uncertain times. During the pandemic our ways of working have changed dramatically with the application of digital technologies such as Microsoft Teams, with virtual meetings routinely taking place. Whilst the adoption of digitalisation has in many ways improved efficiency and more inclusive access, minimising travel and time out of service areas, there can be a risk of back-to-back meetings and failure to take appropriate comfort breaks. To support this new way of working we have adopted a new set of principles that have been designed after listening to the feedback of our staff and staff engagement champions. These principles ensure our staff are able to have screen breaks, rest, opportunities to move around from their workspace and have "think" time creating space for reflection and innovation.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

- **Procurement Teams Must Consider Wider Benefits Of Public Spending:** The new guidance sets out how public spending should help drive wider benefits from job creation. Please see the first link below for a copy of procurement policy note – national procurement policy statement published on 3 June 2021, the second link is a copy of the annex to PPN 05/21 national procurement policy statement. **For Information: Link; Link**

- **New PPN Published: Update To Legal And Policy Requirements To Publish Procurement Information On Contracts Finder:** Please see the first link below for a copy of PPN 07/21 published on 24 June 2021 that provides guidance and states that NHS Trusts are to be considered as sub central contracting authorities. The second link is a copy of guidance on the transparency requirements for publishing on Contracts Finder. **For Information Link; Link**

- **EU Settlement Scheme Deadline: 30 June 2021:** Please see the link below for a copy of an article published on 10 June 2021 outlining that an alert has been raised relating to service users from the EU, those that lack capacity or service users that do not have settled status. **For Information: Link**

- **Data Saves Lives: Reshaping Health And Social Care With Data (Draft):** Please see the link below for a copy of the article updated on 23 June 2021 that sets out the key priorities to include mental health. **For Information: Link**

4.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by
Angela Horley
PA to Chair, Chief Executive and NEDs

On behalf of
Professor Sheila Salmon
Chair

		Agenda Item No: 6
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 July 2021**

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**	**X**	**Level 3**	

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

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

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

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

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			x
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			x
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
HSE	Health & Safety Executive		

Supporting Documents and/or Further Reading
Accompanying Report

Lead
Paul Scott Chief Executive Officer

Agenda Item: 5
Board of Director Part 1
28 July 2021

CEO Report
July 2021

1.0 Introduction

We are now entering a new phase of the pandemic. Restrictions are likely to have been eased by the time the Board meets in July. Whilst this will be welcome for many we remain conscious that the pandemic is far from over and many people will remain anxious about the impact on them and their loved ones as cases continue to grow. We can take heart that the incredible vaccine programme, that EPUT has been part of, has changed the course of the pandemic for the better, whilst also recognising the risks of the high infection rates. As a health organisation we will take our responsibility to protect our staff and patients from infection as seriously as we did in the earlier phases of the pandemic. We will follow NHS infection control guidance fully and retain social distancing and mask wearing in our non-clinical areas.

The Board has continued meeting our staff and visiting our sites and we have seen, and heard, how tired our teams are from the last 18 months of the pandemic. Our physical and mental health teams have seen increasing caseloads, and have been adapting to new ways of working, whilst having less ability to check in with their colleagues. Ward based staff have seen very strict protocols enforced, restrictions on patient leave and family visiting, high levels of sickness, and increased acuity. Many of our physical health teams have had to work prolonged periods at different locations and had increased case loads. Office based staff have also seen a surge in workload whilst having to work remotely. We have heard that more is needed to have a positive impact on staff wellbeing and resilience and the Executive team will ensure that there is more IT support, a focus on supporting staff who work remotely, and continued efforts to address our staffing shortfall.

I remain in awe, and am very grateful, of the ongoing dedication of all of our staff. It is a credit to all EPUT staff that they remain so committed to serving our patients in such challenging times.

We were able to take a moment for reflection and celebration in July as the NHS celebrated its 73rd Birthday. A number of events marked this amazing milestones across the Trust. As we welcome a new Secretary of State, a new CEO of the NHS and the introduction of legislation to parliament to create Integrated Care Systems as statutory bodies this is a time of opportunity to build on the principles that has underpinned the NHS for 73 years, and prepare for the future with a focus on collaboration with partners and of reducing health inequalities. Mental health and physical community services will be fundamental to the future NHS and we will make sure the voice of our services, and their users, is heard.

2.0 Key Issues

HSE Prosecution

On 16th June 2021 EPUT was sentenced at Chelmsford Crown Court, following a prosecution by the Health and Safety Executive (HSE). Last November the Trust entered a guilty plea to one charge under Section 3(1) of the Health and Safety at Work Act 1974 following a HSE investigation into one of our predecessor Trusts, the North Essex Partnership University NHS Foundation Trust (NEP). This investigation focused on how former NEP managed environmental risks from fixed potential ligature points in its inpatient wards between October 2004 and March 2015. EPUT was fined £1.5m, which was reduced from a higher amount

because of our early guilty plea and our focus on continual improvement with respect to safety.

I was in court for the sentencing and hearing the families describe their experience, and the impact of the loss of loved ones on their lives, was deeply saddening but also incredibly powerful. I will not forget that day and it will drive me to continually improve safety in EPUT's services.

Independent Inquiry
As noted in my previous reports this year, historical events relating to services in North Essex were debated in parliament resulting in the commissioning of an Independent Inquiry. The Trust has been contacted by the Essex Mental Health Independent Inquiry Secretariat, and has received some initial requests for information from them. The Trust has published a statement from the Secretariat on its website. EPUT is fully co-operating with the Inquiry to ensure learning is built into our safety practice.

Safety
In January we approved a safety strategy for EPUT, "Safety First, Safety Always" setting out safety as our priority and our ambitions within this.

Since that approval, we have appointed a Director of Patient Safety, adopted ground breaking new technology to enhance safety, introduced a new investigation methodology to include families from the start and significantly increased the financial investment in our wards.

We have also undertaken a full diagnostic and engagement programme to fully understand what challenges our staff face on the wards. Following this work, we are clear that, despite significant improvements since EPUT was formed, there is more to do on the fundamentals of care on our wards.

Based on the feedback received we have focussed on short term priorities that we expect to have an impact on our wards in the next 6-9 months:

- Staffing – increased acuity on our wards has seen an increase need for staffing. This has been met through the increased use of temporary staff – we are committed to increasing the number of permanent staff on the wards. This will mean the burden on existing staff is reduced, allowing more time to care; team ethos and communication will be improved; and patients will have more staff they are familiar with enhancing the therapeutic environment.
- Ward environment including ligature risk – as I reference earlier in my report we have significantly increased investment in our ward environments from an average of £1m per anum to £10m last year and £10m planned for this year. With this level of investment appropriate project management and associated systems of control and oversight become even more important and we are committed to improving these.
- Culture of Learning – repeatedly, we have seen the importance of embedding learning from when things do not go as well as we expected, systemically, across all of our wards. We have identified that we can improve our systems, culture and processes in this respect.
- Observation and engagement – partly driven by the staffing issues noted above, and partly driven by too much paperwork, we know that our adherence to policies on observation are not as consistent as we would like. We will focus on ensuring the improved staffing position means that this is changed.
- NHSIE – we have received an offer of support from colleagues at NHSIE to assist in our action planning to address the S.31. A joint team from EPUT and NHSIE will be meeting for a formal kick off W/C 19th.

We have also identified that our structures and governance can be brought up to date. Over the summer we will be introducing structured conversations, based on data and a focus on improving safety, with strengthened, multi-disciplinary, leadership teams in all of our clinical areas. We will ensure that there is enough leadership capacity to enact the changes we want to see and that our governance is appropriately focussed on this. We will also ensure the Executive, and senior leadership team, are visible and engaging with our ward teams as these changes are made to ensure they are having the desired impact on helping our staff and adapting them as necessary based on feedback.

We have also learned that many of our inpatients could be safely supported in their communities and I am really pleased that we have agreed with our local commissioners that circa £20m will be invested into our community mental health teams over the next year. This will be primarily focussed in supporting GP's and those in crisis.

These priorities will be the key focus for the Executive Safety Oversight Group and there will be a Non-Executive Director assigned to support and challenge the Executive.

Partnerships
We are committed to working collaboratively with our health and care partners to ensure health and care resources are best utilised for the populations needs. I am, therefore, delighted that we have now agreed two formal partnerships with our health partners.

The first is a collaborative between the three physical community health providers in Mid and South Essex (EPUT, North East London Foundation Trust and Provide). We want to bring the best of all three services to all who use them in Mid and South Essex.

The second is a collaborative of Specialised Mental Health Services across the East of England. This is an exciting development where 6 NHS mental health providers have come together and will have delegated responsibility for the commissioning of "tier 4" mental health services in Children's and Adolescent Services, Eating Disorder Services and Secure Services. This means that clinicians will drive investment, transformation priorities and that services will be better connected to local health and care systems.

We also continue to develop our relationships with Local Government to ensure we are ensuring our combined services are working in the best way they can.

The Chair and I have also been engaging with leaders of the voluntary and charitable sector to explore how EPUT can contribute more in this area.

I am committed to ensuring that EPUT is a partner that helps the collective health, care and charitable sectors to increase the positive impact on people's health in the areas we serve.

Health and Care Sector Reform
The health and care sector is undoubtedly under significant pressure as a direct result of the pandemic and my report sets out how these are impacting on EPUT's services. There are many reasons to be optimistic about the future and my report references significant new investment in mental health services, partnerships bringing people together to improve services and a Board committed to learning from the past and improving today.

There are also significant changes planned in health and care structures and I am delighted that the new Secretary of State for Health and Social Care has progressed with these changes. Legislation was placed before parliament in July to create formal new organisations, Integrated Care Systems for April 2022. This brings together health organisations, local government, voluntary sector organisations and patient representatives under one banner with shared objectives. We have already experienced the power of these groups working together and look forward to building on that in the future.

Strategic Objectives
The Trust Strategic Objectives have been refined and are to be discussed during Part 2 of the Board of Directors meeting along with the Trust's Vision and Values ahead of wider sharing with Stakeholders. The aim is for formal approval at the Board of Directors meetings scheduled to take place in September 2021.

3.0 Performance and Operational Updates

Safety and Quality
The overall project portfolio has been through further prioritisation and PMO services continue to be rolled out to support safety projects through their lifecycle. Our highest priority focus is on the 5 safety priorities that deliver our 'Safety First, Safety Always' strategy. These are Ligature Risks, Safe Staffing, Engagement & Observations, EPUT Culture of Learning & NHSIE Support Plan.

Our immediate staffing issues are being addressed by a daily SitRep call with HR, ward staff and operations attendance. The call has escalation routes so that issues can be managed through to resolution as soon as they present. In addition, the outputs feed into a daily stand up meeting with the executive which provides further escalation if required.

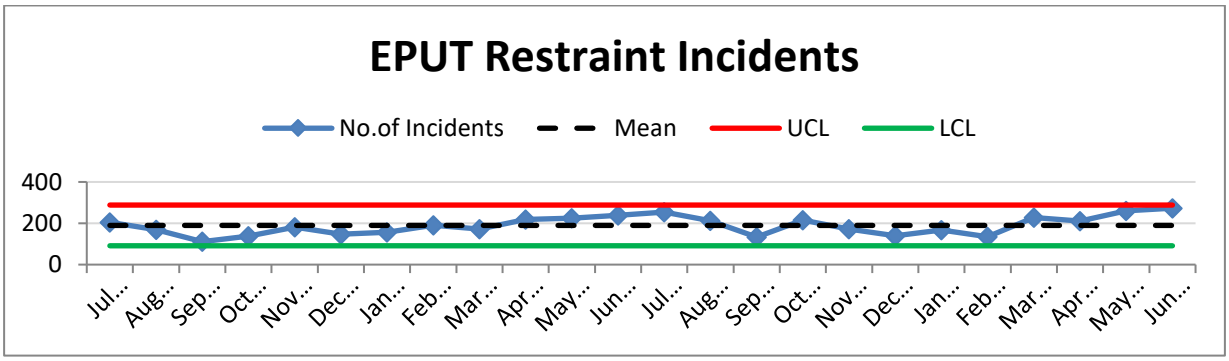
We have increased resource around the mitigation of fixed point ligature, this includes a dedicated project office support working alongside a Patient Safety Ligature Coordinator that will sit in our estates and facilities team. Their focus will be to ensure that all required remediation works, initially with CAMHS wards, are planned and delivered over the next 3 months.

Our Director of Patient Safety is leading on a Culture of Learning project and our ambition to become a learning organisation. The project has both short and long term delivery objectives to address immediate priorities and trust strategic goals. One of the first deliverables has been to collate all lessons learned activity into a centrally managed log, which can be shared with all staff and furthermore, embedded.

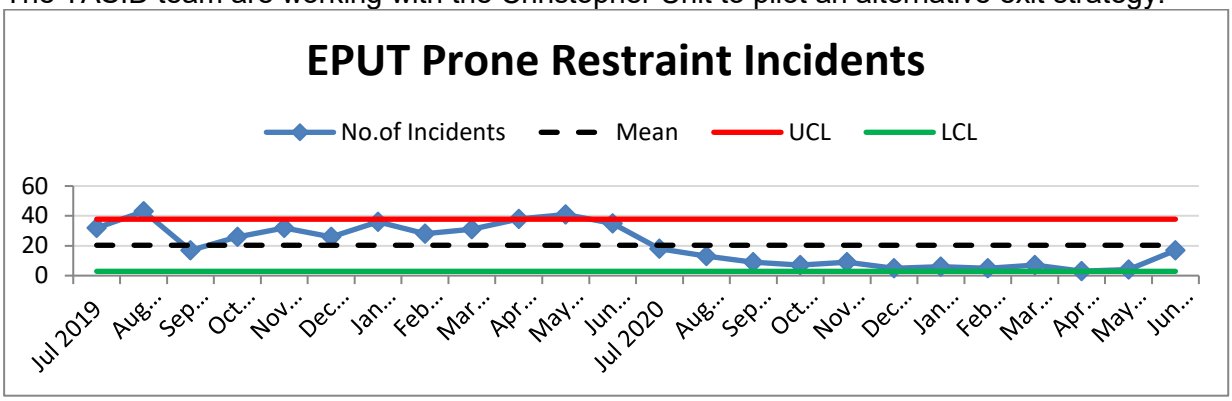
Our Oxehealth implementation rollout continues with 19 wards, four 136 suites and all seclusion rooms operational. The remaining 136 suite at Basildon is due to go live on the 26th July. Gloucester is scheduled for 10th August and Roding is scheduled for the 23rd August. Whilst Cherrydown and Kelvedon have been going through their refurbishment works we have worked alongside the contractor to install Oxehealth, therefore our scheduled date for these are early September.

Restraint
Incidents of restraint have remained within control limits for the last 24 months. An internal quality check did demonstrate a link between Covid-19 restrictions and restraint during the early months of the pandemic. A high proportion of restraint incidents over the last 24 months are attributable to 4 wards, Christopher unit, Poplar unit, Larkwood and Longview. In the months of March 21 to June 21 where the number of incidents rose against the mean there were 938 incidents of restraint Trust wide, 546 (58.2%) were attributable to the 4 identified wards.

CAMHS identifying rise in acuity, Christopher unit continues to be a concern but incidents are often attributable to 1 individual patient at particular points in time.

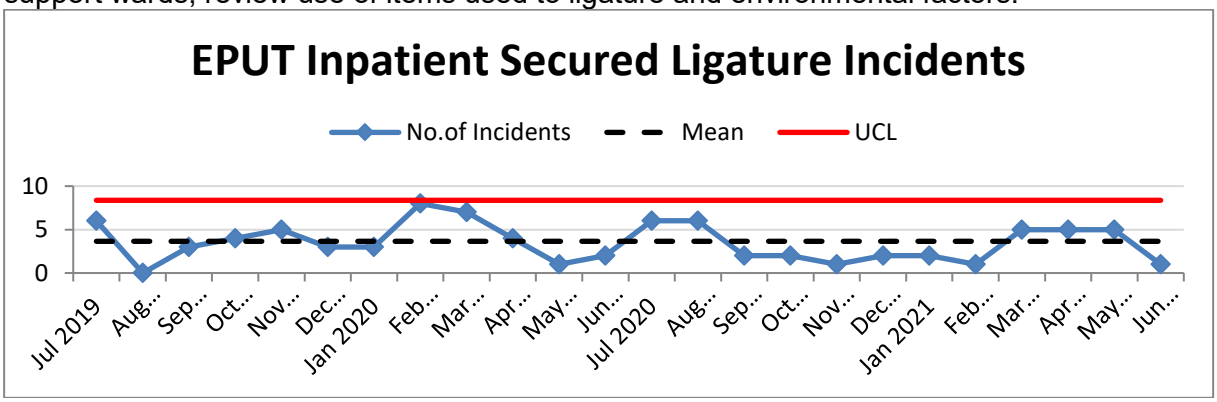


Incidents of prone restraint have maintained a significant decline since June 2020 where all incidents were categorised as critical incidents and subject to scrutiny. At the same time training regarding the administration of IM medication and the use of alternative injection site was put in place and continues. The increase in June 21 that remains below the mean relates to a trust total of 17 incidents, 11 of which are attributable to the Christopher Unit (64.7%). A high proportion of these incidents relate to enabling staff to exit seclusion safely. The TASID team are working with the Christopher Unit to pilot an alternative exit strategy.

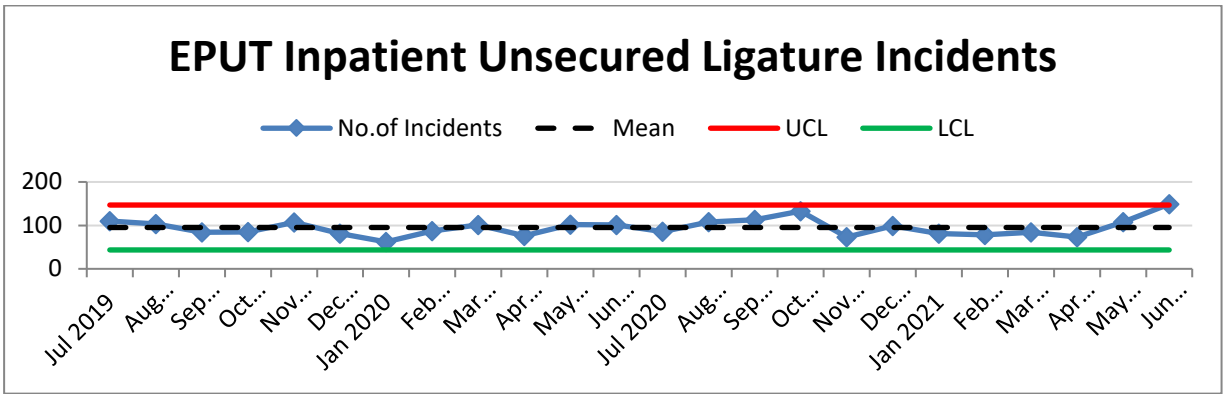


Inpatient Ligature

During 2020/21 100% of the incidents were no/low harm to the patient during 2020/21. The death from a fixed ligature in December 2020 was a patient on one of the older person's functional wards using a profiling bed to secure a ligature. Longview Ward is showing the highest number of incidents and continues to show an upward trajectory (39.5% in 21/22YTD, compared with the 20/21 outturn totalling 40.6%. Workstreams are in place to support wards, review use of items used to ligature and environmental factors.



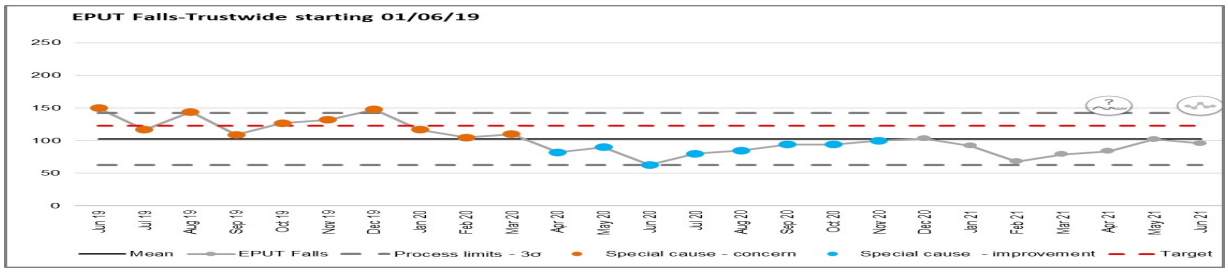
The Lower Control Limit for inpatient secured ligatures is below zero due to the low numbers of reported incidents and has therefore been removed from the above chart.



There were 11 incidents using a fixed ligature point reported during 2021/22YTD compared to 34 during 20/21. The highest levels on Longview, Peter Bruff and Ardleigh (81.9% of all unsecured incidents).

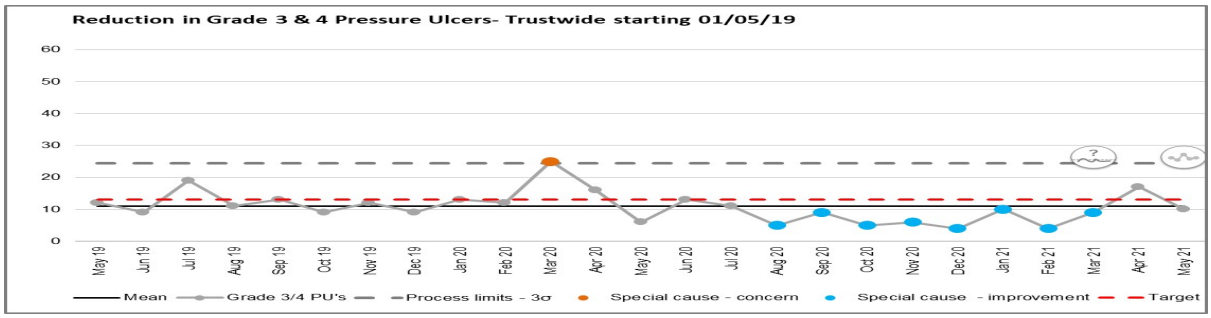
Falls

The overall number of falls and falls resulting in moderate and severe harm continues to decrease. A working group continues to meet and Falls Champions support all inpatient areas.



Pressure Ulcers

The number of pressure ulcers remains constant. Those with omissions in care continue to decrease. Meeting arrangements and support pathways continue to be in place.



Operational Performance

In June there were 24 performance and quality indicators within target, with 7 areas of inadequate performance which included the admission of a person under 18 years to an adult mental health ward via a Section 136 suite, due to the lack of CAMHS Tier 4 bed availability. Psychology waiting times have improved with robust action plans in place for each CCG area

There has been improvement in 4 areas of inadequate performance. CPA 12 month reviews improved from 90.5% to 92.5% with increased performance in all 3 ICS areas. Adult inpatient mental health and PICU sustained a fourth month of better performance. There has continued to be a positive trend in out of area placements (OoAPs), with 20 patients repatriated in June. 23 patients remained in OoAPs at month end and on trajectory to meet the ambition of 0 OoAPs by the end of quarter 2. Performance against the 0% target of clients not seen within in 12 months significantly improved.

Occupancy rates were 98.2 outside the national benchmark of 94%.

Five areas requiring improvement remain unchanged from last month. Cardio metabolic assessments, IAPT recovery rates, Essex STaRS, training compliance and temporary staffing have targeted actions in place to improve performance.

Finance
Month 03 Results

- Revenue position - M3 YTD £0.1m deficit against breakeven YTD plan.
- Capital – YTD spend is £1.4m in line with planned expectations. £14.4m annual programme. Progress on delivery of profiled plans will require continued in year monitoring.
- Cash – Sufficient cash resources in place to meet trading operations - £76m bank balance.

Other key issues

- Continued drive to accelerate recruitment to deliver MHIS (£20.9m funding available) schemes.
- Provider Collaborative arrangements and amendments to funding flows from July 21. EPUT becoming lead Provider for £73m services.
- H2 allocations and funding settlements remain uncertain. Block contracts to continue in H2. National expectation that efficiency requirements will be more demanding in H2 (3-3.5%)
- ICS is undertaking a Financial Sustainability review with participation from EPUT.

Covid 19 Vaccination Programme

Since my last report to the Board of Directors, the roll out of the COVID-19 vaccination has continued at pace with over 68 million vaccinations now delivered nationwide. EPUT has continued to play a major role in the roll out across Essex and Suffolk, with the large-scale vaccination centres provided by EPUT now have delivered in excess of 668,000 vaccinations since commencement of the programme in January. My thanks are extended to all the staff, volunteers and partner organisations who have been involved in this tremendous achievement. We continue to work hard to urge all those eligible for a vaccine to continue to come forward to take up the offer.

As reported in previous reports, Phase 1 of the programme (offering a 1st dose by 15th April to all those in priority groups 1 – 9 by 15th April) was successfully completed. Phase 2 of the programme (offering a 1st dose by 19th July to all those in priority groups 10 – 12 and continuing to vaccines to those in cohorts 1-9 yet to take up the offer) is well underway. It is anticipated that all second doses for those in Phase 2 will be completed by the end of September.

Planning for Phase 3 of the programme has commenced which will seek to implement interim advice from the Joint Committee for Vaccination and Immunisation (JCVI) on the potential COVID-19 booster programme. This advice (which may still be subject to change before being finalised) advises that any potential booster programme should begin in September 2021, in order to maximise protection in those who are most vulnerable to serious COVID-19 ahead of the winter months. Influenza vaccines are also delivered in autumn, and JCVI considers that, where possible, a synergistic approach to the delivery of COVID-19 and influenza vaccination could support delivery and maximise uptake of both vaccines. It is also suggested that the COVID-19 booster vaccines should be offered in two stages from September, starting with those most at risk from serious disease in stage 1, and to a second group of individuals in stage 2.

Further advice is expected from JCVI over the summer in relation to the above which will enable arrangements for the roll out of Phase 3 to be finalised. The offer of a 1st and 2nd dose vaccine will also remain in place throughout Phase 3 for all those who have not yet taken up a vaccination.

It is anticipated that delivery of Phase 3 will again be via a range of delivery models including Primary Care Networks (groups of GP practices), Community Pharmacies and large-scale vaccination centres such as those delivered by EPUT. We are therefore working with our partners organisations across Essex and Suffolk to plan how this anticipated programme for Phase 3 will best be delivered to the local population.

People
Recruitment and Retention Highlights

- **Vacancy rate** 6.4% against target of 12%
- **Turnover rate** 9.5% against target of 12%
- **Starters and Leavers** There were 85 staff members who joined the organisation in May 2021 and 72 new starters in June 2021. This figure has decreased from April 2021 when there were 102 starters. 45 staff left the Trust in April 2021 and 34 staff left in June 2021. The Trust has seen a reduction in leavers since the last report provided.
- **Time to Hire –** The Trust has amended the recording of time to hire. Time to hire is now reported from date advert closes to start date. The Trusts current time to hire is averaging 54.5 days
- **Recruitment Programmes**
    - **Student nurse Recruitment –** 80 Student nurses have been offered employment upon completion of training
    - **International Nurse Recruitment -** The first 9 Registered Nurses have been appointed, with 3 interviews yet to be completed for the first cohort. They are expected to land by October 2021.

Sickness Management

- Trust sickness absence rate is 4.8% (target 5%). The Trust has seen a slight increase in general sickness in the last month. The top reason for sickness absence is anxiety, stress and depression (105 staff off sick as at 12th July 2021 – 62% of which is long term absence).
- Over the last two months there have been further significant decreases in covid related sickness absence, however in July we are starting to see increasing covid related absences. In April 71 staff reported covid related absence and further decreases in May where 42 staff reported covid absence. In June we have seen a slight increase of 66 staff reported covid absence. As at 13th July the Trust has 62 staff reporting covid absence and 46 staff who are isolating but working.

Employee Relations Highlights

- 8 Formal disciplinary cases (1 is in relation to temporary worker)
- 3 Suspensions
- 17 grievances
- 6 Appeals
- 3 Temporary worker appeals (reconsideration)
- 6 Whistleblowing (Supported by HR)
- 3 Employment Tribunals (1 has just had settlement approval by treasury)

Employee Relations activities has remained at similar levels to that previous reported however we have seen an increase in whistleblowing cases supported by HR (increased from 1 to 6)

The HR team have been undertaking a review of Disciplinary policies and procedures based around the seven themes of the National Guidance on NHS Disciplinary processes. The review has also looked at further establishment of just and learning culture when managing staffing concerns. The Trust has worked in partnership with staff side to undertake this review. The Policy and Procedure review has been completed and the policies are currently being ratified by the relevant committees, once ratified the policy will be shared on Trusts public facing internet page and presented at public board meeting. A paper has also been provided to Executive Committee in June on progress of the review.

Temporary Staffing

- Current EPUT Temporary Staffing Establishments

Staff Group	Bank Only	Bank and Substantive
Add Prof Scientific and Technic	47	128
Additional Clinical Services	2087	977
Administrative and Clerical	730	623
Allied Health Professionals	102	139
Estates and Ancillary	134	289
Medical and Dental	55	8
Nursing and Midwifery Registered	836	1314
Grand Total	3991	3478

- Bank and agency usage

	Apr-21	May-21	Jun-21
Timeframe	w/c 29 March 2021 to w/c 19 April	w/c 26 April 2021 to w/c 24 May 2021	w/c 31 May and w/c 28 June 2021
Agency Duties	3915	5752	6584
Bank Duties	22207	30021	31834
Total	**26122**	**30021**	**38418**

- Highest Bank and Agency usage (Hours) – Top 10 teams

Unit (bank Usage)	Hours	Duties	Unit (Agency Usage)	Hours	Duties
364 EA520 Mh Assessment Unit	9854	879	300 Larkwood Ward	5129.85	460
364 EA504 Hadleigh Unit (Picu)	8470.92	753	300 Longview Ward	4738	423
300 Larkwood Ward	8152.17	746	364 EC490 Camhs I/P Poplar Ward	4005.93	348
300 Longview Ward	6934.08	637	300 Christopher Unit	2722.83	241
364 EA505 SE Willow Ward Adult Inp	6199.65	571	364 E5SWD Avocet Ward (Swch)	1790.75	164
364 EC490 Camhs I/P Poplar Ward	5869.75	538	364 EA301 Rawreth Court	1620.35	144
300 Christopher Unit	4909.5	429	364 EA520 Mh Assessment Unit	1559	138
300 Chelmer Ward	4378	382	300 Ardleigh Ward	1502	132
364 EA302 Clifton Lodge	4132.75	370	364 EA505 SE Willow Ward Adult Inp	1499.58	135

364 EA310 Gloucester Ward	4125.17	365	300 Topaz Ward	1407.5	123

Mandatory Training

- The overall compliance for June is 93%, an increase of 1% from last month.
- Fire In-Patient has reached 91% with an increase of 2% from last month and is now above the compliance requirements. Information Governance continues to improve and stands at 93%, 1% up from May, however, it still remains below compliance of the increased target of 95%. (Fire and IG figures are not subject to a Covid-19 adjusted update frequency, all others quoted are)
- Personal safety 1 still remains a concern at 75%; this was in spite of the fact that we have increased the number of courses to meet the capacity, but very few staff are taking up the extra spaces allocated. Safeguarding Children Level 3 is up 3% from 89% to 91% and is now compliant after 5 months being below requirements.
- TASID is also still an area of concern at 85%, up 1% from last month. This is slowly increasing but still a long way off target 90%.
- All non-statutory training had update periods increased by 1 year at the start of the pandemic. These periods will now be decreased back to the normal update length over the next few months to return to usual by the end of December. Communications have gone out to staff.

Apprentices

Currently we have the following apprentices on nursing/therapy related pathways:

- Associate Practitioner – 14 (with a further 22 due to start in the autumn)
- Level 3 support worker – 52 (these will be able to progress to a nursing or a therapy pathway following completion as we now have therapy modules included and Occupational Therapists as assessors)
- We have 5 staff due to start the nurse degree ‘top-up’ and 7 completing this autumn.
- We will also be recruiting 16 on to the nurse associate apprenticeship this autumn.

Staff Engagement & Well Being

Our Engagement & Well Being offer continues to be best in class, the support required by staff continues at an all-time high with an increasing need for team and individual support.

- Promotion of Staff Survey is ongoing, working closely with communications team to ensure promotion is focused in the lead up to 2021 NHS Staff Survey. Plans for future focus groups to discuss confidentiality and staff survey process in place, hoping to take place in August/September.
- Implementation of the new quarterly Pulse Survey is on track for release late July 21.
- Successful event organisied by Staff Engagement Team with attendance by NHS Employers and Survey Leads from other national NHS Trusts to discuss improving response rates.
- Staff Engagement Champions Network Meetings and Grills monthly with last event in July. Newsletter now developed to be shared with Champions. More promotion to encourage new champions. Sponsorship to be implemented with each champion having a senior sponsor to support the delivery of engagement at place of work.
- Continued Staff Engagement/Wellbeing attendance at local team meetings to strengthen staff support message.
- HSJ award for Staff Engagement Award & Menopause Support Group nominations submitted, submissions currently in HSJ judging process and decision expected by end of July.
- Staff Recognition Awards – second round of winners just announced. Received over 290 nominations since new awards scheme launched.

Equality & Inclusion

- Full suite of events and Engagement for LGBTQ+ Pride Month (June), including Video Interview with Staff Network members, “LGBTea Break” session with LGBTQ+

Network Chair, Director for Engagement, Executive Director for People and Culture and Equality Advisor, with special guest appearance from Trans Advocate / Celebrity Jordan Gray. “Show Your Colours” competition throughout month.

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28th July 2021**

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

Risk Assessment of Report	
Summary of Risks highlighted in this report	All inadequate and requiring improvement indicators.
State which BAF risk(s) this report relates to	BAF41 CIP's BAF42 Financial Plan BAF45 CQC BAF58 Record Keepings BAF62 Staffing
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	Continued monitoring of Trust performance through integrated quality and performance reports.

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

Performance Reporting

This report presents the Board of Directors with a summary of performance for month 3 (June 2021).

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

Seven inadequate indicators (variance against target/ambition) have been identified at the end of June 2021 and are summarised in the Summary of Inadequate Quality and Performance Indicators Scorecard.

- Admissions of under 16's
- Timeliness of Data Entry
- CPA 12 Month Reviews

- Inpatient MH Capacity (Adults & PICU)
- Out of Area Placements
- Clients not seen in 12 months
- Psychology waiting times

There are two inadequate indicators which is an Oversight Framework indicator for June 2021.

- Admissions of under 16's
- Out of Area Placements

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

The CQC have completed an unannounced inspection of the CAMHS services in May/June 2021. The Trust has now received the feedback report following the inspection, and this is currently undergoing factual accuracy checks prior to publication on the CQC website.

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

- Capital Expenditure (CDEL)
- Efficiency Programmes

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

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

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

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

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

Acronyms/Terms Used in the Report			
ALOS	Average Length Of Stay	FRT	First Response Team
AWoL	Absent without Leave	FTE	Full Time Equivalent

CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies
CHS	Community Health Services	MHSDS	Mental Health Services Data Set
CPA	Care Programme Approach	NHSI	NHS improvement
CQC	Care Quality Commission	OBD	Occupied Bed days
CRHT	Crisis Resolution Home Treatment Team	OT	Outturn

Supporting Documents and/or Further Reading
Quality & Performance Scorecards

Lead
Paul Scott **Chief Executive**

NHS
Essex Partnership University
NHS Foundation Trust

Trust Board of Directors
EPUT Integrated Quality and Performance Score Cards
June 2021

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

Report Guide

Use of Hyperlinks

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

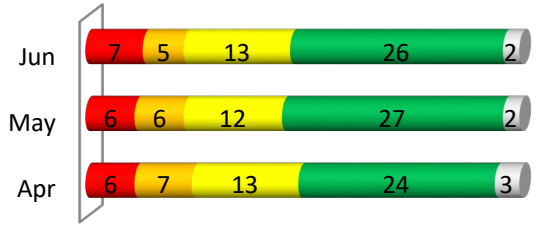
How is data presented?

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

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

SECTION 1 - Performance Summary

Summary of Quality and Performance Indicators

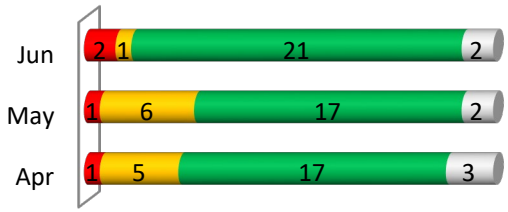


June Inadequate Performance

- Admissions of under 16's
- Timeliness of Data Entry
- CPA 12 Month Reviews
- Inpatient MH Capacity (Adults & PICU)
- Out of Area Placements
- Clients not seen in 12 months
- Psychology waiting times

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

Summary of Oversight Framework Indicators



June Inadequate Performance

- Out of Area Placements
- Admissions of under 16's to an adult ward

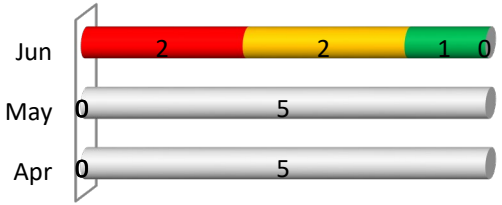
Summary of Safer Staffing Indicators

No risks identified within the Safer Staffing section.

Summary of CQC Indicators

The CQC have completed an unannounced inspection of the CAMHS services in May/June 2021. The Trust has now received the feedback report following the inspection, and this is currently undergoing factual accuracy checks prior to publication on the CQC website.

Finance Summary



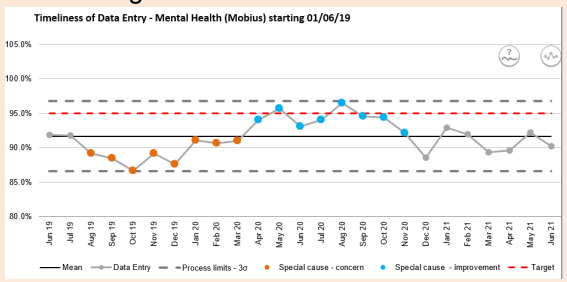
June Inadequate Performance

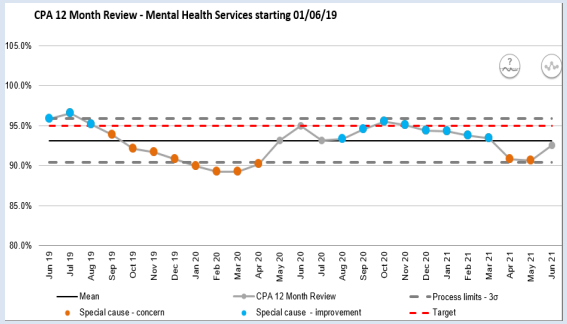
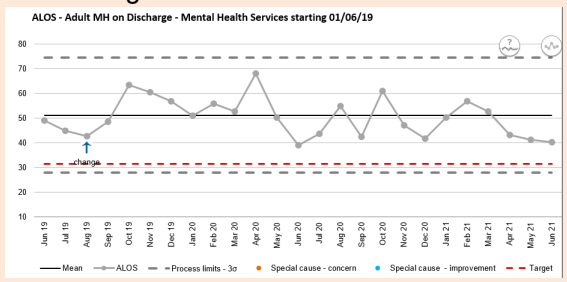
- Capital Expenditure (CDEL)
- Efficiency Programmes

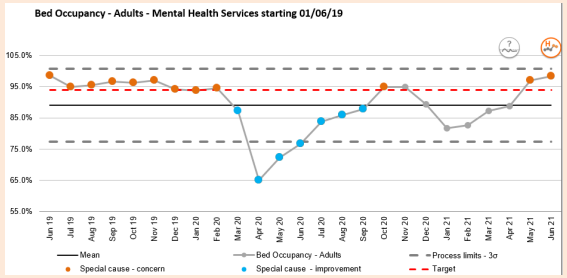
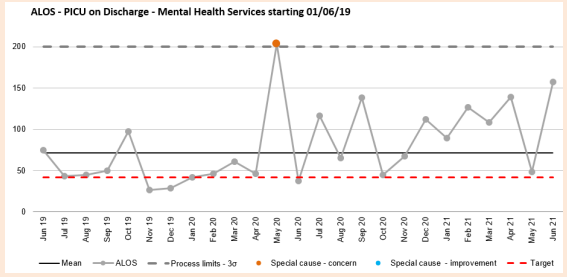
Items were not RAG rated in April and May whilst budgets were still being approved.

SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

Safe Indicators							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
1.15 Admissions to Adult Facilities of under 16's Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	0 admissions to adult facilities of patients under 16	1	●	One admissions in June. One year to date.	N/A	One patient under the age of 16 was admitted to an Adult ward in June (Galleywood), patient admitted via a S135 no available CAMHS Beds. CAMHS bed found on Longview & patient transferred next day.	N/A

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.1 Timeliness of Data Entry Committee: FPC Indicator: Local Data Quality RAG: Green	**Inadequate** It should be noted, that this indicator is a measure of Community MH and CHS contacts and not Inpatient activity. It should also be noted that each of the KPIs for each locality or service are different based on the contractual indicator. Paris is based on appointments, SystmOne is based on activity being recorded within 1 day of being entered on to the system and Mobius is a continuation sheet being completed for x amount of patients per day worked. Both Paris and SystmOne are meeting the 95% against their individual targets. Since the last report the Commissioners have fed back that they are looking at the KPIs that are against the existing contract and will be meeting with the Operational Service Leads to discuss a more appropriate approach to KPI targets. Contacts are a current KPI and the KPI identified as inadequate is what supports the numbers of contacts undertaken by each of the service areas. The measurement is not consistent across the ICS's or the services. We will continue to monitor this KPI but would ask that F&P to understand that this measurement does not reflect activity across the Trust due to the way the data is captured.						
	2.1.2 Timeliness of data entry - Continuation Sheets Completed (Mobius) **Target 95%**	89.7%	●	Above Target = Good 	N/A	June performance : Mobius MH & Specialist Total : 89.7% MH Total : 90.3% Specialist Total : 84.3% Nine (out of ten) MH Services and two (out of two) Specialist Services below target. Six services below 90%	N/A
2.3 CPA Reviews Committee: Quality Indicator: National Data Quality RAG: Amber	**Inadequate** In June, overall performance rose from 90.5% to 92.5% with all STP's witnessing an increase. The Productivity Team investigate all breaches. There are issues with reviews becoming overdue and then completed in the 13th month. The Productivity Team continue sending clinicians a report of Reviews that are becoming overdue in advance to enable the review to be booked and completed before they become overdue. As well as this, teams monitor their CPA review target on a weekly basis. We are currently achieving 92.5% against a target of 95% the biggest impact on this target is the change in the Thurrock locality with Thurrock Local Authority serving notice on the Section 75 agreement and the work needed to split the health and social care caseloads. This is putting pressure on the staff which has had an impact on compliance. Work is underway to support this team getting back on track with CPA reviews. In both North and West there are still issues with Medical input of which the medical directorate are aware of. This is still having an impact on the data provided against this target for this month.						

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	People on CPA will have a formal CPA review within 12 months **Target 95%**	92.5%	●	Above Target = Good 	●	There were ten Teams in the South, one Team in Specialist Services, three Teams in Mid, five Teams in NE and three Teams in West below target.	
2.9 Inpatient Capacity Adult & PICU MH ●	**Inadequate** Adult & PICU Inpatient Capacity MH has been highlighted as inadequate due to parts of the indicator being at variance with EPUT ambition. 2.9.2 ALOS Adults: has reduced again in June to 40.3 days however remains outside National Benchmark of <31.6. This is due to 140 discharges, 21 of which were long stays (60+ days). 2.9.4 Occupancy Adults: has increased in June to 98.2% and remains outside National Benchmark of <94% 2.9.5 ALOS PICU: remains outside target in June at 157.5 days against benchmark of <42 days, this is due to four discharges, two of whom were long stay (60+ days).						
Committee: Quality Indicator: Local Data Quality RAG: TBC	2.9.2 Adult Mental Health ALOS on discharge less than NHS benchmark **Target: 31.6**	40.3 days	●	Below Target = Good 	●	Consistently failing target 140 discharges in June (21 of whom were long stays (60+ days))	TBC

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.9.4 % Adult Mental Health Bed Occupancy below national benchmark **Target: 94%**	98.2%	●	Below Target = Good 	●	Changes to Bed Numbers effective 1st April 2021	N/A
	2.9.5 PICU Mental Health ALOS on discharge less than NHS benchmark **Target: 42**	157.5 days	●	Below Target = Good 	●	Four discharged in June (two of whom were long stays (60+ days))	

<table>
<tr><th colspan="8">Responsive Indicators</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M3
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td rowspan="2">4.5 Out of Area Placements

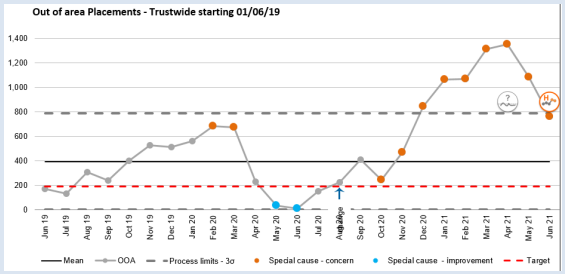
Committee: FPC
Indicator: Oversight Framework
Data Quality RAG: Amber</td><td colspan="7">Inadequate
A further positive reduction has occurred in out of area bed days (762) in June. Recent levels have been in part due to the requirement for social distancing on wards limiting occupancy levels. OOA placements are a key focus in the Phase 3 planning, with increased occupancy of Trust beds agreed to reduce the OOA impact and reinstatement of Topaz in March 21 to further offset any COVID surge demand.

It should be noted that as of December 2020 the Trust purchased 18 beds from the Priory, Danbury ward. These beds are currently counted in our figures however the Trust has received confirmation from NHSE who have provisionally agreed these can be reported as appropriate OOA placements. From next month this will be reflected in our figures.

13 new clients were placed OOA in June, and following the repatriation of 20, there were 23 remaining OOA at the end of the month.

The Trust currently has a target to reduce OOA placements to 0 by the end of September 2021. There are comprehensive actions plans in place to accomplish this.

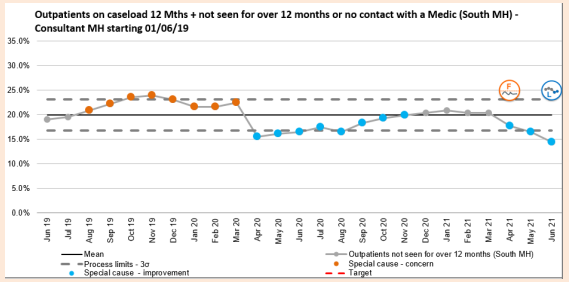
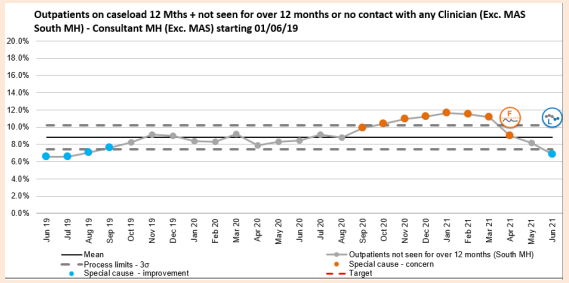
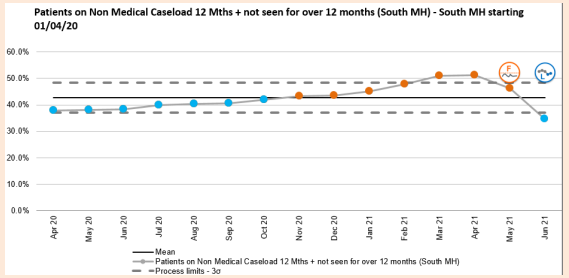
These assumptions are based on recovery from COVID 19 infection. Current numbers are raising concerns that there will be more OOA if wards are closed to admission due to COVID 19</td></tr>
<tr><td>Reduction in Out of Area Placements

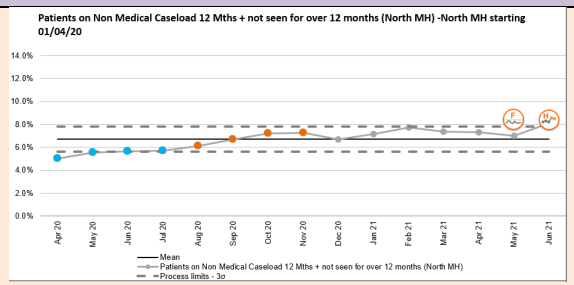
Target: Reduction to achieve 0 OOA</td><td>762 Days</td><td>●</td><td>Below Target = Good
 
</td><td>●</td><td>Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative.
Data currently includes patients placed on Danbury Ward.</td><td>TBC</td></tr>
<tr><td>4.9 Clients not seen in 12 months

Committee: Quality
Indicator: Local
Data Quality RAG: Blue</td><td colspan="7">Inadequate
Further meetings have been held with the clinical task and finish group. The long waiters T&F group has had the conversation now of bringing this group to a close, as the outstanding actions are reducing week on week.

During The meeting held 15th July attended by the consultant representation, IMT & Outpatient Administrative staff concluded the below key outcomes/positions

• Technical issues and bugs (slow forms, auto scheduling gaps) have been remediated.
• Significant progress made on the accuracy of the waiting list dashboard
• The remaining data accuracy issue attributed to patients that have moved between consultants
  ○ Appointments office have adopted a change in process to stop the waiting list inaccuracy when a patient moves between consultants
  ○ New logic will be written into the waiting list dashboard to identify and discount patients that have moved between consultants</td></tr>
</table>

Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	The group will continue to meet until the data in the waiting list dashboard is accepted as a 100% trusted source. A number of "nice to have" actions have been collated and although they are considered out of scope of the remit of this group, they have been collated as learning to contribute to the wider Digital strategy and EPR review.						
	4.9.1 Patients with no consultant review within 12 months **Target 0%**	14.4%	●	On Target = Good 	N/A	The construct of this indicator has been reviewed and now counts the number of clients who have been on a medic caseload for 12 months + and have not been seen or had contact with a medic for 12 months + as at the end of the reporting period. (inc. telephone contacts / inpatients and contacts with any consultant)	
	4.9.2 Patients on Consultant Caseload South Essex not seen / no contact by any clinician for over 12 months **Target 0%**	6.8%	●	On Target = Good 	N/A	As above but excludes MAS Medic Caseload and includes any contact with another HCP.	
	4.9.3 Patients on non-medical South Essex caseload not seen / no contact by any clinician for over 12 months **Target 0%**	34.8%	●	On Target = Good 	N/A	The construct for Patients on a non-medical South Essex caseload has been updated to include telephone contacts from June21. From next month this will be further updated to include contacts on any other caseload, to align constructs with the consultant indicators. Current areas noted as requiring validation are Care Home Liaison teams, Safeguarding, Psychology and transformation services.	
	4.9.4 Patients on any North East, West or Mid caseload not seen / no contact by any	8.1%	●	On Target = Good	N/A		

Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	clinician for over 12 months **Target 0%**					Work continues to validate and improve these indicators with breach and monitoring reports being supplied to the Operational Productivity team. These indicators will also continue to be monitored as part of the Data Quality & Performance meeting group.	

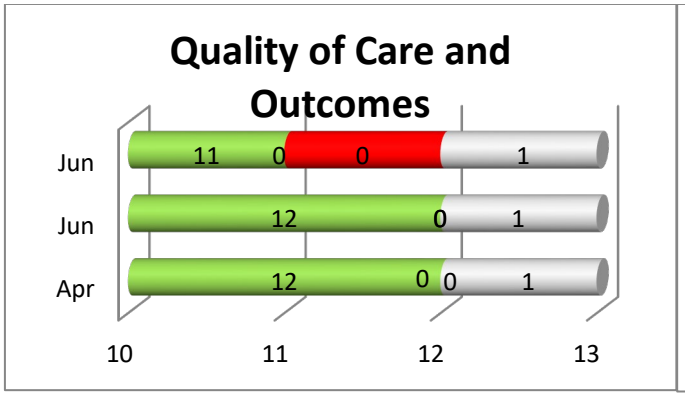
Additional Indicators	
RAG	**Narrative**
Psychology waiting times	EPUT is starting to step some patients down to step 4 in Thurrock and this will have a positive impact on wait times. Basildon and Brentwood will be stepping down cases in August. Recruitment is also taking place to fill newly commissioned ACP posts. A new intake of DBT will be taking place in July for Castle Point and Rochford, enabling 5 more patients to start DBT. In Southend a new DBT group is starting in September, which will pick up all 15 patients currently waiting. A STEPPS group will be starting in July, picking up 12 patients from the wait list across South East Essex. The service has also recruited 6 CAPS (4 in the South East and 2 in the South West) and 1 permanent band 7. We are continuing to recruit to other vacancies as part of the transformation plans, which will all reduce ACP wait times going forward. There are waiting list clearance action plans in place across all areas. Wait times are as follows (as at 10th June 2021): • Basildon: Individual psychology currently has the highest number of clients awaiting intervention with 44 waiting. Across all interventions, the longest waiter is 27 months and this is again for individual psychology. • Brentwood: STEPPS/DBT AX currently has the highest number of clients awaiting intervention with 25 waiting. Across all interventions, the longest waiter is 21 months and this is again for individual psychology. • Thurrock: Individual psychology currently has the highest number of clients awaiting intervention with 23 waiting. Across all interventions, the longest waiter is 24 months and this is for individual psychology and individual DBT. • Southend: Individual psychology currently has the highest number of clients awaiting intervention with 72 waiting. Across all interventions, the longest waiter is 18 months and this is for DTB/STEPPS complex needs screening. • Castle Point: Individual psychology currently has the highest number of clients awaiting intervention with 15 waiting. Across all interventions, the longest waiter is 22 months and this is for complex needs screening to STEPPS group.

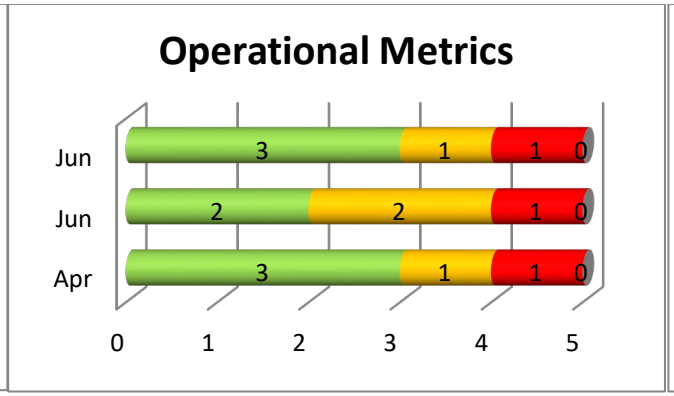
Additional Indicators	
RAG	**Narrative**
	• Rochford/Rayleigh: Individual psychology currently has the highest number of clients awaiting intervention with 20 waiting. Across all interventions, the longest waiter is 19 months and this is for complex needs screening to STEPPS group.

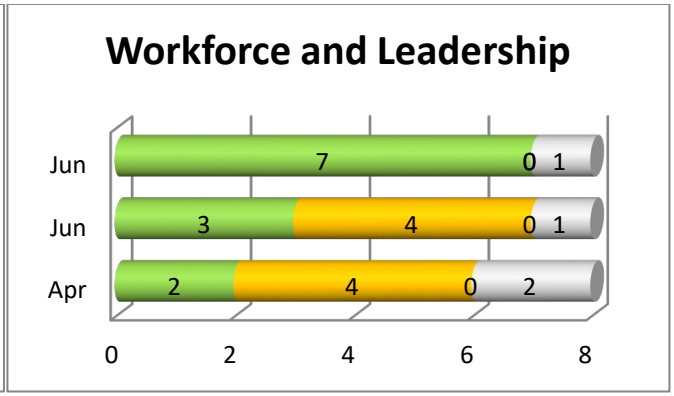
SECTION 3 – Oversight Framework

Click here to return to Summary

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





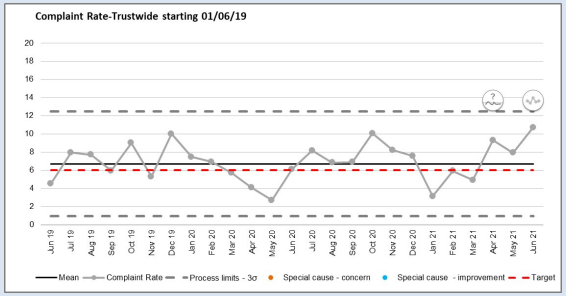


Inadequate

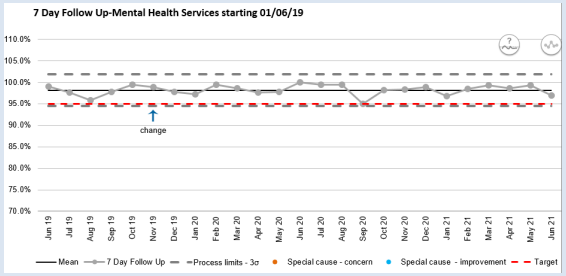
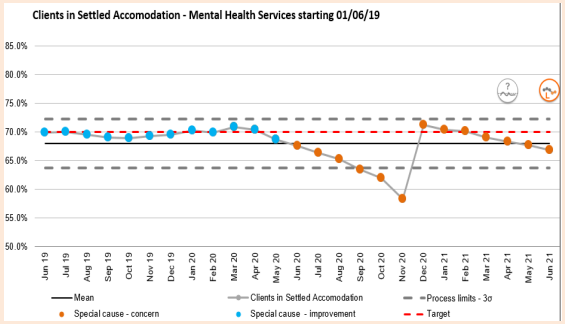
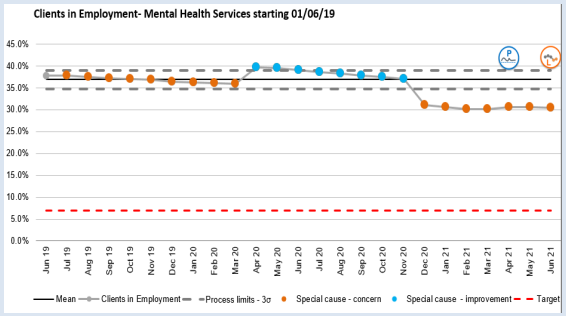
- Under 16s Admissions
- Out of area placements

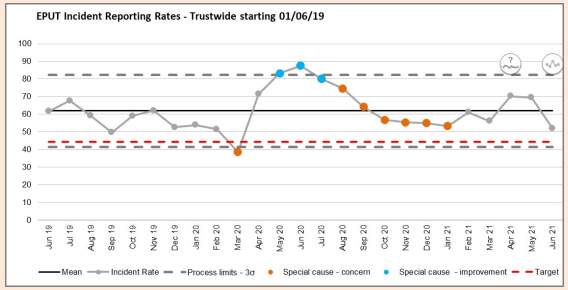
Requires Improvement

- IAPT Recovery Rates

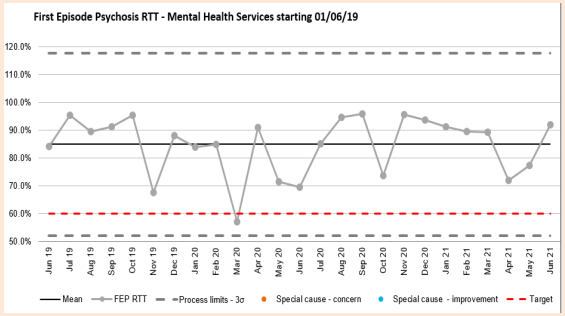
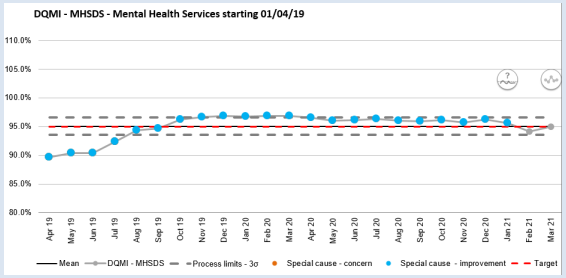
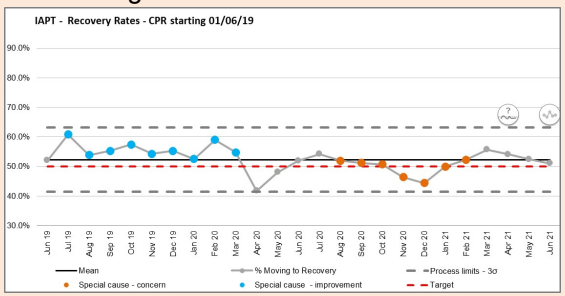
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1 CQC Rating Committee: FPC Data Quality RAG: **Green**	CQC rating of Good or above (no target set)	Good	●	The Trust is fully registered with the CQC.			
4.1 Complaints Committee: FPC Data Quality RAG: **Green**	4.1.1 Complaint Rate **OF Target TBC** Locally defined target rate of 6 each month	10.7	●	Below Target = Good 	●	Performance remains inconsistent and variation indicates inconsistently hitting and failing target.	N/A
5.6 Staff FFT Committee: FPC Data Quality RAG: **Green**	Staff Friends and Family Test % recommended – care (extremely likely or likely to recommend) **Target 74%**		●		●	Indicator continues to be suspended nationally due to Covid, however the expectation is this will be resumed in July 2021.	N/A
1.1 Never Event Committee: Quality	0 Never Events 2019/20 Outturn 0	0	●	Year to Date 0	●		N/A

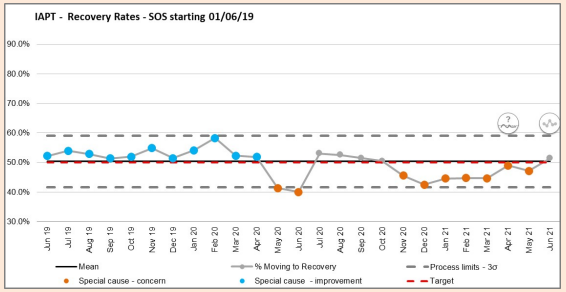
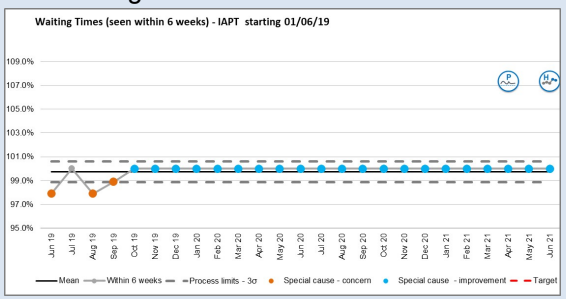
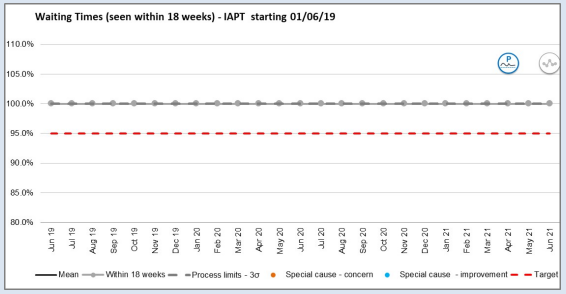
Indicator: Oversight Framework Data Quality RAG: **Blue**							
1.6 Safety Alerts Committee: Quality Indicator: OF Data Quality RAG: **Green**	There will be 0 Safety Alert breaches **2019/20 Outturn 0**	0	●	Year to date there have been no CAS safety alerts incomplete by deadline.	●		N/A
3.1 Patient MH Survey Committee: Quality Data Quality RAG: **Green**	Positive Results from CQC MH Patient Survey	EPUT achieved "about the same" in all 11 domains in the 2020 survey when compared with other Trusts.			●	Responses were received from 105 people at Essex Partnership University NHS Foundation Trust.	N/A
3.3.1 Patient FFT MH Committee: Quality Data Quality RAG: **Green**	Patient FFT MH response in line with benchmark **Target = 88.3%**	90%	●	Consistently achieving target.	●	20 total responses for MH 18 Very Good/Good	N/A
3.3.2 Patient FFT CHS	Patient FFT CHS response in line with benchmark **Target = 96%**	100%	●		●	8 total responses for CHS 8 Very Good/Good	N/A

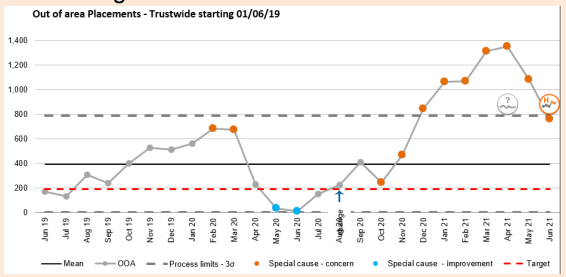
Committee: Quality Data Quality RAG: **Green**							
2.8.1 7 Day Follow Up Committee: Quality Data Quality RAG: **Blue**	95% of people on Care programme approach (CPA) are followed up within 7 days of discharge from hospital **Target 95%**	96.9%		Below Target = Good 		Discharge follow ups form part of EPUT's "10 ways to improve safety" initiative.	N/A
2.4 Settled Accomodation Committee: Quality Data Quality RAG: **Green**	We will support patients to live in settled accommodation **Target 70% (locally set)**	66.8%		Trend above Target = Good 		Paris 62.3% in June Mobius 79.6% in June	N/A
2.5 Employment Committee: Quality Data Quality RAG: **Green**	We will support patients into employment **Target 7% (locally set)**	30.5%		Trend above Target = Good 		Assurance indicates consistently Passing target.	N/A

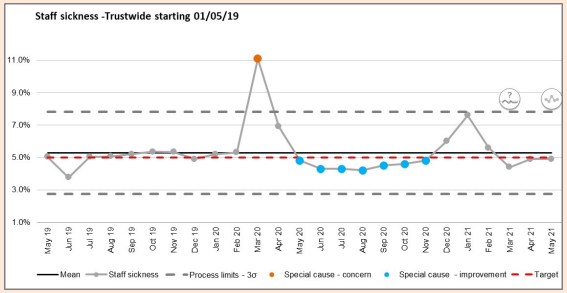
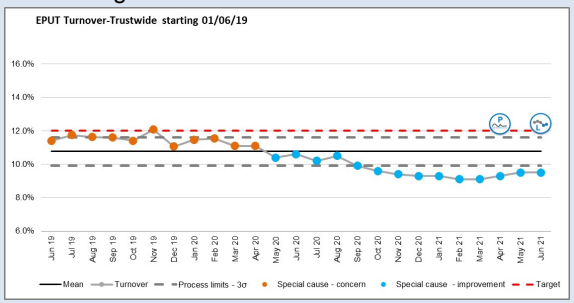
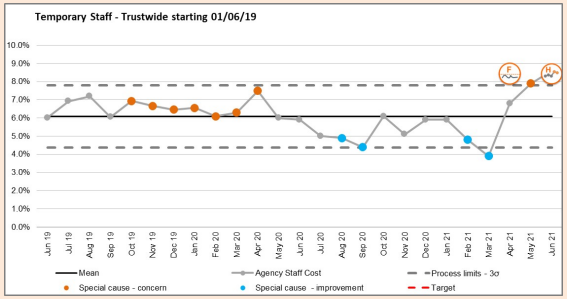
1.8 Patient Safety Incidents Reporting Committee: Quality Data Quality RAG: **Amber**	Potential under-reporting of patient safety incidents **Target >44.33**	52	●	Trend above Target = Good 	●	Potential concern with serveral months of reduced rates. However there was a significant increase in April and May. Additionally, rates are consistently above target. **Fewer incidents have been signed off by managers in time to be included in this report. This is due to the earlier production of performance reporting since November. The March and April data has now been refreshed.**	N/A
1.15 Under 16 Admissions Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	0 admissions to adult facilities of patients under 16	1	●	One admissions in June		One patient under the age of 16 was admitted to an Adult ward in June (Galleywood), patient admitted via a S135 no available CAMHS Beds. CAMHS bed found on Longview & patient transferred next day.	N/A

Click here to return to Summary

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M3**		**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%**	92.0%	●	Trend above Target = Good 	●	June performance represents: 23 / 25 patients.	N/A
2.2 DQMI Committee: FPC Data Quality RAG: TBC **Green**	Data Quality Maturity Index (DQMI) – MHSDS dataset score above 95% **Target 95%**	95.0%	●	Trend above target = good 	●	Latest published figures are for March 2021	
2.16.4/5/6 IAPT Recovery Rates Committee: FPC	Improving Access to Psychological Therapies (IAPT) /talking therapies 50% of people completing treatment who move to recovery **Target 50%**	CPR 51%	●	Above Target = Good 	●	Slight decrease from last month but continues to meet target.	

Data Quality RAG: **Green**		SOS 51%	●	Above Target = Good 	●	Slight increase from the May position and now meeting target.	
		NEE 46.2%	●	Above Target = Good Graphs will be produced once sufficient data is available.		The new Service is not yet meeting target.	
2.16.7/8 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	Improving Access to Psychological Therapies (IAPT)/talking therapies waiting time to begin treatment: **75% within 6 weeks**	CPR & SOS 100%	●	Above Target = Good 	●	Consistently passing target	N/A
		NEE 99%	●	Above Target = Good Graphs will be produced once sufficient data is available.		Meeting target.	
2.16.9/10 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	Improving Access to Psychological Therapies (IAPT)/talking therapies waiting time to begin treatment: **95% within 18 weeks**	CPR & SOS 100%	●	Above Target = Good 		Consistently above target.	
		NEE 100%	●	Above Target = Good Graphs will be produced once sufficient data is available.		Above Target.	

4.5 Out of Area Placements Committee: FPC Data Quality RAG: **Amber**	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by 2021**	762 Days	●	Below Target = Good 	●	In June EPUT placed 13 new clients out of Area (12 Adult and one PICU), 20 patients were repatriated in June (19 Adult & one PICU) and 23 remain (20 Adult and three PICU) OOA at the end of June. The total Occupied bed days for all out of area placements in June was 762, 391 days were on Danbury Ward. OAP's for locked Rehab patients have been excluded (2 patients) as EPUT do not provide these bed types, therefore these would need to be placed out of area.	N/A

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3.1 Staff Sickness Committee: FPC Data Quality RAG: **Blue**	Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**	May -21 4.9% Jun-21 Draft 5.0%	●	Below Target = Good 	●		
5.2.2 Turnover Committee: FPC Data Quality RAG: TBC	Staff Turnover (Benchmark 2017/18 MH 12% / CHS 12.1%) **OF Target TBC** **Target <12%**	9.5%	●	Below Target = Good 	●	Special Cause of improving nature of lower pressure due to (L)ower values. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.	N/A
5.7.3 Temporary Staff Committee: FPC Data Quality RAG: TBC	Proportion of temporary Staff (Provider Return) OF Target TBC	8.6%	●	Below Target = Good 	N/A	Agency spend continues to be high in June. The highest three directorates are: • Medical 17% • Non Delegated 19% • Nursing 11%	N/A
5.5 Staff Survey	5.5.1 Outcome of CQC NHS staff survey 5.5.2 Support & Compassion, Team Work and	**Information from the 2020 Staff Survey** The Staff Survey ran from September to November 2020. The Trust was measured against 10 themes in the 2020 Survey. EPUT scored above average in one theme, in line with average on six themes, and below average against three themes.					

Committee: FPC Data Quality RAG: **Green**	Inclusion	**Support and compassion average rating of:** • % experiencing harassment, bullying or abuse from staff in the last 12 months • % not experiencing harassment, bullying or abuse at work from managers in the last 12 months • % not experiencing harassment, bullying or abuse at work from managers in the last 12 months	

Staff Survey 2020	EPUT	Average	Comments	
Safe Environment – Bullying & Harassment (high is better)	8.0%	8.3%	Below Average	●
Well Being and Safety at Work – Harassment, bullying or abuse at work from managers (low is better)	11.9%	10.5%	Above Average	●
Well Being and Safety at Work – Harassment, bullying or abuse at work from other colleagues (low is better)	17.2%	15.5%	Above Average	●

Teamwork Average of:
• % agreeing that their team has a set of shared objectives
• % agreeing that their team often meets to discuss the team's effectiveness

Staff Survey 2020	EPUT	Average	Comments	
Q4h The Team I work in has a set of shared objectives	75.4%	74.6%	Above Average	●
Q4i The Team I work in often meets to discuss the team's effectiveness	68.5%	69.8%	Below Average	●

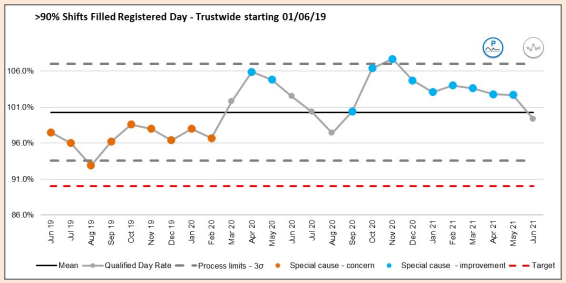
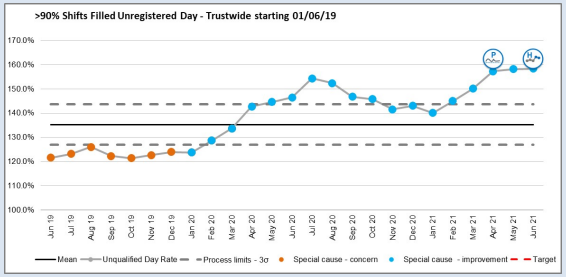
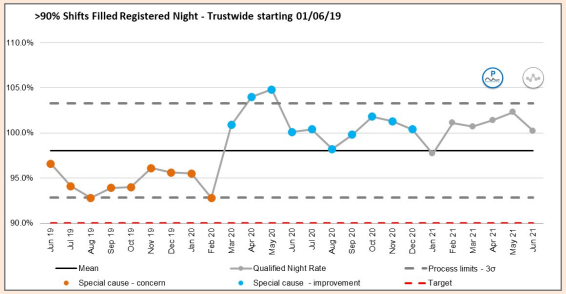
Trusts in lowest third across the sector will represent a concern

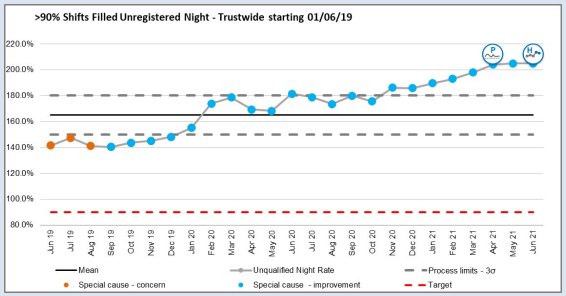
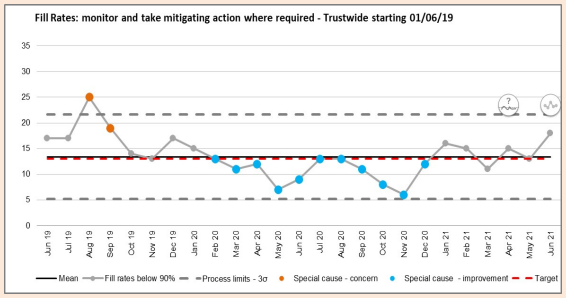
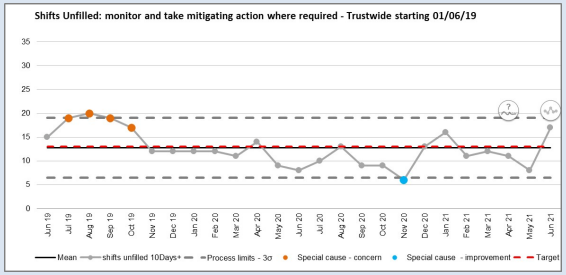
Inclusion (1) Average of
• % staff believing the trust provides equal opportunities for career progression or promotion
• % experiencing discrimination from their manager/team leaderor other colleagues in the last 12 months

Staff Survey 2020	EPUT	Average	Comments	
Q14 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	84.7%	86.6%	Below Average (Better than last year)	●
Q15b Discrimination at work from manager / team leader or other colleagues in last 12 months	8.6%	7.1%	Above average	●

SECTION 4 – Safer Staffing Summary

Click here to return to summary page

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards.							
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	99.3%	●	Trend above target = good 	●	The following wards were below target in June: CAMHS: Poplar ward - Rochford Nursing Home: Clifton Lodge Specialist: Edward House & Fuji Adult: Ardleigh, Basildon MHAU, Willow, Galleywood, Gosfield & Peter Bruff Older: Ruby PICU: Christopher Unit LD: Heath Close	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	158.4%	●	Trend above target = good 	●	The following wards were below target in June: Specialist: Causeway	N/A
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	100.2%	●	Trend above target = good 	●	The following wards were below target in June: Older Adult: Beech – Rochford, Kitwood & Henneage Nursing Homes: Rawreth Court Adult: Gosfield	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts	204.8%	●	Trend above target = good 	●	There were no wards below target in June	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required	18	●	Below Target = Good 	●	The following wards had fill rates of <90% in June: Adult: Ardleigh, Basildon, Willow, Galleywood, Gosfield & Peter Bruff Older Adult: Beech – Rochford, Henneage, Kitwood & Ruby Nursing Homes: Clifton Lodge & Rawreth Court Specialist: Causeway, Edward House & Fuji CAMHS: Poplar ward – Rochford PICU: Christopher Unit LD: Heath Close	N/A
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	17	●	Below Target = Good 	●	The following wards had more than 10 days without shifts filled in June: Adult: Ardleigh, Basildon MHAU, Galleywood, Gosfield, Peter Bruff & Stort Older Adult: Beech – Rochford, Henneage, Kitwood & Ruby Nursing Homes: Clifton Lodge & Rawreth Court	N/A

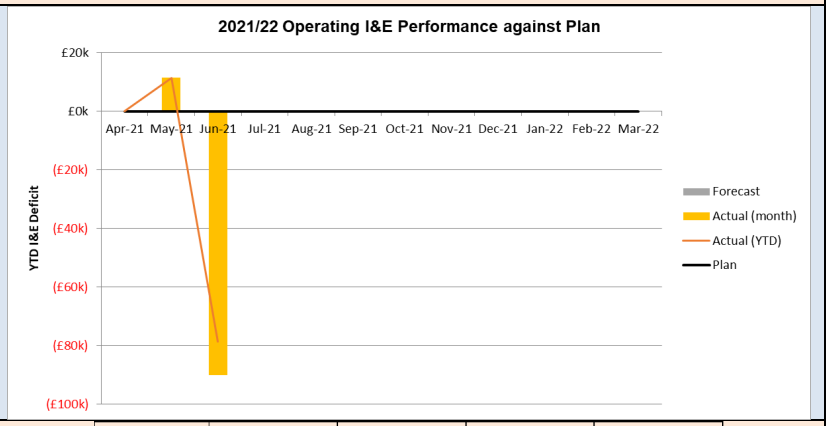
SECTION 5 – CQC

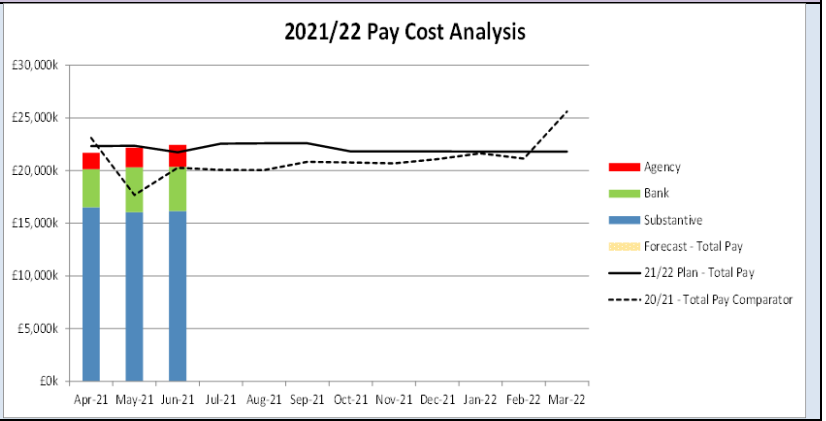
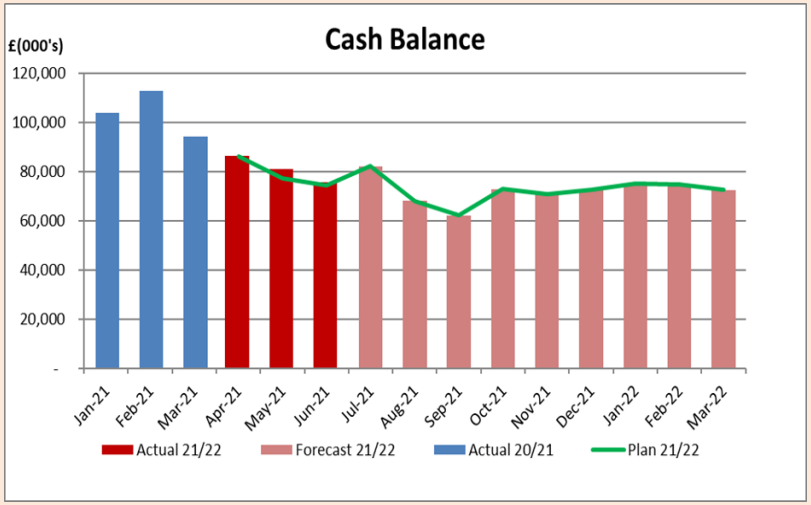
Click here to return to summary page

The CQC have completed an unannounced inspection of the CAMHS services in May/June 2021. The Trust has now received the feedback report following the inspection, and this is currently undergoing factual accuracy checks prior to publication on the CQC website.

SECTION 6 - Finance

Click here to return to summary page

<table>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position</th><th>Trend</th></tr>
<tr><td>Capital Expenditure (CDEL)</td><td>Maximising Capital Resources</td><td>The Trust's Capital programme this year is planned at £14.4m with YTD spend as at M03 at £1.4m, in line with plan. Prioritised schemes for ICT, safety & ligature and backlog maintenance have been approved by Capital Group and are being progressed by Project Managers. There is to be an increased level of oversight at a Regional level including review of capital that qualifies against the ICS capital allocations.</td><td>
<table>
<tr><th>Capital</th><th></th><th colspan="3">Year to Date</th></tr>
<tr><th></th><th>Annual Plan £000</th><th>Plan £000</th><th>Actual £000</th><th>Variance £000</th></tr>
<tr><td>ICT (including ePrescribing)</td><td>2,428</td><td>84</td><td>84</td><td>0</td></tr>
<tr><td>MEMS / Other equipment</td><td>200</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Safety & Ligature</td><td>1,942</td><td>107</td><td>107</td><td>0</td></tr>
<tr><td>Backlog Maintenance</td><td>2,349</td><td>62</td><td>62</td><td>0</td></tr>
<tr><td>Health & Safety</td><td>1,000</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Strategic Schemes:</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Dormitory Project</td><td>2,159</td><td>181</td><td>181</td><td>0</td></tr>
<tr><td>Other</td><td>1,085</td><td>330</td><td>330</td><td>0</td></tr>
<tr><td>Charge against Capital Allocation</td><td>11,163</td><td>764</td><td>764</td><td>0</td></tr>
<tr><td>DHSC Dormitory Project</td><td>3,080</td><td>637</td><td>637</td><td>0</td></tr>
<tr><td>PFI Residual Interest</td><td>109</td><td>27</td><td>27</td><td>0</td></tr>
<tr><td>Net CDEL</td><td>14,352</td><td>1,428</td><td>1,428</td><td>0</td></tr>
</table>
</td></tr>
<tr><td>Trust I&E 2020/21</td><td>Operating Income and Expenditure</td><td>The Trust continues to operate within the adapted financial regime for H1 and has submitted a plan to NHSI on this basis. H2 planning guidance is expected imminently in order that a plan can be finalised and submitted for performance monitoring. The year-to-date £0.1m deficit is behind the submitted plan due to increased pay costs due to continuing high levels of staffing required within CAMHS.</td><td> 
</td></tr>
<tr><td>Efficiency Programmes</td><td>Planned improvement in productivity and efficiency</td><td>The Trust's Efficiency target for 21/22 is £10.1m. In Year savings of £0.5m identified on a non recurrent basis.</td><td>
<table>
<tr><th>EPUT 21/22</th><th>Efficiencies / Waste Reduction Plan £m</th><th>YTD Plan £m</th><th>YTD Delivery (Non Recurrent) £m</th><th>YTD Variance £m</th></tr>
<tr><td>H1 (M1-M6)</td><td>3.5</td><td>1.3</td><td>0.5</td><td>-0.8</td></tr>
<tr><td>H2 (M7-M12)</td><td>6.6</td><td>0.0</td><td>0.0</td><td>0.0</td></tr>
<tr><td>EPUT Total</td><td>10.1</td><td>1.3</td><td>0.5</td><td>-0.8</td></tr>
</table>
</td></tr>
</table>

RAG	Ambition / Indicator	Position	Trend
Temporary Staffing	Level of Temporary Staffing Costs	The Trust is focussing efforts in converting bank staff to substantive positions to enable consistency of care. Overall temporary staffing costs for the month of £6.3m including Bank usage £4.2m, Agency usage £2.1m. This remains high at 28% of the total pay bill.	
Cash Balance	Positive Cash Balance	The cash balance at the end of June £75.7m is better than planned. The cash plan does not yet include the impact of the new provider Collaborative. The reimbursement of mass vaccination expenditure is planned to be received in M05.	

END

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 7(b)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 July 2021**

Report Title:	**Board Champions – NED and Exec Leads Requirements**					
Executive/Non-Executive Lead:	Professor Sheila Salmon – Chair					
Report Author(s):	Professor Sheila Salmon – Chair					
Report discussed previously at:						
Level of Assurance:	**Level 1**	**X**	**Level 2**		**Level 3**	

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

Purpose of the Report		
This report confirms the Board Champions identified by the Chair and CEO following review carried out in July 2021.	**Approval**	
	Discussion	
	Information	X

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

Summary of Key Issues

The identification of an Executive and Non-Executive Director as a lead or champion is a requirement of a range of NSH regulations and best practice guidance.

A review has been carried out of the Board members who are identified as the Trust's leads and these are confirmed in the schedule attached. All changes have been tracked.

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Professor Sheila Salmon **Trust Chair**

Board Champions and Board Leads Requirements 2021

TABLE 1

Statutory or Regulatory Roles	Regulation/Reference	Role/Executive Director Lead	Role/Non-Executive Director Lead
Accountable Officer	NHS Act 2006 designates the CEO of an NHS FT as the Accounting Officer	The Accounting Officer has the responsibility for the overall organisation, management and staffing of the Trust	
		Paul Scott , Chief Executive	n/r
Accountable Officer for Emergency Planning	Civil Contingencies Act 2004 NHS Emergency Planning Guidelines 2013 (Updated 2015) Health & Social Care Act 2012	To ensure that the organisation complies with legal and policy requirements of the acts and regulations involve. To ensure that the Trust is properly prepared and resourced for dealing with an incident To provide the Board with levels of assurance for emergency preparedness, planning and response as appropriate To act as Board champion for all emergency planning matters for staff and patients/service users To ensure strategic review of the Trust's emergency planning occurs	To provide scrutiny and challenge to all emergency planning information and assurance presented to the Board To ensure that the patient's/service user's perspective is considered in all related discussions
		Nigel Leonard, Executive Director Major Projects & Progammes	**Janet Wood (as Audit Committee Chair)**

Statutory or Regulatory Roles	Regulation/Reference	Role/Executive Director Lead	Role/Non-Executive Director Lead
Authorisation of Authorised Officers in relation to Section 120 of the Criminal Justice & Immigration Act 2008	Criminal Justice & Immigration Act 2008 section 120	The procedure for the authorising of authorised officers is not laid out in the Act but it is recommended that authorisation of officers is made in writing by a person at Board level in the NHS FT To ensure assurance is provided that the authorised officers and appropriate NHS staff are suitably trained and competent to carry out their roles	
		Trevor Smith, Executive Chief Finance Officer	n/r
Caldicott Guardian	Health Service Circular: HSC 1999/012 NHS IM&T Security Manual section 18.4	To oversee all procedures affecting access to person-identifiable health data	
		Dr Milind Karale, Executive Medical Director	n/r
Counter Fraud	Secretary of State directions to NHS bodies on counter fraud measures 2004 (Amended 2007)	To champion the counter fraud message throughout the Trust To monitor the effective discharge of the counter fraud function in relation to compliance with the Secretary of State directions	To promote counter fraud measures
		Trevor Smith, Executive Chief Finance Officer	**Amanda Sherlock (as Audit Committee member & SID)**
	DoH *Your Data: Better Security, Better Choice,*	To ensure that the Board is implementing the 10 data security standards (this will be a factor	

Statutory or Regulatory Roles	Regulation/Reference	Role/Executive Director Lead	Role/Non-Executive Director Lead
Data & Cyber Security	*Better Care* publication July 2017 page 5 and 2.17 page 15 and Annex A.1 page 43	considered by CQC and NHSI in decisions to apply their regulatory powers) To develop an 'annual statement of resilience' on behalf of the CEO that confirms essential action to ensure standards are being implemented	
		Trevor Smith, Executive Chief Finance Officer (as SIRO)	**Janet Wood (as Audit Committee Chair)**
End of Life Care	National Care of the Dying Audit Round 4 2014 Neuberger Review, More Care: Less Pathway 2013 LACDP One Chance to Get It Right 2014 National Hospitals End of Life Care Audit 2015 CQC Inspection Framework	To take responsibility for and champion end of life care at Board level To ensure end of life care within the Trust and provided by the Trust is appropriately monitored To demonstrate strong leadership and role model for all Trust staff regarding end of life care To assess the impact of all existing and new policies on end of life care and make recommendations for change To recognise the impact of the perception of poor end of life care on bereaved families and to provide Board assurance that complaints and incidents are dealt with in a way that reduces this impact	To have specific responsibility of care of the dying, focusing on the dying patient, their relatives and carers, and to review how end of life care is provided To support and where necessary challenge the Executive Director end of life care lead To act as a patient/service user, family and public voice and to ensure that the patient/service user, family and public perspective is considered in all end of life care related discussions and Board level scrutiny To provide scrutiny to the monitoring of end of life care, oversight for end of life complaints and the handling of the bereaved within the Trust
		Professor Natalie Hammond, Executive Nurse	**Dr Rufus Helm (as Quality Committee Chair)**

Statutory or Regulatory Roles	Regulation/Reference	Role/Executive Director Lead	Role/Non-Executive Director Lead
Energy & Sustainability	Climate Change Act 2008: NHS Carbon Reduction Strategy 2009 (Updated 2010) *Sustainability and carbon governance should be a responsibility on all JDs for the CEO and Director level posts*	Every NHS organisation should sign up to the NHS Good Corporate Citizenship Assessment Model and produce a Board approved Sustainable Development Management Plan which sets out clear measurable milestones to measure, monitor and reduce direct carbon emissions. To provide the Board with levels of assurance for energy and sustainability as appropriate To act as Board champion for all sustainability related matters To ensure strategic review of sustainability system and processes occur	To act as Board champion for all sustainability related matters To ensure that the patient's/service user's perspective is considered in all related discussions
		Trevor Smith, Executive Chief Finance Officer	**Loy Lobo (Finance and Performance Committee Chair)**
Equality & Diversity	Equality Act 2010: public sector duty The Workforce Race Equality Standard *It is important for Board members to be aware of the equality duty in how they set strategic direction, review performance and ensure good governance*	To act as Board champion to set an example and demonstrate that the Board is committed to promoting equality To challenge and promote the E&D agenda in the Trust To act as a voice at Board meetings for the E&D agenda	To act as Board champion to set an example and demonstrate that the Board is committed to promoting equality To challenge and promote the E&D agenda in the Trust To act as a voice at Board meetings for the E&D agenda
		Sean Leahy, Executive Director of People and Culture	**Manny Lewis (links with Older People's Champion/Age Equality Champion)**

Statutory or Regulatory Roles	Regulation/Reference	Role/Executive Director Lead	Role/Non-Executive Director Lead
			(PIT Committee & Finance & Performance Committee member)
Freedom to Speak Up Guardian	Freedom to speak up: whistleblowing policy for NHS 2016	The guidance states that the Principal Guardian will act in a genuinely independent capacity and will work alongside the Trust Board to help support the Trust to become a more open transparent place to work The Principal Guardian must be entirely independent of the Executive team so they are able to challenge senior members of staff as required The Principal Guardian must be highly visible and support the development of a culture that encourages people to speak up using the local procedures and also ensure that staff who speak up are treated fairly through any investigation or review	
		Sean Leahy Principal Guardian **Exec Director of People and Culture**	**Alison Rose-Quirie**
Health & Wellbeing	NHS Employers/NHS England: Healthy Workforce programme	To lead on the health and wellbeing agenda and strategy for staff To ensure that employee health and wellbeing is reported on and discussed at Board meetings on a regular basis and remains a core consideration throughout all work undertaken To ensure that employee health and wellbeing is considered in all organisational decisions and	

Statutory or Regulatory Roles	Regulation/Reference	Role/Executive Director Lead	Role/Non-Executive Director Lead
		broader organisational goals, including improving staff engagement and making financial savings. To ensure that employee health and wellbeing is embedded in the wider operation of the organisation through policies and procedures To lead by example, demonstrating their involvement and practice of wellbeing in the workplace.	
		Sean Leahy, Executive Director of People and Culture	**Dr Mateen Jiwani**
Older People's Champion/Age Equality Champion	Equality Act 2010: public sector duty		To maintain and introduce policies and practices that do not discriminate unlawfully against older people To give a strong signal within the organisation about the importance of this issue and to ensure that the board receives regular reports about progress in tackling age discrimination and promoting age equality. To ensure involvement of older people and their organisations in issues about age discrimination and promoting age equality

Statutory or Regulatory Roles	Regulation/Reference	Role/Executive Director Lead	Role/Non-Executive Director Lead
			To promote images of old age that are positive and diverse.
		Sean Leahy, Executive Director of People & Culture	**Manny Lewis (links with Equality & Diversity champion)** **Finance & Performance Committee Chair**
Patient Safety	National Quality Board: National Guidance on Learning from Deaths 2017	To take responsibility for the learning from deaths To ensure that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the Board To ensure the development and implementation of a policy and procedure for the engagement with bereaved families and carers	To have oversight of the progress of the implementation of the learning process To champion and support learning and quality improvement To ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care To ensure that the information published is fair and an accurate reflection of achievements and challenges
		Prof. Natalie Hammond, Executive Nurse	**Dr Rufus Helm (as Quality Committee Chair)**
Procurement Champion	Government Better Procurement, Better Value, Better Care 2013	To be accountable and act as a voice for procurement-related matters at Board meetings and ensure that any implications arising from items discussed have been considered and appropriately addressed	To sponsor the procurement function and hold the board to account to prioritise procurement at board level

Statutory or Regulatory Roles	Regulation/Reference	Role/Executive Director Lead	Role/Non-Executive Director Lead
			To gain assurance that the Trust has in place an effective and robust procurement strategy
		Trevor Smith , Executive Chief Finance Officer	**Loy Lobo (Finance & Performance Committee member)**
Responsible Officer for Revalidation	Medical Profession (Responsible Officers) (Amendment) Regulations 2013 Statutory role in medical regulation	To be accountable for the local clinical governance processes, focusing on monitoring the conduct and performance of doctors against agreed national standards To evaluate a doctor's fitness to practise and liaise with the GMC over relevant procedures To ensure that the Trust has appropriate systems for appraising the performance and conduct of doctors, investigate and take actions to address any issues	
		Dr Milind Karale, Executive Medical Director	n/r
Safeguarding Vulnerable Adults	Mental Capacity Act (2005) Mental Health Act NHS England Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework 2015	To liaise with the Trust's safeguarding lead on a regular basis and participate in awareness raising activities To liaise with the Trust's lead for overseeing the mechanisms in place to identify and cater for patients with learning disabilities To liaise with the Trust's dementia lead to encourage the Trust to operate as dementia friendly and participate in awareness raising activities as appropriate	To liaise with the Trust's safeguarding lead on a regular basis and participate in awareness raising activities To liaise with the Trust's lead for overseeing the mechanisms in place to identify and cater for patients with learning disabilities To liaise with the Trust's dementia lead to encourage the Trust to operate as dementia friendly and participate in awareness raising activities as appropriate

Statutory or Regulatory Roles	Regulation/Reference	Role/Executive Director Lead	Role/Non-Executive Director Lead
		Professor Natalie Hammond, Executive Nurse	**Dr Mateen Jiwani (links Mental Health & Safeguarding)**
Security	Secretary of State directions to NHS Bodies on Security Management Measures 2004 (amended 2006)	To be accountable person for security at an Executive level within the NHS Trust To promote security management policy and measures To liaise with appropriate persons in promoting a pro-security culture	To promote security management policy and measures To give support and where appropriate challenge the Executive Director on issues relating to security management at Board level
		Trevor Smith, Executive Chief Finance Officer	**Janet Wood (links to Audit Committee)**
SIRO	Information Governance Toolkit	To lead and foster a culture that values, protects and uses information for the success of the Trust and benefit of its customers To own the Trust's overall information risk policy and risk assessment processes, ensuring they are implement consistently To advise the CEO/relevant accounting officer on the information risk aspects of his/her statement on internal controls To own the Trust's information incident management framework	
		Trevor Smith, Executive Chief Finance Officer	n/r
Training & Development	Deanery Requirements	The Trust to be compliant with RO Regulations Act regarding Appraisal and Revalidation.	

Statutory or Regulatory Roles	Regulation/Reference	Role/Executive Director Lead	Role/Non-Executive Director Lead
	Medical and Nurses Revalidation	**Dr Milind Karale, Executive Medical Director** **Professor Natalie Hammond, Executive Nurse**	**Professor Sheila Salmon**
Whistleblowing	Public Interest Disclosure Act 1998 NHS Constitution Freedom to Speak Up Review 2015		To act as a voice for whistleblowing management and related issues at Board meetings and ensure that any implications arising from items discussed have been considered and appropriately addressed To gain assurance that the Trust has in place effective and robust whistleblowing management procedures and response systems To work closely with the Chief Executive and Executive Director Corporate Governance & Strategy with regard to monitoring whistleblowing To be recognised as one of the channels for members of staff to raise their concern with
		Paul Scott, Chief Executive **Sean Leahy, Executive Director of People and Culture**	**Alison Rose-Quirie**

TABLE 2

Statutory or Regulatory Roles	Regulation/Reference	Lead *Does not need to be a Board level position*	Non-Executive Director Lead
Accountable Officer for Controlled Drugs	Controlled Drugs (Supervision of Management & Use) Regulations 2013 Part 2 (SI 2013/373) Health and Social Care Act 2012	To establish and operate appropriate arrangements for securing the safe management and use of controlled drugs by the Trust To establish and operate appropriate arrangements for monitoring and auditing the management and use of controlled drugs by the Trust	
		Hilary Scott, Chief Pharmacist	n/r
Allied Health Professionals	Allied Health Professions into Action 2017 NHS England's Five Year Forward View	Review organisation strategies to be in line with the Allied Health Professions into Action document: - Ensure explicit consideration of AHPs contribution and ambition in STPs. Ensuring AHP leads have a clear voice and are represented at key clinical forums. - Support AHP services to evidence the quality and cost effectiveness of the care delivered by AHPs, to support continuing improvement and innovation in service delivery. - Have employer support for continued professional development and engagement in research activities for AHPs. And, engage AHPs in the workforce planning process. - Ensure AHPs have access to the tools and support required to continue to develop their use of informatics and technology to continue to deliver quality and cost effective care.	
		Glen Westrop	**Amanda Sherlock**

Statutory or Regulatory Roles	Regulation/Reference	Lead *Does not need to be a Board level position*	Non-Executive Director Lead
Bullying and Harrassment		To support the Bullying Agenda To maintain a link to Trust values and staff behaviours amongst the Trust Board and Senior Leadership Team To set an example of positive respectful behaviours To be a senior front facing leader visual to staff on matters relating to bullying To provide senior leadership advice to other senior leaders and steer their work to ensure Bullying remains high on the agenda To listen out for early warning signs of bullying behaviours and push through action at senior level To ensure proper governance arrangements support fast and regular updates on the Bullying agenda	
		Sean Leahy, Executive Director of People and Culture	**Alison Rose-Quirie (links to F2SU)**
Dementia	Department of Health's Guidance: Living well with dementia: A National Dementia Strategy 2009	Identification of a senior clinician within the general hospital to take the lead for quality improvement in dementia in the hospital Development of an explicit care pathway for the management and care of people with dementia in hospital, led by that senior clinician The gathering and synthesis of existing data on the nature and impacts of specialist liaison older people's mental health teams to work in general hospitals Thereafter, the commissioning of specialist liaison older people's mental health teams to work in general hospitals	

Statutory or Regulatory Roles	Regulation/Reference	Lead *Does not need to be a Board level position*	Non-Executive Director Lead
		Alex Green, Executive Chief Operating Officer	**Dr Rufus Helm (links to Quality Committee)**
Guardian of Safe Working	Junior Doctors new contract 2016 Terms and conditions of service for doctors and dentists in training (TCS) *The guardian is a senior person independent of the management structure for whom the doctor in training is working and/or the organisation by whom the doctor in training is employed*	The guardian is responsible for protecting the safeguards outlined in the 2016 TCS for doctors and dentists in training The guardian will ensure that issues of compliance with safe working hours are addressed as they arise with the doctor and/or employer as appropriate and act as a champion of safe working hours for junior doctors The guardian is accountable to the Board and should not hold any other role within the management structure of the employer The line management arrangements for the guardian are for local determination but this should be independent of the medical director and other medical managers to ensure appropriate independence. The reporting line should be to the appropriate executive director or equivalent, who will contribute to the annual appraisal of the guardian, in line with appraisal policy The guardian will provide assurance to the Trust Board (or equivalent) that doctor's working hours are safe	
		Dr Prabhavathy Sethi	**Dr Mateen Jiwani**
Infection Prevention and Control	Health & Social Care Act 2008: Code of Practice on the prevention and control of infection and related guidance	To be accountable directly to the CEO and to the Board To report directly to the Trust Board To be responsible for the Trust's Infection Prevention & Control Team	To act as Board champion for all infection control related issues and advocate for patient safety To ensure that the patient's/service user's

Statutory or Regulatory Roles	Regulation/Reference	Lead *Does not need to be a Board level position*	Non-Executive Director Lead
		To oversee local control of infection policies and their implementation To be a full member of the infection prevention team and antimicrobial stewardship committee and regularly attend its infection prevention meetings; To have the authority to challenge inappropriate practice To assess the impact of all existing and new policies on Healthcare Associated Infections (HCAI) and make recommendations for change To be an integral member of the Trust's clinical governance and patient safety teams and structures To have the authority to set and challenge standards of cleanliness To assess the impact of all existing and new policies on infections and make recommendations for change To oversee the production of an annual report and make it available to the public To set objectives that meet the needs of the Trust and ensure the safety of service users	perspective is considered in all related discussions and Board level scrutiny
		Angela Wade, Director of Quality	
Learning Disability Champion		To be expert points of contact in their organisation, and promote best practice. This includes disseminating information to colleagues, encouraging myth-busting and	

Statutory or Regulatory Roles	Regulation/Reference	Lead *Does not need to be a Board level position*	Non-Executive Director Lead
	NHS Learning Disability Employment Tools and Guidance 2015 Equality Act 2010	becoming experts on Access to Work, learning disability programmes and networking with other partners Areas of responsibility could include: - promoting the safety and wellbeing of employees with learning disabilities - sharing lessons learnt and best practice across the organisation - ensuring communications are in an accessible format; - being an advocate for employing people with learning disabilities in the organisation and sharing successful case studies - supporting the training, recruitment and retention of employees with learning disabilities - liaising directly with employees with a learning disability, managers and staff groups - supporting colleagues who are new to working with someone with a learning disability	
		Alex Green, Executive Chief Operating Officer	**Manny Lewis (links to E&D role)**
National Gram-Negative Infection Programme	NHS Improvement: letter 28 June 2017 from Ruth May and Prof Jane Cummings	Main point of contact for NHSI (national ambition to reduce healthcare associate GNBSIs by 50% by March 2021 Working with NHSI (and commissioners): - to co-design the programme of support - to identify and implement good practice	

Statutory or Regulatory Roles	Regulation/Reference	Lead *Does not need to be a Board level position*	Non-Executive Director Lead
		- to agree a reduction plan - to develop an improvement plan	
		Angela Wade (w.e.f 11/11/19) Director of Quality	**n/r**
Organisational Development and Culture Lead	The Five Year Forward View (5YFV) states that achieving quality requires a 'caring culture, professional commitment and strong leadership'	To promote a culture where staff at all levels are empowered as individuals and in teams to act to improve care within and across the Trust Working with the Board to ensure: - everyone understands and embodies the vision and values - everyone has clear objectives and data on performance - there is an open, supportive and compassionate approach to people management and how all staff interact with each other day to day - there is a high level of staff engagement - learning and quality improvement are embedded - good team and inter-team working are standard	To ensure the Board's commitment to a healthy and productive culture as well as implementing collective leadership, e.g. changes to structures, systems, behaviours
		Sean Leahy, Executive Director of People and Culture	**Professor Sheila Salmon**
Privacy & Dignity	Human Rights Act 1998 Department of Health's Dignity Champions Action Pack: Human Rights and Dignity 2010	To promote dignity and respect in care within the organisation To ensure there are policies and good practice regarding Human Rights in place and translated to your workplace To use their own local networks to raise the profile of this issue	
		Professor Natalie Hammond, Executive Nurse	n/r

Statutory or Regulatory Roles	Regulation/Reference	Lead *Does not need to be a Board level position*	Non-Executive Director Lead
Reducing Restrictive Interventions	Positive and Proactive Care: reducing the need for restrictive interventions Guidance 2014	To support increasing the use of recovery-based approaches including, where appropriate, positive behavioural support planning, and reducing restrictive interventions To maintain and be accountable for overarching restrictive intervention reduction programmes Ensure governance structures and transparent polices around the use of restrictive interventions are established by the Trust and appropriate training are provided to staffs Providers must have clear local policy requirements and ensure these are available and accessible to users of services and carers Report on the use of restrictive interventions to service commissioners, who will monitor and act in the event of concerns	
		Professor Natalie Hammond, Executive Nurse	**Amanda Sherlock**
Safeguarding Children	DoH working together to safeguard children 2010 (replaced in 2013) Children Act 2004section 11: duty to safeguard and promote welfare	To act as Board champion for all safeguarding issues To inform Board of level of assurance re compliance with safeguarding regulations To act as the Trust's safeguarding ambassador for the local safeguarding children's board To ensure that safeguarding systems are robust and appropriately monitored	To offer scrutiny and challenge to safeguarding risks, performance and evidence presented to the Trust Board To act as advocate for patients/service users in all safeguarding issues

Statutory or Regulatory Roles	Regulation/Reference	Lead *Does not need to be a Board level position*	Non-Executive Director Lead
	Children Act 2004 section 13: statutory partners in the local safeguarding children board Children Act 1989 section 27: help with children in need Children Act 1989 section 47: help with enquiries about significant harm NHS England Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework 2015	To ensure that any gaps in compliance are addressed resulting in improvements to safeguarding of vulnerable children To demonstrate strong leadership for all safeguarding issues To respond to national policy proposals	
		Professor Natalie Hammond, Executive Nurse	**Dr Mateen Jiwani (as Mental Health & Safeguarding Committee link)**
Innovation and Research	Not a statutory role. Priority for the Trust	**Dr Milind Karale/ Professor Natalie Hammond**	**Dr Mateen Jiwani**
Chief Clinical Informatics Officer	DH 2009	*A Chief Clinical Informatics Officer provides leadership and management of ICT and information development activity to support the safe and efficient design, implementation and use of informatics solutions to deliver improvements in the quality and outcomes of care. This includes: providing expert clinical informatics advice and guidance; working collaboratively with others to ensure patient and clinical involvement in the planning, development, delivery and evaluation of systems and services; and championing the use of informatics as an enabler of change and quality improvement*	

Statutory or Regulatory Roles	Regulation/Reference	Lead *Does not need to be a Board level position*	Non-Executive Director Lead
		Dr Milind Karale, Medical Director	**Not Required**
Veterans service	Not a statutory role Important to the Trust		**Professor Sheila Salmon**

		Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28th July 2021**

Report Title:	**Infection Prevention and Control Annual Report 2020/2021**					
Executive/Non-Executive Lead:	Professor Natalie Hammond, Executive Nurse					
Report Author(s):	Kim Shaw, Head of Infection Prevention Control/Angela Wade, Director of Nursing & IPC					
Report discussed previously at:	Clinical Governance & Quality Sub-Committee Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The report outlines the achievements and activities of the Infection Prevention and Control team during the year and includes the work and audit programme for 2021/2022.

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

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

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

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

Acronyms/Terms Used in the Report			
IPC	Infection Prevention and Control		
MRSA	Methicillin Resistant Staphylococcus Aureus		
CDiff	Clostridium Difficile		

Supporting Documents and/or Further Reading
Infection Prevention and Control Annual Report 2020-21

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

Infection Prevention and Control Annual Report

2020 - 2021

Report prepared by
Kim Shaw
Head of IPC
on behalf of
Angela Wade
Director for Infection Prevention and Control

June 2021

Contents

1. Background

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

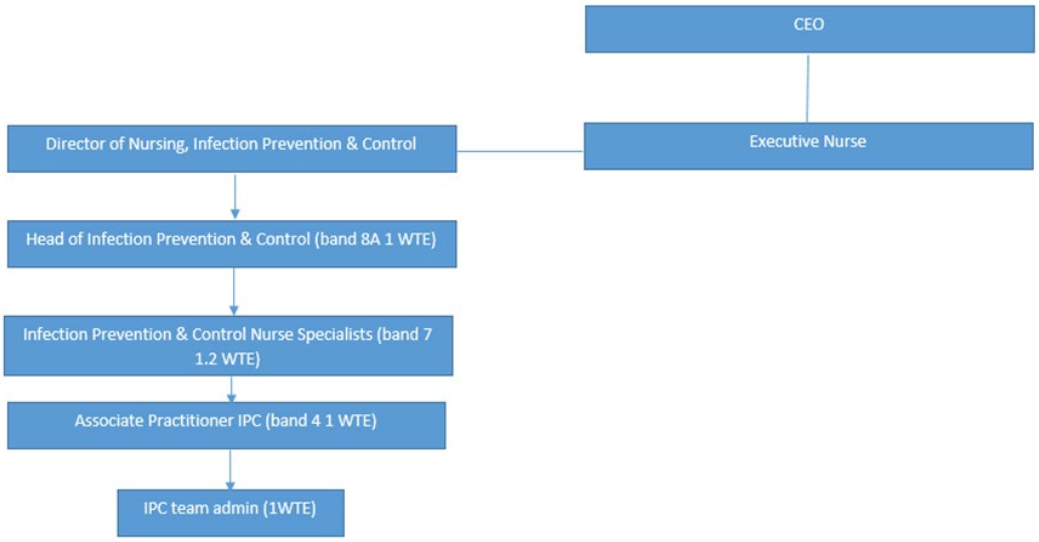
The report outlines the achievements and activities of the Infection Prevention and Control team during the year and includes the work and audit programme for 2021/2022.

The programme is founded on key documents and legislation including:

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

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

The Infection Prevention and Control Team Structure



2. Covid response

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

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

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

3. Compliance

The Trust has declared full compliance with the Code of Practice and maintained registration for 2020/2021. Compliance is monitored and maintained via the infection prevention annual work programme, which is agreed and signed off by the Infection Prevention and Control Group. The group meets quarterly and membership includes commissioners and representatives from the wider health economy.

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

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

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

4. Audit

Some elements of the usual work programme i.e. annual environmental audits, have had to be stopped, and hence the team has declared non-completion of this area of work on the annual work programme.

Audits undertaken prior to the onset of the pandemic:

13 IPC environmental audits were undertaken in 2020/21,

Broken down across the Trust as follows:

5 in South East Essex Community Services,

7 in Essex Mental Health,

1 in Specialist Services.

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

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

Audits undertaken each year include:

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

Audit results year-end 2020/21:

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

Area:	**Hand hygiene:**	**Care bundles for invasive devices:**	**MRSA screening:**	**Environment** Rating Scale : Compliant – 95-100% Partial compliance – 80-94% Minimal compliance -<79%
Nursing Homes	100%	-	-	-
Specialist services Bedford and Essex	Patient observed: **100%** Inpatient: **99.4%**	-	-	**88%**
Learning Disability Services Essex	Patient observed: Nil Received Inpatient: **98.5%**	-	-	-
South Essex MH inpatient and Comm' Services	Patient observed: None received Inpatient: **99.7%**	-	-	**86.4%**
North Essex MH and Comm' Services	Patient observed: Q1 – 100% Inpatient: 98.8%	-	-	**80.8%**
South East Essex	Comm: 89.9%	97.8%	100%	**85.8%**

Community Services	Inpatient: 100%			
West Essex Community Service	Comm: Q1 – 100% Inpatient: 100%	96.1%	100%	-

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

The IPC team continue to liaise with other healthcare providers to ensure high-risk findings in shared premises are communicated and addressed.
Environmental cleaning audits are undertaken monthly by the Facilities team. Facilities issues are also highlighted by the annual IPC environmental audits. Where failing standards of cleanliness are evidenced, action plans are sent to the relevant Facilities Officer (FO) to address them.

To counterbalance the reduction in annual IPC audits being carried out, the IPC team carried out supportive Covid compliance audits to all inpatient areas during July, and thereafter the audit tools were loaded onto the Perfect Ward app and ward managers have been required to complete these on a monthly basis, since then. Compliance with this is monitored via the IPC Covid dashboard.

Antimicrobial Stewardship and Audits:

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

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

5. Surveillance of Infections

The Trust is required to report Healthcare Associated Infections (HCAI) where the causative organism is identified as Methicillin Resistant *Staphylococcus aureus* (MRSA) or *Clostridium difficile.* The 2020/2021 annual set objective ceilings for these organisms remain unchanged from 2019/2020. The IPC team continues to monitor existing control measures, including ensuring that all strategies aimed at minimising risk are adhered to. EPUT works in partnership with members of the wider health economy to share best practice and information. The IPC team attend quarterly HCAI/IPC network meetings in South and West Essex. Additionally, the team participates in various task and finish groups to support care pathway work.
On identification of an HCAI, the relevant service and senior management team are advised. The lead clinician is contacted and a full investigation either via root cause analysis (RCA) or post infection review (PIR) is commenced, led by the clinical staff with support from the IPC team. Investigations include all service providers (health & social care) who have been involved in the care of the patient. Investigations undertaken support assurance for the Commissioners that relevant control measures were adhered to

with the aim of avoiding potential infection. Additionally, those issues identified and lessons learned are fed back to all healthcare providers involved. It must be emphasised, particularly with *Clostridium difficile*, that antibiotics prescribed may be wholly appropriate as an essential part of treatment; in these cases the resultant *Clostridium difficile* infection will be viewed as unavoidable.

Of the identified *Clostridium difficile* cases in 2020/21 that involved EPUT services, there were no incidents with noted lapses in care that resulted in attribution to EPUT.

Incidence of Mandatory Reportable HCAI (MRSA) 2020-2021			
	Community Services (Including 6 Inpatient Units)	Mental Health, LD and Secure Services (Inpatient Units)	Nursing Homes (2)
Incidence of Mandatory Reportable HCAI (MRSA) 2020-2021			
MRSA Bacteraemia **Avoidable cases**	0	0	0
MRSA Bacteraemia **Unavoidable**	0	0	0
HCAI (MRSA) **Cases with EPUT involvement**	0	0	0
Incidence of Mandatory Reportable HCAI (*C. difficile*) 2020-2021			
Clostridium difficile **Avoidable cases**	0	0	0
Clostridium difficile **Unavoidable**	0	0	0
HCAI (*C.diff*) **Cases with EPUT involvement**	3	1	0

Outbreaks:

The Trust reports all outbreaks of infections to the commissioners - an outbreak being defined as two or more connected cases of infectious disease either in patients, staff or visitors. The outbreaks seen within the Trust are usually reflective of trends in the wider community.
Debriefs are conducted on the ward following an outbreak of infection, such as diarrhoea and vomiting. A full and extensive analysis is carried out to identify causative factors, good practice and learning points which feed into an action plan and identify any training issues. Any learning from the outbreaks is shared at the IPC meeting and link nurse training.
There are local arrangements to support Public Health England with screening for influenza and provision of prophylactic treatment in *Influenza* outbreaks in residential care homes. This process is led by some of the District Nursing teams in Essex.

	2019-2020		**2020-2021**

	Community Services (Including 6 Inpatient Units)	Mental Health, LD and Specialist Services (Inpatient Units)	Nursing Homes	Community Services (Including 6 Inpatient Units)	Mental Health, LD and Specialist Services (Inpatient Units)	Nursing Homes
Disease/ condition	1x Influenza A 1x Parainfluenza 2x Diarrhoea and Vomiting	4x Diarrhoea and vomiting 4x scabies	Influenza like illness	0	2x Diarrhoea and vomiting	0
Lost bed days	37	28	10	0	10	0

Coronavirus Outbreaks:

Service area	No' of Outbreaks	Number of staff affected	Number of patients affected	No of deaths
Nursing Homes	1	4	10	1
Specialist services Bedford and Essex	8	44	14	1
South Essex MH inpatient and Comm' Services	10	39	55	8
North Essex MH and Comm' Services	10	99	111	7
South East Essex Community Services	2	7	-	-
West Essex Community Service	4	16	12	2
TOTALS Figures from data collated from Sept 2020 onwards.	35	209	202	19

From November 2020 onwards, we were required to complete and submit daily IIMARCH reports to NHS England.
Regular Incident Management Team (IMT) meetings were held for all outbreaks – at the initial identification, during the course of the outbreak, and to agree when safe to close the outbreak.
These outbreaks were all reported as required, to Public Health England.
The IMT meetings were also attended by a representative from Public Health England and the regional lead for IPC from NHS England.
Clinical teams were also asked to complete a Learning Lessons slide at the closure of the outbreak which were shared with other teams.

6. Training

Training for staff with patient contact was delivered primarily via an OLM e-learning package, developed by the IPC team, in conjunction with the Workforce Development Department.
The figures are monitored by the training department and reported to the Executive team on a monthly basis. The IPC team have continued with the programme of training on request (mostly via Teams) to support compliance and will continue to provide these sessions for 2021/22.

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

Covid 19 training materials were instrumental in creating guidelines, posters, training videos PPE self-assessment of competence and regular training and update live events.
Introduced in Dec 2020, all Trust staff have been required to complete an IPC and PPE standards competency assessment to evidence that all the required training has been accessed. Compliance with this is monitored via the IPC Covid dashboard.

The IPC link worker network has been dormant during the past year. Demands on staff time in clinical areas means that it has proved challenging for the link workers to attend training sessions. The IPC team were in the throes of planning an IPC conference when the Coronavirus Pandemic forced the postponement of the event. The team are hoping to be able to hold the event later in the forthcoming year.

Area (Rating Scale: Red =/<84% Green =/>85%)	**IPC Training –** Annual for all clinical staff		**IPC Training –** 3 yearly for all non-clinical staff	
Specialist services - Bedford and Essex	Bdford 98.4%	Essex 86.3%	Bdford 98.4%	Essex 95.4%
South Essex MH inpatient and Comm' Services	86.4%		94.9%	
North Essex MH inpatient and Comm' Services	80.8%		90.7%	
South East Essex Community Services	85.8%		96.7%	
West Essex Community Services	82.5%		94.4%	
Learning Disability Services	92.3%		98.5%	
South East Essex Nursing Homes	86%		94.2%	

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

7. Sharps Injuries

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

	2018 /2019	**2019/2020**	**2020/2021**
South East Essex Community Health Services			
Needle Stick Injury - Dirty Needle	9	12	8
Needle Stick Injury - Clean Needle	0	1	1
Sharps Injury - Other Instrument	1	0	0
Needle Stick Injury - Unknown Source	2	0	1
Exposure to Blood and/or Body Fluids e.g. Splash	0	0	0
	South Essex Mental Health only	**All Mental Health Services**	**All Mental Health Services**
Needle Stick Injury - Clean Needle	-	-	-

Needle Stick Injury - Dirty Needle	2	7	12
Sharps Injury - Other Instrument	-	1	1
Needle Stick Injury - Unknown Source	0	0	2
Exposure to Blood and/or Body Fluids e.g. Splash	-	2	2
	North Essex Mental Health only		
Needle Stick Injury - Dirty Needle	3		
Exposure to Blood and/or Body Fluids e.g. Splash	2		
Specialist Services & Learning Disability			
Needle Stick Injury - Dirty Needle	1	1	1
Needle Stick Injury - Clean Needle	-	-	1
Sharps Injury - Unknown Source	1	-	-
Sharps Injury - Other Instrument	-	1	-
Exposure to Blood and/or Body Fluids e.g. Splash	2	-	1
West Essex Community Health Services			
Needle Stick Injury - Dirty Needle	2	6	4
Sharps Injury - Other Instrument	-	-	-
Needle Stick Injury - Clean Needle	-	-	1
Sharps Injury - Unknown Source	-	-	1
Corporate Services (Covid Vaccination hubs)			
Needle Stick Injury - Clean Needle	-	-	9
Needle Stick Injury - Dirty Needle	-	-	4
Sharps Injury - Other Instrument	-	-	1
Total	**25**	**31**	**50**

Sharps Injuries / Body Fluid Exposure Incidents

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

With the help of the Procurement and Clinical teams, this market is constantly under review and new/improved products are introduced when appropriate. The use of pre-filled medication/syringes that cannot be decanted into a safety device continues, but regular review, in conjunction with the procurement team, is maintained to support identification of alternative safety products that can be introduced.

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

Bites and Scratches (Assault)

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

Assault including Scratch, Bite or Body Fluid Exposure	**18/19**	**19/20**	**20/21**

Bite	86	67	111
Body Fluid Exposure	143	161	216
Scratch	273	316	263
Total	**502**	**544**	**590**

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

8. Staff Flu Vaccination Programme

The IPC team led the delivery of the Staff Flu Vaccination programme again this year. This programme was delivered in-house with Optima input (held 20 drop in clinics) utilising staff within the Infection Prevention and Control Teams, Immunisation teams, Medicines Management team and support from other areas i.e. operational teams.

Drop-in clinics were held in venues all over the organisation over a 7-week period, as well as 91 members of staff trained as peer vaccinators to vaccinate colleagues in their work bases. An incentive programme of a uptake related raffle was offered.

The uptake figures are outlined in the table below and the total percentage of uptake amongst frontline staff was 64% - a slight increase from last year's uptake of 62%.

There were no CQUINS associated to this vaccination programme this year.

9. Safe Water Systems

The Trust has continued throughout Covid to effectively undertake water management and governance with the Water Safety Group continuing to meet on a bi-monthly basis. There has been a recent review of the previous water management structure with amendments made relating to the Trust now having one Responsible Person (E&F Compliance Manager) and Deputy (Security & Compliance Manager) now in place following renewed enhanced water management training. All previous Responsible Persons and Deputies have been assigned as Authorised and Deputy Persons. The Trust has worked in partnership with its water maintenance contractor, Clearwater, who also now sit on the Water Safety Group. This responsibility is partly shared with the IPC team and the Head of IPC who have successfully completed the training to become the Responsible Officer to provide valuable knowledge and experience.

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

In line with HTM04-01 and L8 ACOP (Approved Code of Practice), in 2019 the Trust commissioned an Authorised Engineer (A/E). The A/E is an external contractor whose role is to offer impartial day-to-day support as well as the completion of site audits for the EPUT responsible property portfolio. The A/E is also a member of the Trust's Water Safety Group and has provided 6 monthly audits on EPUT's water management, looking at all aspects across the Trust and stated an overall improvement from the previous year.

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

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

Outcomes and concerns of the group are raised in the IPC group meeting. The water quality group feeds directly into

the HSSC which is the Trust's most senior Health and Safety committee, to ensure the group is sufficiently managing the risk associated with water.

EPUT employ specialist contractors to support the safe water agenda, to undertake the water risk assessments, planned preventative maintenance and Water Risk Assessment remedial works. EPUT also has an in-house maintenance team of plumbers who support EPUT's water maintenance programme. This work is managed and monitored by the Estates & Facilities team. All staff and contractors undertaking the work are trained in legionella and water systems to ensure they understand the risks involved. This work is audited and managed by the Estates & Facilities team, including the Water Task & Finish Group. The past year has seen commissioned new Water Risk Assessments in the North property portfolio with the South and West Assessments commissioned and due to be submitted this summer.

Following substantial programme of works including sampling, chlorination and reconfiguration of pipework, the Derwent Centre has recently been cleared of legionella although an agreed sampling regime, on a lower frequency, will continue going forwards.

NHS Property services have also alerted EPUT to positive legionella counts at Saffron Walden Community Hospital which has been ongoing for the last 2 years, leading to new tanks being installed, auto chlorination dosing unit and filters being installed on all showers within Avocet ward. EPUT collaboration with NHS Property Services has further identified fundamental systemic challenges within Avocet Ward relating to current pipework which NHS Property Services is now in the process of resolution.

10. Partnership Working

Effective prevention and control of infection is achievable with robust partnership working both within the organisation and with the wider health economy. Specifically, these include the Infection Prevention and Control Networking/HCAI Meetings in North and South Essex, joint working with our procurement services and the day-to -day liaison with our Estates and Facilities teams. In addition to this, the IPC team makes every effort to work in collaboration with the Estates department to ensure Trust premises, and those our staff provide services from, are fit for purpose from an IPC perspective.

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

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

11. Key Achievements

Key achievements for 2020/21 have included:

- Rapid and robust response with continued IPC leadership and mobilisation to requests from National Government, Public Health England and NHS England Regional team to prepare for the management of the Covid 19 Pandemic.
- Key participants in Flu campaign to reach best Trust compliance to date

12. Work Programme for 2021/22

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

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

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

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

It will be presented at the June 2021 Clinical Governance meeting, and will be circulated for approval from members of the Infection Prevention and Control group.

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

Appendix 1

ESSEX PARTNERSHIP NHS FOUNDATION TRUST
ANNUAL INFECTION PREVENTION AND CONTROL WORK PROGRAMME 2021/2022

CODE CRITERIA	ACTION	TIMETABLE	LEAD	REVIEW/PROGRESS	HOT SPOTS	COMPLETE IN PROGRESS INCOMPLETE			
						Q 1	Q 2	Q 3	Q 4
1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.	**Appropriate management and monitoring arrangements will include:** • Submission of the Annual Infection Prevention and Control Report to Board	June 2021	AW	Completed and submitted on schedule – circulated to all IPC group members.					
	• Quarterly quality reports submitted to the appropriate commissioners.	Quarterly	IPCT	Sent via Performance team – IPC info incorporated within Quality Reports.					
	• Collation and submission of Key Performance Indicator data through surveillance programme .	Monthly - KPI's shared with all service areas monthly via performance reports, IPC group meetings, monthly Quality and Safety meetings.	IPCT						
	• Water safety group and water safety plans are in place. • Head of IPC attend meetings	Quarterly	AW						

	• Collaborative working with CCG's and other providers in area.	31/3/2022	IPCT	IPC team attends CCG/STP network meetings, collaborative work on community outbreak management, MRSA and C.diff investigations.					
	• Infection Prevention and Control Group meetings. • Chaired by DIPC. • Attendees include Occ Health, CCG & PHE rep's, and Microbiologist	Quarterly	AW						
	• Raise awareness and inclusion of risks on appropriate Risk Registers	31/3/2022	IPCT						
	• Keep up to date with emerging national guidance on the management of Coronavirus and risks posed to patients and staff and advise on mitigation actions.	31/3/2022	!PCT						
2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection	**Environmental Cleanliness and hygiene** • Monitoring and maintaining a clean and safe patient environment and cleanliness culture through audit and partnership–working with Clinical Leads and Facilities Department. Also includes meetings and liaison with external cleaning contractors	31/3/2022	IPCT/ Facilities team/ External Contractors	All areas feed in monthly environmental cleaning scores and these are reflected on the KPI performance sheets. IPC environmental annual audit reports are also shared with facilities teams for their action on relevant issues identified.					

	in community clinic settings for assurance purposes.								
	• Involvement in drawing up and monitoring of cleaning/laundry/waste contracts, particularly with regards the merging of the two organisations and drawing up of new service contracts.	Ad Hoc	IPCT	See above					
	• inclusion in planning for new builds and refurbishments	Ad Hoc	IPCT						
	• Advise on environmental and medical device decontamination.	31/3/2022	IPCT	Head of IPC attends Medical Devices meeting where approval is sought for purchasing of all new medical devices – this approval includes decontamination methods.					
	Audit Programme: • Environmental and IPC audits on all inpatient units and high risk community service clinics – review audit process across all areas and standardise audit frequencies and annual programme of audit.	Rolling Annual Programme	IPCT	Audit programme was not completed last year due to resource challenges resulting from the Coronavirus pandemic. This year's audit programme will be rearranged to ensure those that are overdue will be completed first.					
	• Hand hygiene audit programme – collation and presentation of nurse and patient observed audits. Review and standardise the process for hand hygiene audit data collection	Quarterly/Bi-annually	IPCT	1. Quarterly peer-observed hand hygiene audits on Perfect ward App in all inpatient units (10 observations per quarter) 2. Bi-Annual patient-observed paper-based feedback across all areas including Mental Health and Community Services (inpatient and community teams) Questionnaires are to be handed out to all patients seen by the team / on the ward on: 1. World Hand Hygiene Day 5th May, each year					

				2. International Infection Prevention week - the third week of October, each year (team to choose most suitable day of that week)					
	• Mattress audit programme	31/3/2022	IPC AP	On Perfect Ward App 6 Monthly in all inpatient settings.					
	• Invasive Device Care Bundle Audits – CHS and nursing homes only.	Quarterly	IPCT	On Perfect ward App.					
3: Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Systems to manage and monitor use of antimicrobials.	31/3/2022	MMT	Meds Management Team leading on this. Audit process in place, and feeds results into IPC Group meeting.					
	• Antibiotic Stewardship Committee/Group – incorporated as part of the IPC Group Agenda	31/3/2022	MMT/IPCT						
	• Local antimicrobial stewardship policy	31/3/2022	MMT						
	• Access to testing results is available via the local Acute Services pathology labs.	31/3/2022		IPC team working with IT team to gain access to all partner Acute Trust's pathology results.					
	• Prescriber induction and training in prudent antimicrobial use, antimicrobial resistance and stewardship competencies	31/3/2022	MMT						
	• Work with and assist Meds Management team to raise awareness for European Antimicrobial Awareness day in November 2021	31/3/2022	IPCT						

4: Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.	• Enhance public awareness through media communication as necessary	31/3/2022	IPCT						
	• Provide Patient information leaflets, hand hygiene posters, Isolation posters, Information sheets at reception desks • Posters/data re: appropriate use of antimicrobials • Posters re: reporting hygiene and cleanliness (Inc. HH) issues. • Review all existing information formats and refresh and standardise to suit all new areas of the organisation.	31/3/2022	IPCT IPCT						
	• Issue timely and appropriate audit feedback to teams – for display in public areas	31/3/2022	IPCT						
	Clinical IPC support: • Telephone advice for clinical staff in relation to treatment for identified infection and preventative measures to minimise risk from infection	31/3/2022	IPCT						
	• Lead on providing all staff in the Trust with the most up to date national guidance on the management of Coronavirus	31/3/2022	IPCT						

	and risks posed to patients and staff and advise on mitigation actions.								
5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	• Provision and regular review of policy/guidelines to support infection outbreaks	31/3/2022	IPCT						
	• Co-ordinate (in liaison with clinical leads) and advise on management of outbreaks	Ad Hoc	IPCT IPCT						
	• Mandatory reporting of Clostridium difficile infection cases and MRSA Bacteraemia cases	Monthly	IPCT						
	• Carry out/support Root Cause Analysis studies on all Clostridium difficile and MRSA Bacteraemia infections, and any other major infection incident • Support lessons learned cascade process	Ad Hoc	IPCT						
	• Attend scrutiny panel and Post Infection review Meetings as and when required.	Ad Hoc	IPCT						

	• Support and monitor the MRSA screening programme	31/3/2022	IPCT						
	• Support and advise clinical staff with known colonised/infected patients	31/3/2022	IPCT						
	• Continue work with the Tissue Viability Team to deliver wound infection presentation at wound care training days • Continue to support the MH wards, as required, with the management of infected wounds/wound care.	Ad Hoc	IPCT/Tissue Viability						
	• Carry out investigative case reviews and identify learning on any patients believed to have acquired nosocomial Covid 19 infection.	31/3/2022	IPCT						
6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	**Maintain Infection Control Link Workers (ICLW) Forum with continued support and training**	Quarterly	IPCT	IPC Conference to be held					
	Ongoing work with purchasing to standardise equipment/products used across Trust, with regard, to IPC, in order to ensure consistency of equipment provision and reduce cost • Roll out standardised IPC related disposable products to all areas.	Quarterly	IPCT						

	Continued monitoring and review of Datix sharps injuries. Information sharing with regards to sharp safe products for staff to trial. Liaise with Occupational Health & Wellbeing as appropriate.	31/3/2022	IPCT						
	Develop and deliver training programmes for: • Mandatory Trust Induction for all staff	Monthly	IPCT	A member of the team attends every Trust Induction to deliver a session to new employees.					
	• Report on uptake of e-learning training programme, which was developed in-house by the IPC team/workforce development and provide targeted adhoc face to face training sessions.	Monthly	IPCT	Training figures reported on monthly KPI sheets					
	• Deliver topic specific sessions when requested.	Ad Hoc	IPCT						
	• Raise Trust wide awareness of sepsis recognition and treatment	31/3/2022	IPCT						
	Co-ordinate hand hygiene training programme: • Deliver light box training sessions on the wards for staff and service users. Maintain training records	Ad hoc		IPC AP					

	Attend individual team meetings to cascade information and training	Ad Hoc		IPCT					
7: Provide or secure adequate isolation facilities.	**Monitor isolation times –** infectious patients to be isolated within 2 hours	31/3/2022	IPCT	Reported on Community inpatients KPI's.					
8: Secure adequate access to laboratory support as appropriate.	• Review and monitor new organisation wide contract with Microbiology department in CHUFT	31/3/2022	DIPC/IPCT						
	• Advise on the collection, storage, transport and interpretation of specimens/samples, including Coronavirus swabs.	31/3/2022	IPCT						
	• Promote collaborative working with acute trust laboratory and microbiological partners, particularly with regard to effective antimicrobial stewardship.	31/3/2022	IPCT						
	• Continue to explore ongoing issues surrounding MH units accessing electronic microbiological results and information for patients.	31/3/2022	IPCT						

9: Have and adhere to policies designed for the individual's care and provider organisations, which will help to prevent and control infections	**Review and monitor Infection Control Guidelines** • Amend, as and when national guidance alters, or new guidance is issued. Ensure information is cascaded Trust wide.	31/3/2022	IPCT						
	• **Antimicrobial prescribing –** programme of audit and staff/management feedback. • Work with Meds Management team to amalgamate and standardise processes.	31/3/2022	MMT/IPCT						
	• **Control of outbreaks** Have in place alert organism system.	31/3/2022	IPCT	When this guideline is due for review, changes will reflect learning from involvement in the iGAS outbreak.					
	• **Provide guidance and support to staff in the event of a Coronavirus outbreak in inpatient units.**	31/3/2022	IPCT						
10: Providers have a system in place to manage the occupational health needs of staff in relation to infection.	**Collaborative working with Occupational health services in particular with regards to:** • Sharps injury / body fluid exposure incident prevention & monitoring	31/3/2022							
	• Planning and coordinating the Influenza vaccination programme. • Develop method for capturing data relating to staff accessing	31/3/2022	IPCT/ CQUIN team						

	vaccination outside of the Trust.								
	• Planning and coordinating a Coronavirus vaccination programme, when vaccine available.	31/3/2022							
11. Physical Healthcare Agenda	**In collaboration with the Physical Healthcare subcommittee, support Mental Health wards as requested/appropriate with clinical and physical health care issues:** • Recognising the deteriorating patient • Wound care advice • Diabetes care advice and basic training • General advice about physical health care e.g. Waterlow hypertension / hypotension • Other aspects of physical healthcare – patient specific	31/3/2022		IPCT in liaison with relevant specialist nurses.					
12. lead IPC provider for MSE community collaborative	**Provide leadership and IPC oversight and collaboration with NELFT and Provide to align IPC strategies for the MSE community services.** • Details to be confirmed following system meetings	31/3/2022							

		Agenda Item No: 7d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28th July 2021**

Report Title:	Learning from Deaths – Mortality Review Summary of Quarter 4 2020/21 information					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Michelle Bourner, Mortality Project Co-ordinator					
Report discussed previously at:	Mortality Review Sub-Committee (27/05/21) Quality Committee (08/07/21)					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report presents to the Board of Directors: • Information relating to deaths in scope for mortality review for Q4 2020/21 (1st January – 31st March 2021) together with updated information for Q1-Q3 and for 2019/20, 2018/19 and 2017/18; and • Learning that has been identified within the Trust as a result of mortality review undertaken since the last report to the Board of Directors.	**Approval**	
	Discussion	
	Information	✓

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

Summary of Key Issues
This report presents information that the Trust is nationally mandated to report to public Board meetings on a quarterly basis – i.e. the number of deaths in scope, the number reviewed and the assessment of problems in care scores; as well as the learning realised from mortality review. The Annexes to the report present the data outlined in the report in the nationally prescribed dashboard format. The report also contains additional information over and above national requirements in order to provide the Board of Directors with information relating to actions being taken in response to trends identified from the data and assurances in terms of the timeliness of review processes. There were **120** deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in Q4. This is significantly higher than the same quarter in 2019/20 and with other quarterly figures for periods not impacted by COVID-19. The quarter has been directly impacted by COVID-19 with over half (n. 69) of the 120 deaths occurring in January 2021 during Wave 2. For February and March 2021, mortality levels had returned to those consistent with previous quarters not impacted by COVID-19. Further information is included in the attached report. Of the 120 deaths, 27 were inpatient deaths and 11 were nursing home deaths. 24 of the 27 inpatient deaths and 9 of the 11 nursing homes deaths have been confirmed as due to natural causes. The remaining causes of death are currently under determination. The attached report includes details of the grade of review to which deaths are being subjected and the timeliness of completion of those reviews. It indicates that the improvement in the timeliness of consideration via the Deceased Patient Review Group has continued. It also indicates that the significant majority of deaths continue to either be closed at Grade 1 desktop review by the Deceased Patient Review Group or investigated at Grade 4 serious incident investigation, with limited use of the Grade 2 case note review option. This will be addressed via the current implementation of the national Patient Safety Incident Response Framework (PSIRF). The attached report also includes details of the profile of problems in care scores assigned to deaths in scope. This indicates that the significant majority of deaths have been assessed as having no problems in care (score 6). As the reviews of all 2017/18 deaths have now been completed and the data presented in this report, data for 2017/18 will not be included in future reports. The Mortality Review Sub-Committee also oversees a dashboard of information on deaths of substance misuse service users who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death. There are no issues of concern to report. Details of learning from mortality review in Q4 are included in the attached report, together with examples of actions taken in response to learning from mortality review.

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

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

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

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

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

Supporting Documents and/or Further Reading

Attached - Report on Mortality Information and Learning from Deaths for Q4 2020/21
Annex A – 2020/21 Dashboard (national reporting format)
Annex B – 2019/20 Dashboard (national reporting format)
Annex C – 2018/19 Dashboard (national reporting format)
Annex D – 2017/18 Dashboard (national reporting format)

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

Lead
 Natalie Hammond **Executive Nurse**

EPUT

LEARNING FROM DEATHS – MORTALITY REVIEW PUBLICATION OF MORTALITY DATA AND LEARNING QUARTER 4 2020/21

1.0 PURPOSE OF REPORT

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

- Information relating to deaths in scope for mortality review for Q4 2020/21 (1st January – 31st March 2021);
- Updated information relating to deaths in scope for mortality review in Q1-Q3 and in 2019/20, 2018/19 and 2017/18; and
- Learning that has been identified within the Trust as a result of mortality review since the last report to the Quality Committee.

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

2.0 BACKGROUND AND CONTEXT

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

2.2 In line with national guidance, quarterly reports of the nationally mandated information are presented to the Trust Board of Directors outlining mortality data and learning from deaths. This report presents data for Q4 2020/21 (and updated data for previous quarters / years) as at the day the report was prepared (i.e. 28th June 2021).

3.0 SCOPE OF DEATHS INCLUDED IN THIS REPORT

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

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

4.0 TOTAL NUMBER OF DEATHS IN SCOPE FOR REVIEW

4.1 There were **120 deaths** which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in **Q4 2020/21**. This is significantly higher than the same quarter in 2019/20 and with other quarterly figures for periods not impacted by COVID-19. The quarter has been directly impacted by COVID-19 with over half (n. 69) of the 120 deaths occurring in January 2021 during Wave 2. For February and March 2021 mortality levels had returned to those consistent with previous quarters not impacted by COVID-19.

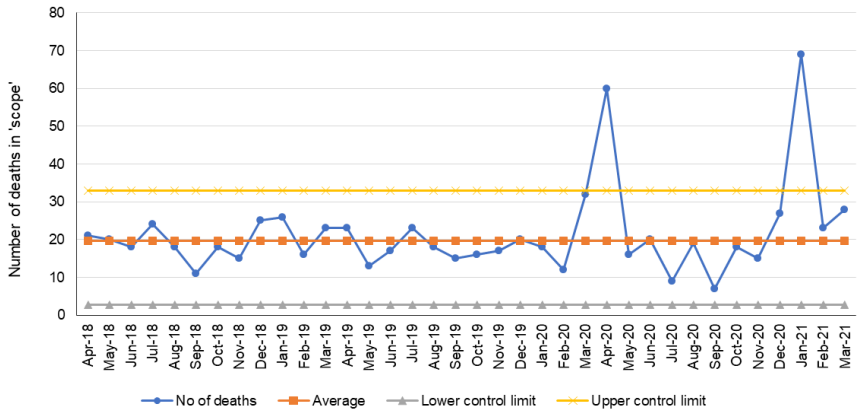
Table 1: Breakdown of total deaths in scope for review

Period	Total 2017/18	Total 2018/19	2019/20 Q1 Total	2019/20 Q2 Total	2019/20 Q3 Total	2019/20 Q4 Total	Total 2019/20	2020/21 Q1 Total	2020/21 Q2 Total	Oct 2020	Nov 2020	Dec 2020	2020/21 Q3 Total	Jan 2021	Feb 2021	Mar 2021	2020/21 Q4 Total	Total 2020/21
Deaths in scope	248	235	53	56	57	62	228	96	35	18	15	27	60	69	23	28	120	311

4.2 Please note, the total number of deaths in Q1 2020/21 was also impacted by COVID-19. Reviews of deaths potentially related to COVID-19 were undertaken in order to identify learning and proactive actions taken to enhance clinical practice based on the findings of those reviews.

4.3 Figure 1 below shows the total number of deaths that fell within the scope of the policy each month in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2017 – November 2018). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. Figure 1 below indicates that the number of deaths in scope in Q4 falls outside of the control limits in January 2021. This is COVID-19 related and further details are included below.

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



4.4 Of the 120 deaths in Q4, 27 were inpatient and 11 were nursing home deaths. Given the nature of the services provided by the Trust, there will be a number of deaths that occur on inpatient wards and in nursing homes which will be expected and which will be due to natural causes. Of the 27 inpatient deaths, 24 have been confirmed as due to natural causes and 9 of the 11 nursing homes deaths have been confirmed as due to natural causes. The remaining causes of death are currently under determination.

4.5 The number of inpatient deaths is significantly higher than quarters not impacted by COVID-19, and is consistent with levels experienced in Q1 2020/12 which was also impacted by COVID-19. There were a total of 26 inpatient deaths for the quarter in community health services, 17 of which occurred in January 2021. These deaths were related to the re-purposing of a number of wards in West Essex Community Health Services and in South Essex Community Health Services during this time to provide end of life care to COVID-19 patients. The number of deaths within the nursing homes, whilst higher than some quarters, is significantly lower than the number of deaths experienced within the nursing homes in Q1 at the height of Wave 1. The number of Learning Disability deaths also appears to be higher than average, particularly in January 2021. All these deaths have been reported to the LeDeR national mortality review programme for Learning Disability deaths as well as work undertaken locally to review these deaths. The learning disability lead commissioner (Essex County Council) is in the process of preparing a report on findings from LeDeR during the COVID-19 pandemic which will be shared with the Trust and other service providers.

5.0 GRADE AND PROGRESS OF REVIEWS / INVESTIGATIONS

5.1 The Trust has assurance that all deaths within scope have been or are in the process of being reviewed. The table below outlines the grade of review / investigation to which deaths in scope have been / are being subjected to. Please see paragraphs 5.4 - 5.8 below for information in terms of timeliness of review progress.

Table 2: Breakdown of grade of reviews / investigations of deaths in scope

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

Grade of review / investigation	2017/18 total	2018/19 total	2019/20 total	2020/21 Q1 total	2020/21 Q2 total	2020/21 Q3 total	2020/21 Q4 total	2020/21 total
Grade 1 Deceased Patient Review Group	148	147	144	72	17	30	65	184
	60%	63%	63%	75%	47%	50%	54%	59%
Grade 2 Case Note Review	11	19	16	3	0	0	0	3
	4%	8%	7%	3%	0%	0%	0%	1%
Grade 3 Critical Incident Review	1	0	1	0	0	0	0	0
	0.5%	0%	1%	0%	0%	0%	0%	0
Grade 4 Serious Incident Investigation	88	69	65	17	16	18	21	72
	35%	29%	28%	18%	46%	30%	18%	23%
Final grade under determination	0	0	2	4	2	12	34	52
	0%	0%	1%	4%	8%	20%	28%	17%
TOTAL	248	235	228	96	35	60	120	311

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

- closed at Grade 1 desktop review by the Deceased Patient Review Group (60% 2017/18, 63% 2018/19, 63% thus far 2019/20 and 59% thus far 2020/21); or
- being investigated as Grade 4 serious incident investigations (35% 2017/18, 29% 2018/19, 28% 2019/20 and 23% 2020/21).

5.3 There has been limited use of the Grade 2 clinical case note review option (only 4% in 2017/18, 8% in 2018/19, 7% in 2019/20 and 1% thus far in 2020/21). This has been kept under review and has been taken into account in development of the national Patient Safety Incident Response Framework (PSIRF) arrangements being put in place across the Trust.

5.4 Positive progress has continued since the last report to the Board of Directors in terms of the timely consideration of deaths via mortality governance processes, with only 17% of deaths in 2020/21 and 1% of deaths in 2019/20 requiring the grade of review to be determined. The Deceased Patient Review Group is awaiting further requested information on the 2 deaths in 2019/20 requiring a grade of review to be finalised.

5.5 As the reviews of all 2017/18 deaths have now been completed and the data included in this report, data for 2017/18 will not be included in future reports.

5.6 There has been good progress with completing Case Note Reviews this quarter as and when capacity has allowed. Since the last report to the Quality Committee, eight Case Note reviews have been completed and approved by the Deceased Patient Review Group.

5.7 Case Note Reviews constitute all reviews still in progress for 2018/19 deaths. A total of three Case Note Reviews are still outstanding – all have been completed and were considered by the Deceased Patient Review Group in May. However they have been referred for further information prior to final sign off. The seven open Case Note Reviews for 2019/20 deaths are due to be scheduled for consideration by the Deceased Patient Review Group at the end of July.

5.8 Reviews / investigations have already been completed for 79% of deaths in 2020/21. The continuation of improvement of timeliness of consideration via the Deceased Patient Review Group has continued with virtual Group meetings being held on a monthly (sometimes fortnightly) basis to ensure timely review of deaths within scope of the Mortality Review Policy.

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

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

Score	*2017/18 (Number)	*2017/18 (as a %)	2018/19 (Number)	2018/19 (as a %)	2019/20 (Number)	2019/20 (as a %)	2020/21 (Number)	2020/21 (as a %)
6 - definitely less likely than not	115	86%	191	81%	169	74%	204	65%
5 - slight evidence	14	10%	22	9%	28	12%	22	7%
4 - not very likely	3	2%	11	5%	14	6%	8	3%
3 - probably likely	2	2%	6	3%	4	2%	0	0%
2 - strong evidence	0	0%	1	1%	0	0%	0	0%
1 - definitely more likely than not	0	0%	0	0%	0	0%	0	0%
Under determination	0	0%	4	2%	13	6%	77	25%

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

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

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

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

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

8.0 LEARNING FROM MORTALITY REVIEW OF DEATHS

8.1 LEARNING FROM INDIVIDUAL MORTALITY REVIEW

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

8.1.2 Example of learning themes from Q4 have related to documentation/recording of information; risk assessments and care plans; physical health; communication; care coordination; disengagement and engagement with family/carer.

8.2 LEARNING FROM THEMATIC MORTALITY REVIEW

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

8.2.2 The outcomes of the review of a random sample of 9 unexpected deaths in 2019/20 closed at Grade 1 by the Deceased Patient Review Group were presented to the Mortality Review Sub-Committee in May 2021. The care during the phase of end of life care in all patients reviewed was deemed to be adequate according to notes on records. In all the cases the reviewer noted evidence of good collaborative care

between the nursing teams and medical teams. Some areas of good practice as well as lessons learnt were identified within the reviewed records. Learning and recommendations included issues related to ensuring that all patients have a recent risk assessment available within their care record that staff can access; ensuring clinical records are updated to document circumstances, where known, relating to deaths; and increasing the number of clinical staff across the Trust with access to, and trained in navigating, the Health Information Exchange system to assist obtaining a full picture of a patient's physical health using electronic records in an emergency medical situation. Based on the fact that no significant problems in care were identified by the reviewers during the review of care provided by EPUT, it is concluded that it was not inappropriate for the deaths to be closed by the Deceased Patient Review Group at Grade 1 thus providing a degree of assurance that the Trust is not missing significant care issues as a result of its current review processes.

8.3 EXAMPLES OF LEARNING IMPLEMENTED

8.3.1 The Trust actively ensures that learning identified from the reviews leads to improvements in practice. Examples of actions taken in response to learning identified from reviews include:

- New guidance has been implemented to support staff when calling an ambulance or to transfer a patient – this uses the SBAR approach (Situation-Background-Assessment-Recommendation). It supports the effective transfer of clinical information along with ensuring the ambulance service understand that our hospital environments are not equipped for the deteriorating patient and that response times reflect this.
- Oxehealth, a digital system, has been introduced to support observation and engagement.
- A review of the Trust's Observation and Engagement Policy/Procedure was undertaken by the Observation and Engagement Task and Finish Group. There is a plan to further review the Policy/Procedure in September in order to take into account the findings of the Care Quality Commission led national group on Observation and Engagement which should be concluded by that time. It is anticipated that this national group will advise on the details of good practice from the regulators view. In addition, by September, information will be available on the implementation of the Engagement and Supportive Observation Plan (see below) in practice within the Trust including audit data.
- The above internal review led to the implementation of the Engagement and Supportive Observation Plan across all EPUT mental health wards. The intention is that this plan is started on admission for every patient, noting the current observation level and clinical reason for the level. When the levels are being reviewed and there is a change, a new plan should be completed to record the clinical reason for change. The implementation of this new process is being monitored and refinements will be made as necessary.
- An airlock time delay system has been added to the exit route from one of the Trust's inpatient units to ensure that one door cannot open before the other is closed. A site inspection was carried out by Estates and actions taken to implement the learning identified from a review. Learning was also shared with unit staff and Trustwide via the 5 Key Messages Bulletin.
- Whiteboards and a dashboard have been introduced to support effective handover between shifts. Through piloting of these electronic handovers, it has

been possible to equip wards with the necessary IT equipment so they are ready for implementation as the approach is rolled out across the Trust.

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

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

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

The Trust also uses these quality reviews to demonstrate a culture of reflection and learning within EPUT i.e. to HM Coroner, Commissioning bodies.

9.0 CONCLUSIONS AND FUTURE ACTIONS

9.1 This report provides assurances that all deaths in Q4 which were within scope for mortality review have been reviewed / investigated or are in the process of being reviewed / investigated. The report also provides assurances that the overarching aim of mortality review – i.e. learning from deaths - is being achieved with examples of the learning themes being acted upon.

10.0 ACTION REQUIRED

10.1 The Board of Directors is asked to:

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

Report prepared by:
Michelle Bourner, Project Co-ordinator

On behalf of:
Natalie Hammond, Executive Nurse

July 2021

ANNEX A – MORTALITY DATA DASHBOARD 2020/21

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

Trust	EPUT
Month	Jun-21
Year	2020-21

Total Deaths in Scope:

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

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

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2020-21	Q1	96	8	88	64	0	0	3	0	0	17	0	6	0	0	0	4	8	68	8
YTD		**96**	**8**	**88**	**64**	**0**	**0**	**3**	**0**	**0**	**17**	**0**	**6**	**0**	**0**	**0**	**4**	**8**	**68**	**10**
2020-21	Q2	35	6	29	11	0	0	0	0	0	13	3	2	0	0	0	1	2	17	9
YTD		**131**	**14**	**117**	**75**	**0**	**0**	**3**	**0**	**0**	**30**	**3**	**8**	**0**	**0**	**0**	**5**	**10**	**85**	**17**
2020-21	Q3	60	15	45	19	0	0	0	0	0	15	3	8	0	0	0	3	6	23	13
YTD		**191**	**29**	**162**	**94**	**0**	**0**	**3**	**0**	**0**	**45**	**6**	**16**	**0**	**0**	**0**	**8**	**16**	**108**	**30**
2020-21	Q4	120	32	88	38	0	0	0	0	0	16	5	29	0	0	0	0	6	44	38
Total 2020-21		**311**	**61**	**250**	**132**	**0**	**0**	**3**	**0**	**0**	**61**	**11**	**45**	**0**	**0**	**0**	**8**	**22**	**152**	**68**

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

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

Trust	EPUT
Month	Jun-21
Year	2020-21

Learning Disability Deaths

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

Financial Year	Quarter	Total Number of Learning Disability Deaths (inc inpatient and community)	Total number of these LD Deaths subjected to national LeDeR programme	Number of these LD deaths subjected to review by the Trust									Extent that these LD deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
				Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CI)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
				Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2020-21	Q1	8	8	8	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0
YTD		8	8	8	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0
2020-21	Q2	6	6	5	0	0	0	0	0	0	0	1	0	0	0	0	0	5	1
YTD		14	14	13	0	0	0	0	0	0	0	1	0	0	0	0	0	13	1
2020-21	Q3	15	15	11	0	0	0	0	0	0	0	4	0	0	0	0	0	11	4
YTD		29	29	24	0	0	0	0	0	0	0	5	0	0	0	0	0	24	5
2020-21	Q4	32	32	28	0	0	0	0	0	0	0	4	0	0	0	0	0	28	4
Total 2020-21		61	61	52	0	0	0	0	0	0	0	9	0	0	0	0	0	52	9

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

ANNEX B – MORTALITY DATA DASHBOARD 2019/20

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

Trust	EPUT
Month	Jun-21
Year	2019-20

Total Deaths in Scope:

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

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

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2019-20	Q1	53	8	45	24	0	5	1	0	0	15	0	0	0	0	0	2	6	34	3
YTD		53	**8**	45	24	0	5	1	0	0	15	0	0	0	0	0	2	6	34	3
2019-20	Q2	56	3	53	24	0	3	0	0	0	26	0	0	0	0	3	4	12	34	0
YTD		109	11	98	48	0	8	1	0	0	41	0	0	0	0	3	6	18	68	3
2019-20	Q3	57	11	46	26	0	0	4	0	1	14	0	1	0	0	1	5	6	30	4
YTD		166	**22**	144	74	0	8	5	0	1	55	0	1	0	0	4	11	24	98	7
2019-20	Q4	62	8	54	39	0	2	2	0	0	10	0	1	0	0	0	3	4	41	5
Total 2019-20		228	30	198	113	0	10	7	0	1	65	0	2	0	0	4	14	28	139	12

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

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

Trust	EPUT	**Learning Disability Deaths**
Month	Jun-21	
Year	2019-20	• All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system

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

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

ANNEX C – MORTALITY DATA DASHBOARD 2018/19

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

Trust	EPUT
Month	Jun-21
Year	2018-19

Total Deaths in Scope:

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

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

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2018-19	Q1	59	7	52	34	0	5	1	0	0	12	0	0	0	0	2	0	3	46	1
YTD		59	**7**	52	34	0	5	1	0	0	12	0	0	0	0	2	0	3	46	1
2018-19	Q2	53	11	42	19	0	3	1	0	0	19	0	0	0	1	3	3	4	30	1
YTD		112	18	94	53	0	8	2	0	0	31	0	0	0	1	5	3	7	76	2
2018-19	Q3	58	4	54	27	0	5	0	0	0	22	0	0	0	0	0	5	7	42	0
YTD		170	**22**	148	80	0	13	2	0	0	53	0	0	0	1	5	8	14	118	2
2018-19	Q4	65	10	55	35	0	3	1	0	0	16	0	0	0	0	1	3	8	42	1
Total 2018-19		235	32	203	115	0	16	3	0	0	69	0	0	0	1	6	11	22	160	3

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

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

Trust	EPUT	**Learning Disability Deaths**
Month	Jun-21	
Year	2018-19	• All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system

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

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

ANNEX D – MORTALITY DATA DASHBOARD 2017/18

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

Trust	EPUT	**Total Deaths in Scope:**
Month	Jun-21	• All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services) • All community Learning Disability deaths (detailed on sheet 2) • All community deaths meeting Serious Incident criteria
Year	2017-18	Plus from Q3: * Deaths subject to a complaint / claim * Deaths subject to a serious staff concern * Severe Mental Illness as defined in Policy (not already included in above categories)

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)			1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress	Under determination							
2017-18	Q1	59	13	46	19	0	3	0	0	0	24	0	0	Please note, prior to implementation of the Mortality Review Policy from 1st October 2017 (timeframe in line with the National Guidance on Learning from Deaths), the Trust did not operate a process to assess the extent to which deaths reviewed / investigated were due to problems in care using a scale of 1 - 6. It is therefore not possible to complete this information for quarters 1 and 2. All Grade 4 (Serious Incident) investigations undertaken during this period used established root cause analysis methodology and identified learning arising from the investigation. Further information is included in the narrative report accompanying this dashboard.						
YTD		59	**13**	46	19	0	3	0	0	0	24	0	0							
2017-18	Q2	55	9	46	23	0	0	0	0	0	23	0	0							
YTD		114	22	92	42	0	3	0	0	0	47	0	0							
2017-18	Q3	58	9	49	26	0	6	0	1	0	16	0	0	0	0	1	2	5	41	0
YTD		172	31	141	68	0	9	0	1	0	63	0	0	0	0	1	2	5	41	0
2017-18	Q4	76	9	67	41	0	2	0	0	0	24	0	0	0	0	1	1	9	56	0
Total 2017-18		248	40	208	109	0	11	0	1	0	87	0	0	0	0	2	3	14	97	0

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

Learning from Deaths Dashboard - Breakdown for learning disability deaths

Trust	EPUT
Month	Jun-21
Year	2017-18

Learning Disability Deaths

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

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

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

		Agenda Item No: 7e
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28th July 2021**

Report Title:	**Duty of Candour Annual Review**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Fiona Thomas, Head of Patient Safety Incident Management & Mortality					
Report discussed previously at:	Executive Committee					
Level of Assurance:	**Level 1**		**Level 2**	**x**	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	None
State which BAF risk(s) this report relates to	BAF63 - Learning and Improving
Does this report mitigate the BAF risk(s)?	Yes
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
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 annual position on Duty of Candour compliance • An updated summary of associated workstreams for the year 2020/21 • An overview of the updated guidance on meeting the Duty of Candour (CQC Regulation 20)	**Approval**	x
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Request any further information or action.
3 Approve the 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 an extended training programme, further work being undertaken around family involvement in investigations as part of PSIRF implementation and further improvements to incident reporting and management to support transparency.
- The Trust was compliant with Duty of Candour timeframes and requirements for all applicable incidents during 2020/21.

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

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

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

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

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

Agenda Item 7e
Board of Directors
28th July 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DUTY OF CANDOUR

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 2020-21. 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 both the Patient Safety Incident Response Framework and the EPUT Patient Safety Incident Response Plan (PSIRP). The Trust's PSIRP was reviewed following the updated guidance and no changes were required. 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 WORKSTREAMS

A review of the Patient Safety Incident Management Team resource was undertaken as part of the planning for implementation of PSIRF. As a result of this, the Trust created two Band 7 Family Liaison/Inquest Lead roles whose duties include:

- 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.
- Ensure that patients/families/carers are fully involved in the investigative process and supported by the allocated Family Liaison Officer to access appropriate support as and when required, fulfilling Duty of Candour principles.
- Undertake the role of Family Liaison Officer for more complex and/or sensitive cases.
- Responsible for the management of inquest cases from investigation through to completion and closure.
- Routine reporting on inquest activity and the highlighting of any potentially problematic cases and those likely to become high risk and/or high profile to the organisation.
- Advise and support staff called to give evidence at Coroners' Inquests and will establish strong relationships across operational services within the Trust and with HM Coroner's Office.

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

- Mandatory Being Open/Duty of Candour training for staff via e-learning and within the Trust induction programme.
- FLO's 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 process.
- Patients/families are central to the review/investigation process as detailed in 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 investigations required.
- Commissioning of case note reviews and monitoring via the Deceased Patients Review Group and presentation of learning to the Mortality Review Sub-Committee.

4.0 COMPLIANCE

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

Directorate	Total applicable cases	DoC timeframe achieved	Total
North Essex MH	39	39	**39**
South Essex MH	31	31	**31**
Specialist Services	2	2	**2**
South Essex CHS	0	0	**0**
West Essex CHS	1	1	**1**
EPUT TOTAL	73	73	**73**

5.0 RECOMMENDATIONS

It is recommended that the Board of Directors:

1. Note the content of this report
2. Recommend any further actions as required

6.0 ACTION REQUIRED

The Board of Directors is asked to:

1. Approve the Report
2. Request any further information or action

Report written by

Fiona Thomas
Head of Patient Safety Incident Management & Mortality

On behalf of:

Natalie Hammond
Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 7f
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28th July 2021**

Report Title:	Emergency Preparedness, Resilience and Response Annual Report					
Executive/Non-Executive Lead:	Nigel Leonard Executive Director – Major Projects					
Report Author(s):	Amanda Webb, Senior Emergency Planning and Compliance Officer					
Report discussed previously at:	Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	No risks identified
State which BAF risk(s) this report relates to	BAF38 - C19 Emergency Planning
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report for the Board of Directors to provide assurance that EPUT has effective organisation resilience measures in place to respond to a Major Incident, Critical Incident or Business Continuity issue. The report provides evidence of the Trusts achievements and continued commitment to the organisational resilience during 2020-21 in order to meet the requirements of the Civil Contingency Act 2004 and NHS England's Emergency Preparedness, Resilience and Response Framework 2015.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

- Consider the detail within this report.
- Note the positive assurance provided.
- Request further action / information as required.

Summary of Key Issues

The DOH requires all NHS Trusts to be prepared to be a category 1 responder and EPUT has systems and processes in place to be prepared to this level and fulfils its civil protection duties.

Two Major Incidents have taken place over 2020-21 Covid 19 and EU Exit.

Governance

NHS England EPRR Core Standards 2020-21

The Trust remains "fully compliant" with a total of 54 out of the 54 standards applicable to mental health and community care trusts.

Major Incident Plan

EPUTs Major Incident Plan has been enacted throughout 2020/21 in response to Covid 19. EPUTs Major Incident Plan details EPUTs response to a major incident including clear action cards and details the role of EPUT in the wider system. Due to Covid-19 no 'Live Play' testing of the Major Incident Plan was undertaken.

Business Continuity Plans (BCP)

Throughout 2020/21 BCPs have successfully been enacted at different times in response to Covid 19 and other incidents which have impacted on individual areas.

EU-Exit

The Trust Task and Finish Group has continued in 2020/21 and no significant risks were realised in 2020/21 due to EU Exit.

Covid19

The Trust continues managing EPUTs response to Covid 19 and has remained in a major incident response throughout 2020/21. A virtual Incident Control Centre was established which remains operational 7 days a week as is required.

A full command structure was initiated at the start of Covid 19 with three levels of command Gold, Silver and Bronze. Command meetings were initially held daily but the frequency has been continually reviewed as the system pressures change. Command is currently held via Microsoft Teams due to the Social Distancing. An electronic log is being maintained by a team of Loggists.

Leadership

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

In addition there is a dedicated EPRR team, which was expanded in 2020/21 in response to Covid 19. The EPRR team is led by Jane Cheeseman, Head of Compliance and Emergency Planning supported by Amanda Webb, Senior Emergency Planning and Compliance Officer for day to day actions

Culture

Due to Covid 19 2020/21 has been a challenging year for everyone and has created specific challenges for the NHS. The Trust staff have continued to provide services to our population throughout this challenging period and have worked in partnership with the wider system to support pressures on acute colleagues. The Trust has supported in a range of ways including:

- Changing EPUT wards into Covid step down wards
- Embracing new technology to continue patient care
- Changing how some community service are undertaken
- Adopting new ways of working in line with Covid 19 guidance

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

Continuous Learning

The Major Incident Plan (RM14) and relevant individual plans have been reviewed, incorporating learning from Covid 19 and are being presented to Health, Safety and Security Committee June 2021 for approval.

BCPs - Learning from enacting of BCPs has led to a review of the EPUT BCP template to simplify and ensure the template can BCP can be applied regardless of the type of incident. The new BCP template was approved by the Health, Safety and Security Committee in May 2021.

Covid19 - Silver Command undertook a reflection on changes made throughout Covid-19, focussing on what had worked well and what had not. The aim was to identify those changes that have been of benefit to the service and those that have been a challenge. The feedback has been shared to explore areas that could be built on to inform the Trusts Operating Model where change led to working more efficiently and effectively.

The majority of the changes have been areas that have supported home working while still being able to provide a full service whether that be for our patients or corporate functions of the Trust and the use of virtual meetings to avoid staff having to travel to one site to attend a Trust meeting.

The Lakes: Power Outage – Learning from the power outage at the lakes identified that the back up generator had run out of fuel as Estates were not made aware that there was a power outage. Two key changes are being made following this incident:

- Process to be identified of how Services are aware the generator is powering the building – Estates
- New BCP to have clear Action Cards in place although it appears the site did everything as expected in response to the Power Outage – EPRR Team

Wellbeing

Here for you:- In response to Covid 19 the Trust implemented a new “hear for you” service open to all staff and offered to other organisations in the local area. This service has been set up to support all staff, clinical and non-clinical, across health and social care, primary care and voluntary services. Support services are already in place for many staff through Employee Assistance Programmes and Occupational Health, as well as Mental Health First Aiders. Here for you is an overarching service which prioritises staff needs, signposts to the right help at the right time, provides a priority referral if needed and helps rebuild resilience levels. Here for you is run by experts in the mental health field

Strategic Commanders and Loggist Training - A number of directors and staff are trained and up to date with their training with further training scheduled for 2021-22.

EPRR Award - Due to volume of applications only one funded place has been offered to the Trust for 2021-22

Innovation

In response to Covid 19 the organisation moved rapidly to a virtual workforce where possible with staff providing equipment needed to work from home. A central part of this has been implementation of new technology including Microsoft Teams. This has enabled the Trust to continue to operate all Trust committees (some with reduced frequency) and set up a virtual Incident Control Centre.

The Trust has also implemented new live briefings via virtual technology. This has enabled Covid 19 and EU Exit messages to be shared in person weekly from the CEO and Executive Team to all staff members.

New ways of virtual work have been welcomed and have led to a number of benefits including less travel for clinical staff to meetings and less use of office space enabling social distanced working.

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

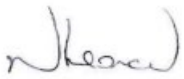
Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19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

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

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

Acronyms/Terms Used in the Report			
EPRR	Emergency Preparedness, Resilience and Response	MIRT	Major Incident Response Team
LHRP	Local Health Resilience Partners	ICC	Incident Control Centre
BCPs	Business Continuity Plans	CCG	Clinical Commissioning Group

Supporting Documents and/or Recommended Further Reading
Emergency Preparedness, Resilience and Response Annual Report 2020-21

Lead
 **Nigel Leonard** **Executive Director – Major Projects**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Emergency Preparedness, Resilience and Response Annual Report 2020-21

1. INTRODUCTION

1.1. PURPOSE

The purpose of this annual report it to provide assurance to the Health, Safety & Security Committee, and ultimately the Trust Board, that EPUT has robust and effective organisational resilience measures in place to respond to a Major Incident, Critical Incident or Business Continuity issue.

This report also presents evidence of the Trust's achievements and continued commitment to organisational resilience during 2020-2021.

1.2. ACCOUNTABILITY

The NHS Act 2006 (as amended) places a duty on relevant service providers to appoint an individual to be responsible for discharging their duties under section 252A. This individual is known as the Accountable Emergency Officer (AEO) who is an Executive Director of the Board (Nigel Leonard) and Deputy AEO who is a Non-Executive Director of the Board (Janet Wood). However the Chief Executive Officer, Paul Scott holds overall responsibility. In addition there is a dedicated EPRR team, which is led by Jane Cheeseman, Head of Compliance and Emergency Planning supported by Amanda Webb, Senior Emergency Planning and Compliance Officer for day to day actions.

1.3. RELEVANT GUIDANCE

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

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

2. NHS ENGLAND EPRR CORE STANDARDS 2020-2021

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

The NHS England Core Standards for EPRR are split into ten domains:

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

Due to COVID 19; NHSE/I did not request a full review of the core standards in 2020, but for Trusts to provide assurance that they remain compliant from the previous year and to provide an update on progress of any non-compliant standards.

An assurance meeting was held on 23rd September 2020 to confirm the Trusts compliance with the 2020 core standards. The CCG assurance lead was satisfied that the Trust remained fully complaint with the 2020 core standards, this was presented at board on the 25th September 2020. Following approval by Board, full compliance was confirmed to the assurance lead in order for it to be fed into the NHSE/I Regional and National EPRR team.

The Trust remains to be "fully compliant" with a total of 54 out of the 54 standards applicable to mental health and community care trusts. The Trust is awaiting for the NHS England EPRR Core Services for 2021-22.

3. CIVIL CONTINGENCIES ACT 2004

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

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

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

For the NHS, incidents are classed as either:

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

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

support from other agencies, to restore normal operating functions.

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

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

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

1. Assess the risk of emergencies occurring and use this to inform contingency planning
2. Put in place emergency plans
3. Put in place business continuity management arrangements
4. Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
5. Share information with other local responders to enhance co-ordination
6. Cooperate with other local responders to enhance co-ordination and efficiency

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

4. RISK ASSESSMENTS

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

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

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

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

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

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

The Trust's approach to emergency planning ensures that the Trust would be in a position to respond appropriately in the event of an incident relating to those significant risks identified in the community risk registers. The Trust also uses its standard risk management framework and

processes to identify any specific local risks relating to business continuity / resilience and these are managed in line with standard Trust risk management processes.

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

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

5. MAJOR INCIDENT PLAN

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

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

The Major Incident Plan (RM14) and relevant individual plans are being presented to Health, Safety and Security Committee June 2021 following a full review as required.

6. BUSINESS CONTINUITY PLANS

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

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

An Organisational Business Continuity Plan is in place which priorities services which should be provided in the event of a business continuity incident. This was approved by the Health, Safety and Security Committee in July 2018. Again, this is formally reviewed every three years or earlier if required due to changes within the health sector, the Trust or Emergency Planning legislation. This was reviewed and each service business continuity plan was updated in March 2020 due to the COVID19 pandemic.

To underpin the organisational Business Continuity Plan, all services across EPUT have developed Business Continuity plans which:

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

Over the past year teams have continually been asked to update their BCP particularly as and when a new incident has been identified or occurred (EU-exit, Winter Planning and Covid-19). The review of BCP's identified that these should be designed and written to encounter any situation, as the risk on the service would be the same, for instance:

- Loss of People (knowledge and skills)
- Loss of Premises (buildings and facilities)
- Loss of Resources (IT, information, equipment, materials)
- Loss of Suppliers (products, services supplied by a third party)

The cause of the risk to service is largely irrelevant, as they will still be managed in the same way.

In addition, the learning from Covid-19 has enabled us to identify that the current format of the BCP's are not fit for purpose and do not necessary provide the Ward / service with the steps to take in the event of an incident. The template is also difficult for services to complete.

A new BCP template was approved by the Health, Safety and Security Committee in May 2021 therefore the EPRR Team are in the process of working with Services in order to transfer the data from the existing BCP and aiding the completion of the new BCP. Some of the key changes with the new BCP template are:

- It can be adapted per location or per Service
- There are clear Action cards identify what the service needs to do in the event of an incident
- Identification of back up premises in the event of an incident and the resources required to move the service

7. COMMUNICATIONS PLAN

A well-informed public is better able to respond to an emergency and to minimise the impact of the emergency on the community so it is vital to ensure consistent messages appropriate to the needs of the audience. The trust has a Communications plan in place to ensure that this happens in a timely manner. There are various means available to be utilized i.e. Pando, WhatsApp, intranet, cascade text messages, resilience direct etc.

8. PARTNERSHIP WORKING

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

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

9. LOCAL RESPONDERS

9.1. Local Resilience Forums

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

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

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

9.2. Local Health Resilience Partnerships (LHRP)

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

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

Due to Covid-19, all forums have been cancelled however, when they resume the Head of Compliance and Emergency Planning or Senior Emergency Planning and Compliance Officer will attend.

10. NATIONAL GUIDANCE

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

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

However due to Covid-19 and the continual 'Live Play' incident, further exercises have not been undertaken.

10.1. COMMUNICATIONS

Exercise Starlight is a six monthly communications test exercise facilitated by NHS England and the CCG's. Due to the pandemic, exercise Starlight did not occur during 2020 – 21.

10.2. TABLETOP

There have been no exercises held for 2020 - 21 due to the pandemic, which is covered below in the live play section.

10.3. LIVE PLAY

The Trust experienced the following events of note during 2020 - 21:

10.3.1 EU-Exit

The end of the transmission stage for leaving the UK was the 31st December 2020. Leading up to the date, in preparation, the Trust participated in regular SITREPS with NHSE, CCG and partner agencies preparing for a no deal EU Exit.

Following leaving the EU, the Trust continues to hold task and finish group meetings on a monthly basis alongside monthly admin meetings to review and monitor any requirements that are relevant to the Trust and our services. EU Exit correspondence is included in the daily ICC procedures covering the mailboxes between 8am-6pm 7 days a week. The Trust continue to highlight any areas of concern relating to EU EXIT in our National Daily Sit Rep return to NHSEI positively or negatively as required since 23rd December 2020. Members of the Task & Finish Group are in attendance at Silver/Gold Command and confirmation is obtained on the above requirements for any EU Exit related issues which are expected to impact business critical services.

10.3.2 COVID19

The Trust continues managing the Trusts response to the current Pandemic of Coronavirus. We remain to be in major incident response, with the Command meeting frequency being continually reviewed as the system pressures change.

As the Lockdown has been gradually lifted and a reduction in the receipt of national and regional guidance continues, the (virtual) Incident Control Centre remains operational 7 days a week however, the hours have reduced from 8am until 8pm Monday to Friday to 8am until 6pm as the NHS response level reduced to Level 3 on the 25th March. Weekends continue to operate 8am until 6pm in line with the East of England Operational Centre working hours.

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

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

10.4 COMMAND POST

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

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

11 LESSONS LEARNED

11.3 Covid-19

Silver Command undertook a reflection on changes made throughout Covid-19, focusing on what had

worked well and what had not. The aim was to identify those that have been of benefit to the service and those that have been a challenge. The feedback has been shared to explore areas that could be built on to inform the Trusts Operating Model of areas where change led to working more efficiently and effectively.

The majority of the changes have been areas that have supported home working and still being able to provide a full service whether that be for our patients or corporate functions of the Trust.

The introduction of Microsoft Teams has been the biggest impact cited by many teams as beneficial for reasons such as:

- Less travelling to meetings giving back more time for work/clinical care and environmentally friendly
- Improved attendance and productiveness of meetings
- Flexibility of communication and improved communications
- Enabled virtual supervision and improved staff morale as able to check in with staff more frequently
- Increased engagement at team meetings and wider trust meetings
- More privacy of meetings and eliminates need for demand of room bookings
- Ability to hold larger meetings

The only challenges to this being the ease of booking meetings has led to staff being on back to back meetings with little or no breaks. Virtual contact in certain situations has felt less personal and it has been difficult to organise patient group activities.

Staff have adapted to home working and the following have been identified as positive aspects of this change:

- Staff felt able to be more productive
- Decreased staff absence
- Improved work / home life balance
- Improved staff communication, engagement and participation in meetings
- Ability to focus on work without interruptions or distractions of a noisy office environment
- Ability to spend more clinical time with patients as not having to travel to patient homes
- Less travel supporting the eco-friendly approach

Challenges were highlighted when it came to new starters and making them feel involved in the team. Not everyone's environment at home is suitable for home working therefore concerns were raised in regards to suitable working conditions and confidentiality and for some individuals the feeling of isolation.

The restrictions on face 2 face appointments enabled the Trust to identify different contact methods to enable the patient care/consultation to continue and teams have seen this as a benefit as:

- Provided a greater flexibility for patients to have assessments via other methods
- Decrease in DNA due to remote consultations
- Appointment times were able to be increased therefore improving on the time spent with patients
- Enabled a focus on service spec and ability to filter out non-complex patients that were historically on the caseload resulting in efficiencies within the service and an improved outcome for complex patients.

- Patients benefited from having continuity to their care from the service
- Patients not having to travel to the clinics

However there have been some challenges due IT requirements, availability and support for both staff and patients, unable to undertake physical checks and some patients not wanting do via video call therefore had to opt for telephone which meant the clinician had no visual contact with the patients. Many felt that adopting a mix of different methods would be beneficial moving forward and should be led by individual patient clinical need.

There were numerous reflections where there had been an actual change to a service or new service started however these were areas that are already being taken forward by the Trust in working more effectively and efficiently so have not been included.
Having summarised the reflections it appears that staff are keen for Microsoft teams to continue; they want the balance of mainly home working and the option to work from base on occasion and to be able to offer a hybrid of virtual and clinical visits for the people that use our services.

11.4 The Lakes – Power Outage

On the 5th April 2021 at 12:30hrs it was reported that there was a Power Outage at The Lakes and that the generator had stopped working. The site was advised the engineer would attend within 2 hours. Power was returned between 19:00hrs and 19:30hrs.

It became apparent that there was a short Power Outage on Saturday 4th April whereby the Generator tripped in and had been running for the whole period until the Power Outage on the 5th. No one was aware that the building was powered by the Generator therefore the generator had run dry of fuel leading to the power outage on the 5th. Fuel was added to the generator however, the generator was not functioning and was deemed a mechanical breakdown. It is unclear if the breakdown is due to it running dry.

Identified Issues:

- EDF were not aware that the power cable they cut affected the Lakes
- Staff in the building were not aware that there has been a power cut which switched the unit over to the generator
- On Call Maintenance was unable to identify that the building power had been switched over to the generator
- Site Officer was upstairs and unable to get down (however have been informed the power cut affected the ACT therefore all doors were locked but could be open with keys)
- Door Top Alarms stopped working
- Care Plans were unable to be accessed (Hard copies of Patients Safety Plans were available)
- BCP did not cover eventuality of the generator failing/stopping

Fire exit doors were unaffected as, within MH inpatient areas, they are opened by the use of a key.

Reflections from an Emergency Planning Perspective

- Process to be identified of how Services are aware the generator is powering the building – Estates
- New BCP to have clear Action Cards in place although it appears the site did everything as expected in response to the Power Outage – EPRR Team

12 TRAINING 2020-2021

During the year a number of training courses have been completed by EPUT staff relating to Organisational Resilience training, as follows:

12.3 Internal Training

- **General Awareness Training** - Some E-learning resources in relation to organisational resilience and response were available on the Trust's intranet and during the Risk management input of the staff induction course.

12.4 External Training

- **Strategic Commanders Training -** This programme is run by NHS England (East) and provides those who may become involved in managing a major incident response with appropriate knowledge and skills to undertake the role. A number of directors and staff are trained and up to date with their training with further training scheduled for 2021-22.

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

12.5 EPRR Award

EPUT has been offered one place on the EPRR Award course for 2021/22. This will be taken up by the Head of Compliance and Emergency Planning for the Trust.

13 Culture and Wellbeing

Due to Covid 19 2020/21 has been a challenging year for everyone and has created specific challenges for the NHS. The Trust staff have continued to provide services to our population throughout this challenging period and have worked in partnership with the wider system to support pressures on acute colleagues. The Trust has supported in a range of ways including:

- Changing EPUT wards into Covid step down wards
- Embracing new technology to continue patient care
- Changing how some community service are undertaken
- Adopting new ways of working in line with Covid 19 guidance

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

Here for you:- In response to Covid 19 the Trust implemented a new "hear for you" service open to all staff and offered to other organisations in the local area. This service has been set up to support all staff, clinical and non-clinical, across health and social care, primary care and voluntary services. Support services are already in place for many staff through Employee Assistance Programmes and Occupational Health, as well as Mental Health First Aiders. Here for you is an overarching service

which prioritises staff needs, signposts to the right help at the right time, provides a priority referral if needed and helps rebuild resilience levels. Here for you is run by experts in the mental health field

14 Innovation

In response to Covid 19 the organisation moved rapidly to a virtual workforce where possible with staff providing equipment needed to work from home. A central part of this has been implementation of new technology including Microsoft Teams. This has enabled the Trust to continue to operate all Trust committees (some with reduced frequency) and set up a virtual Incident Control Centre.

The Trust has also implemented new live briefings via virtual technology. This has enabled Covid 19 and EU Exit messages to be shared in person weekly from the CEO and Executive Team to all staff members.

New ways of virtual work have been welcomed and have led to a number of benefits including less travel for clinical staff to meetings and less use of office space enabling social distanced working.

15 EPRR WORKPLAN 2020-21

Due to a full review not being undertaken for the Core Service in 2020, a new workplan was not identified. The Trust is awaiting for the NHS England EPRR Core Services for 2021-22 which will then which will then dictate the content of the EPRR Workplan moving forward.

It should also be noted that during 2020-21 the following significant achievements:

- Comprehensive review of all BCP's
- Comprehensive review of all Lockdown exercises
- Comprehensive review of all policies and procedures relating to EPRR
- Secured further Gold Command and Loggist training courses for 2021-22
- The Head of Compliance and Emergency Planning secured a place on the EPRR Award training
- The Trust is involved in one live EPPR case which remains ongoing.

16 ASSURANCE

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

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

Report prepared by:

Amanda Webb
Senior Emergency Planning and Compliance Officer

On behalf of

Nigel Leonard

		Agenda Item No: 7g
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 July 2021**

Report Title:	**Disciplinary (Conduct) Policy and Procedure**					
Executive/Non-Executive Lead:	Sean Leahy Executive Director of People & Culture					
Report Author(s):	Debbie Prentice HR Business Partner					
Report discussed previously at:	Policy Sub-Group – agreed 15 July 2021 Workforce Transformation Group (Chair's Action) Joint Partnership Committee (Chair's Action) Executive Team Committee – 20 July 2021					
Level of Assurance:	**Level 1**		**Level 2**	√	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	If EPUT does not develop a culture based on what is morally right and fair in response to incidents and errors, and is unable to demonstrate that lessons are learnt, then protection of both staff and patients is reduced which may result in poor quality services and patient experience together with lack of actions consistent with prevention impacting on CQC rating
State which BAF risk(s) this report relates to	BAF35
Does this report mitigate the BAF risk(s)?	Yes
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	Employee relations activity is monitored through quarterly and annual reporting as well as through WRES and WDES metrics. Data relating to investigation and disciplinary procedures will be collated, recorded and regularly and openly reported at board level

Purpose of the Report		
This report provides the Board of Directors with the Trust's Disciplinary (Conduct) Policy, Procedure and associated Appendices.	**Approval**	√
	Discussion	
	Information	

Recommendations/Action Required
The Board of Directors is asked to: 1 Review and discuss the Disciplinary (Conduct) Policy & Procedure. 2 Request any further information or action. 3 Approve the Disciplinary (Conduct) Policy & Procedure

Summary of Key Issues
On 22 June 2021 the Executive Team noted the recommendations made in the Learning Lessons to improve People Practice Update on National Guidance regarding Disciplinary Process Report which included: • The reviewed Disciplinary (Conduct) Policy and Procedure to be presented for ratification to the Executive Team. The enclosed policy, procedure and associated appendices has been reviewed and updated in accordance with the recommendations made within Baroness Dido Harding's letter to Trust Chairs and CEOs dated 24 May 2019. The policy, procedure and associated appendices promotes the application of a Just and Learning Culture and ensures objectivity and independence across all disciplinary (conduct) procedures, putting staff health and wellbeing at the centre. The Disciplinary (Conduct) Policy and Procedure will be reviewed and discussed at the Trust's Public Board on 28 July 2021 prior to being published on our public website as requested by Prerana Issar, NHS Chief People Officer, in her letter to HRD's dated 1 April 2021. The policy, procedure and associated appendices have been reviewed and aligned to the patient safety values of 'safety first / safety always' through learning, reflection and taking ownership and accountability to change things for the better.

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

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

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

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

Communication and consultation with stakeholders required			√
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			None
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			
WRES	Workforce Race Equality Standards		
WDES	Workforce Disability Equality Standards		

Supporting Documents and/or Further Reading

Disciplinary (Conduct) Policy
Disciplinary (Conduct) Procedure
Appendix 1 – Disciplinary Hearing Process
Appendix 2 – Disciplinary Rules
Appendix 3 – Delegated Authority
Appendix 4 – Agreed Outcome Principles
Appendix 5 – Investigation Toolkit
Appendix 6 – Disciplinary Decision Tool
Appendix 7 – Conduct Investigation Support Leaflet

Lead

Sean Leahy
Executive Director of People & Culture

Essex Partnership University
NHS Foundation Trust

Disciplinary (Conduct) Policy

POLICY REFERENCE NUMBER	HR27A
VERSION NUMBER	2
KEY CHANGES FROM PREVIOUS VERSION	Reviewed in accordance with Chair, NHS Improvement recommendations issued 24 May 2019
AUTHOR	HR Business Partner
CONSULTATION GROUPS	Policy Sub-Group Joint Partnership Committee
IMPLEMENTATION DATE	April 2017
AMENDMENT DATE(S)	November 2018
LAST REVIEW DATE	March 2021
NEXT REVIEW DATE	March 2024
WORKFORCE TRANSFORMATION COMMITTEE RECOMMENDATION FOR APPROVAL	
APPROVAL BY FINANCE & PERFORMANCE COMMITTEE	
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POLICY SUMMARY

The Disciplinary (Conduct) Policy sets out the framework for the Trust's approach to the management of conduct, behaviour and practice concerns for managers, staff and staff representatives as well as the scope of the policy to whom it applies.

It aims to ensure that the Trust sets out and maintains high standards of conduct, behaviour and practice by its employees and the principles to ensure any issues that may arise are dealt with in a timely, fair, reasonable and consistent manner within the legislative framework and in accordance with the ACAS Code of Practice and Guidance.

The management of disciplinary (conduct) matters within the Trust will be built on and demonstrate the Trust's corporate values and behaviours of being open, compassionate and empowering.

This policy should be read in conjunction with the Disciplinary (Conduct) Procedure.

The Trust monitors the implementation of and compliance with this Policy and Procedure in the following ways:
The Disciplinary (Conduct) Policy and Procedure compliance is monitored via monthly reports to Directorate Senior Management Team Committees. Quarterly and Annual Reports are presented to the Workforce Transformation Group. In addition data is included within WRES and WDES reports published nationally.

Services	Applicable	Comments
Trustwide	Yes	
Essex MH&LD	Yes	
CHS	Yes	

The Director responsible for monitoring and reviewing this policy is the Executive Director of People & Culture

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Disciplinary (Conduct) Policy

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DISCIPLINARY (CONDUCT) POLICY

Assurance Statement

The Policy aims to ensure that Essex Partnership University NHS Foundation Trust ['the Trust'] sets out and maintains high standards of conduct and performance amongst its employees to ensure high standards of conduct, behaviour and practice.

The Policy sets out the Trust's principles ensuring they are dealt with in a timely, fair, reasonable and consistent manner, within the legislative framework and in accordance with the ACAS Code of Practice and Guidance and recommendations made by Baroness Dido Harding (Chair, NHS Improvement) on 24 May 2019.

The management of disciplinary issues within the Trust will be built on and demonstrate the Trust's corporate values and behaviours. These values being:

Open
Compassionate
Empowering

In demonstrating these behaviours and values, supporting the achievement of its strategic objectives to:

SO1: Continuously improve service user experiences and outcomes
SO2: Achieve top 25% performance
SO3: Valued system leader focused on integrated solutions

Equality and Diversity Statement

The Trust is committed to ensuring that equality, diversity, and inclusion is considered in our decisions, actions and processes. The Trust and all trust staff have a responsibility to ensure that they adhere to the Trust principles of equality, diversity, and inclusion in all activities. In drawing up this policy all aspects of equality, diversity, and inclusion have been considered to ensure that it does not disproportionately impact any individuals who have a protected characteristic as defined by the Equality Act 2010

1.0 INTRODUCTION

1.1 This policy introduces the Trust's principles in relation to resolving disciplinary matters. Disciplinary rules and procedures are necessary for promoting positive employee relations and for safeguarding of patients.

1.2 The policy set instruction to understand that the vast majority of it employees provide the very best care they can, given the circumstances they are working in.

1.3 The Trust recognises it is very rarely the intention of staff to provide care that did not go as expected or planned. While this policy is predominantly about how employees are treated, this is with the intent to ensure that the benefits of a '**Just and Learning Culture'** for staff will have a significant and positive impact on patients and their families.

1.4 The policy guides managers and advisers to ensure they attempts to understand all actions before judging employees and that those employees should be supported to learn from their actions. Those responsible for the management of incidents should use the science of human factors, including investigative techniques, skills, expertise and methods that help us fully understand what happened in order to learn from errors or harm in the future.

1.5 The Trust recognises that disciplinary issues can relate to conduct (complying with Trust policy, rules and procedures), including negligence.

1.6 The policy emphasises the Trusts expectation of high standards of conduct from everyone and is committed to applying a **'Just and Learning Culture'**. This policy and associated procedure is designed to ensure a fair, systematic and consistent approach is taken when an employee's behaviour or action is in breach of disciplinary rules or falls short of the expected standards.

1.7 The fair treatment of employees supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame.

1.8 An objective and prompt examination of the issues and circumstances should be carried out to establish whether there are truly grounds for a formal investigation and/or for formal action. Would training for the employee, support, guidance or informal management be more appropriate and productive.

1.9 Where an employee's ability to do their job is affected by a lack of skill or knowledge this will be managed by following the Capability (Performance) Policy and Procedure or, in the case of ill health, the Management of Sickness and Ill Health Procedure.

1.10 This policy is in addition to the provisions, as set out in the terms and conditions of employment. Unless otherwise stated, this policy does not form part of an employee's terms and conditions of employment but is a statement of the Trust's current practice and may be changed from time to time.

1.11 The Trust recognises its responsibility in ensuring that all employees are aware of their obligations whilst at work and the behaviour and conduct expected of them. Employees also have a responsibility to familiarise themselves with the general rules and procedures referred to in their conditions of service and as related to their specific area of work and as required of them by their professional code(s) of conduct and NHS Constitution.

1.12 It is the commitment of the Trust and responsibility of all employees to not discriminate on any grounds. In formulating this policy, aspects of discrimination have been considered so that particular groups are not disadvantaged.

1.13 This policy and associated procedure applies to all employees except Medical and Dental staff or Temporary staff (including bank workers) – please refer to the Procedure For Maintaining High Professional Standards Policy and Procedure or Temporary Worker Conduct & Complaints Policy and Procedure

2.0 DUTIES

Chief Executive

- The Chief Executive has delegated responsibility for ensuring compliance with this policy to the Executive Director of People & Culture.
- Promoting and leading on a **'Just and learning Culture'**

Lead Executive Director

- Executive Director of People & Culture has strategic responsibility for ensuring there is compliance with this Policy and that it is applied in a fair and consistent manner.
- The Executive Director will cascade and communicate to all Executive Directors, Directors, Managers, Human Resources staff, Staff Side representatives / networks and staff so that they are fully aware of the Disciplinary (Conduct) Policy and Procedure and are aware of their responsibilities.
- The Executive Director will ensure that data relating to investigations and disciplinary procedures is collated, recorded and regularly and openly reported at Board level. The Executive Director may share lessons learnt following disciplinary investigations and cascade those to relevant parties to initiate change. **Deputy Director of Human Resources**

- Ensure a disciplinary policy and procedure which promotes good employment relations and a **'Just and Learning Culture'** is in place
- Ensure managers are trained and supported in the implementation of the policy and procedure
- Ensure the disciplinary policy is reviewed and monitored regularly

Human Resources

- Monitor policy implementation to ensure fairness and consistency across the workforce
- Monitor and report on the outcomes of disciplinary action to ensure fairness and consistency across the workforce and encompass the **'Just and Learning Culture'** by promoting and sharing lessons learnt
- Provide training on the implementation of the policy
- Provide advice and guidance on matters relating to the policy
- Inform the relevant Professional Lead of any allegation(s) made involving registered practitioners.
- Ensure the integrity of any investigation by maintaining confidentiality
- Assist in making arrangements for formal hearings in line with agreed timescales.

- Support the Chair of the hearing in ensuring the fair conduct of the hearing and compliance with the Trust Disciplinary Policy.
- Ask questions or clarify any issues raised during the hearing.
- Do not lead on the hearing or questioning.
- Provide advice to the Chair to support their determination of the appropriate sanction taking account of mitigation offered, the seriousness of the case, the sanctions applied in similar cases in the past, any previous warnings which are still in effect, the nature of the employee's job, the work record of the employee.
- Following disciplinary hearing, arrange for Investigatory Reports to be appropriately archived.

Commissioning Manager

- Notify and consult with a Human Resources representative prior to any formal disciplinary action (including investigation) taking place
- Responsible for the completion of the Decision Making Tool. Produce Terms of Reference, which clearly outline the allegations to be investigated, the timescales for the investigation, the communication plan as well as the resources identified to support the investigation and an assessment of the independence of the investigation team.
- Identify an appropriate Investigating Officer and administrative support
- Identify an appropriate Support Officer and inform the employee of this support mechanism.
- Ensure the integrity of any investigation by maintaining confidentiality
- Consider the suspension, redeployment or restriction of duties of any employees within the scope of the investigation.
- Immediately following the review of an event, notify (in writing) the employee under investigation of the decision to commission an investigation, and of any subsequent changes to the Terms of Reference of the investigation
- Ensure all Terms of Reference are addressed within the Investigation Report, and sign off the report as complete
- Inform the employee of the outcome of the investigatory process and review decision
- If necessary, invite the employee to a formal agreed outcome meeting
- Delegate a hearing chair to an appropriate officer with the required scheme of authority **(APPENDIX 3)**
- Inform the employee of the outcome of any agreed outcome meeting., Notify any Professional Lead of any decisions as appropriate.

Investigating Manager

- Establish and investigate the facts arising from the Commissioning Manager Terms of Reference
- Undertake the investigation in a timely manner and maintain the communication plan.
- Ensure the integrity of any investigation by maintaining confidentiality
- Highlight any additional allegations which may need to be included within the Terms of Reference to the Commissioning Manager
- Present an investigation report to the Commissioning Manager outlining investigation findings and subsequent recommendations in a timely manner
- Present Investigation Report at any formal disciplinary hearings

Support Officer

- Keep the employee up to date and informed of any organisational / divisional changes
- Signpost the employee to appropriate welfare support e.g. Staff Support, Occupational Health, Here for You service, Wellbeing Adviser.
- The Support Officer should not discuss the case with the employee.
- In the case of suspension, a Support Officer should be identified for the employee to support them in keeping in touch and supporting wellbeing.

Line Manager(s)

- Ensure employees are aware of the disciplinary rules, Trust values and standards of conduct required whilst at work, signposting to Trust policies
- Where an employee has breached misconduct under the disciplinary rule the manager must ensure appropriate action is taken under the informal procedure.
- Provide a thorough support and guidance including supervision, appraisals and induction to new employees by way of probation and local induction processes
- Provides impartiality and oversight to decision making in cases of misconduct. The role of the Line Manager is to constructivly challenge and seek assurance on behalf of the Trust that cases are being handled fairly and proportionately, that decisions are well informed and the welfare of employees is given priority. The senior manager will seek to establish the following:
- Clarity about the allegations and assurance that the manager has gathered enough initial information to support their proposed course of action
- The action proposed by the manager is necessary, proportionate and justifiable in the circumstances and consistent with similar cases
- That all alternatives have been fully explored to ensure the matters are being dealt with in the most constructive way and in accordance with just culture principles.
- If further fact finding is needed, whether the manager can carry this out (has the time and appropriate skills) or if a trained investigator should be commissioned. For cases that may result in dismissal a trained investigator must carry out the investigation.
- That the welfare of the employee and anyone else affected by the issues has been properly considered and a plan for support and communications has been developed and carried out.
- That the manager themselves is getting the right support.
- That no bias or conflicts of interest are potentially influencing the proposed actions
- That there are sufficient grounds and understanding of the issues and circumstances to conclude there is a case to answer at a formal hearing.

Employees

- Attend investigatory meetings and disciplinary hearings as required in order to answer questions regarding the allegation(s) raised within the Terms of Reference
- Return statements and any other information requested for the completion of the investigation in a timely manner
- Ensure the integrity of any investigation by maintaining confidentiality

Witnesses

- Attend investigatory meetings and disciplinary hearings as required
- Return statements and any other information requested for the completion of the investigation in a timely manner
- Ensure the integrity of any investigation by maintaining confidentiality
- Seek support through HR and various mechanisms where necessary

Accredited Trade Union Representatives

- Support the timely completion of any investigations conducted in accordance with this policy
- Ensure the integrity of any investigation by maintaining confidentiality, see **Appendix 6**

Hearing Manager

- Ensures the fair conduct of the hearing in accordance with the Trust's Disciplinary Policy.
- Makes sure that the employee is aware of their right to be accompanied
- Explores if any adjustments should be made to proceedings to support employees and particularly for disabled employees or those with health conditions.
- Explains the procedure to be followed, introduce the parties taking part
- Checks that each side has all relevant documents
- Ensures each side has the opportunity to state their case
- Makes sure all relevant evidence is considered
- Considers whether further investigation is required if new matters arise
- Adjourns to consider the decision and weigh up all the evidence presented
- Decides whether allegations are substantiated on balance of probabilities
- Takes account of mitigating factors
- Considers any 'previous disciplinary records and live sanctions'
- Decides on sanction with advice from other panel members, where applicable, and HR support
- Acts consistently with previous decisions.
- Informs the employee of the decision and the reasons for it
- Informs the employee of their right of appeal.
- Ensures adaptations and adjustments are made to proceedings to support disabled employees and those with particular needs.

3.0 DEFINITIONS

For the purposes of applying the provisions contained in this document a glossary of terms that are used within the policy and associated procedure are as follows:

Conduct	The manner in which a person behaves, especially in a particular place or situation.
Gross Misconduct	Gross misconduct is when an employee has done something that's very serious or has very serious effect and serious enough to destroy the contract between the employer and the employee, making any further working

	relationship and trust impossible.
Misconduct	Unacceptable or improper conduct or behaviour.
Negligence	Failure to take proper care over something.
Temporary Staff	Staff engaged by the Trust on a fixed term, secondment or bank working arrangement (Also includes agency staff).
Safeguarding	Protect from harm or damage with an appropriate measure.
Fraud	Wrongful or criminal deception with the intent to cause a gain for themselves or another, cause a loss to another or expose another to a risk of loss
Disciplinary Rules	Indicate the standards of conduct, behaviour and practice at work that the Trust expects from all its employees.
Theft	To dishonestly appropriate property belonging to another with the intention of permanently depriving the other of it
Bribery	The giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith.
Corruption	A form of dishonest or unethical conduct by a person.
Suspension.	Suspension is where an employee continues to be employed but does not have to attend work or do any work.
Restricted/Redeployed	Restricted duties or redeployed is where an employee has a temporary change to their substantive roles and responsibility during a short period of time

4.0 PRINCIPLES – Just & Learning Culture

4.1 The Trust accepts the evidence that we will provide safer care and be a healthier place to work if we are a learning organisation. Humans are fallible; they make mistakes and errors.

4.2 Patients' physical and mental health must remain the paramount concern of any treating health professional, whether or not there is a dispute over treatment or a clinical error is alleged to have been made.

4.3 The vast majority of things that do not go as planned are due to unintentional acts and choices, and only a tiny minority are as a result of

intentional acts, recklessness or wilful behaviours. Processes should be designed to support the vast majority of staff to help them work safely.

4.4 The Trust will make attempts to change the mind-set and the language associated with safety – from blame to learning. However, this does not mean an absence of accountability. Accountability is about sharing what happened, working out why it happened learning and being responsible for making changes for the future safety of staff and patients.

4.5 The Trust will always want to understand why things don't go as planned in order to redesign systems and processes to minimise the chances of them happening again in future, and support individuals to work safely.

4.6 The Trust will learn about what works well, and why, in order to replicate and optimise these behaviours and processes.

4.7 The Trust will recognise that people are less willing to speak up if they are afraid of being punished or prosecuted. The Trust will build a '**Just and Learning Culture'** where individuals feel able to speak up, offering different levels of access (e.g. freedom to speak up guardians) and ensure that when they do speak up they are fully supported within the organisation.

4.8 As part of the Trusts '**Just and Learning Culture'**, Disciplinary Rules will be published to ensure employees are clear about where the line must be drawn between acceptable and unacceptable behaviour. The Trust recognises that incivility, rudeness and bullying are damaging both to staff wellbeing and patient safety, and will seek to address these issues. That means being **Compassionate, Empowering and Open.**

4.9 The Trust will ensure that all our staff recognise that inappropriate responses may disproportionately impact on some groups of staff.

4.10 People must be confident that their identity, or the identity of any person implicated in any report they make, will not be disclosed without their knowledge, unless this is required by law.

4.11 If a more formal investigation is required, the Trust will ask what happened and why through 'Fact Finding' methods, and what can be learnt. A decision will be reached in accordance with the Disciplinary procedure and decision making tool. When we investigate when things go wrong, we will try to recognise and minimise the natural bias we all have, such as hindsight, outcome and confirmative bias. At all stages the emphasis will be on learning, not blame, and on why it happened rather than 'who did it'.

4.12 Those who report concerns will be notified in a timely way of the steps taken in response.

4.13 The Trust recognises that there will be circumstances where referral to a professional regulator may be appropriate for some staff in certain instances within the thresholds set by the regulator. When that happens, it will only be done in accordance with our principles of learning and never as an additional punishment, advice from the relevant Professional Lead should

be sought prior to any referral being made to a professional / regulatory body.

4.14 The Trust recognise the importance of engagement with staff on this issue - linking patient safety to staff health and wellbeing, and recognising the contribution that frontline staff can bring. As an organisation we will emphasise the importance of staff wellbeing as a foundation for helping people to work safely. The Trust will ensure that advice given by Occupational Health will be followed in a timely manner.

4.15 The Trust will encourage and expect all staff to continually consider what factors can affect behaviour and performance, such as design of systems, processes, products, equipment and environmental factors. We will also consider factors including fatigue, workload, team relationships and communication on working safely.

4.16 No disciplinary hearing will be held without a level of investigation taking place; this may simply be the gathering of facts. The employee will be advised of the nature of the allegations against them and be given the opportunity to state their case prior to any decision being made

4.17 Any employee being investigated under this Policy will be afforded the right to representation, (by an accredited trade union representative or a work colleague) at disciplinary hearings where there may be a formal disciplinary sanction applied.

4.18 Where the events surrounding a disciplinary matter are clear, an investigation may consist purely of the gathering of facts and supporting documents; an investigatory meeting may not be necessary prior to an agreed outcome meeting or disciplinary hearing.

4.19 The Commissioning Manager and Investigating Manager will receive advice and guidance throughout all stages of the procedure from Human Resources.

4.20 Malicious allegations (made in conjunction with any policy) which are found to be untrue may be deemed as a disciplinary offence.

4.21 Except in a case of gross misconduct or gross negligence, an employee will not be dismissed for a first breach of misconduct.

4.22 Disciplinary sanctions can only be applied by Managers with the authority, experience and training to do so under the Scheme of Delegation **(APPENDIX 3)**

4.23 Where the facts are in dispute, no disciplinary penalty will be imposed until the case has been carefully investigated and it is concluded on the balance of probability that the allegations are substantiated and proven.

4.24 The disciplinary process will be dealt with as swiftly as is reasonably possible

4.25 Confidentiality will be observed at all stages of the disciplinary process by all parties including witnesses. Failure to maintain confidentiality is in itself a disciplinary offence.

4.26 Employees have the right of appeal against any formal sanction applied under the disciplinary policy

4.27 Where a person who is the subject of an investigation or disciplinary procedure suffers a form of harm, whether physical or mental, this will be treated by the Trust as a 'never event' and the Adverse Incident (including Serious Incidents) Policy and Procedure will be invoked.

5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

The Disciplinary (Conduct) Policy and Procedure compliance is monitored via monthly reports to Directorate Senior Management Team Committees. Quarterly and Annual Reports are presented to the Workforce Transformation Group. In addition data is included within WRES and WDES reports published nationally.

All disciplinary outcomes will be monitored to ensure that the policy and associated procedure is applied fairly and equitably and to ensure that no group is over represented through this process.

The Human Resources Department will collate and provide to the Trust Board, at least annually, monitoring information relating to disciplinary cases. This may include analysis of:

- Types of cases brought
- Outcomes
- Equality and Diversity metrics

Training will be provided to Managers via the Management Development Programme [MDP] on the application of the Disciplinary (Conduct) Policy and Procedure and update training is made available on a yearly basis. Accredited Trade Union Representatives also receive training via their union's training resources or can also attend MDP.

6.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION (EXTERNAL)

- Nurse Amin Abdullah Independent Inquiry Report – Press Release by Terence Skitmore, partner of Amin Abdullah and Imperial College Trust Report
- Baroness Dido Harding, Chair NHS Improvement Letter dated the 24 May 2019
- ACAS Code Disciplinary Guidelines
- NHS Code of Conduct and NHS Constitution
- Employment Rights Act 1996 & Employment Act 2008
- Maintaining High Professional Standards Policy
- Health & Social Care Act 2008 (Regulated Activities) Regulations 2014
- Duty of Candour
- Southend, Essex & Thurrock Safeguarding Children & Vulnerable Adults Procedures
- The Equality Act 2010
- Health & Safety at Work Act
- Children Act 1989 and 2004

- Employment Act 2002
- Trade Union and Labour Relations (Consolidation) Act 1992
- Data Protection Act 1998
- Computer Misuse Act 1990
- Sharing Information on Healthcare Workers 2013 (National Guidance)
- General Data Protection Regulations (2016/679EU)
- The Money Laundering Regulations 2007
- Fraud Act 2006

7.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES (INTERNAL)

- Disciplinary (Conduct) Procedures (Appendices)
- Maintaining High Professional Standards Policy and Procedure
- Raising Concerns (Whistleblowing) Policy
- Capability (Performance) Policy and Procedure
- Fraud and Bribery Policy
- Appeals Procedure
- Information Governance Incident Reporting Procedure
- Grievance and Dignity and Respect Policy and Procedure[s]
- Maintaining High Professional Standards Policy
- Adverse Incidents (including Serious Incidents) Policy and Procedure

8.0 GLOSSARY

Term	Meaning
ACAS	Advisory, Conciliation & Arbitration Service
WRES	Workforce Race Equality Standards
WDES	Workforce Disability Equality Standards
MDP	Management Development Programme
LCFS	Local Counter Fraud Service

END

DISCIPLINARY (CONDUCT) PROCEDURE

PROCEDURE REFERENCE NUMBER	HRPG27A
VERSION NUMBER	2
KEY CHANGES FROM PREVIOUS VERSION	Reviewed in accordance with Chair, NHS Improvement recommendations issued 23 May 2019
AUTHOR	HR Business Partner
CONSULTATION GROUPS	Policy Sub-Group Workforce Transformation Group Joint Partnership Committee
IMPLEMENTATION DATE	April 2017
AMENDMENT DATE(S)	November 2018
LAST REVIEW DATE	March 2021
NEXT REVIEW DATE	March 2024
RATIFIED BY FINANCE & PERFORMANCE COMMITTEE	
COPYRIGHT	

PROCEDURE SUMMARY
This procedure sets out the framework for the Trust's approach to the management of conduct, behaviour and practice concerns and the process to be followed in dealing with disciplinary (conduct or negligence) matters. Where issues of concern relate to capability (performance) these should be dealt with in accordance with the Trust's Capability Performance Policy and related procedure. This procedure should be read in conjunction with the Disciplinary (Conduct) Policy.
The Trust monitors the implementation of and compliance with this procedure in the following ways;
The Disciplinary (Conduct) Policy and Procedure compliance is monitored via monthly reports to Directorate Senior Management Team Committees. Quarterly and Annual Reports are presented to the Workforce Transformation Group. In addition data is included within WRES and WDES reports published nationally. Data relating to investigations and disciplinary procedures will be collated, recorded and openly reported at Board level on a quarterly basis.

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this procedure is the Executive Director of People & Culture

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DISCIPLINARY (CONDUCT) PROCEDURAL GUIDELINE

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APPENDICES

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DISCIPLINARY (CONDUCT) PROCEDURE GUIDELINE

1.0 INTRODUCTION

1.1 This procedure introduces the Trust's principles in relation to resolving disciplinary matters. Disciplinary rules and procedures are necessary for promoting positive employee relations and for safeguarding of patients.

1.2 The Trust recognises that disciplinary issues can relate to conduct (complying with Trust policy, rules, values and procedures), including negligence. The disciplinary procedure will be invoked by management in circumstances where it is alleged that conduct has fallen below the required standards.

1.3 Unless otherwise stated, this procedure does not form part of an employee's terms and conditions of employment but is a statement of the Trust's current practice and may be changed from time to time.

1.4 The Trust recognises its responsibility in ensuring that all employees are aware of their obligations whilst at work and the behaviour and conduct expected of them. Employees also have a responsibility to familiarise themselves with the general rules and procedures referred to in their conditions of service and as related to their specific area of work and as required of them by their professional code(s) of conduct and NHS Constitution.

1.5 This procedure applies to all employees of the Trust with the following provision:

a. Medical and Dental staff – this procedure does not apply to issues concerning professional conduct and / or competence of Medical and Dental staff who are subject to the provisions of the Maintaining High Professional Standards Policy and Procedure.

b. Temporary staff (including bank workers) – temporary workers are required to maintain the Trust's expected standards of conduct, behaviour and practice. Any issues of conduct will be addressed using the Temporary Worker Conduct & Complaints Policy and Procedure.

c. Trade Union Officials – such staff are subject to the provisions of this procedure. However, in most cases no formal action will be taken until a senior trade unions representative or full time officer has been informed.

2.0 GUIDING PRINCIPLES – JUST AND LEARNING CULTURE

2.1 The principles of a Just and Learning Culture are set out in Section 4.0 of the Disciplinary (Conduct) Policy.

2.2 Any allegations of misconduct in the Trust will mean a commitment to developing a **Just and Learning Culture**, whereby cases are thoroughly assessed to ensure there is sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action.

2.3 The Trust and those involved with utilising this procedure should always be asking whether any actions are **proportionate** and **justifiable** and whether managing situations informally achieves a more productive outcome.

2.4 Before any disciplinary investigation or formal procedures are followed, the Trust must ensure those involved include trained and / or experienced investigators and managers who hear cases at formal hearings and expanded our pastoral support for employees. The Commissioning Manager will be accountable when applying the **Just and Learning Culture**.

2.5 The HR service must be fully consulted prior to any action being taken in relation to this procedure.

2.6 Regular communication and pastoral support will be maintained at each stage of the disciplinary procedure, to ensure its effective implementation and application.

2.7 In usual circumstances employee(s) affected will be made aware of the nature of the allegations made prior to the instigation of this procedure.

2.8 Where there are allegations of misconduct, or negligence, the Trust will conduct an investigation as soon as possible, having due regard to all the circumstances.

2.9 All employees and parties involved in disciplinary procedures must ensure the confidentiality of events and discussions. An unreasonable breach may be considered as a disciplinary offence in itself.

2.10 In addition to their statutory rights all employees have the opportunity to be accompanied at suspension or investigatory meetings by a work colleague, an accredited representative of a recognised trade union, or an official employed by a recognised trade union. The Trust will not normally agree a request for an employee to be accompanied by an individual deemed to be a witness or who could compromise any investigation including cause unnecessary delay.

2.11 All employees have the right of Appeal against any formal disciplinary action taken (see Section 11) in accordance with the Appeals Procedure.

2.12 The Trust will ensure that a written record is maintained at all stages in the disciplinary procedure.

3.0 INTERFACE WITH OTHER POLICES AND PROCEDURES

When this Disciplinary Procedure is applicable and Interface with other Policies/Processes

3.1 Allegations of Fraud and the interface with NHS Counter Fraud

Any internal investigation into allegations of potential fraud should be deferred until a full and detailed discussion has taken place with the nominated Local Counter Fraud Specialist (LCFS). The involvement of NHS Counter Fraud does not necessarily mean a disciplinary investigation will not take place and each situation is to be judged on its own merits.

For both the LCFS and HR, any matter referred which raises any suspicion of fraud, bribery or corruption must be dealt with in accordance with the requirements set out in this procedure and the Trust's Fraud and Bribery Policy (CP11).

All and everyone aware of potential fraud is responsible for raising this directly to the LCFS.

3.2 Duty of Candour

There is a duty for NHS bodies to be open, honest and transparent. This includes:

3.2.1 The Trust sharing information from a disciplinary investigation with Service Users and carers regarding a patient safety incident, where appropriate and in accordance with Information Governance rules regarding confidentiality

3.2.2 Encouraging open and honest dialogue with Service Users

3.2.3 Where appropriate, interviewing service users as part of the process.

3.3 Whistle-blowing (Raising concerns)

3.3.1 When concerns are raised about unlawful conduct, financial malpractice or dangers to the public or the environment, this will be investigated in line with the Trust's Raising Concerns (Whistleblowing) Policy and Procedure regarding patient care or Matters of Business Probity/Conduct Policy and Procedure. If as a result of this, there are concerns about the conduct of an employee, the Disciplinary (Conduct) Procedure will be invoked.

3.4 Dignity and Respect at Work (Grievances)

3.4.1 Any complaints raised in relation to bullying and harassment will be investigated in line with the Trust's Dignity and Respect at Work Procedure. If it is found that there are concerns about the conduct of an employee, the Disciplinary (Conduct) Procedure will be invoked.

3.5 Safeguarding

3.5.1 All allegations of safeguarding concerns should also be referred to the Trust's Safeguarding team irrespective of employment status of the worker.

3.6 Information Governance

3.6.1 Information Governance ensures that one of the Trusts most important assets, information, in both clinical and management terms, is respected and held in secure and manageable conditions. It is therefore of paramount importance to ensure that information is efficiently managed on the basis of the HORUS categorisation:

3.6.1.1 **H**eld safely and confidentially
3.6.1.2 **O**btained fairly and effectively
3.6.1.3 **R**ecorded accurately and reliably
3.6.1.4 **U**sed effectively and ethically

3.6.1.5 **S**hared appropriately and lawfully

The Trust has put into place a range of appropriate policies, procedures and management arrangements to provide a robust framework for Information Governance.

3.6.2 All data loss/data breach incidents should be raised via DATIX and will be fully investigated by the Trust, and should it be identified that there has been any misconduct by staff then the seriousness of the incident will determine the level of misconduct applicable. For further information see Trust Information Governance & Security Policy and Procedure.

3.7 Registered Body and referral to leads

3.7.1 Where any allegations of gross misconduct and / or gross negligence have been raised against a registered member of staff, including temporary workers, then the relevant Professional Lead will need to be notified immediately. The Management of Referrals to Regulatory Bodies Policy and Procedure will need to be adhered to when any referrals are being considered.

3.8 Special Rules – Criminal Charges

3.8.1 Staff must disclose to their manager any convictions, cautions, warnings, reprimands or bind overs that are issued to them prior or during employment. Where an employee conduct is the subject of a criminal investigation, charge or conviction an investigation of the facts will be undertaken before deciding whether to take formal disciplinary action.

3.8.2 Each disclosure will be considered on a case by case basis. The investigating officer will need in writing a statement from the Police or relevant safeguarding authority including a rationale as to whether or not the fact finding/preliminary investigation can continue. This information should also be included in the final disciplinary report.

3.8.3 A criminal investigation, charge or conviction relating to anything outside work may be treated as a disciplinary matter if considered that it is relevant.

4.0 INFORMAL PROCEDURE

4.1 Cases of misconduct can often be addressed effectively and swiftly by the employee's immediate line manager having a structured discussion (meeting) with the employee regarding the standards required and the required improvement in their conduct or behaviour.

All incidents or concerns must be assessed as to whether learning or informal procedures can achieve a resolution prior to any decision being made to proceed.

Examples of what may be considered as misconduct are found on the disciplinary rules **(APPENDIX 2)**.

4.2 Utilising the Decision Making Tool may not always be necessary when identifying misconduct, however managers can utilise it in making the decision and may assist in the application of the

Just and Learning Culture.

This meeting can occur within supervision or during an individual meeting where the Manager should;

- Explain that the meeting is informal in approach and is to discuss some concerns that have been identified.
- Discuss the concerns with the employee and explain that the reason for holding an informal meeting is to reflect on them and take any corrective action in given timelines, where necessary.
- Inform the employee of the standards expected by the Trust and the level of improvement needed.

4.3 A record of the meeting must be kept and shared with the employee, and a review period should be agreed. Any review period should generally not exceed 6 months.

This record could involve a reflective statement which is a statement of reflection by both the manager and the employee as to what has been learnt and what additional support or training may be required in relation to the situation which has occurred. The reflective statement will be signed by both the manager and the employee and retained as a supervision record. Reflective statements are not a conduct record.

4.4 The Informal Procedure is not designed to replace the disciplinary procedure and may be referred to in future conduct concerns. In appropriate cases it allows an alternative approach to achieving improved conduct and / or behaviour.

4.5 Statements

4.5.1 After an incident or an allegation is made the manager should request staff members to write an account about what they have witnessed immediately after the incident or the alleged incident has occurred. Staff will be asked to sign and date the statement.

4.5.2 Managers must advise witnesses that their information may be utilised as part of the disciplinary procedure and be seen by the alleged individual for their response to the allegations made.

5.0 PRELIMINARY INVESTIGATION & FAST TRACK PROCEDURE

5.1 Fact Finding and Preliminary Investigation

5.1.1 Where an incident or concern comes to light, the manager will need to undertake an initial preliminary investigation (fact finding). Only if the facts of the matter are clear and established, or the incident or concern potentially constitutes gross-misconduct or gross-negligence, can a decision be made to proceed immediately to a more formal investigation, which can be established through the Decision Making Tool.

5.1.2 Where CCTV, body worn cameras or other recordings are in use these should be viewed or heard within 24 hours of the incident occurring and any footage secured and saved. A

decision will be made based on the recording as to whether any further procedure should be instigated.

5.1.3 The fact finding should not be an extensive investigation and or all of the witnesses to be spoken to; gathering of documentation etc. it should normally be completed within a maximum period of 72 hours.

5.1.4 The 'Fact Finding' is normally undertaken by the manager of the employee or a delegated individual who is able to collect statements from the main witness(es). The fact finding manager, in consultation with HR, would then come to a conclusion as to whether a more full and thorough investigation is necessary in keeping with the relevant policy (i.e. performance or conduct) and refer to the relevant Commissioning Manager. The Commissioning manager or fact finding manager will at this point need to complete the Decision Making Tool.

5.1.5 Depending on the seriousness of the allegation[s] made management may meet with the employee and share the raised concerns with them for their response. Managers should not do this without first consulting with HR and it may be necessary to review this action as part of the Decision making Tool.

5.1.6 If the employee is met with then copies of evidence can be shared with them as long as prior consent has been obtained from witnesses. All other evidence can also be shared. The 'Fact Finding' or 'Preliminary' meeting can have HR support present depending on the circumstances.

5.1.7 The employee should be given the opportunity to be accompanied by an accredited representative of a recognised Trade Union or current work colleague. A fact finding meeting will not be delayed if a chosen representative is unable to attend.

5.1.8 Notes of the meeting must be taken and shared with the employee following the fact finding meeting.

5.2 Fast Track (Agreed Outcome) Procedure

5.2.1 The Trust, must ensure its commitment to a **Just and Learning Culture** and has introduced a 'Fast Track' process to help expedite the Disciplinary (Conduct) Procedure wherever possible. Where the facts are not in dispute, or admitted, and where the outcome of the investigation would not result in dismissal the fast track / agreed outcome procedure can be followed.

5.2.2 Where it is identified that the 'Fast Track' process can be utilised the procedure for this is set out at **Appendix 4**.

5.2.3 The 'Fast Track' process cannot be used for matters of serious allegation(s) of Gross Misconduct or Gross Negligence or where a continued pattern of behaviour or live sanction is evidenced. There may however be occasions where the alleged act constitutes Gross Misconduct or Gross Negligence but after admittance and consideration of mitigation dismissal is not considered a possible outcome.

Individuals who are appointed as Commissioning Managers, Investigating Managers and / or Hearing (and Appeal) Managers will have received comprehensive training and will be

able to demonstrate the aptitude and competencies required to undertake these roles. Where training has not been undertaken within the preceding 12 months an update briefing will be provided by a member of the HR service.

6.0 SUSPENSION

6.1 Suspension should never be an automatic approach for the Trust to use when dealing with a potential disciplinary matter. The suspending manager must consider the guiding principles of the **Just and Learning Culture** as set out in the Disciplinary (Conduct) Policy at Section 4.0. Suspension must not be a reactive decision and managers should consult with HR and utilise the decision making tool **(APPENDIX 6)** before a decision to suspend is applied.

6.2 Suspension should be only by exception and as a last resort. Although seen as a 'neutral act' by the Trust it may be perceived as a detrimental one if not correctly and sensitively applied. Any decision made to suspend must be approved by a senior manager, at Band 8b or equivalent.

6.3 Managers looking to suspend staff must read this section in conjunction with 'Investigation Toolkit' **(APPENDIX 5)**

6.4 Managers **must** ensure they approach suspension in a **sensitive** and **compassionate** manner and ensure the appropriate support mechanisms are provided to the employee, which can be obtained from the HR team.

6.5 Most disciplinary procedures should not require suspension. Consideration must be given as to whether the employee will usually be able to continue doing their normal role while the matter is investigated.

6.5.1 Suspension should usually only be considered if there is an allegation of serious misconduct and:

- the employee could tamper with evidence, influence witnesses and / or sway the investigation into the allegation
- there is a risk to other employees, property or patients
- the employee is the subject of criminal proceedings which may affect whether they can do their job.

6.6 Suspension must be a last option and the suspending manager must first consider if a temporary adjustment to the employee's working arrangements would negate the need for suspension.

It should not be necessary to consider suspension employee who is absent from work in any event. Any potential requirement for suspension will be reviewed when a return to work date is known.

6.7 Alternatives to suspension could include the employee temporarily:

- being moved to a different area of the workplace

- working from home
- changing their working hours
- being placed on restricted duties
- working under supervision
- redeployed to a different role within the Trust.

There should be no financial detriment experienced by an employee who is suspended from duty and any suspension will be on full pay.

Only if all other options are not practical or have been exhausted, may suspension become necessary.

6.8 There should be no assumption of guilt associated with a suspension and suspension must not be used as a disciplinary sanction. However, a suspension can still have a damaging effect on the employee and their reputation.

6.9 Therefore, if a suspension is necessary, the suspension and the reason for it should be kept confidential. If it is necessary to explain the employee's absence, the manager should discuss with the employee how they would like it to be explained to colleagues and/or Service Users.

6.10 The following matters must be considered in all circumstances where suspension is applied::

- Help the employee remove any belongings from the workplace e.g. ID badge/workplace pass etc.
- Explain the reasons for suspension and how long it is expected to last.
- Explain the employee's responsibilities during their suspension e.g. being available during their contracted hours.
- Provide a point of contact 'Support Officer' (usually the line manager) that they can contact if they have any concerns.
- Agree how they will keep in regular contact with the employee throughout.
- Give details about support from the Employee Assistance Programme (EAP), the Here for You service, EPUT Health and Wellbeing Leads and Occupational Health details/advice.
- If it is also necessary for the employee to continue liaising with work colleague(s) for support then it would need to be explained that the case cannot be discussed.
- If possible inform the employee who will be the Support Officer to assist in their wellbeing needs during the entirety of the investigation or at least explain that this will be provided to them in the launch letter.

7.0 PROCEDURE FOR FORMAL INVESTIGATIONS

7.1 Formal procedure

7.1.1 The formal procedure will only be instigated in the following circumstances, where it can be justified that:

a. The incidents or concerns cannot be resolved through learning (informal procedure),
b. Where the incidents or concerns cannot be resolved through the 'fast track' (agreed

outcomes) procedure, OR

c. Where the incident or concern potentially constitutes gross-misconduct or gross-negligence.

Prior to any formal investigation being launched a review of the allegations and fact finding must be undertaken and a decision making tool **(APPENDIX 6)** must be completed by the manager, in consultation with HR.

7.1.2 If the employee is of an ethnic minority (such as Black, Asian or any other Ethnic Minority Group) then the decision making tool must also be shared with BAME Network Lead(s) for review. The BAME Network Lead must respond within 24 hours with any comments, where any comments are received after 24 hours these will be forwarded to the Investigating Manager for consideration during the investigation process.

7.1.3 If there is no agreement that the disciplinary investigation process should be launched and Commissioning Manager still decides to continue with a formal investigation, then this should be noted within the Terms of Reference.

7.1.4 Employees who are the subject of an investigation should be made aware of any investigation to be launched verbally and followed up in writing within 5 working days of the alleged incident being known, wherever possible. This letter should inform the employee of the allegation(s) which should be sufficiently detailed to enable the employee to respond.

7.1.5 The conduct investigation support leaflet (Appendix 7) should be included with the letter informing the employee of an investigation.

7.1.6 An HR representative, not previously involved in any decision to instigate disciplinary proceedings or be a potential witness to the events, will be assigned to support the Investigating Officer. As part of the investigation, the Investigating Officer must write to the employee to invite them to a meeting to discuss the allegations. A record of the meeting will be made, written and / or electronically and shared with the employee.

7.1.7 The Investigating Officer must provide an update to the Commissioning Manager every two weeks for the duration of the investigation process. Regular contact must also be maintained with the staff member every two weeks as a minimum, or alternative time period as agreed and detailed within the terms of reference. The format and regularity of this contact, e.g. letter, email, should be agreed at the outset of the investigation. If the employee is suspended from work a review of the suspension must be undertaken after six weeks and the outcome of the review communicated with the employee in writing.

7.1.8 If for any reason the investigation exceeds the six week deadline the Commissioning Manager, along with their HR support must write to the Service Director, and include the Associate Director of Human Resources, providing them with an update of the delay and request the necessary extension. If an extension is approved the employee will be informed of this and advised of the date by which a further review of suspension will take place.

7.2 Terms of Reference and Employee Support

7.2.3 The Commissioning Manager will set the Terms of Reference at the commencement of the investigation. If new issues come to light during the course of the investigation, the Terms of Reference must be amended and an update provided to the employee.

The Terms of Reference must outline the allegations to be investigated, the timescales for the investigation, the communication plan as well as the resources identified to support the investigation and an assessment of the independence of the investigation team.

7.2.4 The Trust recognises that investigations, meetings and hearings can cause anxiety and / or distress to any party involved. Every attempt will be made to ensure that these proceedings are conducted in accordance with the timescales set out in the policy and with dignity, courtesy and respect.

7.2.5 The Commissioning Manager will be responsible for providing the necessary support to employees involved in disciplinary proceedings including:

- Delegating a Support Officer to assist in the employee wellbeing needs during the entirety of the investigation.
- Advice and support will also be available from managers, Human Resources, recognised Trade Union representatives and Professional Leads.
- Additional advice and counselling will be available through Occupational Health.
- Employees can also access confidential support/career advice/counselling through the Trusts' Employee Assistance Programme or Here for You service workplace options

7.2.6 Any concerns can be raised in confidence with the Freedom to Speak Up Guardian Service, BAME Network and Equality & Inclusion Network(s) who will provide information and emotional support in a strictly confidential, non-judgemental manner.

7.2.7 Employees who are subject of a disciplinary investigation process must be provided with the Conduct Investigations Support Leaflet which can be found at Appendix 7.

7.2.8 Any employee experiencing stress and anxiety symptoms related to the disciplinary investigation must be offered Occupational Health support. Managers doing the referral to Occupational Health must ask for their opinion whether or not the employee is fit to attend investigatory or disciplinary meetings/hearings. Occupational Health advice should also be sought to understand if any additional adjustments are required to enable the employee to participate in these proceedings.,

7.2.9 The employee's Manager and / or Support Officer must keep in regular contact, as mutually agreed, with the employee, whilst the investigation is ongoing.

7.3 Investigation Procedure

The procedure for conducting investigations is set out in detail within the Investigation Toolkit at **Appendix 5**. The Investigating Manager should familiarise themselves with the Investigation Toolkit and review this alongside the Terms of Reference provided in

consultation with their allocated HR support.

During the investigation procedure the employee should be provided with the opportunity to identify to the Investigating Manager potential witnesses and evidence, in addition to that provided in the Terms of Reference. The Investigating Manager should provide a clear rationale within their final report as to why any witnesses were not contacted for statement(s) or their evidence not considered.

7.4 Notes of Investigatory Meetings

7.4.1 All individuals interviewed as part of the investigation will be provided with a copy of the notes of the investigatory meeting. They will be given the opportunity to make amendments and additions where appropriate and they are required to confirm that it is an accurate reflection of what has been said, and return to the Investigating Officer.

Notes must be returned as soon as possible after receipt of the draft statement and by the date for return provided, extensions may be agreed in exceptional circumstances. Failure to return the notes in a timely manner will mean that the notes of the investigatory meeting will be understood to be agreed.

7.5 Employee resignation during an investigation

7.5.1 Where an employee leaves before an investigation is completed, notes will be kept so that any reference provided for that employee will indicate that there is an unresolved investigation into alleged misconduct. Such references must be fair and accurate, but will state that procedures have not been completed, reflecting the current position. In some cases, it may be necessary to conclude the investigation following resignation of an employee. In addition, referral to the Disclosure and Barring Service and/or professional body may also be necessary. Advice should be sought from the HR team in these circumstances.

7.6 Where a grievance is raised

7.6.1 Where a formal grievance is raised during a disciplinary process, the appropriate action will be determined on a case by case basis.

7.6.2 If the issues relate to the content of the disciplinary process or the disciplinary process itself the matter will generally be dealt with as part of the disciplinary process.

7.6.3 The two processes may run concurrently where possible, following agreed timescales, unless the content of the grievance is so significant in relation to the disciplinary case that a deferral of the disciplinary proceedings becomes inevitable.

7.7 Deciding if there is a case to answer

Once the investigation is complete, the Investigating Officer will prepare a report for the Commissioning Manager. The investigation report and associated statements / evidence should be submitted to the Commissioning Manager within 15 working days of completion of the investigation.

Having received and reviewed the report, the Commissioning Manager will decide whether there is a case to answer in consultation with the allocated HR support. Human Resources will offer professional support/advice to the Commissioning Manager.

At any point during the formal investigation if admission is received by the employee the Commissioning Manager must be notified. The Commissioning Manager may decide to stop the investigation and invoke the 'Fast Track' (Agreed Outcome) process immediately. This decision may be applied when it is in no-one's interest to proceed with the investigation and disciplinary hearing where both parties are in agreement not to do so.

The outcome of the Commissioning Manager's review should be notified to the employee, in writing, within 5 working days of receipt of the investigation report.

8.0 DISCIPLINARY HEARINGS

8.1 Accredited Trade Union Representation and Work Colleagues

8.1.1 Employees are entitled to be accompanied by an accredited trade union representative or a current work colleague to any Agreed Outcome, Disciplinary or Appeal Hearing under this procedure. Any work colleague accompanying an employee to a hearing should not themselves have any prior involvement in the proceedings

8.1.2 If a worker's chosen companion will not be available at the time proposed for the hearing by the employer, the employer must postpone the hearing to a time proposed by the worker provided that the alternative time is both reasonable and not more than five working days after the date originally proposed. Wherever possible and providing it does not cause unnecessary delay the date of the hearing should be agreed with all parties in advance.

8.1.3 The Trust does not permit legal representation at any stage during the disciplinary or appeal procedures.

8.2 Disciplinary Hearing Procedure

8.2.1 If it has been established that the matter should be referred to a formal disciplinary hearing, then arrangements for this should be made without delay. Disciplinary hearings will be conducted in accordance with the Disciplinary Hearing Process set out at **Appendix 1**.

8.2.2 The Hearing Manager must not be the Commissioning Manager; another senior manager must be appointed to hear the case, in line with the Trusts Level of Authority as detailed in **Appendix 3**.

8.2.3 Disciplinary hearings should be held as early as possible. As a general guide, the hearing should take place within 10 weeks of the commencement of the investigation wherever possible. In order to avoid delay, the manager hearing the case should agree a mutually convenient time and date as soon as possible for the hearing with the individual and their accredited trade union representative. Where an accredited trade union representative cannot attend on the date proposed, the individual can request that an alternative time and date be arranged within the next 5 days of the original hearing.

8.2.4 A letter containing details of the allegation(s) and setting out details of the date and time of the disciplinary hearing, together with copies of all documentation that will be used or referred to during the Disciplinary Hearing, should be sent to the individual at least five working days in advance unless otherwise mutually agreed. However, best practice would be that where possible documents would be sent out as soon as possible.

8.2.5 The Disciplinary Hearing Panel will be appointed by the Commissioning Manager and it's composition needs to ensure objectivity and independence is maintained.

The Disciplinary Hearing Panel will be chaired by a senior manager different to the Commissioning Manager in accordance with **Appendix 3** (Levels of Authority) and will include a HR representative. The nature of some allegations may make it appropriate for an additional manager / representative or professional advisor to form part of the panel.

The composition of the panel should be considered to take into account gender, race, disability, age, religion and sexual orientation and forethought should be given to this when determining panel membership.

8.2.6 In circumstances where an employee requests the postponement of a Disciplinary Hearing and is unable to offer an alternative date within five days of the original hearing it will be re-arranged. If the employee is not able to attend a second hearing there is no obligation on the Trust to rearrange it again and the Hearing Manager may decide to proceed with the hearing in the absence of the employee. The letter confirming the rearranged meeting should include notification to the effect that the matter may be dealt with in their absence.

8.2.7 The Disciplinary Hearing Panel the case at the disciplinary hearing will not have any prior involvement in the formal investigation. Decisions relating to the level of disciplinary action to be taken, if any, will be a matter of judgement for the Hearing Manager, in consultation with the Disciplinary Hearing Panel, who has listened to the information presented during the Disciplinary Hearing. They will take into consideration:-

- the seriousness of the disciplinary breach in question
- the relevance and context of facts/information presented
- issues relating to fairness, consistency and the substantial merits of the information presented
- any currently live relevant disciplinary warnings

8.2.8 If the disciplinary hearing could result in dismissal, the individual should be notified of this in the invitation letter sent. The employee should, no later than five working days prior to the Disciplinary Hearing, also make available copies of any statements and/or written material which they intend to refer to, along with details of any witnesses who will be present to give evidence.

8.2.9 Both the employee who is subject investigation and the Hearing Manager will be given the opportunity to request witnesses to attend the Disciplinary Hearing, this may include requesting the attendance of the Investigating Manager. Their subsequent evidence should clearly demonstrate why their attendance is relevant.

8.2.10 Support must be given to the witnesses by the HR support to the Hearing Manager. Their attendance may be necessary but it can be daunting for any witnesses attending and support

mechanisms must be offered. This can include discussing the process of the hearing; what the witness's expectation is; advising them to bring their statement with them.

8.2.11 Character witnesses are not relevant to the disciplinary hearings. Where possible, agreement will be reached on which witnesses should be invited to attend the Disciplinary Hearing. The Disciplinary Hearing Panel considering the case may also request the attendance of witnesses if their presence is necessary.

8.2.12 Although the Disciplinary Hearing Panel may support attempts to invite the witnesses the onus is upon the employee, or their representative, to ensure that their witnesses have been contacted and invited to attend. The Trust will ensure that every effort is made to facilitate their availability at the hearing.

8.2.13 Variations to the Disciplinary Hearing procedure detailed above and within **Appendix 1** can be made with the mutual agreement of the employee and / or their representative and the Disciplinary Hearing Panel.

8.2.14 On conclusion of the presentation of case and witness evidence, the Disciplinary Hearing will be adjourned while the relevant matters are considered by the Disciplinary Hearing Panel. Once the Disciplinary Hearing Panel has considered all matters, the hearing will usually be reconvened so that the Hearing Manager may give their decision.

8.2.15 The Hearing Manager will consider the allegations made as they relate to the Trust's Disciplinary 'Rules' as set out in **Appendix 2**. These rules are not exhaustive and serve only as a guide, although do form part of the terms and conditions of employment.

8.2.16 Once a decision that the allegations have, on the balance of probability, been proven the Hearing Manager will be informed of any 'live' disciplinary sanctions or previous related warnings which may need to be considered in the determination of sanction.

8.2.17 The HR adviser will be responsible for advising the Hearing Manager on previous sanctions imposed on cases of a similar nature to ensure there is consistency and fairness considered in the application of these.

8.2.18 In all cases following a Disciplinary Hearing, all relevant parties will be notified of the outcome in writing usually within five working days. The employee will be notified of their right of appeal.

8.2.19 After the conclusion of the Disciplinary Hearing, the outcome should be confirmed by the Hearing Manager in writing within 5 working days of the date of the hearing where possible, any delays in the decision for exceptional circumstances must be communicated in writing. If the decision of the Chair/panel has been that no formal sanction is to be issued, then this should be confirmed, along with any other associated recommendations.

8.2.20 In addition it may be deemed necessary to refer the case to a professional body in accordance with the Referrals to Regulatory Bodies Policy e.g. NMC as well as a DBS Referral. This will be confirmed in the outcome letter where necessary.

9.0 OUTCOMES OF DISCIPLINARY HEARINGS

The disciplinary hearing may result in any of the following formal actions:

i. No Action

The case was unsubstantiated or there was a case to answer but no action is to be taken as there are exceptional mitigating circumstances. The employee will be informed in writing and all records of the hearing and investigation will be removed from the employee's personal file.

The only exception would be where the allegation(s) related to issues around the abuse, care or bullying and harassment of patients, clients and/or employees, in which case the records of the hearing should be retained.

There is no right of appeal on this action.

ii Further investigation required

This is where the Hearing Manager feels that they require further evidence to be obtained, by the Investigating Manager before making a final decision. If this is the case, the disciplinary hearing will be adjourned and reconvened at a future date at which time the additional information can be considered and final outcome reached.

There is no right of appeal on this action.

iii. Informal Action

This is the first formal disciplinary stage and will normally be for cases where there is minor misconduct, unacceptable conduct and/or failure to conform to standards following supervision advice.

Informal action could include the production of a reflective statement which is a statement of reflection by both the manager and the employee as to what has been learnt and what additional support or training may be required in relation to the situation which has occurred. The reflective statement will be signed by both the manager and the employee and retained as a supervision record. Reflective statements are not a conduct record.

A 'verbal' warning could be given and that the employee has been notified of their right to appeal will be held as a record on the personal file. A verbal warning will be considered as spent after 6 months or any lesser period considered appropriate by the Hearing Manager.

iv. First Written Warning

This will normally be for cases where there is misconduct or unacceptable conduct or behaviour or where there has been a failure to conform to standards following previous management advice and /or previous verbal warning(s) which are not 'spent'. It will warn that further formal action will be considered if there is no satisfactory improvement.

A written warning will normally be considered 'spent' after 12 months or any lesser period considered appropriate by the hearing officer.

iv. Final Written Warning

This will normally be for cases where the misconduct or unacceptable conduct or behaviour is considered more serious or where there has been failure to conform to standards following a previous written warning(s) which is not considered 'spent'. It will notify the employee that dismissal will be considered if there is no satisfactory improvement.

A final written warning will be for a period of 12 months or for up to 18 months (in cases of misconduct of a serious nature or unacceptable conduct or behaviour following previous warning(s) or as an alternative to dismissal). It is intended to provide the employee a last, and final, opportunity to demonstrate acceptable conduct and / or behaviour.

v. Dismissal

This will normally be for cases of misconduct of a serious nature or unacceptable conduct or behaviour following previous warning(s) which are not considered to be gross misconduct. The employee will be provided with written reasons for dismissal and the date on which the employment will terminate. The dismissal will be with notice or with pay in lieu of notice and will include any accrued, untaken statutory annual leave to which they are entitled.

It should be noted that there is nothing in the ACAS Code of Practice that states that there has to be a similarity in the type of misconduct to justify a dismissal. This is particularly so where, as an outcome of a previous warning it has been made clear to the individual that any further misconduct is likely to result in disciplinary action which could include dismissal.

vi. Summary Dismissal

This will be for misconduct or unacceptable conduct or behaviour considered constituting gross misconduct or gross negligence **(see disciplinary rules attached as appendix 2).** The employee will be provided with written reasons for dismissal and the date on which the employment is terminated.

In cases of gross misconduct, gross negligence or gross professional misconduct, the employee will normally be dismissed summarily i.e. without notice or pay in lieu of notice, although any accrued, untaken statutory annual leave to which they are entitled will be paid.

The dismissal will take effect from either the date of the hearing, where the individual was verbally informed, or if the decision was conveyed in writing, the date on which the Trust could reasonably expect the employee to have received the letter and therefore be informed of their dismissal.

vii. Transfer to an Alternative Post (Dismiss and Re-engage)

In exceptional circumstances, as an alternative to the termination of employment (dismissal) and / or in conjunction with a written warning, the employee may be dismissed and re-employed in an alternative post. This may be at a different band, and if so the employee will assume the terms and conditions of the new post without protection of pay.

Where it is as an alternative to dismissal, if the employee does not accept the offer of re-employment then dismissal will be effective from the end of the notice period.

10.0 DISCIPLINARY RECORDS & EXPIRED SANCTIONS

10.1 Normally the validity of disciplinary warnings will be considered to have expired after the specified period (see above). This is provided that there has been the desired and sustained improvement conduct and / or behaviour and there have been no further warnings or action taken against the employee during this time.

10.2 In these circumstances, previous warnings should generally be disregarded for future disciplinary purposes. In exceptional circumstances it may be permissible to take into account previous spent warnings in relation to subsequent disciplinary action.

10.3 These exceptional circumstances are where a clear reason to dismiss has already been established, and past misconduct would evidence that a lesser penalty would not be warranted.

10.4 Additionally, such circumstances could relate to where a pattern of behaviour emerges and/or there is evidence of abuse. However the circumstances in which this will be the case are rare and advice should be sought from HR when this is being considered.

10.5 Where an employee is absent during the course of a 'live' warning for a continuous period exceeding four calendar weeks, the warning will normally be extended by the length of the period of absence.

11.0 APPEALS

11.1 Employees have the right to appeal against any formal sanction issued under this procedure, with the exception of informal action(s), the decision to suspend and 'Fast Track' (Agreed Outcomes).

11.2 Appeals will be conducted in accordance with the Appeals Procedure HRPG58

12.0 VARIATION TO TIMESCALES

12.1 Time scales regarding the procedural steps indicated in this procedure and within the Disciplinary Hearing Procedure at **Appendix 1** are subject to reasonable variation.

12.2 Any references to 'working days' mean Monday to Friday, excluding weekends and bank holidays.

END

Appendix One

DISCIPLINARY HEARING PROCESS

1. The Hearing Manager will ensure that all parties are introduced and will explain the purpose of the hearing.

2. The employee/representative will be asked to state whether they admit or deny the allegation(s).

3. If the employee admits the allegation(s), they may present any mitigating circumstances to the panel.

   Questions may then be asked by the Hearing Manager and panel. The process is then continued as paragraph 11 below.

4. If the employee denies the allegation(s) the Hearing Manager will call witnesses, including the investigating manager (where agreed) and will have the opportunity to ask questions of them.

5. The employee and / or their representative will have the opportunity to cross-examine the witnesses.

6. The Hearing Manager and panel will have the opportunity to re-examine the witnesses on any matters arising from prior examination.

7. The employee or their representative will present their case to the Hearing Manager and panel.

8. The Hearing Manager and panel will have the opportunity to ask questions of the employee.

9. The employee or their representatives will call any witnesses and have the opportunity to question them.

10. The Hearing Manager and panel will have the opportunity to ask questions of the employee's witnesses.

The Hearing Manager may adjourn the hearing at any time up to this point in order that any party may produce further evidence or conduct further investigation.

11. The employee or their representative will have the opportunity to sum up their case. No new information should be introduced at this time.

12. The Hearing Manager and panel may ask the employee or their representative to clarify any points made in their summary statement.

13. The Hearing Manager will bring the hearing to a close and will ask parties to withdraw to allow deliberations to take place. This will take place in private and be attended by the Hearing Manager and panel only. The employee and their representative will be recalled should clarification of evidence be needed.

14. The employee and their representative should be recalled and informed of the Hearing Manager decision verbally wherever possible and reasonable to do so.

    In all cases, and whether or not the decision has been given verbally at the end of the hearing, the employee will be sent a letter outlining the reasons for the decision usually within five working days and will be advised of their right to appeal.

APPENDIX 2

DISCIPLINARY RULES

Employees need to be aware of the standards required of them in the course of their normal day-to-day duties and the possible consequences of any failure to adhere to these standards.

Listed below are the types of issues that, if breached, may result in disciplinary action. These rules are not exhaustive and serve only as a guide, although they do form part of your contract of employment.

1. CONDUCT

Attendance

Every employee is required to attend regularly for work within the terms of their contract of employment. Employees may not be absent from work nor leave their place of work or duties without the relevant authorisation of their line manager.

Time keeping

Every employee is required to attend work punctually, and where directed, to maintain an accurate attendance record.

Confidentiality

All information, including manual or computerised records, relating to patients, employees, salaries, tenders or other potentially sensitive information, is to be regarded as confidential at all times.

Following Instructions

All employees must carry out instructions given by management effectively and efficiently as required. Any concern about the practicality, legality or safety of an instruction, should be raised with the manager.

Health and Safety

In accordance with the Health and Safety at Work Act 1974, employees have a duty to take reasonable care to avoid injury to themselves and others whilst at work. Any personal and protective equipment provided, must be used appropriately. The occurrence of any incident that poses an actual or potential hazard to a patient, employee, contractor or member of the public, must be reported in accordance with the Trust's Incident Reporting Procedure.

Use of Trust Facilities

Employees must not use the Trust's facilities, materials or equipment for purposes unrelated to their job, without the manager's agreement.

Appointments and Business Interests

Employees are not precluded from accepting other employment outside of their normal working hours. However, such employment must under no circumstances hinder or conflict with that employee's contractual obligation to the Trust. Employees

are therefore required to inform the Trust of any outside employment or activity which may do so.

Employees must declare if they (or anyone else in their immediate family or household) have any business interests in a contract that is made between the Trust and a third party. If an employee becomes aware of any contract being entered into by the Trust in which they (or anyone else in their immediate family or household) might have a pecuniary interest, they must notify the Trust in writing.

Additional Employment

Employees are reminded that under the terms and conditions of their employment, they must declare any other employment they undertake in addition to their work with the Trust.

Written consent must be gained from the line manager prior to undertaking external to the Trust, the Trust does not prevent employees from taking secondary employment and will not unreasonably withhold permission to do so provided it does not interfere and is not likely to interfere, with the employees performance of their employment with the Trust.

It is an express term and condition of employment that employees must not undertake any work in any capacity whilst off sick.

Declaration of Interests, Bequests, Gifts & Hospitality

Failure to comply with the Trust's requirements for all employees to declare interests and any gifts, bequests and hospitality received is likely to be construed as a breach of the Trust's regulations.

Communication with Press, Media or Other Third Parties

Any employee who intentionally passes on information obtained during the course of employment that is likely to harm the interests of the Trust, its patients, service users, employees or property, may be subject to disciplinary action. Employees are expected to notify and liaise with the Trust's Communications team when dealing with media.

The attention of staff is drawn to the recognised internal channels by which they can make representation to the Trust, for example, use of the Whistleblowing and Grievance Policies or by contacting the Guardian Service.

Appearance and Personal Hygiene

Employees are expected to be clean and tidy at work and to wear clothing appropriate to their occupation. This may be subject to departmental safety or hygiene rules that must be observed.

2. GROSS MISCONDUCT

Exceptionally serious offences such as those given below will be regarded as gross misconduct and may warrant summary dismissal. Examples of gross misconduct are, but not limited to:

Theft
Any instance of theft, attempted theft or dishonesty arising out of employment with the Trust.

Fraud

Any deliberate fraudulent act, for example, falsification of timesheets, sickness certification or other claim forms etc. Offences, criminal or civil which could be related to fraud or corruption (behaviour outside the boundaries of accepted NHS business practice) will be subject to the Trust's Counter Fraud Specialist's scrutiny in consultation with the Director of Resources and in accordance with the Trust's Fraud and Corruption Policy.

Assault

Any verbal or physical assault (or attempted assault) upon a patient, employee, contractor or member of the public.

Criminal Action/Inquiries

Any criminal police inquiry or action resulting from a criminal inquiry, arrest, charge, caution or conviction in circumstances where there is a connection between the criminal action/ inquiry and the employment relationship which brings about a loss of trust and confidence or where the Trust has been brought into disrepute.

Any failure by an employee to disclose any of the above.

Gross Negligence

Any action or failure to act, that threatens or could threaten the security or health, safety and well-being of a patient or service user, employee, contractor or member of the public or which seriously damages public confidence.

Harassment, Bullying and Discrimination

Breaches of the Trust's Equalities Policies or Respect and Dignity at Work Policy, including any form of harassment, bullying or discrimination including sexual offences, verbal abuse or intimidation directed at a patient, service user, employee, contractor or member of the public.

Relationships with Patients

The Trust regards as wholly unacceptable and close, personal relationship between an employee and a patient whom they meet as a result of their employment. Personal relationships of a sexual nature may additionally be considered a criminal offence.

Confidentiality

All information, including manual or computerised records, relating to service users, employees, salaries, tenders or other potentially sensitive information, is to be regarded as confidential at all times. Serious breaches of confidentiality will potentially amount to gross misconduct.

Following Instructions

All employees must carry out instructions given by management effectively and efficiently as required. Any concern about the practicality, legality or safety of an

instruction, should be raised with the manager. Where there is a serious breach i.e. a wilful refusal to obey lawful instruction without proper reason, it will potentially amount to gross misconduct.

Breach of the Trusts Standing Orders or Financial Instructions

Any serious breach of the Trust's Standing Orders or Financial Instructions.

Corruption

Receipt of money, goods, favours or excessive hospitality in respect of services rendered. (see NHS circular HSG(93)5 which sets out the principles for Standards of Business conduct for NHS staff). This includes the acceptance of any gift or consideration from individuals or contractors that may be considered as an inducement.

Serious Misrepresentation

Any serious misrepresentation/falsification including, declaration of health, qualifications held, previous positions held, falsification of date of birth. Also any failure to disclose a criminal conviction, charge or caution prior to or during employment other than where non- disclosure is protected by the Rehabilitation of Offenders Act. Or deliberate falsification of professional registration, immigration status; or the requirements to satisfy the Fit and Proper Person Test.

Records

All employees are expected to keep clear and accurate records (including electronic records) relevant to their practice a failure to maintain appropriate care records including misrepresentation, falsification or retrospective recording would constitute a breach of policy.

Misuse of Information Technology

Any serious breach of policy as set out in the Trust's IM&T Security Policy, Internet Usage and Social Media policies in relation to the inappropriate or excessive use of IT equipment, Internet access and/or Email or Social network sites.

Data Protection

Any deliberate misuse of data protection information and/or deliberate interference with computerised information or information held on manual files.

Malicious or Wilful Damage to Property

Any deliberate damage to property belonging to the health service, a patient, employee, contractor or member of the public.

Health and Safety

Serious breaches of health and safety legislation and/or the Trust's Health and Safety Policy.

Fitness for Duty

Being unfit for duty, other than for medical reasons, for example, through substance and/or alcohol misuse. This may include sleeping whilst on duty.

Policies or Statutory and Contractual Codes

Serious breaches of the Trust's policies or relevant statutory or professional, Codes of Practice and Conduct, the NHS Code of Conduct for NHS Managers (e.g. practising whilst unregistered) and NHS Constitution. This includes actions outside of the normal workplace and hours of work which as a result, may question the honesty or integrity of the employee or potentially harm the Trust reputation or bring the Trust into disrepute.

Failing to bring to the Trust's attention any investigation or action taken by either their professional body, or any other statutory body, regarding their conduct, behaviour or practice.

Failure to maintain Professional Registration

It is a statutory requirement to maintain professional registration in certain professions to practice without registration is a breach of the terms and conditions of employment, this includes where registration has lapsed, revalidation is not approved or the employee is suspended or removed from the register for whatever reason.

Mental Health Act 1983 and 2007

The Sexual Offences Act 2003 confirms that it is a criminal offence for a care worker to engage or attempt to engage in behaviour of a sexual nature with a person with a mental disorder.

Conduct likely to bring discredit to the Trust or relevant organisation or profession

This rule may be breached when an employee intentionally, recklessly or without reasonable cause acts in a manner which damages, or is likely to damage, the reputation of the Trust or organisation or profession to which they belong.

Breach of Trust and Confidence

This rule may be breached when an employee acts in a way which can reasonably be considered as damaging or likely to damage, the relationship of confidence and trust between them and the Trust. This confidence and trust can be explicit or implied.

Bribery Act

Offences described under the Bribery Act 2010.

Duty of Candour

An employee will have breached Duty of Candour if they fail to be open and honest with a patient in relation to their care or take part in investigations or audits relating to patient care.

EPUT NHS FOUNDATION TRUST LEVELS OF AUTHORITY

CATEGORY OF STAFF	SUSPENSION/ISSUE OF VERBAL OR FIRST WRITTEN WARNING BY:	ISSUE OF FINAL WARNING BY:	DISMISSAL DOWNGRADING OR TRANSFER BY:
Chief Executive	Trust Chair	Trust Chair	Trust Chair with Non-Executive Trust Members
Executive Directors	Chief Executive	Chief Executive	Chief Executive with Trust Chair/Non-Executive Trust Members
Other staff directly responsible to the Chief Executive	Chief Executive	Chief Executive	Chief Executive
Staff Directly responsible to: Executive Directors (Directors/Deputy Directors)	Executive Director	Executive Director	Executive Director
All other staff	Immediate Manager	Next Level Manager above Immediate Manager	The appropriate: Executive Director / Divisional Director or Associate Director (or equivalent). Senior (Service) Manager as authorised by the Executive or Divisional Director.

APPENDIX 4

FAST TRACK/AGREED OUTCOME PRINCIPLES

Where the disciplinary outcome of a particular case is anticipated to result in a sanction e.g. first written warning, an employee and /or staff side may ask management to move directly to that conclusion without completing a full investigation. The Manager may also suggest to staff side that the case may be suitable to be dealt with under Fast Track/agreed outcome. It should be noted however that there should be sufficient information for both the employee to request a Fast Track/agreed outcome and for management to make a decision on the appropriateness of the request i.e. Datix form, At the meeting there must be a belief that the employee has learnt from the experience and is unlikely to repeat their misconduct and adhere to the values of the Trust.

Fast Track/agreed outcome will not be considered for matters of gross misconduct or where dismissal maybe appropriate. Nor can it be used if any of the allegations are contested by the employee or if there is a connected disciplinary process involving another employee.

In the event that the Manager/Senior Manager considering the facts decides that there may be no case to answer with the detail/evidence they have been given; this should be discussed with Human Resources.

Staff who are not in a union should discuss their concerns with their manager, the Trust's staff side chair, Human Resources or a workplace colleague before considering a request for 'Fast Track/agreed outcome.

1. All requests must be submitted to the fact finder, commissioning manager or line manager, who will liaise with the HR department, before any investigation commences.
2. A meeting with the employee and their staff side representative (if in a union) will be necessary at this point to gather further information. The Line Manager/Senior Manager will be responsible for the collection of this information so that this can be passed on to the fact finder, commissioning manager or line manager for the decision making.
3. The Investigations Team Leader will seek to ensure that the employee has discussed the matter with their staff side representative, Human Resources or a workplace colleague if they are not a member of a staff side organisation before making such a request.
4. There will be no right of appeal against a warning given using Fast Track/agreed outcome

Cases that may fall under the Fast Track/agreed outcome but not exhaustive could include: social media, drug errors, lack of documentation, confidentiality, minor IG breaches, breaches of procedure internet misuse etc. Please note that this list is not exhaustive.

Please note that medication errors will be considered as part of the Fast Track/agreed outcome process, however every error will be reviewed by a panel, consisting of Lead Nurse, HR and Manager to consider the suitability of the Fast Track/agreed outcome process.

If the Fast Track/agreed outcome process is agreed; a meeting will take place with a senior manager of the Service, no witnesses will be called. Notes will be kept of the meeting. The senior manager hearing the case will not be the manager who was involved with any of the previous direct discussions with the employee.

This meeting must have taken place within 72 hours of the issue being raised with their manager or staff representative.

The process for a Fast Track/agreed outcome meeting will be as follows:

- Introductions
- The senior manager outlines the nature of the allegation(s) accepted by the employee and advises that it (they) will be awarded the agreed sanction.

- The senior manager confirms with the employee that they accept the allegations previously stated.
- The employee or their representative will have the right to put forward any comments or statements relating to the incident (including any mitigation).
- The senior manager may wish to question the employee.
- The senior manager will adjourn briefly to give consideration to the case. If more information is required to make a decision on the sanction the meeting may be adjourned to allow a further investigation to take place.
- The senior manager will then communicate their decision to the employee and their representative. The penalty will not exceed the previously stated limited sanction but in exceptional circumstances (e.g. the employee denies some of the allegations) the manager may decide that the matter should be referred for further investigation and/or to a full disciplinary hearing for potentially a higher sanction to be considered.
- The senior manager will send a letter confirming the decision to the employee. The record of any warning will be kept on the personal file.
- The disciplinary sanction imposed will be given in accordance with the Trusts' Disciplinary policy, procedure and related appendices.

APPENDIX 5

INVESTIGATION TOOLKIT

This toolkit sets out the steps to be taken when concerns about the conduct of an employee that needs to be investigated or when suspension may be required. This toolkit is to be read in conjunction with the Trust's Disciplinary Procedure.

1. INTRODUCTION

The purpose of this toolkit is to ensure that concerns regarding the conduct or performance of staff, which require formal investigation, are investigated in a fair and consistent manner. Investigation may be a preliminary step which leads to action being taken in accordance with other Trust policies.

If you have any queries in relation to this or the policy then please do not hesitate to contact your HR Business Partner or HR Advisor.

2. SCOPE

This process applies to all staff and formal investigations unless overridden by other policies relating to a specific staff group or set of circumstances.

In the case of some straight forward line management concerns in relation to conduct or performance of an employee, a formal investigation may not be necessary. A decision may be made to deal with the matter informally. Examples of where an informal process may be used would include sickness issues and persistent lateness.

However, in more complex cases, or where others may have witnessed alleged incidents or may have relevant information, a matter should be fully investigated before a decision is made regarding further action to be taken. In cases where the manager suspects financial irregularities the matter should be brought to the attention of the Director of Finance. It should be noted that in cases of suspected fraud, the matter will be referred to the NHS Counter Fraud Management Service and interviews may be carried out in accordance with Police and Criminal Evidence (PACE) legislation.

3. SUSPENSION

In certain circumstances (as outlined below) it may be necessary to suspend an employee from duty pending investigation into allegations made.

The following are examples of what may be considered as gross misconduct. Please note that the list is not exhaustive.

- Theft/Misappropriation – any instance of unauthorised removal of property from the Trust or from a service user, carer or members of staff
- Physical Assault – Physical assault upon a service user, carer, a fellow employee or member of the public;
- Threatening/Menacing Behaviour towards a service user, carer, a fellow employee or a member of the public;
- Recklessness/Negligence in work – any action, or failure to act, which threatens the health and safety of a service user, carer, member of the public or another member of staff;
- Serious Damage – to Health Service property, property of service users'/carers, or members of staff;
- Corruption (FA06) – receipt of money, goods, favours or excessive hospitality in respect of services rendered;
- Confidentiality – loss of confidential information, unauthorised access to confidential information, disclosure or breach of confidence in relation to information regarding a service user/carer or member of staff except where such a breach constitutes a protected disclosure for the purposes of the Trust's Concerns at Work;

- Unlawful discrimination or harassment;
- Breach of Professional Code of Conduct including failure to maintain registration with appropriate professional body;
- The concealment or destruction of evidence of malpractice;
- Inappropriate or Unprofessional relationship with any service user
- Deliberately accessing or downloading material from any site that is of a pornographic, discriminatory or of an offensive nature – IM&T Security Policy (IT02);
- Sleeping whilst on duty;
- Possession or attempt to supply alcohol or substances (which may or may not be illicit);
- Consumption of alcohol or substances (which may or not be illicit), either prior to reporting for duty or whilst on duty, which may impair ability to undertake duties;
- Inappropriately accessing the Internet during working hours (unless related to work or educational purposes);
- Inappropriate use of internet and social network sites, for example Facebook and Twitter;
- Communicating any material which breaches the Trust Equality and Diversity policies;
- Commits a serious act, which is deemed to be prejudicial to the interests of the Trust or its employees;
- Breach of Trust Corporate Smoking Cessation Policy (SA20) on more than 2 occasions;
- Knowingly taking carers/parental/paternity/adoption leave for purposes other than supporting a child/dependant;
- Making false allegations against another employee;
- Victimising an employee who has raised concerns under the Whistleblowing, Dignity at Work, Grievance, Disciplinary Policies/Procedures;
- Serious breach of the Trust's Standing Financial Instructions (SFIs), Standing Orders (SOs), and/or Scheme of Reservation and Delegation (SoRD);
- Misrepresentation at any time, including at the time of appointment or when applying for any post in the Trust, eg previous positions held, qualifications held, date of birth, declaration of health, or failure to disclose a criminal office or pending criminal action, subject to the provisions of Rehabilitation of Offenders Act 1974

The act of suspension is not a disciplinary act. It is a neutral act enabling the individual to be released from their place of work pending investigation and a decision on the appropriate outcome. Whilst suspended, the employee will normally remain on full pay.

Suspension will normally be carried out by the employee's manager. A period of special leave whilst a preliminary investigation is undertaken, this would normally be for no longer than 24 hours could be applied before a decision to suspend. However in exceptional circumstances, in the absence of the employee's manager, another manager may suspend a member of staff on the basis of the criteria above (for example 'out of hours' or during annual leave of the employee's manager).

Notification of the suspension and the reasons for the suspension will be confirmed in writing to the employee as soon as possible and within 5 working days of the date of suspension.

NOTE: - A suspension may have to be carried out 'out of hours' when a staff side representative may not be available. In such a situation, the individual may be accompanied by a workplace colleague.

3.1 Letter of Suspension

The written confirmation of suspension must be sent to the employee within three working days, and should include the following details:

- The reason for the suspension
- The fact that it will be on full pay
- That it is a neutral act, a precautionary measure and is not a disciplinary sanction.
- The name and contact details of the identified Support Officer
- The terms of the suspension e.g. not to enter the workplace other than to obtain treatment for themselves or their family, or to attend an arranged meeting with their trade union representative.
- Not to enter the workplace without prior agreement from their authorised manager.
- Not to access systems
- Not to discuss or disclose any specific information relating directly to the case. Any breaches of confidentiality may be deemed in itself misconduct.
- The support available from the Occupational Health Department if required.
- A contact name and number for any queries.
- That during their period of suspension they must not undertake any bank or agency work.

The letter of suspension will also include the Conduct Investigation Support Leaflet (Appendix 7) ensuring that the employee is aware of all opportunities for support and advice available to them.

During the period of suspension the Investigating Officer or the individual's Line Manager must maintain regular contact with the suspended employee, in order to keep the employee informed of any progress in the investigation.

4.0 The Investigation

The purpose of the investigation is threefold:

- To determine whether or not there is a prima facie case to answer ("sufficient to establish a fact or raise a presumption unless disproved or rebutted.")
- To be thorough, fair and objective, respecting the rights of all the involved parties
- To collect relevant evidence and to establish facts, to be used in preparation for action in the event that formal procedures need to take place.

4.1 The Investigating Manager

Following the reporting of an incident, the appointment of the most suitable Investigating Manager will be discussed and agreed between the Human Resources representative and an appropriate level of Management.

When appointing an Investigating Manager it is important to consider the following factors:

- The independence of the investigator/s;
- Credibility of the investigator/s;
- Specialist knowledge required;
- Sensitivity of the situation;

- Time available to undertake the investigation;
- The necessary skills, training and experience of investigator/s – have they done an investigation before and/or attended management development programme
- The possibility of witness interviews/statements.

5.0 Terms of Reference of the disciplinary Investigation

The Terms of Reference (TOR) for an investigation provides a specification for exactly what the Investigating Manager needs to do and how the investigation should be conducted. It includes key information about the roles of the different people involved and the timescales to work to. This template should provide some standard wording around the conduct of investigations and the terms of reference for an investigation.

These should be shared with the employee/s concerned and with any staff representatives involved. The terms of reference should include the following:

- Allegation points
- Copies of all documents raised to date regarding the issue and any witness statements received to date
- Timescale for investigation
- Plan of communication with employee
- Resources to support investigation
- Assessment of independence of investigating manager
- Details of witnesses that management wish to be interviewed should be included within the Terms of Reference and the Investigating Managermay decide on other witnesses to interview. The employee may also suggest other potential witnesses during the investigation, where an Investigating Manager decides not to interview witnesses suggested by the employee they should provide a clear rationale for this decision.
- Relevant policy and procedures used in conjunction with the investigation

It is important to understand the Trust obligations in regard to Whistleblowing and this must be discussed with a HR Representative prior to the commencement of any investigation.

The Investigating Manager will interview relevant staff, or collate witness statements / questionnaires and collect relevant information and collate this into a written report or outcome letter. In cases which result in a Disciplinary Hearing this will form the basis of the presentation of case.

6.0 Interviews

For the interview process to be successful, it must be seen to be consistent, fair and objective. The investigating Manager/s will approach the investigation with an open mind. This can be achieved by following a few simple rules:-

- The process must be geared to clear criteria and/or terms of reference
- Where the matter is a complaint, the complainant should normally be interviewed first, followed by the individual about whom the complaint has been made.
- Where there is no complainant, the employee against whom the allegations are made would normally be interviewed first.
- During those initial interviews the individual should be asked whom they wish to be interviewed as witnesses. It may also be necessary to collect some background information before these interviews take place.
- Introduce everyone, outline the purpose of the interview and

investigation and the process which will be followed.

- Explain what will happen with the notes of the meeting, signup and timescales
- Consider the use of questionnaires, where necessary – this should be used whereby a witness's information could be captured via this method. If the information captured still leaves questions to be answer please revisit.
- Explain the decision making process and that the role of the Investigating officer is to fact-find only, not to form a judgement. It is important that the investigating manager seeks facts which could either prove or disprove the allegations made.
- Discuss confidentiality and stress its importance and any consequences of breaches.
- Do not make comments regarding findings to date and remain impartial.
- Concentrate on the facts, e.g. events, times, dates what was seen and heard.
- The extent of the investigation should be proportionate to the seriousness of the issue
- The investigating manager should try to put all individuals at ease
- All individuals have the right to be accompanied by either an accredited Trade Union Representative or a Work Colleague.
- Individuals should be available for meetings and not unreasonably delay the investigation. Written testimonials or telephone meetings can be accepted. Where an employee does not cooperate, they must be informed that the investigation will conclude with the information available, if necessary.
- Reluctant witnesses should be told that the interview will be held privately, that a note will be taken which they will be able to verify for accuracy and should be reminded of their obligation of good faith to the employer
- Where a member of staff is absent form work through sickness, Occupational Health will be consulted. An investigation should not be delayed on the grounds of absence nor should it compromise an individual's health. The Investigating Manager should be empathetic to the circumstances and ensure that all measures of support and reasonable adjustments are considered to support participation before making a decision to proceed with the investigation regardless.
- If an individual claims the allegations are vexatious, explain that the allegations at hand must be investigated initially and should there be evidence of malice, this be investigated subsequently.
- To ask non-leading questions you must be comfortable with being vague in how you ask your questions. Here's some examples:
- "How would you use this?"
- "What would you do with this information?"
- "What would you do next?" or my favourites, "What's next?"
- "How do you feel about what you're doing there?"

7.0 Note Taking

Verbatim notes do not need to be taken, but the key points of any answers should be noted. There may be repetition, but it is still important to record these responses.

8.0 Additional Evidence

Other relevant information that may need to be accessed could include:

- Financial records. If there are any doubts around this issue then Audit should always be consulted.
- Occupational health documents (subject to the requirements of the Access to Medical Records Act and the Data Protection Act)
- Minutes of meetings
- Appraisals, training records
- Supervision notes
- Rosters
- Observation sheets
- Details of any performance management documents
- Evidence from clients/patients, it may be appropriate to involve another professional in some incidents with sufficient expertise to communicate with, elicit and evaluate this type of evidence – where it is considered necessary to interview service users / patients the relevant responsible medical officer should be consulted first.
- Documentary evidence which could include policies and procedures, emails, log books
- Emails from IT department
- Closed Circuit Television (CCTV) evidence
- Body worn camera evidence

When collecting additional information Investigating Manager should be mindful of the General Data Protection Regulation (GDPR) 2018, the Telecommunications Regulations 2000 and advice should be sought from the relevant specialists in these areas if necessary.

9.0 Evaluation of Data and Conclusion of the Investigation

Having gathered all the facts the Investigating Manager needs to reach a conclusion and make a recommendation as to whether there is a case to answer under the relevant policy.

Where there is no case to answer the recommendations may include correct guidance for individuals including managers, training, or other appropriate action.

In respect to the disciplinary report this may include deciding whether:

- There is no case to answer and no further action should be taken.
- There is a need to arrange for corrective guidance or a recorded conversation to be given to the employee to correct the misconduct/situation
- The case highlights training or capability issues which should be addressed using the appropriate procedure.
- There is a potential case to answer and a formal hearing should be arranged under the appropriate procedure.

All parties involved, excluding witnesses, need to be informed of the decision in writing.

Where the case is proceeding to a formal hearing the Investigating Manager must agree with their HR Representative the content, investigation reports and all appendices of evidence.

Essex Partnership University
NHS Foundation Trust

Disciplinary Decision Making Tool

This tool supports a conversation between management about whether a staff member involved in an incident warrant's formal investigation/action. The tool highlights the important principles that need to be considered before formal management action is taken, and allows management to make certain they are treating all staff equally, compassionately and fairly, ensuring that any decision taken is not based on unconscious bias.

This tool can be used at any stage of a disciplinary process, and it may need to be revisited if more information becomes available. The Tool should always be used to establish if an alleged incident involving an employee/worker should be formally investigated under the Trusts disciplinary procedure. This guide does not replace HR advice and should be used in conjunction with the Trusts policy and procedure on disciplinary matters

Insert details on where to send the form and who to contact if require further assistance.

Name person completing Form:	
Supporting HR Representative:	
Name of Individual/s under review:	
Individuals Ethnicity	BAME / NON BAME
Date of alleged incident:	
Date form completed:	
Brief details of incident:	

Deliberate Harm Test

1a. Did the member of staff intend to cause harm?

NO ⬇

Yes → **Recommendation:** Investigation required, Consider suspension or deployment of staff, referral to police, contact relevant professional body → End

Health Test

2a. Did the staff member appear to be under the influence or was there any other indications of physical or mental ill health

NO ⬇

Yes → Recommendation: Follow Employee wellbeing policies and procedures and fitness to practice reviews, which is likely to include occupational health referral. Need to review why concerns had not been recognised and addressed earlier. → End

Operating Systems Test

3a. Are there agreed protocols/policies/accepted practices in place?

NO → **Recommendation:** Action singling out the individual is inappropriate where there are Trust wide issues with operating systems. A fact finding exercise should be undertaken to identify issues with operating systems with actions identified to address. Training/supervision support may need to be provided to the individual to improve practice. → END

Skills and Performance Test

3c. Did the individual know how to and can, but chose not to
4a. Would you expect individuals in a similar role/position with similar experience to act in a similar manner?

YES ⬇

4b. The individual has not had training relevant to the concerns?

4c. Has the individual failed to have had regular supervision/handover?

NO

YES

Recommendation: Action singling out the individual is inappropriate where there are Trust wide issues with supporting skills and performance. A fact finding exercise should be undertaken to identify issues with systems with actions identified to address. Training/supervision support may need to be provided to the individual to improve practice.

END

Mitigating Circumstances

5a. Was there any significant mitigating circumstances?

NO

YES

Recommendation: Formal action may not be appropriate, seek HR and relevant technical/clinical advice on what degree of mitigation applies and if informal action would address the concerns appropriately.

END

OUTCOME

Matters to be reviewed prior to deciding outcome:

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the action recommended?
- Considering the circumstances would the application of this action recommended represent a proportionate and justifiable response?
- How will appropriate resources be allocated and maintained to ensure the action recommended is allocated and maintained to ensure it is conducted fairly and efficiently?
- How will you ensure that independence and objectivity is maintained at every stage of the action recommended?
- What will be the likely impact on the health safety and wellbeing of the individual(s) concerned in the action recommended and on their respective teams and services?
- What immediate and ongoing direct support will be provided?
- How will you ensure the dignity of the individual(s) concerned in the action recommended is respected at all times and in all communications and that your duty of care is not compromised in any way, at any stage, of the action recommended?

Please detail below the action recommended (Please tick all relevant boxes)

Informal Disciplinary Procedure or 'fast track' agreed outcome		Performance Management – CAPABILITY PROCEDURE	
Training Requirement		Increased Supervision/Mentoring	

Changes to procedures/policy/guidance/protocols/practices		Notification to professional lead – consideration of referral to professional body	
Suspension/Exclusion		Restricted Duties	
Health Concerns – Sickness and wellbeing procedures		Formal Investigation – DISCIPLINARY PROCEDURE	

In taking the above action is this consistent with how other employees have been treated for the same or similar conduct or concerns? Yes/No

Please provide the rationale for course of action

If Formal Investigation – DISCIPLINARY PROCEDURE is recommended please provide:

Reasons why informal action / learning procedure is not applicable:

Reasons why 'fast track' (agreed outcome) procedure is not applicable:

NHS
Essex Partnership University
NHS Foundation Trust

Conduct Investigations

Support and information for staff

General information

The trust recognises that becoming the subject of a workplace investigation can be extremely stressful. It is important to respond to and participate in an investigation carefully and calmly.

Staff members may find themselves subject to an investigation under either the **Disciplinary (Conduct) Procedure**, if they hold a substantive post, or the **Managing Temporary Worker Conduct & Complaints Policy & Procedure**, if they are a bank worker.

Aside from this being a stressful time due to the investigation process itself, this may be exacerbated by the involvement of a safeguarding process, involvement from the Police, or because of a suspension/preclusion from the workplace as a result of the concerns raised. In light of this, this leaflet will briefly describe the process followed in each of these scenarios.

The trust has a number of different support mechanisms; these are detailed below:

- HELP Employee Assistance Programme on **0800 731 8627**, which is strictly confidential and available 24 hours a day, 7 days a week. You can also visit eput.helpeap.com and enter the organisation code **EPUT1**.
- Here for You staff psychological support service. Call **0344 257 3960** at any time – this service is available 24 hours a day, 7 days a week.
- Optima Health Occupational Health Service on **0333 121 3000** or **nhseast@optimahealth.co.uk** available 9am-5pm Monday to Friday.
- Staff Engagement team: **epunft.staffengagement@nhs.net**
- Equality Advisor: **epunft.equality@nhs.net**
- Freedom to Speak Up Guardian, Yogeeta Mohur: **f2su.eput@nhs.net**
- BAME Network: **epunft.bamenetwork@nhs.net**
- Staffside Chair: **hayley.johnson6@nhs.net**

Keeping in touch

A designated member of line management will be allocated to keep in touch and support you throughout the investigatory period. This is put in place to support your general wellbeing. The designated manager will contact you at the start of the investigatory process and agree a plan for keeping in touch.

The designated manager (Support Officer) will **not** be involved in the investigatory procedure or any other procedures that may follow from this.

One of the Trust's Staff Health and Wellbeing Leads will also be available to provide you with support throughout the investigatory period should you wish to access this.

If you wish to nominate an alternative designated manager or support person this will be considered. Anyone involved in the investigatory process (including potential witnesses) **cannot** also act as the designated manager support.

For bank workers the designated manager will be the Bank Staff Relationship Manager, supported by an appropriate operational manager.

Safeguarding investigation

When a safeguarding process is deemed necessary due to the nature of the concerns raised, the trust's **safeguarding department** will be involved. They will liaise with the senior manager and HR representative concerned as to what information can be released to you both during and after the safeguarding investigation. Where possible, an internal disciplinary investigation will run separately but parallel to the safeguarding investigation.

Police/other involvement

It may also be necessary, due to the nature or seriousness of the concerns at hand, that the Police, Local Security Management Specialist, Local Counter Fraud Specialist, or a combination of these parties be involved in the investigation process. This is where there are concerns that fraud/corruption/bribery or another criminal act may have been committed. These parties may be involved or consulted with prior to any internal investigation or action by the trust.

Any police investigation will take precedence over internal procedures and the trust should take care not to prejudice any investigation by the Police or an external body. To avoid this it may only be possible to inform a staff member that an allegation has been made against them. No further information will be provided at the initial stages as clearance from the Police will be required to ensure that potential evidence is not prejudiced as a result of information regarding allegations being shared.

Suspension

Suspension, if you're a substantive staff member, or **preclusion**, if you're a bank worker, may be necessary to support you during the investigation process, either where your continued presence could compromise the process, or where management feel that there may be a risk to the health and safety of patients and/or others. Suspension will only occur as a last resort and other options, such as temporary redeployment or restricted duties, will be considered as alternatives in the first instance. Suspension will be for as short a time period as possible.

If you are suspended or precluded, you will be unable to work while the investigation is taking place. You may be able to undertake some training if this is deemed appropriate. Substantive staff members will receive their full contractual pay which will be calculated on the basis of your average earnings over the three months prior to the date of suspension.

Your suspension will be reviewed at regular intervals: after **two weeks**, **four weeks**, and after **eight weeks**. You will be kept informed of the progress of the investigation in writing by the Investigating Manager at these intervals.

If you are off sick during a period of suspension you will receive sick pay accordingly and will need to report your absence/provide any certificates to your line manager as you usually would. During any period of suspension you must be available to attend investigatory meetings as if you were at work. If there are periods of time when you will not be available, you will need to book annual leave in the usual way via your line manager.

		Agenda Item No: 8a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 July 2021**

Report Title:	Board Assurance Framework 2021/22 July 2021					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Susan Barry, Head of Assurance					
Report discussed previously at:	ET BAF Sub-Group June and July 2021 (single reports)					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report presents the EPUT Board of Directors with an overview of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) 2021/22 as at 28 July 2021 covering the two month period June and July 2021	**Approval**	✓
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note progress on the BAF refresh and actions from the Board Development Session on risk appetite
2 Note progress on procurement of an electronic risk register
3 Note assurances to Executive Team and the Audit Committee
4 Review the risks identified in the BAF 2021/22 July summary (Appendix 1) and approve the risk scores including recommended changes outlined below taking account of actions by the BAF ET Sub-Group at its June meeting
5 Approve the BAF risk closures and amendments iterated in the key issues and main report
6 Note the July Key Performance Indicators (Appendix 2)
7 Review the risks identified in the CRR 2021/22 July summary (Appendix 3) including actions taken by BAF ET Sub-Group at its June meeting
8 Approve the CRR risk closures and amendments iterated in key issues and main report
9 Identify any further risks for escalation to the BAF, CRR or Directorate risk registers

Summary of Key Issues

Introduction

- This report covers two months of reporting to the ET BAF Sub-Group and the July summary includes reference to any changes made by it in June 2021
- The ET BAF Sub-Group established in January, is a dedicated forum for detailed review of the BAF and CRR
- In view of the work progressing at Board/ Executive level around governance, structure and accountability, the BAF, CRR and Directorate Risk Registers (DRR) continue to roll over until Board approval of Strategic Objectives for 2021/22

Board Assurance Framework (Appendix 1)

- There are **17 risks** on the Board Assurance Framework. Recommendations in the report take this to **15**.
- The **summary sheet (Appendix 1)** iterates the current mitigating actions/ controls in place for risks on the BAF and any further actions required.
- **BAF action plans** are under regular review with Executives and their direct reports. All action plans receive review and scrutiny by the relevant Board Standing Committees on a quarterly basis. Approval and monitoring of action plans sits with the relevant sub-Committee or Group.

- **Actions and decisions made by ET Sub-Group at its June meeting**
  - Approved separation of risks relating to staff recovery (BAF62 amended) and recovery of services (new BAF65)
  - Approved closure of BAF41 CIPs 2020/21 (end of financial year) and approval of new risk BAF66 Efficiencies 2021/22
  - Approved closure of BAF57 HSE (risk materialised)
  - Noted the request from May Board that BAF64 remains at 5 x 4 = 20
  - Noted Project Initiation Document in train for BAF58 Clinical Activity (record-keeping) project aligned to patient safety PMO
  - Noted the following summaries for June 2021 – BAF, CRR, Covid-19 and Mass Vaccinations
  - Noted review and scrutiny of action plans by Standing Committees – Quality, Finance and Performance and People, Innovation and Transformation
  - Noted Q1 Key Performance Indicators
  - Approved proposal for Electronic Risk Register
  - Reviewed and approved Terms of Reference for ET Sub-Group

- **Actions taken following ET Sub-Group June 2021**
  - Assurance report submitted to and approved by Executive Team
  - Verbal assurance report to Audit Committee July 21
  - Risk Management and Assurance Framework extended until September 2021 to allow for review to take account of current governance and BAF work
  - Amberwing presentation and discussion with Board on risk appetite

- **Actions, decisions and recommendations from ET Sub-Group July 2021**
  - Noted that the G-Cloud procurement framework is the basis for purchase of an electronic risk register
  - Timescale and implementation/ roll out plan to be presented to ET Sub-Group August 21
  - Lengthy discussion on moving forward with strategic risks as the focus for the Board Assurance Framework with most current operational BAF risks moving to a more robust Corporate Risk Register with SMART action plans.
  - Met with Chief Executive to distil risks from draft Strategic Objectives
  - Agreed not to escalate risk on Mountnessing Court due to imminent decision making – risk to remain on SEECHS Directorate Risk Register
  - ET Task and Finish Group to meet 9 August 21 to reflect on additional risks for strategic risk register
  - Noted approval of new action plans for BAF36 Purposeful admissions BAF38 Emergency planning
  - Appraise Board of Directors on BAF refresh work (see main report)

- **There are no risks recommended for escalation to the BAF**

- **The following risks are recommended for closure by Executive Team:**

ID	Risk	Rationale and discussion points
BAF23	If EPUT does not monitor EU Exit trade deal areas without agreements or with further discussions pending then there may be unforeseen circumstances resulting in an impact on service delivery	EU Exit sit rep removed from command meetings. Data adequacy resolved. EU settlement scheme now closed.
BAF64	If the pressure continues for local, regional and national CAMHS Tier 4 capacity, then there is the risk EPUT will be required to admit against clinical best practice, potentially resulting in failure to meet our patient safety ambitions and ensure provision of high quality care.	This risk has materialised and needs replacement with a risk that reflects the consequence of not developing and implementing a strategic plan over the next six months to resettle the CAMHS Tier 4 service. The ET Sub-Group will receive the new articulated risk in August 21.

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

ID	Risk	Rationale and discussion points
BAF36	If EPUT does not focus on and work collaboratively to achieve purposeful admissions then ward environments may become volatile and difficult to manage resulting in increased length of stay and failure to meet our safety ambitions	As discussed in June ET BAF Sub-Group. Still to be discussed in MH SS SMT.
BAF62	If EPUT does not support staff effectively then staff recovery from the HSE prosecution and the Covid-19 pandemic is compromised resulting in a failure to meet our People Plan ambitions	Takes account of the potential impact of the HSE prosecution as recommended by the Finance and Performance Committee and discussed by ET Sub-Group
BAF65	If EPUT does not plan and manage its resources effectively then recovery of services following the HSE prosecution and the Covid-19 pandemic is challenged resulting in a failure to meet our organisational ambitions	Takes account of the potential impact of the HSE prosecution as recommended by the F&PC and discussed by ET Sub-Group

- **There is currently one risk sitting at a score of 20 (extreme) following changes made**:

ID	Risk	Comments/Action
BAF50	If EPUT does not have the **skills, resource and capacity** to deliver on high quality care and other wide ranging of priorities and pressures then achieving our organisational objectives may be compromised resulting in stagnation of risks and failure to maintain our position within the system	Need to ensure we implement new strategies in an integrated way. A new action plan is in development for 2021/22

Key Performance Indicators (Appendix 2)

As at the end of Q1 all KPI's were RAG rated green apart from the percentage of risks with no movement, however, this showed an improvement in June.

For July, KPI2 and KPI2b slipped to red with 15 risks having no movement, although two risks closed. However, in the four months since April 12 risks have seen a decrease. We will review how the calculations are visualised to give a more accurate year-to-date RAG rating.

Corporate Risk Register (Appendix 3)

- There are **14 risks** on the Corporate Risk Register. Recommendations in this report take this to **12** following approval.
- There are no risks recommended for escalation to the CRR

- **The following risks are recommended for closure by Executive Team:**

ID	Risk	Rationale and discussion points
CRR64	If EPUT experiences further serious inpatient safety incidents then high quality patient care is compromised resulting in additional regulatory scrutiny and failure to achieve our Safety First, Safety Always ambitions	Replace with risks related to the focus on EPUT's four big issues, namely ligature, learning, observation and engagement, and staffing. Articulation of new risks will take account of existing risks on the BAF.
CRR75	If EPUT does not achieve ECTAS accreditation then there may be adverse media coverage resulting in a lack of public confidence in the services offered to our patients	ECTAS accreditation now in place for The Linden Centre and Basildon Mental Health Units. Remains on Directorate Risk Register in respect of The Lakes.

- **The following risk is recommended for reduction in score:**

ID	Risk	Rationale and discussion points
CRR11	If EPUT fails to implement and embed its Suicide Prevention Strategy into Trust services then it may not track and monitor progress against the ten key parameters for safer mental health services resulting in not taking the correct action to minimise unexpected deaths and an increase in numbers	Agreed implementation plan in place with STPs and ICS Detailed work plan in place Reduce score to threshold 4 x 2 = 8

Covid19 Risk Register Summary
The Covid19 Risk Register summary forms part of the Covid 19 update report to Board.

Mass Vaccinations Risk Register
The EPUT Mass Vaccination risk register updates contain no significant changes.

EU Exit Trade Deal Risk Register
The EU Exit Trade Deal Risk Register will close in due course.

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

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

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

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

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

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

Acronyms/Terms Used in the Report			
BAF	Board Assurance Framework	CRR	Corporate Risk Register
DRR	Directorate Risk Register	CQC	Care Quality Commission
IT	Information Technology	CVG	Covid19 Gold Risk
CVS	Covid19 Silver Risk	EU	European Union
RAG	Red Amber Green	ESOG	Executive Safety Oversight Group
KPI	Key Performance Indicators	IAPT	Access to Psychological Therapies
EOSC	Executive Operational Sub Committee	ECTAS	Electroconvulsive Therapy Accreditation Standards
PMO	Project Management Office	HSE	Health and Safety Executive
SEECHS	South East Essex Community Health Services	CAMHS	Child and Adolescent Mental Health Services
F&PC	Finance & Performance Committee	MHSS SMT	Mental Health and Specialist Services Service Management Team

Supporting Documents and/or Further Reading
Appendix 1 Summary of BAF as at 28 July 2021 Appendix 2 Key Performance Indicators as at 28 July 2021 Appendix 3 Summary of CRR as at 28 July 2021

Lead
Paul Scott **Chief Executive Officer**

Agenda item 8a
Board of Directors Part 1
28 July 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

BOARD ASSURANCE FRAMEWORK 2021/22 JULY 2021

PURPOSE OF THE REPORT

This report presents the Board of Directors with an overview of the Board Assurance Framework and Corporate Risk Register 2021/22 as at 28 July 2021 and incorporates Q1.

UPDATE AS AT JULY 2021

1. Board Assurance Framework 2021/22

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

There are 17 risks on the BAF. Recommendations in the report take this to 15. **Appendix 1** provides a summary of BAF risks as at July 2021 including a heat map of risks against the 5 x 5 scoring matrix and movement on scoring from August 2019 to July 2021.

The ET BAF Sub-Group meets monthly to discuss the BAF and CRR and a Task and Finish Group meets informally to undertake further work.

1.1 BAF Refresh

Work on a BAF 'refresh' is underway in parallel with high-level governance, assurance and diagnostic work that will frame EPUT's strategic objectives for 2021/22.

A further training and development opportunity took place with the Board at its June development session facilitated by Amberwing, the focus of which was risk appetite. The key actions to take forward from the session are:

- Complete a risk appetite grid
- Consider impact types and their alignment
- Within the impact domains consider the levels of impact and appetite
- Plot risk appetite levels for new strategic objectives
- Validate to ensure 'buy-in' including presentation of new set of risks
- Develop a new visual presentation of the BAF
- ET Task and Finish Group to consider distillation of risks against the strategic objectives and produce a 'straw man' for BOD consideration in September
- Synthesise a risk appetite statement as part of the Risk Management and Assurance Framework review (RMAF extended to September 2021 by Audit Committee)

1.2 Electronic Risk Register

- The G-Cloud procurement framework will be the basis for purchase of an electronic risk register. The timescale for this is in train.

- An implementation/ roll out plan is in development for presentation to the ET BAF Sub-Group in August 21. This will be resource intensive for the Assurance Team at the front end.

1.3 Assurance

- Assurance report submitted to and approved by Executive Team
- Verbal assurance report to Audit Committee July 21
- Review and scrutiny of action plans by Standing Committees June 21
- Monitoring of action plans aligned to relevant Committees/ Groups
- Full engagement with Executive Team on risk management

2. Recommendations for BAF escalation, closures and amendments

The key issues in the cover sheet above iterate:

- There are no risks recommended for escalation to the BAF
- **The following risks are recommended for closure by Executive Team:**

ID	Risk	Rationale and discussion points
BAF23	If EPUT does not monitor EU Exit trade deal areas without agreements or with further discussions pending then there may be unforeseen circumstances resulting in an impact on service delivery	EU Exit sit rep removed from command meetings. Data adequacy resolved. EU settlement scheme now closed.
BAF64	If the pressure continues for local, regional and national CAMHS Tier 4 capacity, then there is the risk EPUT will be required to admit against clinical best practice, potentially resulting in failure to meet our patient safety ambitions and ensure provision of high quality care.	This risk has materialised and needs replacement with a risk that reflects the consequence of not developing and implementing a strategic plan over the next six months to resettle the CAMHS Tier 4 service. The ET Sub-Group will receive the new articulated risk in August 21.

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

ID	Risk	Rationale and discussion points
BAF36	If EPUT does not focus on and work collaboratively to achieve purposeful admissions then ward environments may become volatile and difficult to manage resulting in increased length of stay and failure to meet our safety ambitions	As discussed in June ET BAF Sub-Group. Still to be discussed in MH SS SMT.
BAF62	If EPUT does not support staff effectively then staff recovery from the HSE prosecution and the Covid-19 pandemic is compromised resulting in a failure to meet our People Plan ambitions	Takes account of the potential impact of the HSE prosecution as recommended by the Finance and Performance Committee and discussed by ET Sub-Group
BAF65	If EPUT does not plan and manage its resources effectively then recovery of services following the HSE prosecution and the Covid-19 pandemic is challenged resulting in a failure to meet our organisational ambitions	Takes account of the potential impact of the HSE prosecution as recommended by the F&PC and discussed by ET Sub-Group

- **There is currently one risk sitting at a score of 20 (extreme) following changes made**:

ID	Risk	Comments/Action
BAF50	If EPUT does not have the **skills, resource and capacity** to deliver on high quality care and other wide ranging of priorities and pressures then achieving our organisational objectives may be compromised resulting in stagnation of risks and failure to maintain our position within the system	Need to ensure we implement new strategies in an integrated way. A new action plan is in development for 2021/22

3. BAF Action Plans

Potential risks on the BAF should have (in most cases) a detailed action plan to mitigate risks. BAF action plans are under regular review with Executives and their direct reports.

All action plans receive review and scrutiny by the relevant Board Standing Committees on a quarterly basis, most recently June 21.

Approval and monitoring of action plans sits with the relevant sub-Committee or Group.

4. Key Performance Indicators

Appendix 2 highlights Key Performance Indicators and progress against these for July 21 (in month).

These are not currently year to date and there is a plan to review with the BAF refresh.

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

5. Corporate Risk Register

There are 14 risks on the Corporate Risk Register. Recommendations in this report take this to 12 following approval. **Appendix 3** provides a summary of CRR risks as at July 2021 including a heat map of risks against the 5 x 5 scoring matrix.

- **The following risks are recommended for closure by the Executive Team:**

ID	Risk	Rationale and discussion points
CRR64	If EPUT experiences further serious inpatient safety incidents then high quality patient care is compromised resulting in additional regulatory scrutiny and failure to achieve our Safety First, Safety Always ambitions	Replace with risks related to the focus on EPUT's four big issues, namely ligature, learning, observation and engagement, and staffing. Articulation of new risks will take account of existing risks on the BAF.
CRR75	If EPUT does not achieve ECTAS accreditation then there may be adverse media coverage resulting in a lack of public confidence in the services offered to our patients	ECTAS accreditation now in place for The Linden Centre and Basildon Mental Health Units. Remains on

		Directorate Risk Register in respect of The Lakes.

- **The following risk is recommended for reduction in score by the Executive Team:**

ID	Risk	Rationale and discussion points
CRR11	If EPUT fails to implement and embed its Suicide Prevention Strategy into Trust services then it may not track and monitor progress against the ten key parameters for safer mental health services resulting in not taking the correct action to minimise unexpected deaths and an increase in numbers	Agreed implementation plan in place with STPs and ICS Detailed work plan in place Reduce score to threshold 4 x 2 = 8

6. Covid19 Risk Register

The Covid19 Risk Register summary forms part of the Covid 19 update report to Board (separate agenda item)

7. Mass Vaccinations Risk Register

The EPUT Mass Vaccination risk register updates contain no significant changes. This is available on request.

8. EU Exit Trade Deal Risk Register

The EU Exit Trade Deal Risk Register will close in due course.

9. Directorate Risk Registers

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

10. Recommendations

The Board of Directors is asked to:

1 Note progress on the BAF refresh and actions from the Board Development Session on risk appetite
2 Note progress on procurement of an electronic risk register
3 Note assurances to Executive Team and the Audit Committee
4 Review the risks identified in the BAF 2021/22 July summary (Appendix 1) and approve the risk scores including recommended changes outlined below taking account of actions by the BAF ET Sub-Group at its June meeting
5 Approve the BAF risk closures and amendments iterated in the key issues and main report
6 Note the July Key Performance Indicators (Appendix 2)
7 Review the risks identified in the CRR 2021/22 July summary (Appendix 3) including actions taken by BAF ET Sub-Group at its June meeting
8 Approve the CRR risk closures and amendments iterated in key issues and main report
9 Identify any further risks for escalation to the BAF, CRR or Directorate risk registers

Report prepared by**:**

Susan Barry
Head of Assurance

On behalf of:

Paul Scott
Chief Executive Officer

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

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

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
Strategic Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe and innovative services - Lead Director: Natalie Hammond - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score							
BAF23	If EPUT does not monitor EU Exit trade deal areas without agreements or with further discussions pending then there may be unforeseen circumstances resulting in an impact on service delivery	PS and all Executives	Finance and Performance	Monitoring/ Project Action Log – EU Exit Group	• EU Exit (transition) deal in place • Task and Finish Group in place and meeting monthly • Risk Register in place • Action log in place, monitored and updated monthly • EU Admin meeting monthly • Daily sitrep through Silver Command • Assessment of financial risks in supply chain is that there is negligible impact • EU Settlement Scheme – 107 staff have settlement status and 47 are in application process • HR communicating directly with those needing settlement status • New guidance documentation development re settlement status • Weekly communications • Support clinics in place • Leads have had conversations with above staff and signpost for assistance • Data adequacy resolved • EU Exit sit rep removed from Command meetings • EU settlement scheme now closed	**Risk score recommended to reduce to threshold and close** **4 x 3 = 12** **Target date June 21** **4 x 2 = 8**	• Maintain watching brief on gaps during first six months of deal ○ Mutual recognition of professional qualifications ○ EU staff ○ Medicinal products approval process ○ Pharmacovigilance co-operation

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF63	If EPUT does not continuously learn and improve then serious incidents will occur resulting in a failure to achieve our safety strategy ambitions	NH supported by all Executive Leads	Quality	Action Plan to be developed - ESOG	• Approval of Safety First, Safety Always Strategy • Workstream in place for continuous learning as part of the Safety First, Safety Always Strategy Implementation Project • Task and Finish Group in place (NED led) to integrate quality improvement, research and innovation with governance arrangements • Key principles set • Newton Diagnostic work is the first partnership in relation to Quality Improvement • Executive Safety Oversight Group in place – will monitor action plan • Director of Patient Safety appointed • PSIRF implemented as the alternative SI approach to move to continuous learning	**Score agreed by Executive Team April 5 x 3 = 15** **Align target date with Safety First, Safety Always** **Target score 5 x 2 = 10**	• Newton action plan • As part of the Safety First, Safety Always Strategy ensure improvement journey is a continuing process by taking urgent actions to ensure safe care and developing a culture of continuous learning and improvement • Improve record keeping • Take urgent action on estate and security issues • Scope EPUT Trust wide infrastructure to integrate Executive portfolios into learning and forums at all levels – Individual, Team, Profession, Service and Directorate • Ensure Accountability Framework enables a management leadership culture with mechanisms and processes for robust governance, monitoring and assurance • Approval of implementation plan for Safety First, Safety Always Strategy • Develop standardised language for understanding and communicating continuous learning • Develop action plan • Create dedicated learning time and mentorship • Safety strategy is 3 year strategy for organisational development • PID capturing workstreams for learning

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
							• Reference the themes – continuous improvement, enhancing environments, governance and Executive portfolios • Strategic, tactical and operational
BAF4	If EPUT does not implement fire safety systems and processes then serious injury or death may occur resulting in Fire Authority enforcement action and failure to meet our safety ambitions	TS	Finance and Performance	Action Plan monitoring by FSG	• Trust follows all relevant statutory fire safety legislation and adheres to articles of RRO, HTM Fire Code and Government standards/ guidance as best practice • Fire Safety Policy updated and approved at April 21 FSG • Fire Safety Group (Executive led) • Rolling Fire Strategy programme in place • Fire Risk Assessments in place with spot checks undertaken • Remedial action trackers in place and monitored – As at June 90 Estates remedial actions cleared on P1, 2 and 3 sites with 19 operational actions cleared Good progress made with Open Road sites and PS sites. • Directorate Risk Registers have this risk mirrored particularly in relation to fire wardens and fire drills • BAF action plan 2020/21 signed off by FSG June 21 • BAF action plan 2021/22 approved by FSG June 21 and updated monthly • Improvement of Fire Warden numbers across the Trust • FRA programme now recovered and up-to-date following Mass vaccination work • Edward House compartmentalisation complete	**Risk score unchanged 5 x 3 = 15** **Target date March 2022 4 x 3 = 12**	• Fire drills remain an issue although there is some improvement in form completion for fire evacuation drills. Training to include a reminder that form should be in site folders. • As at 2 July the situation remains an issue at the following sites – Ipswich Road, King's Wood Centre, The Lakes, Landermere, Poplar, Crystal Centre, Basildon MHU and St. Margaret's MHU (the latter has been highlighted three years in a row in the FRA – once current works completed they must do a fire drill.) • Fire wardens remain a significant issue monitored through FSG – further programmes planned, two P1 sites remain high risk – The Lakes and Rawreth (five trained on Landermere 14 June 21) • Fire risk assessment remedial works is an ongoing rolling action for the year monitored through FSG – as at June FSG 134 Estate remedials remaining and 42 operational remedial actions outstanding. Operational remedials remain a challenge. • The Lakes compartmentalisation is 2021/22 backlog maintenance with £100k funding; Robin Pinto and Woodlea being taken forward in this year's backlog maintenance programme

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
							• Category 1 and 2 fire training compliance as at 4 June FSG 89% for Cat 1 (below target of 90%) and 87% for Cat 2 (above target of 85%). Fire trainer now in fixed term contract for one year attached to workforce and funded by Estates. To be evaluated at end of period. • £50k backlog maintenance funding for deal with manual over-rides. Following full evaluation, the situation is more positive than originally thought. • This will link to the accountability framework to ensure clear responsibility for key issues such as fire wardens and fire drills • TS to discuss/ drill down with PM to establish what risks EPUT faces in relation to fire safety. View of ST is that fire warden numbers and fire drills are the biggest issues. From an estates perspective constant reviews related to fire safety are in place and as long as this continues, it mitigates the risk. Compartmentalisation projects are large, expensive and complex. Consistency of fire training compliance is required. • Improve evidencing of controls, in particular driving up number of fire wardens and management of patients. Concern around site awareness for bank and agency staff in relation to fire strategy. Constant operational focus necessary.

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF10	If EPUT does not continue to implement a reducing ligature risk programme of works (environmental and therapeutic) that is responsive to ever changing learning, then there is a likelihood that serious incidents may occur, resulting in failure to deliver our safety first, safety always ambitions	TS supported by PS and all Executives	Quality	Action Plan monitoring by LRRG	• Ligature Risk Policy, Procedures and Assessment Process in place Appendix 9 approved at Quality Committee May • Ligature Risk Training / Awareness Programme in place and monitored • Ligature inspection programme • Floor plan heat maps in place • Ligature Risk Stratification Process including cross referencing with ligature assessments • Ligature Risk Reduction Group • Executive Lead in place • Quarterly reporting to HSSC, Quality Committee and four monthly to Board • Suicide prevention and general ligature e-learning training linked • Human factors training and reflection included in OLM programmes • Retrospective review of serious incident action plans carried out and followed up monthly through LRRG with assurance to LOSC • Recommendations from BDO audit implemented • New corporate risk identified for all inpatient areas from increased ligature incidents involving towels and bedding supplied by new contractor – risk shared by operations, estates/ facilities, and compliance/ assurance • Working with Cambridge University on management of ligature risk	**Risk score unchanged 5 x 3 = 15** **Target date March 22** **Threshold 4 x 3 = 12**	• Develop project plan on open actions and non-compliance, looking at actions more than three years old. ESOG to monitor governance process. Still cross-referencing 3i system with Datix to identify gaps • Mitigation statement work added to Clinical Lead for Compliance and Ligature work plan for further action when new post holder in place discuss in LRRG what the action is going forward • Increase awareness and ownership of ligature reduction work at all levels of the organisation • Develop the process of governance around ligature reduction work including a SOP for use of 3i system and a resource to input and monitor • Review policy by March 22 • Review LRRG TOR by Jan 22 • Review Anti-Ligature shop and the Design in MH Forum work • Re-establish local area ligature forum • Re-instate ligature audit process • Estates Ligature/ Patient Safety Coordinator appointment at interview stage • Task and finish group meeting in July to revisit mitigation statements • Awaiting report from ELFT • Develop robust and systemic processes for disseminating learning related to

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
					• Clinical Lead for Compliance and Ligature appointed with start date of August • Internal Audit May 21 first draft report received and recommendations being reviewed • Re-established task and finish group • Independent review undertaken by ELFT • Tidal training will continue to be offered in 2021/22 • Undertaken independent review of ELFT 15 July 21		ligature reduction – take to clinical support group • Review policy to reflect movement away from setting different standards for amber and red areas – review standards • Develop KPIs and dashboard to highlight progress on ligature reduction
BAF38	If EPUT does not manage Covid19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements	NL	Finance and Performance	Monitoring/ Covid19 Action Log - Command Structure	• Executive lead in place for EPRR • Business Continuity Plans in place and undergoing constant review • Gold, Silver and Bronze Command well established • Sit rep daily monitoring • Covid intranet page and range of staff training in place • Covid dashboard issued weekly to monitor prevalence • Mirrored to Covid19 Risk Register • Action plan developed and approved by ESOG with Covid19 assurance report • Executive Lead for Emergency Planning confirmed as NL	**Risk score remains at threshold 5 x 2 = 10** **Target date – ongoing throughout pandemic**	• Prepare for Covid19 Statutory Inquiry • Set up a single point of contact as Inquiry Co-ordinator – discuss at command structure meeting • Demonstrate lessons learnt from Covid19 • Promote awareness of various media methods that could be called as evidence including retrospective personal and team WhatsApp, MS Teams and Pando messages – discuss at command structure

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF36	If EPUT does not focus on and work collaboratively to achieve purposeful admissions then ward environments may become volatile and difficult to manage resulting in increased length of stay and failure to meet our safety ambitions	AG supported by MK/NH/PS	Quality	Action Plan / Task and Finish Action Log	• BAF action plan completed for 2020/21 • Work has been undertaken on meaningful principles for admission and psychology services to be part of the MDT to link with community services • A task and finish group has been set up with terms of reference and an action log. First meeting discussion purposeful admission, therapeutic offer/model, EUPD Management principles, BAF risk, safety first safety always strategy, implementation and mobilisation plan • Second meeting of Task and Finish Group has moved forward on purposeful admission, therapeutic offer/model • Joint working between operations, psychology services and medical • Agreed outcome based accountability template as part of quality improvement forum and purposeful admissions work stream • Action Plan seen by SMT • Steering Group for monitoring	**Risk score unchanged 5 x 3 = 15** **Target date March 22 Threshold 5 x 2 = 10**	• Agree how we provide care and treatment to individuals diagnosed with Emotionally Unstable Personality Disorder management in acute inpatient settings • Firm up Terms of Reference and Membership of Task and Finish Group • Scope current activity/ therapeutic programme baseline; impact of Covid19 alternatives; therapeutic offer proposals for next three years pending MHIS funding • Get new model up and running for purposeful admission with robust mechanisms for flow and length of stay, and allow 12 months to embed before closing risk • Take immediate action around current long-stay patients by taking to Executive panel • SMT to discuss wording of this risk following discussion at BAF ET
BAF45	If EPUT does not learn from focused inspections, patient safety incidents and meeting CQC fundamental standards then further regulatory action may take place resulting in a failure to maintain or improve on our Good rating	PS supported by all	Quality	Action Plan monitored by ESOG	• CQC 'to outstanding' meetings with operational teams • Quality and Safety meetings – CQC on agenda • Operational meetings – CQC on agenda • Clinical Support Groups • Quality leads in place for operations • Compliance Team with Clinical Leads • Monitoring through Executive Safety Oversight Group and Quality Committee	**Risk Score unchanged 4 x 3 = 12** **Target date July 2021 Threshold 4 x 2 = 8**	• PHSO/HSE action plan testing 21/22 • Develop action plans from all internal support visits to wards • Implement all action plans from internal support visits • Implement conduit between compliance team and Matrons • Ensure communications strategy in place to work at pace up to, during and post inspection

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
					• Internal support visits, expanded to include participation from corporate nursing team. All wards visited March-May 2021 • Action plan testing ongoing as part of compliance Workstream, this includes testing against findings from CQC warning notice • Safety First, Safety Always Strategy and implementation plan • Preparation project plan in place and 90% implemented • Dedicated communications team resource • New inspection resources issued and revamped CQC intranet page • Regular reporting to ESOG, QC and BOD • Intensive Support Group established and initial action plan developed • CQC 2020 Adult Acute Inspection action plan testing completed and tools produced • CQC 2019 Well Led inspection action plan testing complete • Undertaken internal support visits to wards • Self-assessments circulated to community team • All evidence requests from CQC complete • Fortnightly audit reporting to CQC in place on actions resulting from inspection • Quality leads in place		• Consider any reporting requirements to relevant operational meetings as part of the accountability framework • Develop process for internal insight metrics – underway as at July 21 • Develop process and timetable for safety walk rounds and internal CQC testing • Gaps in 2019 well led action plan testing allocated to key Committees to address • Development of process for single learning framework covering all action plans • Complete internal support visits to community teams • Undertake factual accuracy of draft CQC report received July 21 • Develop longer-term plan with clear engagement with partners to meet CQC requirements • Produce a clear list of clinical information on patients who are unsuitable for the St Aubyn Centre • Review intensive support process

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
					• Process and timetable for safety walk rounds and internal CQC testing underway in partnership with Corporate Nursing Team • Report on training, staffing and temporary workers in relation to CAMHS submitted to CQC		
BAF54	If EPUT is not open, transparent or demonstrates learning from the Essex Mental Health Independent Inquiry then it may not deal with the consequences of past failings resulting in undermining our Safety First, Safety Always Strategy	NL/All Executives	Quality	Monitoring	• Executive Lead identified • Establishing governance arrangements • Updated stakeholders including NHSE/I • Principles developed on EPUT approach • Job matching and posts advertised on secondment or permanent basis • Core team with appropriate skills, and resources required to support EPUT internally • Met with Inquiry Team and first phase now underway • Final interviews pending for team members. Independent Director appointed and Independent Medical Advisor in train. • Consultation underway on the Inquiry Terms of Reference	**Risk score unchanged 5 x 3 = 15** **Target date April 23 (or length of Inquiry)** **Threshold 5 x 2 = 10**	• Consultation to commence shortly on the Inquiry's Terms of Reference • Pick up the historical elements of the HSE investigation through the Inquiry • Demonstrate how we are supporting staff through the impact of the HSE investigation • Demonstrate how we are improving partner approaches to EPUT through the impact of the HSE investigation • Demonstrate actions on fixed ligatures and safety strategy
BAF58	If EPUT does not record clinical activity in real time, accurately and on the patient information system(s) then patient and staff safety is compromised resulting in failure to deliver its Safety	AG/MK	Quality	Action Plan to be developed by	• Recognised that this is a fundamental shift in philosophy with 5% gap being identified as patient safety risk, rather than the tolerated variance • 'Safety First Safety Always' Strategy approved at January Board • Task and finish group set up with Chairs of Quality and Safety Groups, Clinical	**Risk score unchanged 4 x 4 = 16** **Target to be aligned with project action plan**	• Project Team to be set up with Operations Lead, Terms of Reference and link to appropriate Committee for monitoring • Specialist Services identified a problem with the Medical Secretariat. Whilst records are now contemporaneous there is a backlog going back to October 2020 that needs addressing. This may be more widespread than Specialist Services.

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
	First Safety Always Strategy				Governance, Performance and Assurance Teams – met 1 April • Operations project team lead identified • Discussions with Programme Management Office for patient safety • PID developed	**Threshold 4 x 2 = 8**	• Obtain approval for PID
BAF50	If EPUT does not have the skills, resource and capacity to deliver on high quality care and other wide ranging priorities and pressures then achieving our organisational objectives may be compromised resulting in stagnation of risks and failure to maintain our position within the system	PS and all Executives	PIT	Action Plan to be developed for 2021/22	• Participation in system calls • Command structure in place for Covid19 • Project Board in place for mass vaccination programme • Project Group for EU Exit Trade Deal • Creating resilient teams • Continuous improvement work stream as part of Safety First, Safety Always Strategy • Collective leadership – identifying senior talent, succession planning and Quality Champions • Leadership handbooks • Robust and forward thinking Executive Leadership Team • Programme Management Office related to Safety First, Safety Always Strategy • Preparation for Independent Inquiry • Mirrored on Mass Vaccs risk register	**Risk score unchanged 5 x 4 = 20** **Ongoing for duration of pandemic** **Threshold 5 x 2 = 10**	• Develop new strategic and corporate objectives for 2021/22 and articulate risks to achieving those • Newton diagnostics to ensure systems and processes are effective • Bolstering staffing and project support as required • Redefining Executive portfolios to best manage services and resources • Develop a new action plan for 2021/22
BAF64	If the pressure continues for local, regional and national CAMHS Tier 4 capacity, then there is the risk EPUT may be asked to admit against clinical best practice, potentially resulting in failure to meet	AG	Quality	Action Plan in development –	• Task and Finish Group led by MSE looking at social care aspects of crisis • A model has been identified for crisis bed management founded on evidence based practice • Negotiations are in place with partners including NELFT, providers of community services for young people	**Recommend closure of risk and replace with new risk** **Risk score unchanged 5 x 4 = 20**	• Agree a crisis care pathway and Standard Operating Procedure • Reprofile agreed number of beds at Longview and Poplar Wards that are gate kept as crisis beds for a maximum stay of 72 hour crisis admission (one bed per ward)

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
	our patient safety ambitions and ensure provision of high quality care.				• Mitigation currently is inappropriate care in HBOS beds, Emergency Departments and adult inpatient beds • Ongoing system working including collaboration with acute sector, work with ICS's, work with Local Authorities and regional focus.	**Target Score 4 x 2 = 8** **July 2021**	• Identify and agree any resource implications • Agree a go live date • Work closely with NELFT CYPS community provider • Evaluate service after agreed time period • Working group in place to design service and regular sessions with local partners to support implementation • Action plan in development • Engage with the Regional system and escalate capacity shortfall for low secure placements, crash pads and support for 'looked after children' to all quality surveillance groups • Address pressures from the community and top down (regional and national) to fill gaps in the system • Board challenged the reduction in score of this risk and it was therefore left unchanged at 5 x 4 = 20 • Young people placed under S136 diverted to acute hospital for assessment to ensure HBPoS remains available • Focus on lifting the restrictions to admissions • Develop a strategic plan for the next six months to look at resettling the service – session planned with key leads, Executive Team and Consultants to agree an approach • This risk has materialised and will be replaced

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
Strategic Objective 2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts - Lead Director: Paul Scott supported by all other Executive Directors - Impact of not achieving the Strategic Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score							
BAF61	If EPUT does not address inequalities then it will not embed, recognise and celebrate equality and diversity resulting in a failure to meet our People Plan ambitions	SL supported by all Executives	PIT	Action plan to be developed and monitoring by EIG	• Risk was escalated from Corporate Risk Register to the BAF in March 2021 • Range of Equality and Diversity Networks • Equality and Inclusion Hub on InPut • Staff Network pages and virtual networks • Equality Champions • Equality, Diversity and Inclusion Group • The NHS People Plan • Equality Advisor and Network Chairs • Executive Lead	**Risk score unchanged 4 x 4 = 16** **Target March 2022 or aligned with action plan when complete Threshold 3 x 2 = 6**	• People and Culture Team will be undertaking an Equality and Diversity root and branch review • Engagement of a senior Equality, Diversity and Inclusion lead • Develop BAF action plan • Will have a Director of Equality, Diversity and Inclusion in post by 1 September
BAF62	If EPUT does not support staff effectively then staff recovery from the HSE prosecution and the Covid19 pandemic is compromised resulting in a failure to meet our People Plan ambitions	SL supported by all Executives	PIT	Action Plan to be developed and monitoring group to be identified	• Diagnostic work being undertaken by Newton around Health Rosters, reliance on temporary staff and establishment budgets • Proposal presented to EOSC regarding staffing establishment issues and the larger piece of work that needs to take place in reviewing staffing numbers and skills mix to mitigate this risk • Recruitment successes • Continue high visibility of Executive and Non-Executive Directors	**Risk score unchanged 5 x 3 = 15** **Target Nov 21 5 x 2 = 10**	• Develop action plan from Newton diagnostic work • Transfer Bank staff into permanent roles to fill vacancies to capacity of safer staffing levels • Establishment review as part of project initiation document • Allocate software diagnostic around rostering software • Demonstrate how we are supporting staff through the impact of the HSE investigation • Manage the level of exhausted staff including burn out • When permitted and safe to do so Executive and Non-Executive Directors physical visits will happen

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF65	If EPUT does not plan and manage its resources effectively then recovery of services following the HSE prosecution and the Covid19 pandemic is challenged resulting in a failure to meet our organisational ambitions	AG	F&PC	Monitoring is in place via various action plans and groups	• Daily management of resources in place • Recovery support in place •	**New risk 5 x 3 = 15** **Target Nov 21 5 x 2 = 10**	• Review of systems and processes • Action plans and monitoring is in place, for example, sit reps, oversight meeting for adult Mental Health and various monitoring of service delivery in each of the areas. There is also daily operational planning. Covers Mental Health and Community. Further discussions ongoing
BAF66	If recurrent efficiencies for 2021/22 are not identified then delivery of the programme is compromised resulting in a challenge to the sustainability of EPUT going forward	TS	F&PC	As above	• EPUT is working with the MSE ICS regarding the efficiencies for 2021/22. The Efficiency Plan target for 2021/22 is £10.1m. H1 target £3.5m and H2 target £6.6m with a recurrent requirement of at least £4.1m. • The key activities and workstreams have been communicated to the Finance and Performance Committee with a focus on delivery plans, quantification and implementation	**New risk Score 4 x 4 = 16** **Target April 2022** **Threshold 4 x 2 = 8**	• Deliver the key activities and workstreams with a focus on delivery plans, quantification and implementation
BAF42	If the Covid19 crisis continues then EPUT may experience an adverse impact on its financial plan as a knock on from system wide financial planning resulting in additional risk for EPUT to its sustainability	TS	F&PC	Monitoring through finance meetings	• The Trust's 21/22 financial plan has been set to deliver a breakeven position. The plan includes £8.1m of Covid allocation for H1. • Continuous monitoring of the financial position through reporting to F&PC, EOSC finance and performance meetings and the Board will continue. • Continue to monitor financial situation, Covid19 and Mass Vaccination costs to ensure recovery. • Efficiency requirements are included in the financial plan and schemes under	**Risk score unchanged 4 x 3 = 12** **Target April 2021 Threshold 4 x 2 = 8**	• The financial settlement for H2 are not finalised and will be informed by future National Guidance

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
					development. Some internal schemes developed and others in development alongside combined work with ICS and NHSI/E. • The ICS has also undertaken a financial sustainability exercise. Year to date M12 Covid19 costs of £16.2m with M7-M12 recovery anticipated from M&SE and H&CP • Mirrored on Covid19 risk register		
Strategic Objective 3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve - Lead Director: Nigel Leonard supported by all other Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score							
BAF51	If EPUT does not effectively direct and implement the mass vaccination programme then it will not meet its deliverables/ timescales resulting in a failure of the programme in MSE and SNEE	NL	Quality	Monitoring by Project Management Group	• A risk register set up specifically related to the Mass Vaccination programme to strengthen governance around the project • New BCPs developed for vaccination centres • Programme Board in place • Allocation of some sites to be operated by acute partners • Working with Local Resilience Forums, Local Authorities and other providers to deliver the programme • Guidance implemented on vaccines in use • Security Audits • All costs passing through NHSE and laptop costs supported by skill mix work • Robust communication in place with vaccination centre • Good coverage in both MSE and SUNEE with robust joint working (rationale for reducing consequence to 4)	**Risk score unchanged 4 x 3 = 12** **Target date is ongoing for the duration of the mass vaccination programme** **Target 4 x 2 = 8**	• Awaiting outcome of extension to existing licences for premises – no licences will be extended as part of phase 3 • Implement phase 3 from early September to late February 22 – guidance awaited • Alternative models may be implemented including mobile vehicles and drive through centres which will require alternative skill mix • Work to ensure that individuals are not at risk of missing a second vaccine due to booking system • Maintain watching brief on variable vaccine supply and impact on programme • Confirmation awaited of the national position on proactive contact with those needing second vaccines • Assessment of recently published national security guidance to draw out any actions

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
					• Moving towards phase 3 preparation for mainstreaming the vaccination programme to become business as usual • Walk-in availability implemented at all sites, agreed on a weekly basis and advertised through media channels • Implementation of bus model from this month (July) to use in hard to reach areas (reactive and covering additional capacity) • Pop ups vaccination facilities set up in hard to reach areas and hard to reach communities e.g. South Essex College • Process in place to reach people needing second vaccine as data is available – making proactive contact. For the 'big weekender' event 4,500 people were contacted inviting them for earlier appointments • Mirrored on Covid19 and Mass Vaccs risk register		

Table 2 – Heat Map against 5 x 5 scoring matrix

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2				~~23~~↓	38↔
	3				42↔ 45↔ 51↔	4↔ 10↔ 36↔ 54↔ 63↔ 62↔ 65↔
	4				58↔ 61↔ 66↔	50↔ ~~64~~↔
	5					

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

Risk ID	Initial Score	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Risk ID
BAF4	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF4
BAF6	12	12↔	12↔	12↔	12↔	12↔																				BAF6
BAF9	16	12↔	16↑	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	8↓	8↔	8↔	8↔	close					BAF9
BAF10	12	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF10
BAF13	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	6↓															BAF13
BAF14	12	12↔																								BAF14
BAF15	15	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	Close									BAF15
BAF16	12	12↔																								BAF16
BAF18	15	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔															BAF18
BAF20	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	Close								BAF20
BAF21	15	8↔	8↔																							BAF21
BAF22	16	9↔	9↔																							BAF22
BAF23	15		20↑	20↔										Esc	20	20↔	16↓	16↔	12↓	12↔	12↔	12↔	12↔	12↔	Close	BAF23
BAF28	16	12↔																								BAF28
BAF30	12	12↔	12↔																							BAF30
BAF31	16	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	Close									BAF31
BAF32	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	close				BAF32
BAF33	12	New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	6↓															BAF33
BAF34	16		New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	8↓									BAF34
BAF35	16		New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	close					BAF35
BAF36	15				New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF36
BAF37	15						New	15	15↔																	BAF37
BAF38	15							New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	10↓	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	BAF38
BAF39	20							New	16																	BAF39
BAF40	12									New	12	16↑	16↔	16↔	12↓	12↔	Close									BAF40
BAF41	16									New	16	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	9↓	Close		BAF41
BAF42	12									New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	BAF42
BAF43	20									New	15	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	close			BAF43
BAF44	12										New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	close					BAF44
BAF45	12										New	12	12↔	12↔	12↔	12↔	12↔	16↑	20↑	20↔	20↔	20↔	12↓	12↔	12↔	BAF45
BAF46	16											New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	close					BAF46
BAF47	16												New	16	16↔	16↔	16↔	16↔	16↔	16↔	close					BAF47
BAF48	16												New	16	16↔	16↔	Close									BAF48
BAF49	15												New	15	15↔	15↔	8↓									BAF49
BAF50	20															New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	BAF50
BAF51	20															New	20	20↔	20↔	15↓	15↔	12↓	12↔	12↔	12↔	BAF51
BAF52	20															New	20	20↔	20↔	Close						BAF52
BAF53	20															New	20	20↔	20↔	20↔	close					BAF53
BAF54	20																New	20	20↔	20↔	20↔	20↔	15↓	15↔	15↔	BAF54
BAF55	20																New	20	15↓	15↔	close					BAF55
BAF56	20																New	20	Merge	Close						BAF56
BAF57	20																New	20	20↔	20↔	20↔	20↔	20↔	close		BAF57
BAF58	20																New	20	20↔	20↔	20↔	20↔	16↓	16↔	16↔	BAF58
BAF59	20															Esc	from	CRR	20	Close						BAF59
BAF61	20																				20	20↔	16↓	16↔	16↔	BAF61
BAF62	20																				20	20↔	15↓	15↔	15↔	BAF62
BAF63	15																				New	15	15↔	15↔	15↔	BAF63

BAF64	20																					New	16	20↑	20↔	Close	BAF64
BAF65	15																							New	15	15↔	BAF65
BAF66	16																							New	16	16↔	BAF66

Table 4: Milestones

Risk ID	Initial Score	Length of time on BAF	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 22	May 21	Jun 21	Jul 21	Risk ID
BAF4	15	> 2 years																									BAF4
BAF9	16	> 2 years		16↑								12↓						8↓				Closed					BAF9
BAF10	12	> 2 years					20↑					15↓															BAF10
BAF20	12	> 2 years																	Closed								BAF20
BAF23*	15	> 2 years		20↑													20↔	16↓		12↓						Closed	*BAF23
BAF32	16	> 2 years																12					Closed				BAF32
BAF35	16	> 1 year		New	16																	Closed					BAF35
BAF36	15	> 1 year				New	15																				BAF36
BAF38	15	> 1 year							New	15																	BAF38
BAF41	16	> 6 months									New	16					20↑	12↓						9↓	Closed		BAF41
BAF42	12	> 1 year									New	12					16↑	12↓									BAF42
BAF43	20	> 6 months									New	15	20↑											Closed			BAF43
BAF44	12	> 6 months										New	12									Closed					BAF44
BAF45	12	> 1 year										New	12						16	20↑				12↓			BAF45
BAF46	16	> 6 months											New	16								Closed					BAF46
BAF47	16	>6 months													16							Closed					BAF47
BAF48	16	<6 months													16			Closed									BAF48
BAF49	15	<6 months													15			Closed									BAF49
BAF50	20	>6 months															New	20									BAF50
BAF51	20	>6 months															New	20			15↓		12↓				BAF51
BAF52	20	>6 months															New	20			Closed						BAF52
BAF53	20	>6 months															New	20				Closed					BAF53
BAF54	20	>6 months																New	20					15↓			BAF54
BAF55	20	<6 months																New	20	15↓		Closed					BAF55
BAF56	20	<6 months																New	20	Merge	Closed						BAF56
BAF57	20	>6 months																New	20						Closed		BAF57
BAF58	20	>6 months																New	20					12↓			BAF58
BAF59	20	<6 months																		20	Closed						BAF59
BAF61	20	<6 months																				20		16↓			BAF61
BAF62	20	<6 months																				20		15↓			BAF62
BAF63	20	<6 months																					15				BAF63
BAF64	20	<6 months																					16↓	20↑		Closed	BAF64
BAF65	15	<6 months																							15		BAF65
BAF66	16	<6 months																							16		BAF66

Appendix 2 - Key Performance Indicators for Board Assurance Framework July 21

KPI Ref	Key performance indicator (KPI)	Target	Q3 YTD	Jan 21	Feb 21	Mar 21	Q4 YTD	Apr 21	May 21	Jun 21	Q1 YTD	Jul 21	Aug 21	Sep 21
Total number of risks on BAF			**24 (19)**	**25**	**22**	**24 (20)**	**24 (20)**	**19 (17)**	**18 (17)**	**18(17)**	**18(17)**	**17(15)**		
KPI 1	% risks with action plans completed by target completion date	90%	Q3 100% (1)	0	0	100% (2)	100% (2)	100% (5)	0	0	100% (5)	0		
KPI 1a	Number of risks open with action plans fully completed	Information only	0	0	0	2 (0)	2 (0)	5 (action plans replaced with new)	1	0	0	0		
KPI 1b	Number of risks with open action plans	Information only	12(11)	9	10	10 (8)	10 (8)	4	4	4	4	5		
KPI 1c	Number of risks with no action plan	Information only	14(13)	15	12	14 (12)	14 (12)	14 (13)	14	14 (7 to develop)	14	12 (10) (5 to develop)		
KPI 1d	Number of risks closed/de-escalated in month (YTD)	Information only	Q3 7(6) YTD 11(10)	0	3	4 (0)	7 YTD 18(14)	1 (1)	1 (2)	2 (4)	4	2		
KPI 1e	Number of new/ escalated risks in month (YTD)	Information only	Q3 9(4) YTD 19(14)	0	0	2 (0)	2 (0) YTD 21(19)	2 (0)	0	3 (0)	5	0		
KPI 2	% stagnant risks (no movement)	Less than 30%	57.8%	56%	45%	55%	55%	88%↑	55.5%↓	88%↑ (15)	41%↓ (7)	88%↑ (15)		
KPI 2a	% of increased risks	Less than 10%	26%	0%	9%	10%	10%	0%↓	0%↔	0	0	0		

KPI Ref	Key performance indicator (KPI)	Target	Q3 YTD	Jan 21	Feb 21	Mar 21	Q4 YTD	Apr 21	May 21	Jun 21	Q1 YTD	Jul 21	Aug 21	Sep 21
KPI 2b	% of decreased risks	60%	26%	8%	4.5%	10%	10%	11.7%↑	38.8%↑	11.7%	58% (10)	11.76%↑ (2)		
KPI 3	% of current risks on BAF over 12 months	Less than 40%	21%	8%	9%	15%	15%	11.7%↓	11.7%↓	23.5%↑	23.5%↑	29%↑ (5)		
KPI 3a	% of current risks on BAF over 24 months	Less than 30%	15.7%	20%	22.7%	25%	25%	0%↓	16.6%↑	11.7%↓	11.7%↓	11.76%↑ (2)		
KPI 3b	% of current risks on BAF over 12 months (excluding known ongoing risks)#	0%	6%	0%	0%	0%	0%	0%↔	0%↔	0%↔	0%↔	23.5%↑ (4)		

Notes:
recommended risks (July) included – figure in parenthesis does not include these risks and % calculations do not include recommended risks
#known ongoing risks – BAF4 Fire Safety BAF10 Ligature Reduction
BAF23 not included in KPI3/3a/3b – intermittent on BAF over two-year period
Any action plans of risks carried forward into a new financial year are reviewed and updated

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

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

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
Corporate Objective 1: To provide safe and high quality services during Covid19 pandemic – Lead: Paul Scott supported by all Executive Directors – impact on not achieving the strategic objective C5 x L3 = 15 risk score						
CRR11	If EPUT fails to implement and embed its Suicide Prevention Strategy into Trust services then it may not track and monitor progress against the ten key parameters for safer mental health services resulting in not taking the correct action to minimise unexpected deaths and an increase in numbers	NH supports by MK	Quality Committee and Sub-Committees	• Implementation of 2018-20 Suicide Prevention Strategy • Local reflective sessions • Links to ligature reduction • Medical lead in place • Draft Suicide Prevention Strategy 2021-23 approved at Mortality Sub-Committee in May 21 and ESOG June 21 • Agreed implementation plan in place with STPs and ICS • Detailed work plan in place	**Risk score recommended to reduce to threshold** **Target March 2022** **4 x 2 = 8**	• Implementation of revised Strategy • Align with Safety First, Safety Always Strategy
CRR64	If EPUT experiences further serious inpatient safety incidents then high quality patient care is compromised resulting in additional regulatory scrutiny and failure to achieve our Safety First, Safety Always ambitions	AG	LRRG	• Risk closely aligned to BAF10 Ligature reduction • Information requests to CQC responded to in a timely manner • Joint meetings across operations to encompass learning from serious incidents • Learning is a key risk for 2021/22 with a Trust wide approach	**Recommend risk score reduced to threshold and replace with other risks relating to four big issues** **4 x 2 = 8** **Target March 2022** **CLOSE**	• Serious incident resulting in death related to an abscond from Finchingfield saw this risk materialise with an unannounced visit from CQC • Serious incident resulting in death related to ligature on Henneage also saw this risk materialise • Serious incident at St Aubyn Centre saw risk materialise • Put into effect Safety First, Safety Always Implementation Plan • Recommend closure and replace with risks related to the four big issues if not already on BAF or CRR

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR75	If EPUT does not achieve ECTAS accreditation then there may be adverse media coverage resulting in a lack of public confidence in the services offered to our patients	MK	ESOG	• EPUT is working to ECTAS standards • ECTAS accreditation now in place for The Linden Centre and Basildon Mental Health Units	**Recommend Risk reduced to threshold and close** **4 x 2 = 8**	• Awareness of media/social media activism related to ECT
CRR48	If EPUT is unable to suitably fill consultant vacancies across clinical services on a substantive or locum basis then the Trust may not be able to deliver safe and effective services, resulting in poor patient flow and possible patient harm	MK	Medical Staffing Committee	• Cover maintained by locum and agency staff • GMC approval to allow overseas doctors to work in the UK • National Fellowship Scheme in place • Staffing deployment is a key risk for 2021/22	**Risk score unchanged** **4 x 4 = 16** **Target September 2021** **4 x 2 = 8** **Above threshold**	• Continue to recruit to vacancies - there are 20 Consultant vacancies, of which Locum posts cover 16. Locums remain hard to source. • New trainees will in time help mitigate recruitment problems
CRR68	If EPUT does not complete annual General Workplace Risk Assessments or they are of poor quality then its statutory requirement is not met resulting in non-compliance with CQC well led standards	PS supported by all Execs	HSSC	• A Task and Finish Group within the Risk, Compliance and Assurance Directorate reviewed and simplified risk assessment paperwork, looking at other Trusts' paperwork as well as HSE guidance • Legal advice received on proposed documentation • Discussion through HSSC • Two options being piloted	**Risk score unchanged** **4 x 4 = 16** **Target ~~June~~ July 2021** **4 x 2 = 8** **Above threshold**	• Evaluate pilot • Formal launch of new GWPRA documentation
CRR74	If EPUT inpatient areas do have robust airlocks in place for access/egress then patients detained under the MHA may abscond resulting in potential serious harm to patients, staff or the public	TS	Executive Safety Oversight Group	• Recent incident on Finchingfield resulted in the death of a patient, injury to a member of staff and a focused inspection by the CQC – all action taken as required by the CQC inspection report • Linden Centre work completed • Rochford work completed • The Lakes work completed	**Risk score unchanged** **5 x 3 = 15** **Target Mar 22** **5 x 2 = 10** **Above threshold**	• HSSC action log requested a one page report confirming the scope of the airlock work – phase 1 perimeter phase 2 interior • Peter Bruff, Crystal Centre and Gloucester – all three areas included in 2021/22 funding and a timescale is in development

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR76	If EPUT continues to receive inferior quality towels and bedding from its contractor then ligature incidents are increased resulting in possible serious patient harm	TS	ESOG/LRRG	• Contractor has visited site to review quality of towels and agreed to add new towels to the system • Manufacturer confirmed towels are for high risk areas • Observation and engagement • Datix analysis undertaken • Safety Alert issued reminding staff to return any sub-standard towels and bedding • Additional quality checks before linen arrives on ward • Daily increased inspections on quality of linen carried out • Alternative linen now being brought in for clinical and operational staff to view and comment upon	**Risk score unchanged 5 x 3 = 15** **Target June 21 5 x 2 = 10** **Above threshold**	• Ensure patient privacy and dignity is not compromised • Enhanced observation and engagement • Look at alternative options for towels as they continue to be an issue • Deep dive into how towels are being torn • Consult Mental Health Forum • Visit to manufacturers by Trust team to look at strengthened linen
CRR77	If EPUT does not track missing/ unregistered medical devices or address the clinical rationale/ pathway then unsafe, non-serviced, non-calibrated and inappropriate devices may be in use resulting in a failure to achieve our safety first, safety always strategy	NH	Medical Devices Group/Physical Health Sub-Committee	• Robust procurement process in place • Executive Nurse is Executive for Medical Devices • Chair of Physical Health Sub-Committee is Director of Nursing and five priorities agreed for 2021/22. Medical Devices Group is the Governance group.	**Risk score unchanged 4 x 4 = 16** **Target date Sept 21** **4 x 2 = 8** **Above threshold**	• Analysis of MD inventory • MD lead communicate with teams • Streamline inventory • Establish financial impact of contracts for missing devices • Review Medical Devices policy to include definitions and robust governance • Identify resource for MD • Assisted technology to align with priorities and clinical rationale/ pathways, training processes • Clarity on nominated person for CAS alerts (AW speak to NJ) • Present paper to Executive Team outlining the current situation

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR40	If the Trust is not adequately prepared, or there is a lack of funding for the cyber team, it could be subject to a cyber-attack that compromises clinical or corporate IT systems, and the consequent cost pressure may result in a financial risk to EPUT	TS	ESOG PST	• Windows 10 upgrade licences now purchased • Cyber Essentials Accreditation • Cyber Team in place • Robust updates and patching • Software asset risk register in place	**Risk score unchanged and at threshold 4 x 2 = 8**	• End of life software in EPUT has been identified and placed on the cyber risk register - mitigation options to be presented to IGSSC
CRR53	If the dormitory elimination project plan is not implemented in line with agreed timescales then there could be a delay to providing single bedroom accommodation by 2021 which could potentially impact on CQC ratings and patient experiences.	TS	Estates Capital Group	• Phases 1 and 2 completed • Tender specification document issued to contractors end Jan 21 • Phase 3: Cherrydown and Kelvedon – redundant pipe work complete. Infrastructure on Cherrydown installed – cabling, new heating pipework, potable water and domestic water services. Walls, ceiling constructed, and being plastered. • Phase 4 moving Cherrydown Ward to Langdon Unit and Sankey House and relocate Kelvedon Ward to Willow Ward completed • Phase 8 alterations to the Assessment Unit to reduce bed numbers to 18 and create better male and female segregation	**Risk score unchanged 4 x 3 = 12** **Target date March 2022** **Target score 4 x 2 = 8** **Above threshold**	• Phase 3: Cherrydown and Kelvedon Ward – Kelvedon slippage due to additional works to remove old pipes and access issues. Late request for assisted bathrooms and these will be in the Assessment Unit. Some access issues due to Covid. Additional work taking place to BMHU in order to remove ligature points, improving ventilation and heat loss as well as aesthetic appearance. • Phase 4 Grangewater Ward/ Thorpe Ward – affected by delays above; works include refurbishing the ward to 16 single en-suite bedrooms. Work planned 21/22. Thorpe Ward will become a staff rest and change area with some offices, touchdown, meeting, conference and training rooms

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR34	If EPUT does not train and support staff effectively in suicide prevention then staff may not have the necessary skills or confidence to support suicidal patients resulting in self-harm or death and a failure to achieve our safety first, safety always strategy	NH supported by MK	Suicide Prevention Group	• Training is now virtual • Suicide prevention month provided a range of events and opportunities for learning for all staff • Access and assessment services no longer exist in West and North East are moving away from this service to new community assessment model. The new Crisis 24 team are also taking referrals • Community transformation paper signed off in NEE, redesign of CMH pathways and provision of IAPT through EPUT • Transparent monitoring through contracting • MH/LD network members discussion on Suicide Prevention Training • ET has approved a paper on moving to STORM training • Business case approved for training	**Risk score unchanged** **3 x 3 = 9** **Target March 2022** **3 x 2 = 6** **Above threshold**	• Exploring Connecting for People training virtual delivery • Improvement trajectory and reporting on suicide prevention training. • Raise frequency of training and adherence to targets with workforce as budget/resource holder – continue dialogue • Cover required for appointed suicide prevention trainer for 12 months commencing late 2021 • Explore whether role can be moved to Nursing Directorate to provide closer support/management and oversight • Workforce to provide ET with further finance information on STORM training • Recruit 1.5 WTE trainers and service based trainers once finance agreed • Gain assurance that ongoing national OLM issue does not negatively affect training numbers – training tracker figures incorrect • Develop a quality improvement project to address the barriers on completing the suicide prevention training

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR72	If EPUT does not have a suitable IT/communication systems in place for its STaRS and dual diagnosis services then patients may not receive appropriate care, treatment or medication, partners may not be able to access clinical records in a timely manner, and data integrity may be compromised, resulting in potential serious harm to patients, staff vulnerability and poor system working	AG	SSMG	• Auditing and monthly data cleansing exercises in place • Dual Diagnosis working group restarted and reviewing Policy and Procedure • Pilot in West using Pando for Consultants at Derwent Centre to ping each other drug and alcohol cases to check with STaRS	**Risk score unchanged 4 x 3 = 12** **Target June 2021** **4 x 2 = 8** **Above threshold**	• Reinforce importance of Datix recording to map incidents and build evidence of problems • Theseus does not constitute an official medical record as content may be deleted – numerous difficulties experienced with Theseus including non-connection to HIE and no access to prescribing activity -ECC advise Theseus 2.0 in development • Open Road not checking if patient known to MH and vice versa – poor system working and communication • Plan to move to SystmOne for prescribing • EPUT ITT working towards a resolution • Follow up with Specialist Services – no update on DRR

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
Corporate Objective 3: Deliver our people agenda for 20/21 with adjustments in line with the Covid19 response – Lead Director: Sean Leahy supported by all other Executive Directors – Impact of not achieving the Corporate Objective 4 x 3 = 12						
CRR14	If EPUT does not continue to work on staff morale then it may not be able to deliver high quality services resulting in a challenge to transformational change, patient experience and outcomes	SL	WTG	• Thank you vouchers sent to staff • Staff are saying they are tired and fatigued as opposed to having low morale • EPUT hero badges sent to all staff	**Risk score unchanged 4 x 3 = 12** **Target March 2021** **4 x 2 = 8** **Above threshold**	• Reviewing and refreshing communication strategies
CRR45	If EPUT does not achieve mandatory training policy requirements then patient and staff safety may be compromised resulting in additional scrutiny by regulators and not meeting the IG Toolkit requirements	SL supported by all Executives	Training and Development Group	• Local trajectory in place for safety focused and IG mandatory training as a priority • Monthly reporting to ET	**Risk score unchanged 4 x 4 = 16** **Target March 2022** **4 x 2 = 8** **Above threshold**	• Plan to return to recommended update training intervals • All staff to ensure that mandatory training is up-to-date as soon as possible, including Information Governance and fire training for all staff and Grab Bag and TASI training for frontline colleagues • Managers are reminded to check training trackers and prompt staff whose training is overdue • Risk materialised on meeting the Information Governance Toolkit requirements – further work to be done in 2021/22 • A national OLM issue has been identified whereby some mandatory training is not recording properly even though exit from completion of tests is appropriately carried out – to be resolved

Table 2 – Heat Map against 5 x 5 scoring matrix

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2				11↓ 40 ~~64↓~~ ~~75↓~~	
	3			34	14 53 72	74 76
	4				45 48 68 77	
	5					

		Agenda Item No: 8bi
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 July 2021**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

- Internal Audit
- LCFS
- External Audit
- Data Security and Protection Toolkit Submission
- Draft Governance Development Plan 2021/22
- Committee Governance Review
- Embedding the Learning
- Waiver of Standing Orders
- Statement of Financial Positional Write Offs
- Losses and Special Payments

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead

Janet Wood
Chair of Audit Committee

Agenda Item: 8bi
Board of Directors
Meeting: 28 July 2021

EPUT

ASSURANCE REPORT FROM THE AUDIT COMMITTEE CHAIR

1.0 PURPOSE OF REPORT

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

2.0 EXECUTIVE SUMMARY

Audit Committee Meeting 14 July 2021

The Audit Committee met on the 14 July 2021 and approved the minutes of the meeting held on 6 May 2021. These minutes are available to Board members on request.

At the meeting held on 14 July 2021 the following matters were discussed:

The Audit Committee

1. **Internal Audit**

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

- Ligature Risks Site Visits – Design (Substantial) and Operational Effectiveness (Moderate)
- Data Security and Protection Toolkit – Moderate Assurance

The following report has been issued in draft:

- Inpatient Deaths

Internal Audit and Annual Report and Annual Statement of Assurance
The above report has now been finalised, subject to minor changes. It was pleasing to note that the majority of audit reports now receive 'substantial' assurance.

LCFS Progress Report

Referrals
The Committee received an update on the current investigations/referrals.

Counter Fraud Annual Report & Functional Standard Return
The LCFS Annual Report and Functional Standard Return was presented to the Committee. The report was discussed and noted.

2. **External Audit**

Annual Audit Report
The above report is due to be presented to the Council of Governors in September 2021.

3. **Data Security and Protection Toolkit Submission (DSPT)**
The Committee were assured that the return for 2020/21 was submitted therefore successfully attaining DSPT compliance.

4. **Draft Governance Development Plan 2021/22**
The above report was discussed and noted.

5. **Committee Governance Review**
The above report was discussed and noted.

6. **Embedding the Learning**
Following the presentation of the Annual Governance Statement at the Audit Committee meeting on the 25 June 2021 it was agreed that Natalie Hammond would lead on this issue with PMO support and provide a regular report to the Audit Committee on how learning is embedded across the organisation.

7. **Waiver of Standing Orders**
During the period from 29 April 2021 to 30 June 2021, standing orders for competitive quotations were waived on four occasions to the value of £163,955 (including VAT). It was noted that two of these related to the mass vaccination to the value of £111,682.

For the same period, standing orders for competitive tenders were waived on two occasions to the value of £576,565 with one order relating to the mass vaccination for the value of £334,727.

8. **Statement of Financial Position Write Offs**
It was noted that there were no write offs.

9. **Losses and Special Payments**
The report highlighted that as at the end of Month 3 the Trust is reporting losses and special payments of £1,698.

3.0 MANAGEMENT OF RISK

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

4.0 NEW RISKS

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

5.0 ACTION REQUIRED

The Board of Directors is asked to:

1. Note the summary of the meeting held on 14 July 2021
2. Confirm acceptance of assurance given in respect of risk
3. Request further action/information as required.

Janet Wood
Non-Executive Director
Chair of Audit Committee

		Agenda Item No:8(b)ii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28th July 2021**

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

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

Purpose of the Report		
This report provides the Board of Directors with details that: • 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

Performance Report

This month's report has been aligned to the CQC scoring metrics in order to align the monitoring of key performance indicators, using inadequate, Requires improvement and Good as the principles for the prioritisation of focus. This report covers the position for months 2 and month 3.

Performance and Quality

In May 2021, there were 5 areas of **inadequate performance** with an additional 2 in June 2021, Psychology Waiting Times and Admissions of under 16's.

June 2021 Position:

- Timeliness of Data Entry
- CPA 12 Month Reviews
- Inpatient MH Capacity (Adults & PICU)
- Out of Area Placements
- Clients not seen in 12 months
- Psychology waiting times
- Admissions of under 16's

In May 2021, there were 6 areas **requiring improvement** and a reduction of 1 in June 2021, Staff Survey Results.

June 2021 Position:

- Cardio Metabolic Assessments / SMI
- IAPT (Recovery Rates)
- Essex STaRS
- Training, Supervision & Appraisals
- Temporary Staffing (Agency & Bank)

The Executive Director of Operations updated the Committee on each of the inadequate performance areas and gave the Committee assurance that each of the areas identified had an improvement plan and significant progress have been made in many of the areas identified.

Members of the Committee wanted to thank the commitment of the Consultants that had taken part in the Task and Finish Group looking at Clients waiting longer the 12 months for the excellent work undertaken against this KPI.

There was an outstanding action regarding the work on outturn targets/trajectories. The Committee discussed this and it was agreed that this action would now be reviewed as part of the implementation of the Accountability Framework KPIs. The Committee agreed that this would be an appropriate way forward.

Financial Update – Month 3 Results

- Revenue position - M3 YTD £0.1m deficit against breakeven YTD plan. Position includes YTD spend of £4.3m on Covid related costs and £6.9m on Mass Vaccination.

Capital position :

Trust Capital - The Trust's capital position is YTD spend is £1.4m in line with planned expectations with an annual programme of £14.4m.
System Capital – Financial plan is £73.2m of which £14.4m relates to EPUT.

- Cash – Sufficient cash resources in place to meet trading operations - £76m bank balance.

- Efficiency Savings – Trust has developed a number of efficiency saving schemes and is working with ICS and NHSI/E to further develop these. Internal workshops also being established to identify opportunities.

Other key issues

- Continued drive to accelerate recruitment to deliver MHIS (£20.9m funding available) schemes and ensure outcomes and benefits of investments deliver expected impact.

- Provider Collaborative arrangements and amendments to funding flows from July 21. EPUT becoming lead Provider for £73m services.
- H2 allocations and funding settlements remain uncertain. Block contracts to continue in H2. National expectation that efficiency requirements will be more demanding in H2.
- ICS is undertaking a Financial Sustainability review with participation from EPUT.
- CHS data collection and benchmarking exercise.

System Capital Position @ Month 3

The Executive Chief Finance Officer updated the committee on the current system Capital

- System Capital – Financial plan is £73.2m of which £14.4m relates to EPUT

Extension of Policies & Procedures

The Committee approved the extension of the policies & procedures listed below:

- ITT Purchasing Policy
- Virtual Private Networks (VPN) Policy
- IT&T Security Procedure
- Information Risk Policy
- Purchasing Policy

Any risks or Issues
There were no risks or issues

Any Other Business

There was no other business

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

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
Accompanying Report

Lead
Manny Lewis **Non-Executive Director**

Agenda Item 8(b)ii
Board of Directors Meeting Part 1
28th July 2021

FINANCE AND PERFORMANCE COMMITTEE ASSURANCE REPORT

1.0 Purpose of Report

This report is provided by the Chair of the Finance and Performance Committee, Manny Lewis to provide assurance to Board members that the performance operational, financial and governance as at Month 2 May 2021 and month 3 June 2021

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

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

2.0 Quality and Performance Report

Performance Report

This report covers the position for month 2 and month 3.

In May 2021, there were 5 areas of **inadequate performance** with an additional 2 in June 2021, Psychology Waiting Times and Admissions of under 16's. Total position for June 2021 is 7 areas of inadequate performance.

June 2021 Position:

- Timeliness of Data Entry
- CPA 12 Month Reviews
- Inpatient MH Capacity (Adults & PICU)
- Out of Area Placements
- Clients not seen in 12 months
- Psychology waiting times
- Admissions of under 16's

In May 2021, there were 6 areas **requiring improvement** and a reduction of 1 in June 2021, Staff Survey Results.

June 2021 Position:

- Cardio Metabolic Assessments / SMI
- IAPT (Recovery Rates)
- Essex STaRS
- Training, Supervision, & Appraisals
- Temporary Staffing (Agency & Bank)

The Executive Director of Operations updated the Committee on each of the inadequate performance areas and gave the Committee assurance that each of the areas identified had an improvement plan and significant progress has been made in many of the areas identified.

Discussions around the Timeliness of data took place and it was agreed that this should be removed from this category until the Commissioners have agreed a better metric to measure this KPI. It was also agreed that the work looking at the KPIs for the Accountability Framework would look at this area and agree a better measure for local monitoring.

The Director of ITT, Business Analysis & Reporting updated the Committee on the work undertaken by the Consultants who are part of the Task & Finish group looking at Clients waiting longer than 12 months. This group had made significant progress on the actions required for this KPI and reported that the work for this group would finish after the next meeting. The Director of ITT informed the Committee the involvement of the Consultants made a significant contribution to the improvement with the KPI.

Members of the Committee wanted to thank the commitment of the Consultants that had taken part in the Task and Finish Group looking at Clients waiting longer the 12 months for the excellent work undertaken against this KPI.

There was an outstanding action regarding the work on outturn targets/trajectories. The Committee discussed this and it was agreed that this action would now be reviewed as part of the implementation of the Accountability Framework KPIs. The Committee agreed that this would be an appropriate way forward

3.0 Financial Position – Month 3

The Director of Finance updated the Committee on the current financial position at Month 3:

Income & Expenditure

- The National the adapted financial regime for H1 (M1-M6) remains in place.
- M3 YTD £0.1m deficit against breakeven YTD plan.
- YTD COVID spend totalled £4.3m. H1 allocation is £8.1m.
- YTD Mass Vaccination spend £6.9m with full recovery expected from NHSI/E.
- YTD spend on MHIS totals £3.0m compared to indicative YTD budget of £5.2m with an annual indicative budget of £20.9m.

Temporary Staffing Spend

- In Month spend £6.3m (28% of pay) YTD spend £17.6m (27% of pay)
    - Bank spend M3 £4.2m, YTD spend £12.1m
    - Actual Agency spend M3 £2.1m , YTD spend £5.5m
- YTD COVID £3.0m (Bank £2.2m, Agency £0.8m)
- M3 Total Mass Vaccination YTD £3.1m (predominantly bank)

Capital

- Annual plan £14.4m. YTD spend £1.4m in line with revised plan. In year monitoring and regular progress reports from project officers.

- System Capital – Financial plan is £73.2m of which £14.4m relates to EPUT and £57.8m to MSE FT. M3 YTD position is overspent by £1.2m.

Cash

- M3 balance £75.7m; better than planned £74.4m

Key Risks

- Uncertainty of H2 allocations.
- Delivery of recurrent efficiencies.
- COVID expenditure being greater than System allocation
- Impact of new Commissioning responsibilities as part of the Provider Collaborative – wider risk and benefit sharing across the Systems.

H2 and 22/23 Planning Update

- H1 System envelopes to form basis of H2.
- Block contracts to continue.
- Increase in efficiency / waste reduction requirement in H2. 3.5%.
- COVID allocations to continue but may be subject to an efficiency target.
- H2 settlement – Sept – Nov 21
- Spending Review outcome – Dec 21

Other Matters

- Provider Collaborative financial arrangements planned for go live in July 21. EPUT will be lead Provider for £73m of services.
- CHS Data Collection exercise underway – submission due 12 August.
- ICS is undertaking a Financial Sustainability Review supported by PwC. Current Assessment is the ICS has a £201m underlying deficit with EPUT element assessed at £8.2m.

The Committee also discussed future enhancements to reporting.

4.0 System Capital Position @ Month 3

The Executive Chief Finance Officer updated the committee on the current system Capital

- System Capital – Financial plan is £73.2m of which £14.4m relates to EPUT

5.0 Extension of Trust Policies & Procedures

The Committee approved the extension of the policies & procedures listed below:

- ITT Purchasing Policy
- Virtual Private Networks (VPN) Policy
- IT&T Security Procedure
- Information Risk Policy
- Purchasing Policy

6.0 Any Risks or Issues

There were no risks or issues identified.

7.0 Any Other Business

There was no other business

Report prepared by:

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

Manny Lewis
Chair of the Finance and Performance Committee

		Agenda Item No: 8biii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28th July 2021**

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

Risk Assessment of Report	
Summary of Risks highlighted in this report	This report provides mandatory information on EPUTs performance against patient safety and quality metrics for 2020/21 overseen by the Quality Committee. It incorporates a number of risks that appear on its Board Assurance Framework
State which BAF risk(s) this report relates to	BAF23 EU Exit (Transition) BAF38 C19 Emergency Planning BAF 55 Independent Enquiry BAF45 CQC BAF63 Learning BAF10 Ligature Reduction
Does this report mitigate the BAF risk(s)?	Yes
Are you recommending a new risk for the EPUT BAF?	Yes
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
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 Note the content of this report.
2 Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3 Request any further information and or action.

Summary of Key Issues

The Quality Committee has reviewed the work of all sub-committees accountable to the Quality Committee. This report is provided to give assurance of the review, monitor and challenge initiated. Overall the Quality Committee has been given assurance that all work streams are in place and actions are being taken to mitigate risk. In addition the Committee commended a number of areas for their best practice. Due to COVID-19 arrangements to drive improvement and give assurance are as follows:

- Assurance is provided that all sub-committees are delivering against agreed action plans and schedules of business
- All sub-committee formal meeting arrangements have taken place virtually as a result of COVID-19.
- Positive progress continues to be against core areas of delivery.
- Corporate teams are focusing their efforts on supporting operational teams with both frontline delivery and putting arrangements in place to reduce risk.
- Against each sub-committee agenda risks have been identified and where possible actions to mitigate have been taken.
- Due to the rapidly changing landscape the scope of work is reviewed against each sub- committee and actions taken to mitigate risk on an ongoing basis

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

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

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

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

Acronyms/Terms Used in the Report			
EPUT	Essex Partnership University NHS FT	PD	Personality Disorder
PICU	Clinical Commissioning Group	SMI	Severe Mental Illness
ALOS	Average length of stay	CQC	Care Quality Commission
OPEL	Operational Pressure Escalation Level	BAF	Board Assurance Framework

Supporting Documents and/or Further Reading

Lead
Amanda Sherlock **Non Executive Director**

Agenda Item 8biii
Board of Directors Meeting
28 July 2021

ESSEX PARTNERSHIP UNIVERSITY NHS TRUST

QUALITY COMMITTEE ASSURANCE REPORT

1 Purpose of Report

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

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

2 Executive Summary

2.1 Minutes of previous meetings

The minutes of the Quality Committee meeting held on 11 May 2021 and 10 June 2021.

Assurance from meeting held on 10 June 2021

2.2 Summary of discussions and issues identified as well as assurances provided at the meeting on 10 June 2021.

Due to an urgent requirement to respond to other events the meeting was not quorate and as a result a number of items were deferred to the July meeting or circulated for Chair's action.

2.2.1 Quality Performance Report

The Committee received the report that gave an updated position as April 2021. There are 52 indicators within the report 31 of which have been identified as Quality Indicators for review by the Quality Committee In addition, five physical health indicators reported to commissioners were included within the report. In April 2021 there were 19 indicators within target. There were 3 areas of inadequate performance as set out in previous reports:

- CPA 12 Month Reviews – Performance in April was below the national 95% falling in month to 90.9%. Performance remains inconsistent with monthly fluctuations below and above target. Performance is required to meet target for three months until this indicator can be downgraded. The Committee was advised that this indicator remained under review with Commissioners. It was noted that there is big drive underway with validation work being carried out in terms of data quality although concern was expressed that performance had fall further below target.
- Inpatient MH Capacity (Adults & PICU) – Continued pressures on inpatient units remains a significant factor in April with three Adult and PICU indicators breaching targets. In addition there had been three days at OPEL 4 in April.
- Clients not seen: It was noted that in April all four indicators relating to

patients not seen 12+ months are In relation to clients requiring psychology appointments recruitment has taken place to fill six new posts under the Clinical Associate in Psychology (CAP) apprenticeship programme with successful recruitment taking place. There are waiting list clearance action plans in place across all areas that will be supported by the new appointments.

In April there were 2 areas identified requiring improvement:

- Cardio Metabolic/SIM indicators continue to be at variance with local targets however improvement is being seen across all indicators since the introduction of analysers.
- Readmissions (Adults). It was noted that there had been a sudden increase in relation to adult readmission and a review was taking place to understand the issues.

The Committee was informed that significant progress had been made against CPA reviews since this report was compiled. Mid and South Essex are now operating above target. North has fallen below target due to a reduction of 2wte in medical input but assurance was given that steps were taken to source Locums until permanent replacements have been found. It was noted that this was a system issue rather than one of compliance.

A major amount of work has been undertaken in relation to waiting lists. A task and finish has been established with good representation from the medical teams. Dashboards have been established and as a result the Committee was advised that a paper would be taken to Finance and Performance with a proposal that this could be removed as a patient safety risk.

Concern was raised in relation to the data in relation to patient harm. The Committee was advised that the data shown was out of date. This was partially due to timing issues with the report being prepared for a number of Committees without having ongoing iterations throughout the month. It was agreed that it was unnecessary for the report to go to duplicate committees and the Committee would support this report being considered by Finance and Performance rather than Quality Committee. This would enable the Committee to focus on specifics and actions being taken to improve quality and patient safety.

2.2.2 Quality Committee Review

The Committee received a verbal update on the current position of the internal governance review. Work is ongoing and outcomes would be aligned with work taking place in relation to the Accountability Framework. A strawman model would be produced for consideration.

2.2.3 Clinical Audit Annual Report

The Committee received the annual report that confirmed that during 2020/21 the Trust undertook an extensive programme of clinical audit in a range of Trust clinical services. It was noted that processes are in place to ensure that clinical audit is integral to the Trust's quality improvement and assurance agenda and are used to inform the Trust's clinical governance requirements in a robust and timely manner. It was agreed that this paper would be circulated for Chair's action.

2.2.4 Quality Account 202/21

The Committee received an updated version of the Quality Account that was inclusive of partner commentaries, some quarter four data and a statement from the Council of Governors that is anticipated during June. It was noted that the Trust Board would be asked to approve this document at the June Board meeting.

Some minor amendments were noted and it was agreed that changes would be made to the master document.

2.2.5 Board Assurance Framework Action Plans

The Committee received an update of Board Assurance Action Plans covering all risks allocated to the Quality Committee for review and scrutiny. It was noted that since the last report in March the following risks have been closed:

- BAF9 No Force First
- BAF46 CAMHS Complex Care
- BAF53 Patient Safety
- BAF55 CQC S29A Warning Notice.

An update and scrutiny was provided against 8 risk areas as follows:

- BAF63 Continuous learning and improvement – it was confirmed that an action plan is being developed and will be approved and monitored by ESOG.
- BAF10 Ligature Reduction – This area has an unchanged risk score of 5 x 3=15. Further development is taking place in relation to all open actions and local area ligature forums and ligature audit processes are being reinstated that will be supported by a Ligature Coordinator that is currently being recruited.
- BAF36 Purposeful Admissions – A Task and Finish Group has been instigated to develop and drive delivery against an action plan.
- BAF45 CQC – It was noted that a range of actions has been taken with further actions to be agreed following internal support visits and review of PHSO/HSE action plans.
- BAF51 Mass Vaccination Programme – Key actions being undertaken are in relation to formalization of contract arrangements, licenses for premises and alternative models of delivery.
- BAF54 Essex Mental Health Independent Inquiry – This has been identified as a new risk. Consultation on the Terms of Reference is now in train.
- BAF58 Record Keeping – A project team with terms of reference is currently being developed with a senior operational lead. Outcomes will be monitored by the Patient Safety PMO.
- BAF64 CAMHS Tier 4 – This area is currently scored as the highest risk with a score of 5 x 4 =20. Action plan is in development with monitoring by ESOG.

It was agreed that Chair's action would be taken in relation to this paper.

2.2.6 CQC Exception Report

An update was given in relation to CQC related activities that are being undertaken within the Trust in association with BAF45 – CQC Inspections and Learning. It was confirmed that EPUT is fully registered with the CQC.

Following the unannounced inspection on the 11 and 12 May 2021 to the CAMHS unit at St Aubyns Centre following a serious incident resulting in the death of a Young Person there has been several requests for information following which the Trust has received a Section 31 notice. The seriousness of this was acknowledged and it was noted that structures were in place whereby the issues would be reviewed in more detail. An Intensive Clinical Support Group that had been established immediately after the incident occurred and the Committee were assured that improvements were being made.

A project has been initiated to ensure that appropriate preparation has been undertaken in the Trust for future CQC visits inclusive of support visits, self-

assessments, learning and staff engagement and the updating of resources

The Compliance Team supported by members of the senior nursing team have been focusing work on the following areas:

- CAMHS Intensive Clinical Support Group
- Action Plan Testing
- Nursing Home IPC
- Community based services (MHS and CHS) support visits.

In April 2021 the CQC published the Mental Health Services Insight Report for EPUT. The Committee was advised that the document provides an update on the data currently held by the CQC in relation to the Trust and develops a profile, which may be used to target any inspections or instigate an inspection if a risk is seen to be emerging.

Following extensive consultation the CQC launched an ambitious new strategy. The Committee were advised that it is set out under four themes:

- People and communities
- Smarter regulation
- Safety through learning
- Accelerating improvement.

2.2.7 Learning Disability Standards
The Committee agreed to defer this paper until the July 2021 meeting.

2.2.8 Patient Story
The Committee received a patient story that has supported organizational learning. It provided an account of the patient's journey whilst in hospital, subsequent follow up and Trust learning. The following action and learning points were identified:

- The importance of consulting with patient's relatives prior to discharging patients back to the care of their GP when they are unable to make contact with the patient directly has been reiterated to staff.
- The Trusts disengagement guidelines require review to strengthen the importance of family involvement.
- The Patient Safety Incident Team strengthened communication systems and process related to families and Family Liaison Officers.
- A clinical focus group was in place to improve the standard of record keeping.
- The patients' sisters' personal account of her experience was shared with the Associate Director of Inpatient Services to share with the staff.
- A presentation to the Inpatient Quality and Safety meeting is scheduled.

The Committee were assured that the patient's sister was happy with the detailed and considered report received from the Trust and Janet Wood advised that this was a report that she had reviewed and commended Jo Paul for the high standard of the investigation, report and learning..

Assurance from meeting held on 8 July 2021

2.3 Summary of discussions and issues identified as well as assurances provided at the meeting on 8 July 2021.

The Committee were advised that there were items in the minutes from 10 June 2021 that required Chairs actions and this had been completed relating to:

- Quality Performance Report
- Clinical Audit Annual Report
- Board Assurance Framework Action Plans
- CLP1 Clinical Audit Policy
- CP75 Ligature Risk Assessment and Management Appendix 1
- RM08 Security Policy
- Health & Safety of Young People Policy
- Policies for Extension.

2.3.1 Schedule of Business/Work Plan
The Committee was advised that the current timescale to update the work plan was likely to change as the governance review process was still underway which would inform the schedule of business for the Committee. However, it was confirmed that the work plan had been reviewed reducing duplication with other Committees and as such the work plan would continue with a rolling programme of papers.

2.3.2 Mortality Data and Learning
An update was given to the Committee regarding the outstanding review from 2017/18 and a request for narrative to be incorporated within the Mortality Data and Learning Report regarding deaths in the nursing homes that occurred during the period of March/April 2020. The Committee received assurance that the review had been completed and an update made in relation to COVID-19 deaths in the nursing homes.

2.3.3 Combined Sub-Committee Assurance Report
The Committee were presented with a report providing assurance on actions being taken by sub-committees to progress key aspects of the quality agenda and identify any risks associated with COVID-19 pandemic and associated pressures on services. It was reported that a number of themes connected with workforce and pressures in the system were having an impact on attendance at some meetings. Workforce has been acknowledged as a fundamental risk within the organisation and work programmes are in place focusing on recruitment, retention and staff morale. It was noted that ligature remained a hotspot. The Committee were given assurance that programmes of action were in place against all hotspots with positive progress being made in all areas.

In response to questions raised the Committee were assured that the risks were recorded on risk registers and reviewed on a regular basis. It was noted that dates should be added when new risks were added and reviews had taken place. Assurance was provided in relation to the oversight of the risk register process, in terms of the Executive Safety Meeting, meetings with the Head of Assurance and meetings with individual staff.

2.3.4 Quality/Patient Safety Strategy Report
The Committee were presented with a report providing an update of actions being taken to implement the Trust's Patient Safety Strategy and deliver against agreed quality priorities. A Programme Management Office is in place to ensure delivery against this strategy.

It was confirmed that the Trust had achieved the objective as an early adopter of PSIRF and were approached by other oganisations to give support. Following visits by CQC, intensive support groups are in place completing actions in line with issues raised.

This year's Quality Account has the same quality priorities as 2019/20 and work

continues in relation to improvement, innovation and transformation. To date ongoing work is delivery improvement in services and outcomes. The Trust is also working in collaboration with the CAMHS taskforce and mental health safety programme to deliver against a range of patient safety priorities.

It was noted that a new time limited full board committee was being established which has been developed to oversee the implementation of the safety strategy. This will provide the non-executives with assurance that delivery is being made against the Patient Safety Strategy.

2.3.5 COVID-19 Board Assurance Report

The Committee received an update report providing assurance regarding IPC during the COVID-19 pandemic. The assurance template had been updated nationally in response to emerging COVID-19 evidence and the effective IPC measures. It was noted that a further national update had been issued since the report was last presented.

The Committee were advised that there is an issue in relation to FFP3 provision as the previous stock had expired and was being fully replaced. This has resulted in the need for further training regarding the fitting of masks. An attempt at recruiting a dedicated trainer had been unsuccessful but actions had been put in place to mitigate risk. The Committee explored if there was a risk in the gap between the previous PPE expiring and the process for training staff in the new equipment. The narrative set out the responsibility for all staff to ensure they can use the new PPE as it protects them and patients. It was noted that there was a potential risk in terms of staff performing CPR, however, staff have been identified that are FFP3 trained that can respond to emergency situations. The risk register for the command structure includes this as a risk and mitigation is in place.

2.3.6 CQC ASSURANCE REPORT

The Committee were presented with a report providing an update and assurance on key CQC related activities. Details of the CQC inspection of CAMHS services in May/June 2021 and the response to the issues identified had been resource intensive. The focus had been on repairing and recovering, with work undertaken within the system to gain assurance. Assurance was given that the Trust had met the CQC deadline for taking specific actions and no further requirements have been identified by the CQC. IT was noted that a meeting is scheduled for the following week with CQC at which Natalie Hammond would provide an oversight report showing the wider governance changes, monitoring of key performance indicators and system working to show overall improvements within the service.

The Committee queried if there was a programme in place in terms of the CQC lifting registration restrictions. It was confirmed that the requirement was for the Trust to approach the CQC when it was felt that it was ready for re-inspection. This would happen once there is confidence that the improvements made are sustainable and it was considered that at the moment assurance could not be given in that respect. Internal compliance, NHS England and commissioners are involved in the process.

It was noted that there had been a number of inappropriately placed patients, which contributed to staffing issues as the number of staff were not in place to manage the acuity of the patients. Once this issue was resolved the ward would be staffed in accordance with the specifications, not the pressure in the system. Issues remained with the use of temporary staffing and this may take time to resolve. In the meantime system calls take place on a weekly basis and admissions are managed accordingly. The Committee were advised that there had been no feedback from the provider collaborative. It was confirmed that the CQC would be attending the Board meeting

scheduled on the 28 July 2021 where actions being taken would be discussed inclusive of the approach being taken in terms of managing staffing and admissions.

2.3.7 Progress against Learning Disability Standards
The Committee were presented with an update on progress made against the delivery of the Learning Disability Standards. They were informed that the second wave had delayed some progress. The outcome of benchmarking for 2019/20 was now complete and the Committee were advised that a summary would be provided to the next NHSLD on 29 July. The Trust had agreed to participate in the next data collection and to maximize the data collection increased engagement from staff and patients is required. Discussions have taken place to ensure the standards were embedded across inpatient wards and a communication plan was being developed to relaunch and raise awareness. Training in relation to making reasonable adjustments is scheduled to become mandatory and a schedule is in place to commence full roll-out commencing October 2021.

The Committee were advised that there would need to be a greater focus on reviewing incident data in relation to self-harm in CAMHS and Learning Disability services. It was acknowledged that the Trust is not an outlier in terms of incident data but it was agreed that it would be beneficial to specifically review any learning disability deaths.

The Committee noted that further work was required and requested a quarterly update report.

2.3.8 Mortality Data and Learning Report
The Committee was presented with a report providing information relating to deaths that incorporated learning within the Trust as a result of mortality reviews undertaken since the previous Committee. The report highlighted the impact of COVID-19 pandemic with clear peaks shown at different points of the year. The Committee advised that closer integration would take place between PSIRF and mortality reviews to maximize the opportunity for learning.

The Committee noted positively the level of detail shown in the learning section of this report.

2.3.9 Infection Prevention and Control Annual Report

The Committee were provided with a report that gave assurance that the Trust provided a robust, proactive and effective Infection Prevention and Control service in compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. The assurance also extended to the CQC Fundamental Standards and other related standards.

It was noted that the report was similar to last year, except for information in relation to the response to COVID-19. This had been significant in terms of support provided to staff and the system during the pandemic. The report showed the Trust had remained compliant with IPC standards and action plans had been completed during the pandemic.

The Committee were advised that it was not yet clear on the forward plan in terms of the flu vaccination and this will impact the future plan for the coming year.

The Committee requested that a thank you should be given to the IPC team for their work and effort during the pandemic.

2.3.10 Emergency Preparedness & Resilience & Response Annual report

A report was providing giving assurance that EPUT has effective resilience measures in place to respond to a Major Incident, Critical Incident or a business continuity issue. The report also provided evidence of the Trust achievements and continued commitment to the organisational resilience during 2020/21 in order to meet the requirements of the Civil Contingency Act 2004 and NHS England's Emergency Preparedness, Resilience and Response Framework 2015.

The Committee acknowledged the efforts made by staff and agreed processes had been well-tested and honed.

2.3.11 EU EXIT REPORT

The Committee received an update on the Trust's position in regards to the EU Exit that has taken place. It was noted that an intensive piece of work had taken place. The biggest risk had been in relation to staff and ensuring the right to work permits were in place. There were a small number of staff requiring support in this area but it was not detrimental to the overall workforce.

The Committee requested clarification in relation recording individual's right to work and recognition of professional qualifications. It was agreed that Natalie Hammond would raise these issues with HR and provide a response to the Committee.

2.3.12 COVID ASSURANCE REPORT

The Committee were presented with a report providing assurance in relation to the actions taken in response to the Covid-19 pandemic. The report incorporated many areas discussed in previous papers.

Janet Wood confirmed she received a copy of the risk register with the report whenever it was updated and raised a concern that a number of risk assessments were not up to date. It was confirmed that a more current risk register would be circulated to the Board of Directors.

The Committee were advised that the Trust was in the process of developing principles in terms of future working, which will sit alongside any guidance published. It was expected that a steady state would be maintained initially.

2.3.13 Patient's Story

A patient's story was presented regarding a gentleman that had transferred from Basildon Mental Health Unit to the acute hospital. Concerns had been raised by the acute hospital trust regarding the manual transfer of the patient, in terms of using a wheelchair rather than an ambulance and issues with the prescription paperwork. An ambulance had been called but due to the requirement of a lengthy wait staff decided to transfer the patient manually using a wheelchair. It was found that communication with the ambulance service could have been better and the response may have been different had the nature of the situation been communicated.

There was an issue in relation to the patients medication and this was related to the scanning of documents. It was agreed that it may have been prudent for the mental health and acute doctors to have engaged in communication. The Committee were advised the identified learning had been shared with the team and the relationship with the ambulance service was being taken forward. The use of SBARD as a communication tool was currently being taken forward as part of delivery against the

patient safety strategy. The Committee were advised that the tool was not new but clarity was required regarding actions required by the ambulance service and a change of thinking for staff.

2.3.14 Information Governance Framework 2021-23

The Committee received a report providing details of changes made to the Information Governance Framework. The Framework was due for annual review and new sections had been added including an expansion in relation to Cyber Security. Minor amendments had also been made due to changes in legislation.

2.4 Policies and Procedures

The Committee approved the following policies and procedures:

- CLP1 Clinical Audit (3 year review)
- CP73 Work-related Driving (amendment)
- CP75 Ligature Risk Assessment and Management (new version Appendix 1)
- RM09 Security Policy (Amendments)
- RM15 Health and Safety of Young Persons (3 year review)
- Joint Working and Provision of Services between Mental Health and Learning Disability Teams within South Essex (CLP66)
- Record Management Procedures B-E
- Responding to External Visits Policy (CP43)
- Use of Mobile Phones Policy (CP54)
- Information Sharing and Consent Policy (CP60), subject to review of a hyperlink
- Work Related Driving Procedure (CPG73)
- Infection Prevention and Control Procedure Sections 1,3 and 9
- Major Incident Plan (RM14)
- Lone Working Policy (RM17)

Policy extensions were agreed for the following:

- CLP30 CPA Policy
- CP36 Communicating Patient Safety Incidents 'Being Open' Policy
- Responding to External Agency Visits Policy
- Private and Independent Practice Policy.

2.5 Risks/Hotspots:

The Committee identified:

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

The Committee identified the following areas of good practice:

- Patient story following a complaint, and the good proactive in relation to the investigation, lessons learnt and communication
- Extensive Clinical Audit Programme during pandemic
- The work undertaken by the Infection Control Team
- Good practice put in place in relation to emergency preparedness.

Report prepared by:
Gill Mordain, Strategic Advisor

On behalf of:
Amanda Sherlock/ Rufus Helm, Non-Executive Directors/Chair of the Quality Committee

		Agenda Item No: 9i
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28th July 2021**

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

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

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

Recommendations/Action Required

The Board of Directors are asked to:

1. Note the content of this report.
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3. Approve the BAF38 Emergency Planning (Appendix 1)
4. Note the Covid 19 Gold risk register and summary mitigations (Appendix 2).
5. Request any further information and or action

Summary of Key Issues

Background

- The country has now been dealing with the corona virus outbreak for over 18 months. The Trust's arrangements continue to be in place and are working effectively.
- Across the country we now are seeing an increase of prevalence, currently this is not significantly impacting on the locally system however learning from previous Covid waves suggests close monitoring is required.
- Nationally we remain at a level 3 incident response
- Nationally the Government have lifted Covid restrictions from 19th July 2021, however guidance for healthcare settings remains that masks should be worn and social distancing should be maintained
- We continue to monitor prevalence amongst our patients and staff

Command Structure

- The Trust Gold/Silver Command has been stood up to 2 days a week in response to the increasing demand
- The (virtual) Incident Control room operational times continue to run 8am until 6pm 7 days a week
- The Covid Risk Register is regularly reviewed and updated by Gold and Silver Command.
- National daily / regular sit reps remain in place.
- 6 additional staff have now attended the full Strategic Command Training with more scheduled during the remainder of 2021 along with a series of refresher courses booked for those staff who have previously undertaken the full strategic command training

Impact to Date

- There is one new outbreak within the trust in 1 ward involving 3 patients.
- Regular lateral flow testing of both our patients and asymptomatic staff continues across the trust.
- There have been no further reported patient or staff deaths as a result of Covid-19 as a direct or indirect cause since last reporting
- At time of writing we have a total of 32 staff off sick due to covid-19 (slightly more than last reporting but overall remains a significant reduction) There are 3 Covid-19 confirmed patients
- The Trust Committee and Governance Structures have now fully resumed through the utilisation of Microsoft Teams on a virtual basis.

Trustwide Response

- All wards have fully returned to their original functions
- In recognition that people can experience ongoing symptoms following COVID-19 well after their initial infection (Long Covid) the Staff Engagement team have created a support group for staff to share their experiences and offering advice on managing the physical and mental challenges associated with COVID-19 recovery.
- Announcement of a statutory inquiry commencing next spring 2022. This is part of an entire Government response, UK wide. There will be requests for evidence and every organisation will need to be prepared as a potential to be part of the inquiry. This has been built into our BAF 38 Emergency Planning document as attached in Appendix 1 for approval.

Communication

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

Risks

- Covid 19 pandemic remains a risk on the Trust BAF.

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:

- Further reflection on what has worked well and what has not, to identifying working practices moving forward.
- Incorporation of staff support offered into reflective learning.
- Daily data analysis at ward level of Staff and Patient Covid sickness/isolation rates where applicable
- Continued attendance at the Keith Willett webinar's to gain greater understanding nationally in order to adapt any process' or working practices internally.
- In order to successfully sustain Incident Control Centre cover a review was undertaken whereby the EPRR Team will manage Monday – Friday 0900-1800 with a rota of admin support for weekend cover.
- Continual reminder of IPC process' to ensure staff do not become complacent and maintain our current reduction of Covid positive cases.

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

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

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

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

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

Supporting Documents and/or Further Reading
Covid Assurance Report BAF 38 Emergency Planning Gold Command Covid Risk Register Summary

Lead
Paul Scott **Chief Executive Officer**

Agenda Item 9i
Board of Directors
28th July 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FT

COVID 19 ASSURANCE REPORT

Purpose of Report

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

Background

The country has now been dealing with the corona virus outbreak for over 18 months and the Trust's arrangements continue to be in place and working effectively. Since last reporting there has not been the need for Covid beds within the trust and nationally we remain at a level 3 incident response.

Across the country we now are seeing an increase of prevalence, currently this is not significantly impacting on the locally system however learning from previous Covid waves suggests close monitoring is required.

Nationally we remain at a level 3 incident response

Nationally the Government have lifted Covid restrictions from 19th July 2021, however guidance for healthcare settings remains that masks should be worn and social distancing should be maintained

We continue to monitor prevalence amongst our patients and staff and respond promptly to guidance as and when provided.

Command Structure

We continue to hold the joint Silver and Gold command meetings moving up to twice weekly on a with Bronze command mirroring this meeting to ensure information continues to cascade through the organisation.

The (virtual) Incident Control room remains operational 7 days a week 8am until 6pm in line with the East of England Operational Centre. This is mainly covered by the Compliance and Assurance Directorate with the additional help of other corporate staff on a rota at the weekends buddied by the EPRR leads for support and on call should there be any Covid-19 Patient Notification System (CPNS) death reporting required.

The regular sit rep submissions required by the Centre continue, namely the National Covid daily sitrep, Community discharge daily sit rep, (also required at weekends) and the regular Lateral Flow Testing numbers and more recently any Long Covid activity.

There continues to be a noted decrease in the national and regional information and guidance into the incident control inbox. However the continued monitoring of the inbox ensures that should anything of urgency come through we are able to respond. Any national and regional guidance, information and requests are cascaded to the appropriate Directors and through discussion at the Command meeting for information and consideration of the actions required with a timely response.

The equalities network leads continue to attend 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 Strategic Command training offered for all staff that have a command role has been booked with the first session undertaken on 2nd July 2021 with a total of six EPUT staff attending that have a command role during incident or emergencies. There are further dates planned for later in the year along with a series of refresher courses booked for those staff who have previously undertaken the full strategic command training. The first of these was 18th June with two EPUT staff in attendance.

The 17 remaining staff are scheduled onto either a full or refresher course in the latter part of 2021.

Impact to Date

Since last reporting in May, there has been an increase in our reporting of Covid-19 positive cases and at time of writing we have 3 confirmed positive inpatients. Due to this we have 1 open outbreak on one of our wards. There are currently a total of 32 staff off sick due to Covid-19 related illness which is an increase from 16 at last report but remains a significant reduction overall.

I am also pleased to report that we have not had any additional patient deaths to report onto the Covid-19 Patient Notification System (CPNS) and there continues to be no further reported outbreaks within the trust.

The regular lateral flow testing of both our patients and asymptomatic staff continues across the trust and the Trust Committee and Governance Structures have all now resumed through the utilisation of Microsoft Teams on a virtual basis.

Trustwide Response

All wards have now returned back to their original functions and we continue to monitor the pandemic situation.

It has been recognised that people of all ages and backgrounds can experience ongoing symptoms following COVID-19 well after their initial infection irrespective of the severity of the initial infection. It also reported that people can experience ongoing Symptomatic COVID-19 and Post COVID-19 Syndrome, also known as 'Long COVID' (NHS England and NHS Improvement June 2021)

Nationally we are still learning about this condition however, in recognition of the effects of Long Covid for our staff the Trust has developed guidance for staff and the Staff Engagement team has created a group for staff to share their experiences of how COVID-19 has impacted on their life and the ability to access support and advice on managing the physical and mental challenges associated with COVID-19 recovery.

It has been announced that there will be a statutory inquiry commencing next spring 2022. This is part of an entire Government response, UK wide. There will be requests for evidence and every organisation will need to be prepared as a potential to be part of the inquiry.

Early indication of key areas will be in relation to outbreaks, high admissions or deaths and as a Trust we will need to ensure we issue a 'do not destroy notice' to keep records of key decisions and decision logs going back to January 2020. Looking at where were the pinch points for staff or groups of clinicians or anything that was a concern and to consider records of leavers who were making decisions and how we make contact if required. We have built this into our BAF 38 Emergency Planning document as attached in Appendix 1 for approval.

Communication

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

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

Risks

The Trust Covid risk register has remained a live document with the risks constantly being updated to reflect the changing environment and are detailed in the summary Covid Gold Risk Register in Appendix 2. There are currently 1 Extreme Risk, 13 High Risks and 11 Medium Risks open.

From this it can be seen that major risk currently facing the Trust is: -

Skills, Resource and Capacity, the following controls have been noted

- This risk has full engagement in the EOSC BAF sub group; the demands and pressures on EPUT are immense with very high stakes projects and issues
- Participation by EPUT on system calls
- Programme Management Office related to Safety First, Safety Always Strategy and continuous improvement work stream as part of Safety First, Safety Always Strategy
- Collective leadership – identifying senior talent, succession planning and Quality Champions

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:

- Further to the reported reflection on what has worked well and what has not, this is being looked at further to identifying working practices moving forward.
- Incorporation of staff support offered into reflective learning.
- Daily data analysis at ward level of Staff and Patient Covid sickness/isolation rates where applicable
- Continued attendance at the Keith Willett webinar's to gain greater understanding nationally in order to adapt any process' or working practices internally.
- In order to successfully sustain covering the Incident Control Centre, a review was undertaken whereby the EPRR Team will manage Monday – Friday 0900-1800 with a rota of admin support for weekend cover.
- Continual reminder of IPC process' to ensure staff do not become complacent and maintain our current reduction of Covid positive cases.

Action Required

The Board of Directors are asked to:

1. Note the content of this report.
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3. Approve the BAF 38 Emergency Planning (Appendix 1)
4. Note the Covid 19 Gold risk register and summary mitigations (Appendix 2).
5. Request any further information and or action

Report compiled by:

Jane Cheeseman,
Head of Compliance and Emergency Planning

On Behalf of

Paul Scott
Chief Executive Officer

Draft BAF38 Emergency Planning Action Plan

Assumption	Potential Risk	Escalated – Risk Score	Controls
EPUT will manage Covid-19 through effective emergency planning	If EPUT does not manage Covid19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements	**Consequence 5 x Likelihood 2 = 10** **Risk is at threshold** **Risk ongoing through pandemic and subject to fluctuations**	Executive Lead in place for EPRR Business Continuity Plans in place and undergoing constant review Gold, Silver and Bronze Command well established Sit rep daily monitoring and submission Covid-19 InPut page and range of staff training in place Covid-19 dashboard issued weekly to monitor prevalence Risk mirrored to Covid-19 risk register

Action	Action Detail	Target Completion Date	Lead	Progress	RAG
Preparation for Covid-19 Statutory Inquiry	Impose legal stop notice	Immediate	JL	In place	
	Command structure record keeping is managed and up-to-date	Ongoing	NJ	Robust command structure with notes, logs, action logs, dashboards. Nothing is over-written. Archiving in place.	
	Patient death documentation	Ongoing	NJ	All documentation in place for patient deaths – information available through EPRR team	
	Staff deaths documentation	Ongoing	KK	All documentation in place for staff deaths – investigation reports available through HR team	
	Set up a single point of contact to act as Inquiry Co-ordinator	July 21	JC	Discuss at command structure	
	Demonstrate lessons learnt from Covid-19	Immediate and ongoing	JC		
	Promote awareness of various media methods that could be called as evidence including retrospective personal and team WhatsApp, MS Teams and Pando messages	July 21	NJ/JL	Discuss at command structure	

Table 1 – COVID RISK REGISTER 2021/22 Summary of Risks as at end June 2021

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

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF38	If EPUT does not manage Covid19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements	PS	Finance and Performance	Monitoring/ Covid19 Action Log - Command	• Executive lead in place for EPRR • Business Continuity Plans in place and undergoing constant review • Gold, Silver and Bronze Command well established • Sit rep daily monitoring • Covid intranet page and range of staff training in place • Covid dashboard issued weekly to monitor prevalence	**Risk score remains at threshold 5 x 2 = 10** **Target date – ongoing throughout pandemic**	• Develop an action plan • Prepare for Statutory Inquiry
BAF50	If EPUT does not have the skills, resource and capacity to deliver on high quality care and other wide ranging of priorities and pressures then achieving our organisational objectives may be compromised resulting in stagnation of risks and failure to maintain our position within the system	PS and all Executives	PIT	Action Plan to be developed for 2021/22	• Participation in system calls • Command structure in place for Covid19 • Project Board in place for mass vaccination programme • Project Group for EU Exit Trade Deal • Creating resilient teams • Continuous improvement work stream as part of Safety First, Safety Always Strategy • Collective leadership – identifying senior talent, succession planning and Quality Champions • Leadership handbooks • Robust and forward thinking Executive Leadership Team • Programme Management Office related to Safety First, Safety Always Strategy • Preparation for Independent Inquiry	**Risk score unchanged 5 x 4 = 20** **Ongoing for duration of pandemic** **Threshold 5 x 2 = 10**	• Develop new strategic and corporate objectives for 2021/22 and articulate risks to achieving those • Newton diagnostics to ensure systems and processes are effective • Bolstering staffing and project support as required • Redefining Executive portfolios to best manage services and resources • Develop a new action plan for 2021/22

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF42	If the Covid19 crisis continues then EPUT may experience an adverse impact on its financial plan as a knock on from system wide financial planning resulting in additional risk for EPUT to its sustainability	TS	Finance & Performance	Monitoring through finance meetings	• The revised planned deficit is £8.3m • The Trust has received an additional £9m income from NHSE/I in recognition of national planning process income error assumptions • As a consequence of the above, in March 2021 M12 the Trust recorded a pre audit draft year end break even position • Year to date M12 Covid19 costs of £16.2m with M7-M12 recovery anticipated from M&SE and H&CP • Cash was £94m in M12, which remains better than planned • Continuous monitoring through reporting to F&PC, EOSC finance and performance meetings and the Board	**Risk score unchanged 4 x 3 = 12** **Target June 2021 Threshold 4 x 2 = 8**	• Continue to monitor financial situation and Covid19 costs to ensure recovery • Financial planning for 2021/22 – draft plan by 6 May and final plan by 3 June (system and internal colleagues)

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF51	If EPUT does not effectively direct and implement the mass vaccination programme then it will not meet its deliverables/ timescales resulting in a failure of the programme in MSE and SUNEE	NL	Quality	Monitoring by Project Management Group	• A risk register set up specifically related to the Mass Vaccination programme to strengthen governance around the project • New BCPs developed for vaccination centres • Programme Board in place • Allocation of some sites to be operated by acute partners • Working with Local Resilience Forums, Local Authorities and other providers to deliver the programme • Guidance implemented on Oxford Astra Zeneca Vaccine • Security Audits • All costs passing through NHSE and laptop costs supported by skill mix work • Robust communication in place with vaccination centre • Good coverage in both MSE and SUNEE with robust joint working (rationale for reducing consequence to 4)	**Risk score unchanged 4 x 3 = 12** **Target date is ongoing for the duration of the mass vaccination programme** **Target 4 x 2 = 8**	• No contracts have been issued to us and at this stage we are unable to sub-contract any elements of the service to other organisations • Awaiting outcome of extension to existing licences for premises • Alternative models may be implemented including mobile vehicles and drive through centres which will require alternative skill mix • Work to ensure that individuals are not at risk of missing a second vaccine due to booking system • Maintain watching brief on variable vaccine supply and impact on programme

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVG19	If EPUT does not manage Infection and Prevention Control (IPC) during COVID19 then infections may increase resulting in a negative impact on the pandemic	NH	Quality	Monitoring by Command Structure	• 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	**Risk score at threshold 4 x 2 = 8** **Ongoing**	• None identified
CVG33	If EPUT does not ensure that staff are Fit Tested for the variation of FFP3 masks coming through the PPE push system then it may delay the utilisation of these masks resulting in lack of PPE for aerosol generating procedures	NH	Quality	Monitoring by Command Structure	• Plan in place for the ongoing requirement for fit testing	**Risk score 4 x 3 = 12** **Ongoing** **Target 4 x 2 = 8**	• Appoint to fixed term role so Fit Testing programme has a sustained resource
CVG51	If EPUT staff do not follow the rules and guidance issued around PPE then there will be breaches resulting in the potential for outbreaks and related staffing issues and harm to patients	NH	Quality	Command Structure	• Staff continuously reminded that they must not breach PPE by car sharing, removing masks in handover meetings etc. • Training including PPE Self-Assessment	**Risk Score to reduce 5 x 3 = 15** **Ongoing** **Target 5 x 2 = 10**	• Continue with vaccination programme for patients and staff • Continue reminders around PPE

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVG37	If EPUT does not maintain Covid-19 secure risk assessments then premises may not conform to guidance resulting in a possible spread of infection	PS	Quality	Command structure	• Covid19 Secure risk assessments are being carried out by member of risk team • Datix is monitored in order to pick up any risks	**Risk score 4 x 3 = 12** **December 21** **Target 4 x 2 = 8**	• As at June 21, 28 Covid-19 secure risk assessments out of date
CVG10	If EPUT is unable to maintain its planned capital programme through lack of contractor access then delays or deferments may occur resulting in increased pressure on the capital programme in recovery	TS	F&PC	Command structure	• 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	**Risk score 3 x 3 = 9** **Ongoing** **Target 3 x 2 = 6**	• Contractors working within social distancing guidelines still an issue
CVG45	If EPUT does not manage clinical waste during COVID19 then hazardous material may be stored longer at a local level resulting in the potential for spread of infection and harm to patients and staff	TS	F&PC	Command structure	• Procurement put in place alternative storage arrangements whilst there was an issue with the contractor • Contact maintained with contractor • Environment agency are aware of any issues and understand the necessity to store waste on site in locked cages • Team of clinicians, risk management, infection control and estates set up to market test the service	**Risk score at threshold 4 x 2 = 8** **Target March 22** **Ongoing**	• Facilities continue to monitor the situation around issues with collection of clinical waste during the second wave • Specification for total waste contract (following extension to April 2022) will be reviewed along with Risk and Infection Control to take the service out to the market as a combined service or separately • Carry out market testing using multi-disciplinary team

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVG48	If EPUT does not manage staff levels, staff engagement and input for recording of lateral flow staff testing then resource requirements may not be met resulting in failure to deliver the staff testing project and asymptomatic testing	NH	Quality	Command structure	• Staffing risk assessment completed with identified mitigating actions • NHS Lateral Flow Testing Webinar attended • Range of learning from other Trusts produced regionally • Weekly Task and Finish Group and Project Team to ensure project continues with phase 3 roll out • Dashboard monitoring	**Risk score 4 x 3 = 12** **Ongoing** **Target 4 x 2 = 8**	• Some gaps in staff reporting their LFT • Continue to monitor
CVG52	If EPUT does not have sufficient resource/ finance to effectively project manage and deliver the asymptomatic testing programme across the Trust then it may not meet the deliverables and timescales and potential failure of the programme	NH	Quality	Command structure	• EPUT distributes Covid19 swab testing kits for asymptomatic patient facing staff • Page dedicated to asymptomatic testing on InPut including video guides, manager action lists, FAQs and self-testing guide • Live event held on asymptomatic testing including the video • Daily submission using form on InPut to report on LFT for the previous day, 7/7. • Delivering phase 3	**Reduce risk score to threshold 4 x 2 = 8** **Ongoing** **Target 4 x 2 = 8**	• Gain clarity on continuation of funding for asymptomatic testing
CVG55	If EPUT continues to experience ward closures due to Covid19 outbreaks then availability of beds to acutely ill patients may diminish resulting in additional community/ virtual support and potential harm to patients	AG	Quality	Command structure	• 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 • No current outbreaks as at 14 May 2021 • Extend completion date in line with national lockdown easing	**Risk score 5 x 3 = 15** **June 21** **Target 5 x 2 = 10**	• None identified

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVG24	If EPUT does not ensure that staff have the new range of skills required to deal with the C19 crisis then appropriate care may not be delivered to patients resulting in potential harm to patients and challenges for staff	NH	Quality	Command structure	• Competency skills assessment carried out in wave 1 reviewed • IPC competency self-assessments • Covid care pathway document in place and updated with any new guidance	**Reduce risk score to threshold 5 x 2 = 10** **Ongoing** **Target 5 x 2 = 10**	• Continue to review training in line with national guidance
CVG46	If EPUT does not manage the delivery of valid server generated emails to staff outlook inboxes (following NHS mail national update) then important or urgent COVID19 emails may be missed resulting in a delay in information cascade or the submission of urgent returns	TS	F&PC	Command structure	• ITT working with NHS Digital to resolve this issue for EPUT • Staff have been reminded to check their junk email boxes for any important missed information • Changes to the NHS Mail junk filtering configuration made to minimise the likelihood of legitimate emails being marked as spam/ junk	**Risk score reduced 4 x 2 = 8** **June 21** **Target 4 x 1 = 4**	• Maintain watching brief • Changes to the NHS mail junk filtering configuration has demonstrated to have significantly reduced the volume of legitimate emails going into junk – continue to monitor
CVG56	If EPUT does not prepare for potential strike action then then there may be a shortfall of staff resulting in a lack of sustainability to run local services	SL	PIT	Command structure	• Talk of strike action is currently quiet • National discussions ongoing over pay award	**Risk score 5 x 3 = 15** **Ongoing** **Target 5 x 1 = 5**	• Await outcome of Unison national conference June 21 • Consider closure of risk following above

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVG57	If EPUT continues to experience delays in staff Covid investigations then RIDDOR submissions may be may more than 12 months late resulting in failure to comply with regulations and manage staff safety	NH	Quality	Command structure	• IPC has taken over responsibility for staff Covid sickness investigations to confirm if RIDDOR reportable • Regular RIDDOR outcome meetings in place to agree submissions • Additional resource in place to support investigation • Draft letter to HSE • Presented paper to Executive Team with actions to resolve the issues	**Risk score 4 x 4 = 16** **Ongoing during C19 crisis** **Target 4 x 2 = 8**	• Volume of outstanding investigations to be addressed • Regular reporting to Silver Command • Communications to staff and HSE being discussed with legal team
CVS3	If EPUT does not respond appropriately to Government guidance on clinically extremely vulnerable people then those with underlying health conditions may be missed resulting in the potential for serious illness	NH MK AG	Quality	Command structure	• National guidance on clinically extremely vulnerable people ceased on 1 April 21 • Staff risk assessments updated	**Risk score at threshold 3 x 2 = 6** **Ongoing**	• Maintain watching brief
CVS27	If EPUT is unable to maintain management oversight for the backlog of incidents on Datix then some more serious incidents may slip through the net resulting in no investigation taking place or action being taken	PS	Quality	Command	• Business as usual management oversight reinstated on 1 October 20 • Routine monitoring in place	**Risk score 3 x 3 = 9** **Target passed Target score 3 x 2 = 6**	• Monitor situation via HSSC and ESOG – as at May 21 there are a number of outstanding incidents for sign off

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVS28	If EPUT has bank staff working at several sites then track and trace is more difficult to implement resulting in the potential for further Covid-19 cases CAN THIS RISK BE REDUCED AND CLOSED?	AG	Quality	Command structure	• Bank staff shifts logged on Health Roster: The Trust needs to know where members of staff have been working each day for track and trace purposes in case there is a COVID-19 outbreak at a Trust workplace. This includes our temporary workforce (bank and agency). Where possible, bank staff should be booked via the bank office. However, the Trust appreciates that the bank office is not a 24-hour service. For this reason, where a bank or agency worker is booked directly, entry will be on to health roster during the shift they work and no later. Late entries on to health roster will result in the Trust not being able to track our workforce effectively in line with COVID-19 expectations. • Operating of the Bank office is from 8 am - 6pm Monday to Friday and from 8am - 12 noon on Saturdays for shift enquiries only.	**Risk score 3 x 3 = 9** **Ongoing** **Target 3 x 2 = 6**	• Notifications of sickness can come in as early as 5.00 a.m.
CVS29	If EPUT staff do not comply with Covid-19 requirements and Covid Secure arrangements then the safety of patients and colleagues are put at risk resulting in a dip in staff morale, the potential for increased cases and the CQC requesting significant improvements	AG	Quality	Command structure	• Number of outbreaks has reduced to zero • Reduction in breaches of Covid secure • Local guidance in place	**Risk score 4 x 4 = 16** **Ongoing** **Target 4 x 2 = 8**	• Ensure continuous rigour of PPE and IPC is reinforced through Bronze command

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVS30	If EPUT does not manage the levels of fatigue within the organisation then sickness levels may rise resulting in a failure to deliver services in a safe way	SL	PIT	Command structure	• 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	**Reduce score to 4 x 3 = 12** **Ongoing** **Target 4 x 2 = 8**	• 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
CVS25	If EPUT is unable to meet the rehabilitation needs of Covid-19 patients in recovery then their recovery from Covid-19 may be delayed, resulting in possible adverse health and socioeconomic outcomes for the patient and associated impacts on their families & carers.	AG	Quality	Command structure	• National and local guidance in place on Covid rehabilitation • Piloting 'Living with Covid' Recovery App from AHSN for the West Essex Long Covid assessment service – has evidenced outcomes in supporting access and flow in Covid assessment services • AHP led Fatigue management training delivered in EPUT and on behalf of partners • Other Long Covid services led via respective ICS systems in Essex all governed by a regional approach with second funding imminent to support all systems	**Reduce score to threshold 4 x 2 = 8** **Ongoing** **Target 4 x 2 = 8**	• Continue engagement with ICS/ STP workstreams regarding Covid recovery • Continue collaborative work to address gaps in knowledge and skills • Work with partner agencies across Essex to devise treatment plans • Staff issues re Long Covid covered by support groups and continuous monitoring of data
CVB7 (MHI-OA57)	If EPUT is unable to safely care for vulnerable older people who are at higher risk then they may become infected resulting in an exacerbation of the spread of Covid19 infection	AG	Quality	Command structure	• National and local guidance in place • Patients with capacity and at higher risk offered choice of nursing in isolation Query – there are discrepancies with this and the same risk on the Directorate Risk Register (Mid/South and West) – threshold score should be 4 x 2 = 8. Also on the DRR there appear to be many outstanding mitigating actions. Please review	**Risk score at threshold 4 x 2 = 8** **Ongoing**	• Continue to check patient vital signs frequently •

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
CVB16 (MH-LD21)	If EPUT is unable to continue supporting community learning disability patients during Covid-19 in a routine manner then their clinical presentation or mental health state may deteriorate due to a change in routine and change in care provision, resulting in poor patient outcomes and possibly harm to the patient through self-harm or behavioural changes	AG	Quality	Bronze Command	• Enhanced support team • Duty team in place • Alternative support mechanisms in place Query – why is this at such a low score when there are a number of outstanding mitigating actions? Please review	**Risk score at threshold 4 x 1 = 4** **Target date passed September 21**	• Monitor Datix for any reports of service user deterioration • Continue to risk assess for likelihood of deterioration and mitigate appropriately • Issue letters to patients and carers detailing need to change routine in order to access services and social activities • Explore with legal any complications resulting from the letters that are to be issued to patients and carers • Explore alternative means of providing support remotely • Continue to work with partner agencies for support • Provide information on easing of lockdown and service accessibility

Table 2 – Heat Map against 5 x 5 scoring matrix

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1				CVB16	
	2			CVS3	CVG19 CVG45 CVG46↓ CVG52 CVB7 CVS25	BAF38 CVG24
	3			CVG10 CVS27 CVS28	BAF42 BAF51 CVG33 CVG37 CVG48 CVS30	CVG55 CVG56 CVG51↓
	4				CVG57 CVS29	BAF50
	5					

		Agenda Item No: 9ii
SUMMARY REPORT	**BOARD OF DIRECTORS** **PART 1**	**28 July 2021**

Report Title:	**EU Exit**					
Executive/Non-Executive Lead:	Nigel Leonard, Executive Director – Major Projects					
Report Author(s):	Lara Brooks, AD Risk and Compliance (Interim)					
Report discussed previously at:	Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

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

Recommendations/Action Required

The Trust Board of Directors is asked to:

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

Summary of Key Issues

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

NHSEI highlighted to Trusts key areas of concern on the exit immediately post the transition period and following the agreement with the EU on the relationship for future. The below are the key areas and messages received to date:

Medicines
To date the Trust have had no reported issues regarding Medicines

Medical Devices, clinical consumables, non-clinical goods and services
To date the Trust have had no reported issues regarding Medical Devices, clinical consumables, non-clinical goods and services.

Workforce
The national Legal Framework confirms that there is no requirement for organisations to confirm with staff, who were employed prior to 1st Jan 2021, their settlement status. The Framework further confirms that there is no requirement for staff to inform employers of their settlement status and that organisations should be mindful of potential discrimination when enquiring about settlement status.

The Trusts legal defence should we be employing someone who has not got settlement status would be the right to work checks undertaken on employment.

At this time the Trust has 42 workers who have not shared their pre-settled/settled status. The breakdown of these staff in terms of assignment are as follows:

- Permanent = 14
- Fixed Term Temp = 4
- Bank = 24

Trust Bank workers have different requirements under the legal framework meaning there is a need to check status. This requirement has been shared with Trust solicitors to confirm and Hempsons have provided advice to the Trust. Advice confirmed that each Bank shift is seen as a new assignment therefore do need settlement status confirmation. All bank workers where status has not been confirmed have been removed from working and have been given a timescale to provide settlement status, if they fail to provide within this timescale they will be removed from the bank permanently. No significant concerns or impact has been identified for the Trust or specific services.

Data
The EU has now formally adopted 'adequacy decisions' for the UK. These allow for the ongoing free flow of personal data from the EU/EEA to the UK. This means personal data can continue to flow freely between Europe and the UK following agreement by the European Union to adopt 'data adequacy' decisions.

The decisions mean that UK businesses and organisations can continue to receive personal data from the EU and EEA without having to put additional arrangements in place with European counterparts.

The Department for Digital, Culture, Media and Sport (DCMS) recommend that as a sensible precaution, UK organisations should keep a record of regular personal data transfers they receive from EU counterparts, and be ready to put alternative arrangements in place to allow these to continue should EU adequacy decisions cease to be in effect in the future. This recommendation is currently being reviewed by the Trusts Data Protection Officer for any additional actions the Trust may need to take.

Reciprocal healthcare and cost recovery
To date the Trust have had no reported issues regarding Reciprocal healthcare and cost recovery.

Vaccines
To date the Trust have had no reported issues regarding Vaccines that is EU Exit related.

Research and clinical networks
To date the Trust have had no reported issues regarding Research and clinical networks.

Health Security
To date the Trust have had no reported issues regarding Health Security.

The above key messages were circulated to the Task & Finish Group members who continued to provide assurance in the EU Exit Task & Finish Group that there were no risks or concerns arising.

The Trusts EU Exit Task & Finish Group to date has been meeting by exception although in the last 2 months there has been no requirement to do so, therefore it is planned that the group will be stood down in July 2021.

The requirement for highlighting any areas of concern relating to EU EXIT on the Daily Sit Rep return to NHSEI has now ended and is no longer discussed in the Gold/Silver commands.

This perhaps indicates that due to the lessening impact of EU Exit, reduction of notifications and reducing risks there are no significant concerns at a regional level following the transitions period of EU Exit at this present time. Key messages and correspondence will continue to be monitored by the Emergency Planning team and cascaded to relevant parties for information or action as required. The Task and Finish Group can be stood up immediately should this be required.

The Executive Team BAF Sub-Group agreed the recommendation to reduce the risk score to threshold and close due to the lessening impact of EU Exit, reduction of notifications and reducing risks. This recommendation is on the Board agenda for 28th July 2021.

The BAF action plan has been brought up-to-date with the above and actions identified by the task and finish group and is and is available on request to Board Members.

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

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

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

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

Acronyms/Terms Used in the Report			
MHRA	Medicines and Healthcare products Regulatory Agency	NIHR	National Institute for Health Research
NHSEI	NHS England/Improvement	HR	Human Resources
PHE	Public Health England	EEA	European Economic Area

LED	Law Enforcement Directive	DCMS	Department for Digital, Culture, Media and Sport
GHIC	Global Health Insurance Card	EHIC	European Health Insurance Card
GDPR	General Data Protection Regulation	EU	European Union

Supporting Documents and/or Further Reading
EU Exit Report

Lead
   Nigel Leonard Executive Director – Major Projects

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

EU Exit

1.0 PURPOSE OF THE REPORT

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

2.0 BACKGROUND

This report presents an update on EPUT's position within the Trust for EU Exit and agreement being reached as to the relationship beyond the end of the transition period and assurance on EPUT's continued response to this. The UK government has agreed a trade agreement with the EU. There will still be changes following the end of the transition period and having left the Single Market and Customs Union. The Trust's preparations for the end of the transition period and post transition have been taking place alongside our response to Covid-19 and winter pressures.

3.0 EU Agreement

NHSEI highlighted to Trusts key areas of concern on the exit immediately post the transition period and following the agreement with the EU on the relationship for future. The below are the key areas and messages received to date:

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

  To date the Trust have had no reported issues regarding Medicines

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

  To date the Trust have had no reported issues regarding Medical Devices, clinical consumables, non-clinical goods and services.

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

  The national Legal Framework confirms that there is no requirement for organisations to confirm with staff who were employed prior to 1st Jan 2021 their settlement status. The Framework further confirms that there is no requirement for staff to inform

employers of their settlement status and that organisations should be mindful of potential discrimination wen enquiring about settlement status.

The Trusts legal defence should we be employing someone who has not got settlement status would be the right to work checks undertaken on employment.

At this time the Trust has 42 workers who have not shared their pre-settled/settled status. The breakdown of these staff in terms of assignment are as follows:

- Permanent = 14
- Fixed Term Temp = 4
- Bank = 24

Trust Bank workers have different requirements under the legal framework meaning there is a need to check status. This requirement has been shared with Trust solicitors to confirm correct and Hempsons have provided advice to the Trust. Advice confirmed that each shift is seen as a new assignment therefore do need settlement status confirmation. All bank workers where status has not been confirmed have been removed from working and have been given a timescale to provide settlement status, if they fail to provide within this timescale they will be removed from the bank permanently. No significant concerns or impact has been identified for the Trust or specific services.

- **Data**

NHS organisations and staff should continue to handle data as they currently do.
The agreement the Government has reached includes a provision to provide for the continued free flow of personal data from the EU and EEA until adequacy decisions are adopted (and for not longer than 6 months).

The EU has now formally adopted 'adequacy decisions' for the UK. These allow for the ongoing free flow of personal data from the EU/EEA to the UK. This means personal data can continue to flow freely between Europe and the UK following agreement by the European Union to adopt 'data adequacy' decisions. Formal adoption of the decisions under the EU General Data Protection Regulation (GDPR) and Law Enforcement Directive (LED) allows personal data to flow freely from the EU and wider European Economic Area (EEA) to the UK.

The decisions mean that UK businesses and organisations can continue to receive personal data from the EU and EEA without having to put additional arrangements in place with European counterparts.

NHS organisations had previously been asked to ensure that appropriate safeguards were in place. While these are no longer required, they remain good practice. The Department for Digital, Culture, Media and Sport (DCMS) recommend that as a sensible precaution, UK organisations should keep a record of regular personal data transfers they receive from EU counterparts, and be ready to put alternative arrangements in place to allow these to continue should EU adequacy decisions cease to be in effect in the future. This recommendation is currently being reviewed by the Trusts Data Protection Officer for any additional actions the Trust may need to take.

- **Reciprocal healthcare and cost recovery**

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

To date the Trust have had no reported issues regarding Reciprocal healthcare and cost recovery.

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

  To date the Trust have had no reported issues regarding Vaccines that is EU Exit related.

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

  To date the Trust have had no reported issues regarding Research and clinical networks.

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

  To date the Trust have had no reported issues regarding Health Security.

  The above key messages were circulated to the Task & Finish Group members who continued to provide assurance in the meetings on these areas that there were no risks or concerns arising.

4.0 EU Exit Task and Finish Group

4.1 Frequency

The Trusts EU Exit Task & Finish Group to date has been meeting by exception although in the last 2 months there has been no requirement to do so, therefore it is planned that the group will be stood down in July 2021.

4.2 Review of Guidance

The requirement for highlighting any areas of concern relating to EU EXIT on the Daily Sit Rep return to NHSEI has now ended and is no longer discussed in the Gold/Silver commands.

This perhaps indicates that due to the lessening impact of EU Exit, reduction of notifications and reducing risks there are no significant concerns at a regional level following the transitions period of EU Exit at this present time. Key messages and correspondence will continue to be monitored by the Emergency Planning team and cascaded to relevant parties for information or action as required. The Task and Finish Group can be stood up immediately should this be required.

4.3 BAF23 Action Plan

The Executive Team BAF Sub-Group agreed the recommendation to reduce the risk score to threshold and close due to the lessening impact of EU Exit, reduction of notifications and reducing risks. This recommendation is on the Board agenda for 28th July 2021.

The BAF action plan has been brought up-to-date with the actions identified by the task and finish group and is and is available on request to Board Members.

5.0 RECOMMENDATIONS

The Executive Safety Oversight Group are recommended to:

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

Prepared by:
Lara Brooks
Associate Director of Risk and Compliance (Interim)

On behalf of:

Nigel Leonard
Executive Director - Major Projects

		Agenda Item No: 10a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28th July 2021**

Report Title:	**Digital Strategy Refresh**					
Executive/Non-Executive Lead:	Trevor Smith, Executive Chief Finance Officer					
Report Author(s):	Adam Whiting, Deputy Director of IM&T					
Report discussed previously at:	IMT Strategy Group					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	A new digital strategy is essential to ensure that the enablement, efficiencies and assurances that digital provide are delivered safely and in line with local, ICS and national expectations.
State which BAF risk(s) this report relates to	
Does this report mitigate the BAF risk(s)?	
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	

Purpose of the Report		
To sight the board on the updated position and progress towards a new EPUT Digital Strategy	**Approval**	
	Discussion	x
	Information	x

Recommendations/Action Required

The Trust Board of Directors is asked to:

- Note the contents of the report and engage with the Author with comments and requests for further information.

Summary of Key Issues

A new digital strategy is essential to ensure that the enablement, efficiencies and assurances that digital provide are delivered safely and in line with local, STP and national expectation.

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

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

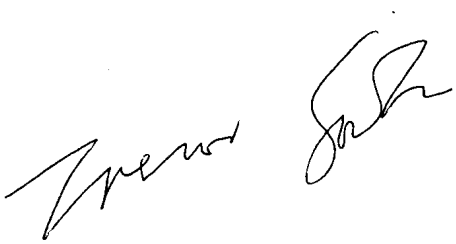
Which of the Trust Values are Being Delivered	
1: Open	x
2: Compassionate	x
3: Empowering	x

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
New Digital Strategy Planning - Briefing Paper

Lead



Trevor Smith
Executive Chief Finance Officer

Agenda Item: 10a
Board of Directors – Part 1
28th July 2021

DIGITAL STRATEGY REFRESH

1 Purpose of Report

The purpose of this report is to sight the Trust Board on the progress and next steps towards a new EPUT digital strategy and provide the opportunity to participate in its development.

2 Position update

The previous IMT strategy has served EPUT well and has driven digital transformation for the last 5 years.

With the imminent formation of refreshed strategic objectives, coupled with the finalisation of the ICS digital strategies, the timing is perfect to ensure that digital is woven into the transformation of EPUT to continue to be enabler for change.

The Trust was successful in obtaining National funding through the Digital Aspirant Seed funding programme to support digital transformation.

With this financial support, the IMT Team commissioned independent advice and support (Digital Healthcare Advisory, DHA) who have worked with all three Essex ICS's on a digital maturity model.

DHA have already undertaken a trust wide engagement on behalf of the IMT directorate to validate EPUT's approach to shared care records (Interoperability)

During their engagement they interviewed over 25 senior EPUT leaders, providing clarity of direction for both the interoperability strategy and the expectations for a wider Digital strategy and EPR review.

3 Next Steps

The headlines from their report were presented at an Executive briefing session on the 21st June where support was obtained to launch a Digital Strategy engagement programme.

The programme will engage both clinical and corporate leaders across EPUT to help shape the direction and priorities for Digital for the coming years.

These engagement and direction sessions are expected to begin in August 2021 as a series of workshops. The launch event will initially be to socialise the expectation with the most senior leaders (L30) and a cascade approach taken whereby digital champions will be identified from across the trust as stakeholders to help shape the future of digital in EPUT.

The final draft of the strategy is expected to be presented to the Executive by November 2021.

The governance for the implementation of new Digital Strategy will be defined as part of its creation. It will be asked that the implementation of the strategy be co-owned by the senior leadership team and maintained as a blueprint for alignment of any digital change project within EPUT.

Please contact: Adam.whiting@nhs.net or Janette.leonard@nhs.net with any questions or if there are any nominations for stakeholders to be involved in the engagement sessions.

Report Prepared by:

Adam Whiting,
Deputy Director of ITT, Business Analysis and Reporting

On behalf of

Trevor Smith
Executive Chief Finance Officer

		Agenda Item No: 11a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28th July 2021**

Report Title:	CQC Compliance Update					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Amanda Webb, Senior Emergency Planning and Compliance Officer					
Report discussed previously at:	Executive Safety Oversight Group Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	Non-compliance with internal CQC Action Plan timeframes July-August 2019 Action plan testing identified gaps of non-compliance
State which BAF risk(s) this report relates to	BAF45 - CQC Inspections and Learning
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and requirements and to support the Trust's ambition of achieving an outstanding rating by 2022.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Identify any further action that is required to be taken.

Summary of Key Issues

Meeting Registration Requirements

EPUT is fully registered with the CQC. No changes were required in this reporting period.

Internal Compliance Programme

A new compliance framework is under development with the aim to utilised available information to identify potential areas at risk of non-complianceA\ and provide focus for the Trust Compliance Team in undertaking sit visits. This will work alongside a new safety walkaround process.

CQC Provider Collaboration Reviews

The CQC have been carrying out Provider Collaboration Reviews (PCR) looking at how providers are working collaboratively in an Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP) in response to COVID-19. EPUT was selected to be

part of the latest review with the Children and Young people and the review was scheduled for the 23rd June 2021.

CQC and PHSO Action Plan Testing
As previously reported the Compliance Team are continuing to test action plans completed to ensure actions have been embedded. Where gaps are found these are escalated to the appropriate Trust Committee to agree and take forward the actions required to ensure changes have been embedded.

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

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

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

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	LRRG	Ligature Risk Reduction Group

Supporting Documents and/or Further Reading
Accompanying Report – CQC Compliance

Lead
Paul Scott **Chief Executive Officer**

Agenda Item 11a
Board of Directors
28th July 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Compliance Update

1. Introduction

This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and requirements and to support the Trust's ambition of achieving an outstanding rating by 2022.

2. Meeting Registration Requirements

EPUT is fully registered with the CQC. No changes were required in this reporting period.

3. Internal Compliance Programme

A project has been completed to ensure appropriate preparation has been undertaken in the Trust for future CQC visits. As previously reported there are 5 key components to the project plan for which updates are provided below:

3.1. Support Visits

The Compliance and Corporate Nursing Team continue to joint work in supporting the wards to prepare for inspections. All inpatient areas have now had a support visit undertaken.
Support visits will be arranged to a random selection of Community Service ensuring all geographical areas are covered.

3.2. Self-Assessments

All inpatient areas have completed their self-assessments.
The self-assessments for the Community based teams (MHS & CHS) have been rolled out.

3.3. Learning

Following a review of all the information received via the Support visits and Self-assessments, all Core Service action plans have been populated and distributed. These will be monitored through the relevant Quality & Safety Groups.

3.4. Staff Engagement

Staff engagement is underway with a number of reflective sessions held and future sessions planned. Attendance at sessions has been patchy and work is underway to join existing meetings to undertake engagement sessions. MDP CQC sessions have recommenced the first undertaken 9th July and bimonthly going forward.

3.5. Staff Resources

As reported previously, staff resources have been updated and communicated.

Next Steps

A new compliance framework is under development with the aim to utilised available information to identify potential areas at risk of non compliance and provide focus for the Trust Compliance Team in undertaking sit visits. This will work alongside a new safety walkaround process

4. CQC Provider Collaborative Review

The CQC have been carrying out Provider Collaboration Reviews (PCR) looking at how providers are working collaboratively in an Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP) in response to COVID-19. EPUT was selected to be part of the latest review with the Children and Young people and the review was scheduled for the 23rd June 2021. The review looked at 4 KLOE's:

- **P:** In responding to COVID-19, how have providers collaborated to ensure children and young people (CYP) that are moving through mental health and care services have been seen safely in the right place, at the right time, by the right person?
- **S:** How has system wide (operational and strategic) governance and leadership for children and young peoples' mental health services worked to produce a shared plan for provision of services during the COVID-19 pandemic?
- **W:** Is there a strategy for ensuring that staff in health and social care settings have the right skills and training, and are kept safe whilst
- **D:** What contribution have digital solutions and technology made to the providers' ability to support children and young people with mental health needs during the pandemic period?

The PCRs gives the CQC a greater ability to recognise and respond to risks to people using services through multi-disciplinary working. They facilitate learning between providers and make a positive contribution to planning for any further pressures related to COVID-19, and in planning for services in the future, as systems and providers start to look towards recovery.

A full summary report for all the provider collaboration reviews exploring the themes and trends and sharing learning and good practice will be published on the CQC website. The review would not name Trusts responses however in the event of exceptional practices they would request permission prior to providing the Trusts name. Timing for publication is yet to be confirmed. The Trust may be able to request an individual system summary including responses from the systems once the full report is published.

5. CQC Action Plan Testing

The Compliance Team is now involved in a range of action plan testing including following CQC visits and PHSO action plan testing. Work is currently underway to look at developing one central learning plan which will focus on the testing findings and assurance of action embedding.

5.1. CQC Well Led Inspection (July-August 2019) and Unannounced CQC Inspection (Finchingfield October 2020)

Compliance CQC action plan testing found some gaps in embedded actions following the completion of CQC Action Plans. These have been previously reported to Executive Safety Oversight Group where it was agreed that the gaps found should be allocated to the appropriate Trust Committees to agree and take forward appropriate actions to ensure changes have been embedded.

6. Recommendations and Action Required

The Board of Directors is asked to:

1. Note the contents of this report
2. Identify any further action that is required to be taken.

Report Prepared by:

Amanda Webb
Senior Emergency Planning and Compliance Officer

On behalf of:

Paul Scott
Chief Executive Officer

		Agenda Item No: 11b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28 July 2021**

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 and Guardian of Safe Working Hours					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	x	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	N/A
State which BAF risk(s) this report relates to	N/A
Does this report mitigate the BAF risk(s)?	N/A
Are you recommending a new risk for the EPUT BAF?	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 • Assurance to the Board that doctors in training are safely rostered and that their working hours are compliance with the Terms and Conditions of the Service.	**Approval**	
	Discussion	
	Information	X

Recommendations/Action Required

The Board of Directors is asked to:

- Note the Contents of the report

Summary of Key Issues

The following areas are detailed in the accompanying report:

1. There are three Exception Report raised by trainees.
2. No fines were issued in this quarter.
3. There are gaps in the on call rota which are filled by MTI and LAS doctors.

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

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

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

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

Lead
Milind Karale **Executive Medical Director**

Agenda Item: 11b
Board of Directors Part 1
28 July 2021

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 sixteenth quarterly report submitted to the Board on safe working of junior doctors for the period 1 April to the 30 June 2021. The Trust has established robust processes to monitor safe working of junior doctors and report any exceptions to their terms and conditions.

Exception Reporting: (3 exception reports in this quarter)

Two exception reports were relating to working extra hours and compensatory rest time/ payment was provided to the trainees. The third exception report was related to resting period after night shift. If it is unsafe for the doctors to drive after a night shift, the Trust is expected to provide an appropriate resting place or provide safe transport. The Taxi firm had not updated the Medical Staffing with their new number, this has been resolved and all the doctors in the Mid Essex part of the Trust have received the updated contact details for the Taxi firm.

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on the 7th April 2021

Doctors in Training Data

Number of doctors in training posts (total inclusive of GP and Foundation) (Plus1 additional psychotherapy trainee from NSFT)	126
Number of doctors in psychiatry training on 2016 Terms and Conditions	61
Total number of vacancies	22
Total vacancies covered LAS/ MTI/Agency	16
Total gaps	6

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	107	107	0	1404.5	1405.5
Total	107	107	0	1404.5	1405.5

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-we have successfully recruited 7 LAS doctors recently.

2. Email 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:

Refurbishment work at Linden Centre Doctors' room is complete.
Similar refurbishment work is yet to take place at Doctors' room at other sites of the Trust.
Refurbishment of the junior doctors room at Basildon site is in the site refurbishment plans.
No other issues were raised by Junior Doctors at the Forum.

3 Action Required

Board is asked to note the findings of the report.

No major concerns were raised by doctors at the last Junior Doctors Forum.

Report prepared by

Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours
July 2021

		Agenda Item No: 13
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**28th July 2021**

Report Title:	**Board Safety Oversight Group**					
Executive/Non-Executive Lead:	Natalie Hammond Executive Nurse– Alison Rose-Quirie Non-Executive Director					
Report Author(s):	James Day Interim Trust Secretary					
Report discussed previously at:	Executive Safety Oversight Group					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	The introduction of the element of regular NED oversight of the delivery of the Safety Strategy will support its delivery and reduce the risk of any hindrance to implementation
State which BAF risk(s) this report relates to	BAF 63 – Continuous learning as part of the Safety Strategy
Does this report mitigate the BAF risk(s)?	Yes – Supports the implementation of the Safety Strategy
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	Regular reporting of progress to the Board and Executive team

Purpose of the Report		
This report provides the Board of Directors • With the opportunity to endorse in principle the creation of a monthly NED chaired oversight group dedicated to the implementation of the Trust's Safety Strategy	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors/XXX Committee is asked to:

1 Note the contents of the report
2 Approve in principle the creation of a monthly NED chaired Board Safety Oversight group dedicated to the implementation of the Trust's Safety Strategy
3 Endorse Alison Rose-Quirie as Non-Executive Chair of the Board Safety Oversight Group
4 Endorse in principle the attendance at the group, Ex Officio and as required, of the SID, Chair of Audit and Chair of Quality Committee
5 Approve in principle the draft Terms of Reference appended, including reporting directly to the Board on progress and any issues to be resolved
6 Request any further information or action.

Summary of Key Issues

The Trust has introduced a detailed Safety Strategy, the implementation of which is already considered on a weekly basis by the Executive Team in the Executive Safety Oversight Group, ESOG. The Safety Strategy is a key element supporting the Trust's future direction.

In order to enhance regular Board visibility and understanding of the progress being made to deliver the Safety Strategy, and to provide Non- Executive assurance and governance oversight, it was considered valuable that on a regular basis the progress being made should be subject to NED scrutiny.

Accordingly, and with strong support from the Executive Team and Trust Chair, it has been agreed that on a monthly basis, one of the scheduled ESOG meetings should now become a Board Safety Oversight Group. This will be chaired by a NED and with the Ex Officio attendance of one of the key NEDs most closely linked, namely the SID, Chair of Audit and Chair of the Quality Committee. The Chair of Audit has already indicated agreement.

Alison Rose-Quirie has kindly stepped up to be Chair and has similarly endorsed the proposal, which will also help identify and prioritise resources and support, and challenge the overall status, progress and decision making.

Dates for the meetings have already been set.

Ahead of any detailed changes and final approval at the September Board, the Board is asked to consider the proposal and, given the primary importance of Safety to the Trust,

- Approve in principle the creation of a monthly NED chaired Board Safety Oversight Group dedicated to the implementation of the Trust's Safety Strategy as set out in the draft Terms of Reference attached
- Endorse Alison Rose-Quirie as Non-Executive Chair of the Board Safety Oversight Group
- Endorse in principle the attendance at the group, Ex Officio and as required, of the SID, Chair of Audit and Chair of Quality Committee
- Approve in principle the draft Terms of Reference appended, including reporting directly to the Board on progress and any issues to be resolved

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

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

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

2: Compassionate	✓
3: Empowering	✓

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

Acronyms/Terms Used in the Report			
SID	Senior Independent Director		
NED	Non-Executive Director		
ESOG	Executive Safety Oversight Group		

Supporting Documents and/or Further Reading
Draft Terms of Reference for Board Safety Oversight Group V2.0 in PowerPoint format

Lead
Name James Day **Job Title** Interim Trust Secretary

BOARD SAFETY OVERSIGHT GROUP – Terms of Reference (ToR)

ToR V2.0

NHS
Essex Partnership University
NHS Foundation Trust

TERMS OF REFERENCE FOR:	Board Safety Oversight Group	TERMS OF REFERENCE AUTHORISED BY:		Executive Team	
CHAIRED BY:	Alison Rose-Quirie	SECRETARIAT:	Angela Horley	FREQUENCY:	Monthly
PURPOSE:	• Provide assurance to the board that the safety strategy is being delivered to the agreed time, cost and quality parameters. • Ensure adequate processes and governance are in place to safely enable delivery success. • Ensure the effective and sufficient availability of resources to support safety strategy priorities. • Support and challenge overall status, progress and decision making.				
ATTENDANCE:	**Alison Rose Quirie** Non executive Director **Paul Scott** Chief Executive **Natalie Hammond** Executive Nurse **Trevor Smith** Executive Chief Finance & Resource Officer **Alexandra Green** Executive Chief Operating Officer	**Moriam Adekunle** Director of Safety and Patient Safety Specialist **Matt Gall** Strategy Manager **Richard James** Director of Programme Management **Nicola Jones** Deputy Director of Compliance	**Sean Leahy** Executive Director of People & Culture **James Day** Trust Secretary **Nigel Leonard** Executive Director of Strategy & Transformation **Dr Milind Karale** Executive Medical Director **Mick Di Stazio** Director of Communications and Marketing **NED supporting attendees as required (Ex Officio)** Senior Independent Director Chair of Audit Committee Chair of Quality Committee	The meeting is quorate with the chair or nominated deputy and 3 members from the executive team.	
INPUTS:	▪ Safety strategy related papers ▪ Implementation update & portfolio dashboard ▪ Agenda ▪ Action log		OUTPUTS:	▪ Action Log ▪ Update risks and issues log ▪ Board and Executive Team reports	

Leadership
Culture
Continuous Learning
Wellbeing
Innovation
Governance and Information

WeAreEPUT – Putting safety first and always