Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public via Teams Live Event
Wednesday 25 November at 10:00

Vision: Working to Improve Lives

PART ONE: MEETING HELD IN PUBLIC via Teams Live Event

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
PRESENTATION: NHS Community Mental Health Service User Survey 2020 Charlie Bosher – Quality Health				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 30 September 2020	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	CEO Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	PS	Attached	Noting
(b)	Update on Quality Improvement Framework	NH	Attached	Noting
(c)	Staff Flu Vaccination Programme Self- Assessment	NH	Attached	Noting
(d)	Freedom to Speak Up Guardian Service	YM	Attached	Noting
(e)	Final EPUT Quality Account 19/20	NH	Attached	Approval
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework 2020/21	PS	Attached	Approval
(b)	Standing Committees:			
	(i) Finance & Performance Committee	ML	Attached	Noting
	(ii) Quality Committee - October 2020 (iii) Quality Committee - November 2020	AS	Attached	Noting
	(iv) People, Innovation & Transformation Committee	ARQ	Attached	Noting
	(v) Audit Committee	JW	Verbal	Noting

(c)	EU Exit (Transition) Operational Preparedness	NL	Attached	Noting
9	**RISK ASSURANCE REPORTS**			
	(i) COVID-19 Assurance Report	PS	Attached	Noting
	(ii) Covid-19 Infection & Prevention Control Board Assurance Report	NH	Attached	Noting
10	**STRATEGIC INITIATIVES**			
(a)	COVID-19 Mass Vaccination	NL	Attached	Noting
11	**REGULATION AND COMPLIANCE**			
(a)	Safe Working of Junior Doctors Quarterly Report	MK	Attached	Noting
(b)	CQC Update	PS	Attached	Noting
12	**OTHER**			
(a)	Use of Corporate Seal	PS	Attached	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**	ALL	Verbal	Noting
14	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
15	**Video Presentation**			
16	**DATE AND TIME OF NEXT MEETING** Wednesday 27 January 2021 - Virtual at 10:00			
17	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** Wednesday 31 March 2021 at 10.00 Wednesday 26 May 2021 at 10.00 Wednesday 28 July 2021 at 10.00 Wednesday 29 September 2021 at 10.00 Wednesday 24 November 2021 at 10.00			

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 30 September 2020
Held Virtually via MS Teams Video Conferencing

Attendees:

Prof Sheila Salmon (SS)	Chair
Sally Morris (SM)	Chief Executive
Paul Scott (PS)	CEO Designate
Prof Natalie Hammond (NH)	Executive Nurse
Mark Madden (MM)	Executive Chief Finance Officer
Trevor Smith (TS)	Executive Chief Finance Officer Designate
Andy Brogan (AB)	Executive Chief Operating Officer / Deputy CEO
Alex Green (AG)	Executive Chief Operating Officer Designate (Interim)
Sean Leahy (SL)	Executive Director of People and Culture
Nigel Leonard (NL)	Executive Director of Strategy and Transformation
Dr Milind Karale (MK)	Executive Medical Director
Janet Wood (JW)	Non-Executive Director
Nigel Turner (NT)	Non-Executive Director
Alison Davis (AD)	Non-Executive Director
Alison Rose-Quirie (ARQ)	Non-Executive Director
Amanda Sherlock (AS)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director
Rufus Helm (RH)	Non-Executive Director

In Attendance:

Angela Horley (AH)	PA to Chief Executive, Chair and NEDs (minutes)
Tina Bixby (TB)	Assistant Trust Secretary
Chris Jennings (CJ)	Assistant Trust Secretary
John Jones	Lead Governor
Louise Summers (LS)	Matron, CAMHS Inpatient

SS welcomed Board members, Governors, members of the public and members of staff that were viewing the live broadcast. The meeting commenced at 10:00.

107/20 APOLOGIES FOR ABSENCE

There were no apologies for absence. SS advised that JW would have to leave the meeting for approximately one hour at 11:15.

108/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

109/20 PRESENTATION: REDUCING RESTRICTIVE PRACTICE'S NATIONAL COLLABORATIVE

NH advised that Louise Summers had joined the meeting to advise of the work that had been undertaken on Poplar Ward, Rochford – a CAMHS inpatient unit – to reduce restrictive practice. NH continued that the unit had recently taken part in an Inpatient Mental Health Safety Collaborative and had received national recognition from the MH Safety Collaborative which stated that the team had displayed excellent leadership, with the changes on Poplar Ward seeing practices reduced. NH continued that the ward continue to collect data following the end of the collaborative and have seen a 62% sustained reduction in the use of restraint.

LS advised that the young people on the ward had contributed and been involved in the preparation for this presentation. LS advised that the ward had been selected two years ago to be part of a national collaborative which asked services to take a QI approach to look at areas to study. During this process, the team noted an increase in incidents during school holidays and evenings; it was also noted that more incidents occurred when patients could not leave the ward due to bad weather etc. As part of the process, the team met with young people and their parents / carers as well as staff to look at how change could be implemented. LS advised that learning from other units also taking part in the collaborative had identified that dedicated activity coordinators in post could contribute to a reduction in incidents, this was a post that was not within the structure on the unit and therefore it was agreed to pilot this role for a period of time. LS advised that to ensure change, it was important to promote a culture change for patients and staff. LS continued that as part of the process, the team had looked at staff interests and 'hidden talents' that they could bring to the workplace, this resulted in activities such as circus skills, origami and yoga taking place and broadened the activity programme. A 'prom' was held as well as a BBQ and party to signify the end of schooling. LS advised that data from Datix reports was used to inform a QI approach and learn from incidents to change the way in which the ward worked. It was identified that some young people respond more to longer term projects and some to shorter term projects, therefore activities varied in duration to cater for this. Feedback from staff and young people was sought, and coping strategies and techniques to use on leave or post discharge were shared.

LS reported that following the conclusion of the collaborative, the team plan to continue implementing ideas to engage and support the young people on the unit. LS also confirmed that the role of the activity coordinator has now received approval to become a substantive post.

SS thanked LS for her presentation, suggesting that it was clear why the CQC gave the Trust CAMHS service an 'outstanding' rating and congratulated services on this achievement.

AB noted the outstanding leadership within the team suggesting there was learning to share across the Trust. NH advised that the Trust has also undertaken an 8 week collaborative for ward managers to reduce restrictive practice, during which a number of ideas had been shared; a number of webinars had been set up across the Trust and LS and team had been invited to showcase the process and learning from being part of this successful collaborative.

SM advised that she had visited Poplar Ward recently, stating that it was impressive to see how the unit had developed over the years and echoed congratulations on the well deserved CQC outstanding.

AS advised that the Quality Committee had recently reviewed restraint data and compared with the national picture for CAMHS; AS continued that it was helpful to hear that the service review and reflect on initiatives to ensure a high quality service for our patients.

ARQ noted the increase in incidents during the school holidays and queried whether there had been a reduction once young people had returned to school? LS confirmed that this was correct; LS added that with the disruption to usual school services during the Covid-19 pandemic it had been important to be flexible. A 'school' space was created on the ward as well as in the main building so that routine and structure usually provided by attending school could continue. NH thanked LS for her presentation which demonstrated the power of team work and engagement with patients and their families.

110/20 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 29 July 2020 were agreed as an accurate record of discussions held subject to one typographical error:

- 105/20 – Date of Next Meeting was incorrectly stated as July, amended to 30 September 2020.

111/20 ACTION LOGS AND MATTERS ARISING

The action log was reviewed and it was noted that there were three outstanding actions due in September.

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

The Board discussed and approved the Action Log.

112/20 CHAIRS REPORT INCLUDING GOVERNANCE UPDATE

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

SS advised that the report contained details of recent changes within the Executive Team and Non-Executive Directors as well as the results of the recent Council of Governors election process; SS confirmed that she would detail these changes further at the end of the meeting.

The Board received and noted the Chair's Report.

113/20 QUALITY AND PERFORMANCE SCORECARD

SM presented the Quality and Performance Scorecard, a high level summary of performance against quality priorities, safer staffing levels, financial targets and NHSI key operational performance metrics and confirms quality / performance hotspots. The scorecards are provided to the Board of Directors to draw attention to the key issues that are being considered by the standing committees of the Board. SM confirmed that the content had been considered in depth by those committees.

SM confirmed that the Finance and Performance Committee as a standing committee of the Board of Directors, had reviewed the hotspots in detail for August 2020. Two hotspots have been identified at the end of August – Timeliness of Data Entry and CPA Reviews. There were no hotspots which are Oversight Framework indicators for August 2020 and no hotspots in the EPUT Safer Staffing Dashboard for August 2020. The CQC Reset Action Plan is summarised in the CQC Scorecard; there is one hotspot identified for Overarching actions, with one action past timescale for August 2020, this action is "the Trust must review their risk management system to prevent overly restrictive wards, ensure blanket restrictions are reduced and review the use of prone restraints".

In August there remains one hotspot identified within the Finance scorecard which is Cost Improvement Programmes (CIP). The CIP programme continues to be affected by the response to Covid-19 and the emergency finance regime. The Trust focus is on the recurrent savings in preparation for the emergency finance regime ending.

SM confirmed that where performance is under target, action is being taken and is being overseen and monitored by the standing committees of the Board of Directors.

AD referred to the CQC action regarding reducing restrictive practice, noting that a new target date was not clear. SM confirmed that this was addressed within the CQC action plan. SM continued

that as a learning organisation, when responding to a specific issue, subsequent issues for continual improvement may be identified as is the case here, these subsequent actions are then monitored through the Executive CQC Steering Group.

ML referred to the two hotspots identified by the Finance and Performance Committee noting that they had both been a known issue for some time; ML advised that detailed challenge and review had been held at the Finance and Performance Committee and that overall, the performance in month five was in a reasonable position.

The Board of Directors received and noted the report.

114/20 LEARNING FROM DEATHS – MORTALITY REVIEW Q1

NH presented the Learning from Deaths – Mortality Review for quarter 1. NH advised that the report presents information relating to deaths in scope for mortality review for Q1 2020/21 together with updated information for 2019/20, 2018/19 and 2017/18 as well as learning that has been identified within the Trust as a result of mortality review undertaken since the last report to the Board of Directors.

NH confirmed that this report presents information that the Trust is nationally mandated to report to public Board meetings on a quarterly basis.

There were 90 deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy, this is significantly higher than any previous quarter since the Trust has commenced monitoring and reporting mortality data. The most significant increase occurred in April 2020 (in which there were 59 deaths in scope). This increase has been investigated and NH confirmed that death numbers returned to levels consistent with previous quarters in May and June. NH advised that it is worthy to note that during the Covid-19 pandemic West Essex CHS have repurposed a step down facility for Covid-19 patients to receive end of life care.

Of the 90 deaths within scope, 29 were inpatient deaths and 22 were nursing home deaths. Of these 51 deaths, 44 have been confirmed as due to natural causes. Five causes of death are currently under determination and two have been denoted as unknown.

NH advised that an increase in deaths in Trust nursing homes had been identified; Gold Command commissioned a rapid review to understand this increase and be prepared for a potential second wave of Covid-19. NH confirmed that it was not possible to categorically say that the Covid-19 pandemic was the cause of this increase as the testing regime was implemented in mid-May. A review to look into the symptoms and presentations of patients and the Trust has enhanced daily observations and use of tools to indicate early warning signs of physical deterioration.

MK added that the review identifies learning from deaths and the importance of reflection to lead to change in practice. MK continued that the Trust has established reflective learning sessions where clinician present case examples and discussion is held around actions and learning from incidents.

NH confirmed that the report is presented in detail to the Quality Committee for scrutiny and discussion. NH added that the Trust is a learning organisation and as such there are a number of mechanisms to share learning, such as incidents being discussed at the Learning Oversight and Scrutiny Committee as well as the 'lunchtime learning' sessions as mentioned by Dr Karale. NH stated that it is essential to engage with clinical teams and understand what changes need to be made.

JW felt that the report did not highlight the processes for learning lessons across the Trust and welcomed NH and MK's narrative around these initiatives. JW continued that she had recently attended a lunch time learning session which had been a powerful discussion and sharing of learning. JS queried whether these sessions will continue. MK confirmed that the sessions will continue to be held and are also available to view at a later date if staff were unable to join the live session.

NT thanked NH for the comprehensive report stating that every death is a tragedy. NT sought a point of clarity in regards to patients that had tested positive for Covid-19 and their return to the acute hospital, suggesting that the number of deaths due to Covid-19 may be higher. NH confirmed that patients referred back to the acute hospitals that then subsequently die would be counted as a death for the acute Trust rather than EPUT. NH continued that during the first wave of the pandemic the repurposed ward in WECHS was established to support the acute trusts and nursing homes as a step down facility. SS noted that this demonstrated EPUT's commitment to work together with the system during this crisis.

AS reiterated the value of the lunchtime learning sessions and praised the staff leading the patient safety seminars.

In response to a query regarding PPE available to staff, NH confirmed that weekly live webinars continue to reinforce the importance of PPE and infection prevention and control. Nursing homes are supported by the Infection Prevention team and the new testing regime that has come into force.

SS thanked NH for the leadership and oversight to teams, noting the positive progress in terms of SI investigations. SS agreed that every death is a tragic incident and the value of the this exercise is the learn and take forward changes.

The Board of Directors received the contents of the report.

115/20 COMPLAINTS DEEP DIVE INTO STAFF ATTITUDE

SL advised that following the presentation of the Complaints Annual Report at the Board of Directors meeting on 27 May 2020; it was noted by a Non-Executive Director that the Mid and South area had received considerably more complaints than the other areas of the Trust. It was therefore suggested that a deep dive be undertaken to ascertain the reason for this variance.

SL advised that Mid and South Essex had received 114 complaints, North East Essex 61 complaints and West Essex 15 complaints. These complaints related to Mental Health Integrated Services only as the Medical and Specialist Services are reported Trust wide separately under their own headings, as are the Community Healthcare Services. SL advised that in comparison with previous years, there had been a reduction in the number of complaints received in Mid and South Essex. Mid and South Essex covers a large geographical area and includes older adult wards, acute treatment wards, mental health assessment units as well as several mental health community services. SL confirmed that this will continue to be monitored and if concern continues an update will be provided as appropriate.

SS thanked SS for this update, suggesting that each complaint provides an opportunity for learning.

ARQ noted that it was important to triangulate and understand data that is presented, noting that at first sight, this did appear disproportionate however upon exploration the numbers received in Mid and South Essex were proportionate to previous years.

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

116/20 VIEW OF MEMBERS AND GOVERNORS REPORT

SS was pleased to note the effective outcome of the recent Governors Election process, bearing in mind the virtual engagement due to the ongoing Covid-19 pandemic. SS was pleased to note that there are now 30 Governors in total on the Council with no vacancies.

SS looked forward to working with the refreshed Council, congratulating those Governors that had been re-elected and extending a warm welcome to new Governors. This allowed the opportunity for a strong Council to build on experience and wisdom of the existing Governors and a fresh perspective from new Governors.

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

117/20 NHS WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

SL presented the second annual Workforce Disability Equality Standard (WDES) report. SL advised that of the ten metrics, there had only been deterioration for one but there was still a significant amount of work to do to bring the experience of staff with disabilities in line with that of their non-disabled counterparts. SL advised that the Trust has 3% disabled workforce that have declared a disability, however the Staff Survey would suggest that this number is actually higher. Stated that there is further work to be undertaken regarding disabled staff entering a disciplinary process and there are extensive plans built into the EPUT People Plan.

ML queried whether there was qualitative data available to demonstrate progress as in some cases the number declared is reasonably small. SL advised that the Staff Engagement Survey suggested that 21% of the workforce had a disability, this is a significant difference and therefore there is a huge piece of work to encourage our staff to declare whether they have a disability. SL commented that this is only the second year that the WDES has been reported and therefore it is hoped that as the Trust becomes more advanced, staff will see the benefit of declaring a disability. SL added that the Staff Disability Network had been well received and was engaged in this process.

AD was encouraged to note the progress made to date, and suggested that in terms of the disciplinary process, is there an indication that issues arise due to uncertainty of staff in regards as to how to handle a situation and therefore there may be training available for staff to enable local resolution before the formal process would be instigated. SL advised that the HR team review cases before the formal process begins as well as working together with networks to resolve issues, but this is a work in progress.

ARQ noted that a number of actions were noted on the action plan as being due within the near future and queried when an update on progress may be expected. SL responded that an update on actions would be available in December; SL added that despite there being a number of actions, he was confident that work is happening at pace. SS advised that progress is monitored by the Executive Team however a progress update report would be expected at the Board of Directors to be held in January 2021.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Agreed the proposed Action Plan to address gaps.**
3. **Agreed to the publication of the paper internally and externally**

118/20 NHS WORKFORCE RACE EQUALITY STANDARD (WRES)

SL presented the Workforce Race Equality Standard (WRES) report, thanking David Uzosike BAME Network Chair and Jo Debenham Head of Staff Engagement for their contribution. SL was pleased to report positive improvements across five of the nine metrics, particularly the improvements in the metrics around Bullying and Harassment amongst staff and from mangers. However disciplinary, career development and bullying from patients and the public have not improved and will require strong focus this year. Work is being undertaken around supporting BAME staff members in continuing professional development as well as work looking at how to resolve violence and aggression from the public. The Trust are continuing to work on this alongside NHSE/I.

AD noted the positive work that had taken place and the vast amount of work planned. AD also suggested that there may be an opportunities for staff network leads to become more involved; SL responded that this is something that could potentially be explored.

MK suggested that all parameters within the WRES were important, however it is particularly important that staff are able to feel safe at work. MK advised that the Executive Team had dedicated time to consider this and also how technology can improve the safety of wards.

NT referred to the graphic on page 7 of the report and suggested it may be helpful to include a graphic that demonstrates where deterioration against the national standard had been seen.

NH confirmed that the Trust is committed to all areas of continuing professional development for our staff, and were known as an organisation for the training available to staff.

The Board of Directors:

1. **Discussed the contents of the report and noted the lack of progress across three of the metrics.**
2. **Agreed the proposed Action Plan to address gaps.**
3. **Agreed to the publication of the paper internally and externally.**

119/20	**URGENT ACTIONS TO ADDRESS HEALTH INEQUALITIES IN NHS PROVISION AND OUTCOMES**

SL advised that a letter sent to all Trusts on 31 July 2020 included tackling health inequalities as one of the priorities for Trusts. SL advised that he had been identified as the lead for health inequalities and work was progressing on the Trust's approach to tackling inequalities. SL continued that it is essential that recovery is planned in a way that inclusively supports those in greatest need an it is vital that as a healthcare provider we work collaboratively with our internal and external stakeholders to address the inequalities. SL advised that EPUT are a member of a multi-agency forum which includes the voluntary sector and public heath, local government and health care providers to address inequalities in a collaborative way.

The Board of Directors:

1. **Noted and discussed the approach to addressing health inequalities**
2. **Agree to the Executive Director of People and Culture activing as the Lead for Health Inequalities.**

120/20	**BOARD ASSURANCE FRAMEWORK**

SM presented the Board Assurance Framework reporting that there were currently 21 risks identified. SM drew the Board's attention to BAF15 regarding the potential HSE prosecution, advising of the recent announcement from the HSE. This also links to BAF10 and the work the Trust is undertaking in regards to ligature risk assessment.

In terms of changes to the BAF, the Board are asked to approve the escalation of BAF23 EU Exit Operational Preparedness in light of the ongoing EU Exit discussions.

SM provided assurance that action plans in relation to risks identified were reviewed regularly by the Executive Team, Finance and Performance Committee, Quality Committee and PIT Committee. SM continued that as an example of good practice, key performance indicators were to be identified in relation to the BAF to monitor its effectiveness. AD appreciated the importance of KPIs to monitor effectiveness, however suggested a caveat in regards to issues that may be beyond the Trust's control but the Trust has done all it can to address.

RH welcomed the escalation of BAF23 however was concerned that this may be further complicated by the Covid Pandemic; RH queried whether there had been work taking place in the meantime since this risk was previously de-escalated. SM advised that there was a paper regarding EU preparedness later on the agenda and suggested any queries may be addressed during that item.

ML advised that the Finance and Performance Committee had interrogated the BAF and noted that in regards to BAF41 it was clear that recurrent CIP targets would not be achieved during this financial year; however were confident that this would be offset by underspend in delegated expenditure across the Trust.

The F&P committee had previously raised concern regarding the change in leadership (BAF49) – in particular the departure of three members of the Executive Team in quick succession; however ML noted that the committee were appraised throughout the recruitment process and were pleased and reassured by the appointments of PS, TS and AG. ML advised that the Committee would support reduction or removal of this risk.

BAF42 was identified as a growing risk in terms of the financial position and the impact of Covid-19 and the subsequent recovery programme. SM confirmed that initial focus had been around acute services, however as the pandemic continues, increased demand in mental health and community services is being seen.

The Board of Directors:

1. **Reviewed the risks identified in the BAF 2020/21 September summary and approved the risk scores, taking account of actions taken by EOSC at its August meeting.**
2. **Approved the escalation of BAF23 EU Exit Operational Preparedness to the BAF.**
3. **Approved the new risk for the Corporate Risk Register.**
4. **Noted the CRR September summary table, including actions taken by EOSC at its August meeting.**
5. **Approved the proposal for Key Performance Indicators in relation to the BAF.**
6. **Did not identify any further risks for escalation to the BAF, CRR or Risk Registers.**

121/20 STANDING COMMITTEES

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

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

(iii) Finance and Performance Committee

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

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

(v) People, Innovation and Transformation Committee (PIT)
The Board received and noted the report and confirmed acceptance of assurance provided.

122/20 EU EXIT

NL recalled that earlier in the year the Trust had been well positioned in terms of preparation for the EU Exit with continuity plans in place. The Executive Team recently took the decision the reconvene the EU Exit Group and nationally organisations have been requested to stand up EU Exit arrangements. NL confirmed that he had been identified as the SRO and JW provided NED oversight to this work.

NL advised that previously a number of regional and national calls had taken place and it was anticipated that these would recommence imminently. NL confirmed that the Trust was well prepared previously and had continued to ensure plans and preparation was appropriate.

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

123/20 ENGAGEMENT WITH BOARD OF DIRECTORS POLICY AND PROCEDURE

SM presented the Council of Governors Engagement with the Board of Directors policy and procedure which outlined the mechanisms by which Governors and Directors will interact and communicate with each other to support their role in holding the NEDs to account for the performance of the Board of Directors. SS advised that all Board members and COG members had had opportunity to reflect and comment on this document.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Approved the Engagement with the Board of Directors Policy and Procedure.**

124/20 RISK ASSURANCE REPORTS

i) Covid 19

SM advised that the country has now been dealing with the Covid-19 pandemic for over 7 months and the Trust's arrangements continue to be in place and are working effectively. SM confirmed that the Trust is operating in a reset and recovery phase however indicators suggest the emergence of a second wave. The Trust has responded accordingly and has increased the frequency of Gold Command meetings to twice weekly and will escalate to more frequent if required. A Covid Risk Register is regularly reviewed and monitored and chairs of five equality networks attend Silver Command meetings to ensure no actions agreed in response to the pandemic disadvantage particular groups.

It is recognised that there is an element of uncertainty in regards to the cover of costs incurred due to the pandemic and therefore this is being closely monitored. From a communications point of view, the Trust has continued to engage and keep staff apprised

via a variety of channels including a weekly live staff briefing and regular email updates. The Trust also continues to encourage the reduction of all non-essential, non-clinical face to face contact by the use of digital technology (e.g. Microsoft Teams). Staff are encouraged to work from home where able and appropriate. The Trust is also regularly monitoring, considering and responding to the impact of the surge in mental health activity and the potential second wave of the pandemic and the impact on our services.

ARQ queried how the Trust was managing and supporting staff in terms of fatigue and also queried how despite the encouragement from the government for uptake of the flu vaccination, queried how the Trust is responding to reports of a shortage of vaccinations in the social care sector. SM agreed that there is a risk of staff fatigue, stating that as an organisation EPUT are encouraging staff to take breaks and annual leave. A variety of staff support mechanisms have also been implemented Trust wide to provide information and support to staff. SM continued that there is an acceptance that there is a second wave of the pandemic due to emerge, however was confident that EPUT staff would continue in their professionalism and dedication to provide the best quality care for patients. SM reiterated that EPUT will continue to support staff during this highly pressured and unprecedented time. In terms of the flu vaccination, SM advised that staff are encouraged to receive their vaccination and was assured that there was sufficient vaccinations available to staff. NH added that plans for the flu vaccination programme had changed to meet requirements in line of the Covid pandemic. A booking system was now in place in light of social distancing measures restricting the ability to hold 'walk in' clinics. NH was assured that the Trust had access to a sufficient number vaccines for EPUT staff. NH continued that the Trust would encourage staff members that would usually receive a vaccination via their GP surgery to do so as primary care have identified vaccinations for those in a vulnerable group.

MK commented that during the beginning of the Covid-19 pandemic, the Trust had been able to create inpatient capacity, however this may be challenging during a second wave. MK continued that the Trust was continuously learning from the pandemic to respond to appropriately to further developments.

The Board of Directors:

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

ii) Ligature Risk Report Q2

SM advised that this report was one of series of reports presented to the Board since EPUT was formed in 2017. SM continued that ligature risk assessment was a known risk on the BAF and mitigating ligature risks was a high priority for the Board.

SM continued that the Trust is committed to continuously improving systems and processes in terms of risk identification and management and strive to create a safer physical environment and risk aware culture. Board members are reminded that managing ligature risk associated with the physical environment must be considered in the wider context of care provision that includes staffing, security, patient risk assessment, observation and care planning.

SM confirmed that guidance for CQC inspection teams had been published and the CQC have confirmed that as part of the CQC Well Led inspection the CQC will determine the effectiveness of ligature audits and their mitigations. Work is underway to review the

EPUT position against the CQC well led criteria. A report will be presented to the Trust Board in November with an assessment against the letter and any actions that need to be taken forward. SM was confident that the Trust would remain compliant in this respect, however a report would be presented to the Trust Board to provide assurance this had been considered.

SM confirmed that the Ligature Risk Reduction Group continues to meet at least monthly to oversee a wide range of environmental patient safety improvement works identified as a risk of ligature risk assessment and setting of agreed standards by the Ligature Risk Reduction Group.

SM advised that a national patient safety alert had been received in March 2020 regarding Ligature and Ligature point risk assessment tools and policies which had included three required actions; SM confirmed that all actions had been completed.

SM also confirmed that staff training for online ligature awareness was currently reported at 94% compliance for staff working on inpatient areas. Work is also currently underway to secure ligature assessment training from an external organisation; an initial proposal has been submitted with a preliminary date for implementation of November 2020.

ML thanked SM for this comprehensive report acknowledging that to keep inpatient areas completely free of fixe point ligatures was challenging. ML wished to acknowledge the rigour shown by the Trust to address risks when identified advising that the Trust had invested over £2.4 million towards anti-ligature works, this included redesign of light fittings, toilets, shower rails and door handles as well as many other areas to address fixed ligature risks. ML commented that this was an endless process and commended the Trust on their work undertaken to date. ML queried what other steps the Trust may take suggesting the implementation of Oxehealth may provide a useful contribution. SM clarified that Oxehealth is a digital technology aid that can monitor patients whilst in their bedrooms in a non-invasive way. SM continued that this system is able to alert staff if a patient is in distress and has been piloted across four inpatient wards in the Trust. This technology is able to identify when a patient's vital signs are changing and a proposal has been submitted to expand the use of this technology across the Trust. SM confirmed that this proposal included commercially sensitive information and therefore would be discussed during the closed Part 2 Board meeting. SM continued that this technology was a less invasive way to observe patients to help keep patients safe as part of the Patient Safety Strategy. MK agreed that it was important to ensure ligature risk assessments were part of the overall safety strategy for the wards. MK continued that the Clinical Director for Psychology is currently reviewing the psychological impact and integration with OT to have a structured programme in place for patients to remain engaged and active on wards.

AS queried whether there was further information that the NEDs be sighted on to ensure they are appraised of capital investment and estates changes; SM responded that there are various channels to inform NEDs including updates at Board sub-committees, sharing of Executive Team meeting minutes at the Finance and Performance Committee. SM added that NEDs are also informed of any issues that may be identified.

AD noted ML's comments regarding work that the Trust had implemented in terms of investment to ligature mitigation, adding that the Trust also has a dedicated test area to identify issues as well as engaging with people with lived experience. SM added that training and awareness is an ongoing focus for the organisation.

SM thanked SM and the team for the fantastic job in driving forward this agenda and asked the new Executive Team to consider this and explore the use of Board development sessions and other communication channels to continue to engage and update with the Board. SS noted that this is an ongoing process and the Trust will continue to drive forward.

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

125/20 CQC UPDATE

SM presented the CQC update report which provided information and assurance on progress of actions identified from the 2019 unannounced CQC inspection of the Trust. SM continued that the report provides confirmation that the Trust are in the process of notifying the CQC of changes to Directors (changes to CFO and Executive Operating Director) and the CQC Nominated Individual (change in CEO).

SM advised that the CQC have notified organisations that they have concerns nationally around ligature management processes and will be undertaking ligature focussed inspections / reviews.

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

126/20 PHSO AND HSE STEERING GROUP

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

127/20 EPRR CORE STANDARDS

As SRO for emergency planning across the organisation, NL presented the Emergency Preparedness, Resilience and Response (EPRR) national core standards self-assessment 2020. NL advised that the Trust remains fully compliant with a total of 54 out of 54 standards applicable to mental health and community care trusts. This has also been verified by CCG colleagues who agreed with the rating of standards. The organisational rating will be submitted as part of the regional response to the national NHS England EPRR Team; this will ultimately inform assurances to central government.

SS thanked NL and team for the huge amount of work undertaken.

The Board of Directors:

1. **Noted the information contained within the report**
2. **Approved and noted the rating received from NHS England as fully compliant with all standards**

128/20 REVIEWOF SFI'S AND STANDING ORDERS

SM presented the Review of SFI and Standing Orders paper which detailed proposed changes. SM provided assurance that all proposals had been discussed at the relevant Board Sub-Committees as well as the Council of Governors meeting.

The Board of Directors:

1. **Noted the contents of the report**
2. **Approved the Standing Orders for the Board of Directors**
3. **Approved the Standing Financial Instructions**
4. **Approve the Scheme of Reservation and Delegation**

5. **Approved the Detailed Scheme of Delegation**

129/20	USE OF CORPORATE SEAL

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

- ADSI – for 12 car parking spaces that the Trust leases at Pride House – lease is for three years.
- Report on Lease – 12 Doolittle Mill

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

130/20	CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

There were no items of correspondence circulated to the Board.

131/20	NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

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

132/20	REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

AD reflected on papers received and the discussions held at today's meeting, noting the use of acronyms stating that ensure the inclusion of all of the audience members, it is important to say the full words before using acronyms.

AB noted the coproduction of the earlier presentation with a vulnerable group of patients. AB advised that people with lived experience now take part in ligature audits on wards which had proved successful. This has given a new perspective to the audit process; stating that when people are well and engaged this helps shape our services.

SS thanked the Board of Directors for their engagement at today's meeting.

133/20	CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

SS confirmed that JW had been absent for approximately one hour from 11:15. The remaining Board members confirmed that they had been present during the entirety of the meeting and heard all discussions.

134/20	ANY OTHER BUSINESS

SS referred to the recent changes within the Executive Team, noting that this was the last Board of Directors meeting for SM, MM, AB and NT.

SS thanked SM on behalf of the Board for her steadfast leadership of EPUT and its predecessor SEPT, stating that SM had exemplified an unfailing dedication to the organisation and will be greatly

missed. On behalf of the Board of Directors, SS wished SM well in her retirement. PS thanked SM for her generosity and comprehensive handover period prior to taking the reins.

SS thanked MM for his contribution to the Board, stating that he would be a huge loss to the organisation. SS wished MM well in retirement stating that his wisdom and humour would be missed. ML reinforced SS's good wishes for his retirement on behalf of the NEDs. SS was delighted to introduce TS; TS was pleased and excited to join EPUT acknowledging MM's fantastic achievements within EPUT.

SS noted that AB would also be leaving the Trust, returning to his nursing roots and passion as Chief Nurse. SS thanked AB for his longstanding leadership of operational services, stating that his insight and understanding of the environment and people we serve would be missed. On behalf of the Board, SS wished AB well in his new and exciting role. AS reiterated SS's comments stating that AB focus on quality and experience had been insightful and would be missed. AG echoed thanks and sadness at the departure of MM, SM and AB but was honoured to be part of the organisation's future as it faced the challenge and intensity of the year ahead.

Lastly, SS thanked NT for his contribution to the Board of Directors during his term of office and on behalf of the Board of Directors wished him well in the future. NT expressed his disappointment that he would not be joining the new chapter of EPUT led by PS however wished the new leadership team well.

SS bid a fond farewell to the four departing Board colleagues wishing them well in their future endeavours and noted the start of a new and exciting EPUT journey.

There was no other business.

135/20 DATE AND TIME OF NEXT MEETING

SS thanked all for joining the live broadcast.

The next meeting of the Board of Directors is to be held on Wednesday 25 November 2020, 10:30am, at the Lodge, Lodge Approach, Wickford, Essex, SS11 7XX.

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

136/20 QUESTION THE DIRECTORS SESSION

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

The meeting closed at 12:36.

Signed: …… Date: ……

Appendix 1: Governors / Public / Members Query Tracker (Item 136/20)

Governor / Member / Public	Query	Response provided by the Trust
Judith McMahon, South Essex Advocacy Services	Qualifying patients should be able to speak with IMHAs in a confidential setting. As there are ongoing situations that Pin Point alarms are not in sufficient supply, therefore not available to be given to IMHAs. This stops the meeting between the IMHS and patient taking place, especially in PICU and acute wards. This is a current issue and in settings such as Basildon. Are the Board aware of this and can it be remediated with all speed please?	AB was disappointed to hear there were not sufficient alarms and had discussed with senior management as this was an important service. AB confirmed that there are spare pinpoint alarms and have requested senior leaders ensure there is sufficient available. Should this not be the case more will be ordered. AB thanked JM for raising this important issue.

Judith McMahon, South Essex Advocacy Services	Given the Trust's mission statement, I was surprised that the Mental Health Act department at the Lodge have declined to make available the chronology or index of what and when reports et al are held/submitted to their department and filed on the patients records held with them. These requests occur in keeping with the procedure outlined if and when the client requests their IMHA to access their records. The Mental Health Act Department requires that at the time of request to access records a form is completed that requires the identification of what records and a time frame of those same reports requested be identified and submitted on their pro forma, prior to this request being processed if and as applicable. How can IMHAs identify what records the patient may wish to have accessed if there is no available knowledge for the IMHA to know what records are being held therein at the department. Is this the Trust's position on Access to Records please, as noted, as is possible in keeping with patients rights within the parameters of the Code of Practice?	All requests for Access to Patient Records are dealt with by the Access to Records Team. In terms of chronology of reports being filed on the patient's records, this is not information that the Mental Health Act Office would normally keep. It is the responsibility of the report author to upload their completed report to the electronic patient system. In regards to the form that is mentioned, this is not a Mental Health Act Office form, but a form that is required to be completed by the person requesting access and this would be sent to the recipient by the Access to Records Department. Contact has been made with JM to discuss further.
Pippa Ecclestone	Could you give an update on the progress of the building works taking place to deal with the problem of inpatient dormitory accommodation, and any information we can be given on EPUT plans concerning the Derwent Centre and the new PAH.	MM confirmed that there is a plan to open Willow Ward for patients currently on Keveldon and Cherrydown Wards to be relocated. This will then allow the conversion of these two wards to remove dormitory accommodation. In terms of PAH, the Trust are working with PAH to locate MH services on the new hospital site, however other options are also being explored should this not materialise.

Pippa Ecclestone	Is there a time limit on an event and a public enquiry?	NL confirmed that any discussion regarding a public enquiry sits with the Secretary of State for Health and this will be for the Secretary of State for Health to determine whether this enquiry is progressed. The Trust is cooperating with all parties.
John Jones	SS advised that JJ had sent a question relating to an issue regarding substantive consultants in NEE.	MK advised that despite an improved recruitment package, the Trust are struggling to attract suitable candidates to a substantive position, however MK provided assurance that the wards do receive consultant cover. MK added that the Trust has also discussed with the ARU School of Medicine how to make the position more attractive. SS added that she and PS had met with the Pro Vice Chancellor of the School of Medicine and will proceed with a joint strategic approach to drive forward in a dynamic way.
Paula Grayson	Please can Sean comment about if the service user complaints and the wise triangulation with staff survey results will be analysing the similarities and differences between different ethnicities.	The intention will be to create and intelligent data set that will cover every possible area, we have tools available to look at everything you mention above and will be doing so working with our network leads.
Paula Grayson	In positively involving the Chairs of the diversity networks with the silver command meetings, have they recommended additional risk assessments for vulnerable staff (BAME and with disabilities)?	This forms part of the risk assessment work we agreed with our BAME Network in the early days of Covid. All risk assessments for vulnerable staff are live and ongoing and a recommendation has been made that they are reviewed and updated. Line managers are aware of this. The completion of risk assessments for vulnerable groups is tightly monitored by Silver Command.

Signed: …… Date: ……

Peter Blackman, Chair of South Woodham Ferrers Health and Social Care Group	How is EPUT identifying local community groups providing health & welfare support during the pandemic to isolating people without local support networks & liaising with them as to their mental health? The brief answer at the AMM seemed to be that you are working through Essex CC and local authorities so my follow up to that is to ask how that is being done on a two-way engaging basis? It seems to us that we have had a lot of communications about mental health issues and aspects from various sources but without it seemingly being coordinated? EPUT would seem to be the expert and natural lead in Essex for this. Local community groups have proved ourselves to know our localities, people and capacities best and to be able to liaise best with local health and welfare service providers. With the pandemic continuing and winter pressures approaching what will be done to improve this now in light of the experiences of the last six months?	NL confirmed that AB/AB and NL will meet with Peter outside of the Board of Directors and update on work being undertaken and how the Trust can collaborate further.

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 30 Sept 2020)

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

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

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
September 117/20 (1)	Workforce Disability Equality Standard (WDES) Update on Action Plan to be presented to BOD in January 2021	SL	January 2021		Not due	
May 064/20 (1)	Freedom to Speak Up Report NHS England and NHS Improvement Self Review: review two actions agreed to bring the Trust into compliance with the self-review tool at a future Board Seminar Session.	SL	September	Due to time constraints (Covid-19) the report received from the National Guardian Office along with accompanying slides was circulated to the Board outside of the Seminar session . SL also discussed the report at the August People, Innovation and Transformation Committee.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
July 092/20 (1)	Review of BAF41 wording and mitigation in light of recent conversations held at F&P Committee, where challenges in delivering recurrent CIPs were discussed.	TS	September	Wording updated.	Completed	
July 094/20 (1)	Phase 3 Reset and Recovery Planning to be included on agenda for Board Development Session for discussion.	TS	September 2020	Added to the Board Seminar Agenda for November 2020	Completed	
May 068/20 (1)	Board Assurance Framework – Review BAF9 risk in light of review of data for Q1	NH	July 2020	Risk reviewed. Satisfied that progress is being made to mitigate. No Force First Assurance report provided to Board on the 29th July..	Completed	
March 026/20 (1)	Quality Health to explore lack of correlation in questions relating to staff being pleased with the quality of care they are able to provide and the Friends and Family Test responses in relation to recommending the Trust as a place to work or a place for family or friends to receive treatment.	Quality Health SL	May 20	Quality Health have provided a response which has been shared with ARQ. A further Board Seminar Session Plan on 2019 staff survey results will be scheduled as part of the Covid Recovery Plan in future months. Workforce Transformation will also assess results and set local improvement plans.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
March 026/2020 (2)	SL, ARQ and Quality Health to discuss results in further detail.	SL/ARQ	May 20	On-going discussions in July at the People, Innovation and Transformation Committee	Completed	
March 040/20	AD to check with NL whether the Covid outbreak will impact the ongoing HSE/ PHSO Investigation.	AD/NL	May 20	Our lawyers have confirmed that the Covid19 outbreak has impacted on the HSE progress with responding to the points of clarity requested by EPUT. As soon as an update is received we will reconvene the Task and Finish group and update the Board accordingly.	Completed	
January 023/20 (ii)	Provide the outcome of the deep dive referred to in performance report in respect of older people's readmissions to P. Ecclestone	MK	~~Feb20~~ ~~Mar 20~~ May 20	A higher rate of readmission in the north and west of the Trust is likely due to patients being discharged to acute hospitals and readmitted. In the South East patients are marked on leave whilst transferred to acute. MK to explore why there is not a consistent approach across the Trust. ET discussed and requested operations to agree consistent approach. SW/LW agreed practice should be standardised based on current approach in north Essex.	Completed	

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

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

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

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

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 November 2020**

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The report attached provides information in respect of:

- Coronavirus / Covid-19
- Service Visits
- HSE Prosecution
- Covid-19 Vaccination Programme
- New Staff Recognition Award
- Veteran Aware Accreditation

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

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Professor Sheila Salmon **Chair**

Agenda Item: 5
Board of Directors
25 November 2020

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Coronavirus / Covid-19

The situation regarding the Covid-19 pandemic continues to change rapidly, with infection rates rising on a national scale and tightened control measures. The Trust has put in place the necessary provisions to protect patients and staff in this regard. Nationally, the guidance for healthcare staff is being updated frequently as the situation develops further. The Trust is fully engaged with system, regional and national planning to respond to this situation. The Non-Executive Directors and I have been kept fully briefed during this extraordinary time by the Chief Executive and Executive Team. I and the Board wish to extend our thanks to our dedicated staff who have continued tirelessly and with exemplary resolve to provide services to our patients and service users in light of tremendous challenges and uncertainty.

2.2 Chair and NED Service Visits

Due to the ongoing Covid-19 Pandemic and the enforced lockdown by Government, in order to compress the risks associated with cross infection and to protect patients and staff, the Board of Directors took the decision to cancel all non-essential service visits, which will be restored at the earliest safe opportunity. I am working proactively with the new COO to reinstate NED/Governor connection with our services and staff.

2.3 HSE Prosecution

As Board members are aware, the HSE had indicated their intention to prosecute the Trust as EPUT were considered to be in breach of the Health and Safety at Work Act 1974 due to historic failings to control ligature risks by the former NEP. Legal proceedings in this prosecution process began on 12 November with Paul Scott and Nigel Leonard in attendance on behalf of the Trust. Safety remains a priority for the Trust, with a significant programme of work and tremendous investment to address these failings since its inception in 2017. Board members and Governors will be kept fully appraised going forward.

2.4 Covid-19 Vaccination Programme

EPUT has been appointed one of the three lead providers in the East of England region for the Covid-19 vaccination programme. We will be responsible for delivering the vaccine in two integrated system areas: Mid and South Essex Health and Care Partnership and Suffolk and North East Essex ICS. As vaccine manufacture and delivery plans are still in their early stages, there are no set dates when vaccines will be able to be delivered, but the NHS and EPUT are getting prepared. It is a privilege for EPUT to be chosen for this as well as a huge undertaking and we look forward to sharing updates as preparations get underway.

2.5 New Staff Recognition Awards

I am delighted that a new Staff Recognition Scheme is now open for nominations. Staff are able to nominate colleagues for an award in one of five categories:

- Hero Award – Beyond the Call of Duty

- Peer to Peer Recognition Award
- Team Recognition Award
- Leadership Award
- Research, Innovation and Improvement Award

Patients, Carers and colleagues in partner organisations are all also able to nominate EPUT staff that have gone above and beyond.

2.6 Veteran Aware Accreditation

I am very proud that EPUT has been accredited as a 'Veteran Aware' trust. Veteran Aware trusts lead the way in improving veterans' care within the NHS as part of the Veterans Covenant Healthcare Alliance. Congratulations to our veterans Transition Intervention and Liaison Service (TILS) and to everyone involved in supporting veterans and their families.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

- **'Decision Making and Consent': New Guidance is Published by the General Medical Council -** Please see the link below for a copy of the new guidance which came into effect on 9 November 2020. **For Information: Link**

- **Inquiry Into The Support Available For Young People Who Self-Harm -** The report was carried out by a panel consisting of members of the house of commons and the house of lords and relates to the support available for young people who self-harm. Please see the link below. **For Information: Link**

- **Pushed From Pillar To Post: Improving The Availability And Quality Of Support After Self-Harm In England -** Please see the link below to the report which identifies the needs of people who self-harm. **For Information: Link**

- **Claimant Found Guilty of Criminal Act Cannot Claim Damages Against Negligent NHS Trust -** Please see the link below for a copy the Supreme Court Judgment in the case of Ecila Henderson v Dorset Healthcare University NHS Foundation Trust. **For Information: Link**

- **New Framework Launched To Strengthen Mental Health Support Services -** A new guidance was published on 30 October 2020 to assist the quality of mental health support services. Please see the link below which outlines the services and contains the Competence Framework for Mental Health Peer Support Workers. **For Information: Link**

- **NHS Encourages Children and Young People to Seek Help As new Data Shows Rise in Mental Health Problems -** Please see below a link to the follow up report for Mental Health and Young People Survey which was published in 2017. The new report shows the changes since then to July 2020. **For Information: Link; Link; Link**

- **Percentage of Adults in Contact With Secondary Mental Health Services in Employment -** Please see below the link for the publication dated 22 October 2020. The information is based on data for the time period of June 2016 onwards. **For Information: Link**

- **New Figures On Detentions Under The Mental Health Act In 2019-20 Published Today -** Please see the link below for a copy of the report which was published on 27

October 2020 which is entitled Mental Health Act Statistics 2019-2020. **For Information: Link; Link**

4.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

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

On behalf of
Professor Sheila Salmon
Chair

		Agenda Item No: 6
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 November 2020**

Report Title:	**Chief Executive Report**					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive					
Report Author(s):	Paul Scott, Chief Executive					
Report discussed previously at:	n/a					
Level of Assurance:	**Level 1**		**Level 2**	**x**	**Level 3**	

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The report attached provides information in respect of:

- Covid-19
- Health and Safety Executive Prosecution and Safety
- Performance
- Strategic Developments

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

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

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

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

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

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

Supporting Documents and/or Further Reading

Lead
Paul Scott **Chief Executive**

CEO Report – November 2020

1.0 Introduction

This is my first report to the Board since taking over as CEO on the 24th September. I am very grateful for the warmth of the welcome I have received from staff, patients and stakeholders. I have visited, or met staff from, a large number of our services (Appendix A sets out the full list) with more visits scheduled. The passion and compassion of our staff comes through in every interaction I have had. Staff have been able to describe their services, both the things they are proud of and the things they find challenging, very clearly.

Stakeholders are very supportive of EPUT, recognising the efforts that have gone in to a successful merger whilst also mindful of the ongoing challenges. Without exception, stakeholders want to see an EPUT that builds on its start and flourishes as a key organisation in our local health and care systems as the push for increased integration gathers pace.

I will prepare this report for each Public Board meeting where I will highlight the key issues, update on operational performance and set out key strategic developments.

2.0 Key Issues

COVID-19

Clearly COVID-19 has been a very challenging time for all involved in health and care, and this comes on top of the challenges from restrictions required in everyday life. At the time of writing the East of England was seeing a fast rise in the number of cases and a number of our colleagues in Hospital Trusts were seeing a large rise in the number of beds occupied by those suffering from COVID-19. We will do all we can to support them, and are grateful for their efforts, as we enter a very difficult winter period.

Non hospital services such as Mental Health, Community Services, Care Homes and Primary Care also experience pressures from COVID-19 and we continue to work to support each other. EPUT has seen increased demand across our services and I would like to extend my huge thanks to all EPUT staff who have continued to be there for our patients despite the pressures. Our sickness levels are amongst the lowest they have been at this time of year.

We are pleased that our cases amongst our patients and staff remain low – in no small part due to the professionalism of our teams with respect to infection control. Nonetheless, we are ramping up our preparations as the second wave is upon us.

I am very proud that EPUT has been selected to be the lead provider for the delivery of a COVID-19 vaccination to the general population in Mid and South Essex, North East Essex and Suffolk. When the vaccine is available, we will use our expertise in vaccine delivery to make the vaccine available to the maximum amount of people.

This is a significant undertaking and we will need the help of our partners and staff to deliver the vaccination programme. We will also need to recruit a new workforce that doesn't currently exist. Adverts are prominent in the local community so please join us if you can!

Health and Safety Executive Prosecution and Safety

EPUT is being prosecuted for one charge under section 3(1) of the Health and Safety at Work Act 1974; this follows the HSE investigation of how EPUT's predecessor, North Essex Partnership Trust (NEP), managed environmental risks from fixed potential ligature points in its inpatient wards between 25 October 2004 and 31 March 2015. On 12th November we

pleaded guilty to these charges and we expect to appear in the Crown Court in the new calendar year.

Safety is our absolute priority and since joining EPUT I have asked to see updates on progress to improve the safety on our wards. Whilst I am satisfied that improvements have been made, there remains ambition to keep improving our safety. I am pleased that a draft interim inpatient safety strategy has been prepared that sets out our next steps and ambitions. We will be engaging on this strategy in December and January, please look out for it and we encourage your feedback.

3.0 Performance

Safety and Quality

Safety and Quality in our services continues to be our priority. Delivering safe care and meeting patient's treatment requirements in order to improve health outcomes is our focus. We continue to drive these priorities through the Quality Committee and many sub-groups. We continue to report over 95% harm free care across the organisation and ensure engagement with our service users and community so we learn to improve.

Our Trust ambition for an ongoing reduction in grade 3 and 4 pressure ulcers remains on track with a sustained reduction for 7 months in a row. EPUT is currently projected to have a 15% reduction at year end for 20/21 compared to a 6% reduction in 19/20. IN October we reported an all-time low across the last 24 months in prone restraints.

Operational Performance

Our operational performance has remained consistent during the last month and we are developing conversations with our leadership teams around our performance and how it supports the safety and quality imperative and improved experience and outcomes for our patients.

In October we achieved 23 key performance indicators within target, 13 which require improvement and 2 areas of inadequate performance, including mandatory training and admissions to our adult facilities of young people under the age of 16. We are reviewing the history of admissions for our under 16 year olds to support wider system and regional conversations to find alternative solutions.

With a focus on patient safety, we are also reviewing our waiting times, including those for psychology services and IAPT and will also be undertaking a deep dive into the timeliness and accuracy of record keeping which we anticipate will generate an improved position on a number of KPI's which require improvement.

We have a robust inpatient mental health flow and capacity plan in place which strengthens our internal escalation processes, developing bids for winter funding which include building more community capacity and working with harder to reach groups and securing additional inpatient capacity to ease the increased demands associated with COVID-19.

We are currently working on our staffing establishments and particularly in our inpatient areas to reduce wherever possible high levels of Bank staff usage.

People

Recruitment Highlights

- Recruited 107 newly qualified nurses this year, an increase of over 60% on last year
- Increased our bank by 700 staff to support Covid since March
- Vacancy rate is down to 9.3% target 12%
- Launched internal transfer scheme in September where nurses can apply to transfer to a different ward to increase knowledge and experience

- Increased usage of social media and paid campaigns to support with recruitment attraction
- 1500 declarations of interest received in relation to CoVac advertising

Learning and Development

- We have expanded student capacity to 320 new students which is significantly higher than previous years
- We have been approved as a training provider of Clinical associate phycology apprentices
- Talent management lounges delivered for administration and clinical staff supporting staff to achieve their maximum potential
- Talent conversations have been rolled out since Augusts 2020. Training is being delivered and talent conversations are being woven into training and team sessions.
- A new appraisal process will be introduced in December that encourages conversations around the individuals performance, learning needs and commitment to safety objectives, this includes a self-development rating to inform our Talent process.
- Mandatory training sessions have been expanded to evenings and weekends to support the backlog, the rostering of training has commenced to support the planning.

Staff Engagement

- BE YOU campaign bringing all staff groups and differences together with a shared sense of identity. Dedicated intranet page.
- Staff Survey is at 44% with another two weeks to run (one of the highest response rates in the region)
- 450 Staff Engagement Champions Network engaging with Senior Leaders through events and mission challenges
- The Grill has been introduced creating a forum for engagement champions to have direct access to Executives and Board members to air challenges and frustration

Finance

The Trust continues to operate within the adapted financial regime for the year, this includes national income allocations for month 7 to 12. The allocations are subject to current discussions between the Trust and our Regional and National Finance colleagues.

Having successfully secured additional funds to eliminate mental health dormitories the Trust's Capital programme has significantly increased this year to £17.3m. The Trust is currently mobilising a significant number of schemes to make sure the resources are fully utilised; this represents a significant investment and spend in the latter part of this financial year.

The Trust has made good progress in reducing its historic reliance on agency staffing, however overall temporary staffing costs for the month of £4.3m including Bank usage remain significant.

4.0 Strategic Developments

Over the coming months I will review and refresh the Trust's strategy and strategic plan. In the interim we are working on 3 strategic priorities:

Safety

I am pleased that a draft safety strategy has been prepared by our Director of Nursing. This sets out that safety is our number one priority. It also sets out what we want to achieve in the next 6 months as well as at the end of the strategic period. We will be engaging fully on the content of this strategy in December and January. Please feedback to us – your views are critical.

We are not waiting for the strategy to improve safety and that is why we have approved a significant investment into ground breaking technology as part of our programme to continuously improve patient safety. This technology, produced by a company called Oxehealth, will automate the monitoring of the vital signs of our patients and alert nurses if these deteriorate. This mirrors the safety systems used in hospitals with the added benefit that patients are not attached to the equipment and are free to move around. This technology has been made available to the Trust through innovation surfaced at our clinically led "EPUT Lab" forum where new ideas and solutions are discussed and implemented in conjunction with R&D expertise and small and medium enterprises.
Oxevision technology has so far been installed in 4 wards as part of a pilot project. The second phase of the rollout to install Oxevision in 13 ward areas has commenced. An Oxehealth Project Board with executive oversight will ensure that this initiative is delivered at pace with an ambition to complete the programme of installation within this financial year. The outcomes will measured both qualitatively and quantitatively and include early detection and reduction of incidents and their severity, improved privacy and dignity, improved staff experience and releasing clinical time to care.

We also continue to invest in the safety of our physical environment. As well as ensuring the ward environment continues to be enhanced we have two major projects in place to deliver substantial improvements to our wards. The first is the replacement of dormitories on our Basildon Hospital site with single rooms. The second is the creation of a new ward in the Crystal Centre on the Broomfield Hospital site. We anticipate that both major projects will be completed by the end of the financial year bringing significant improvement to the safety of our accommodation for our patients and staff.

Partnerships

As our name suggests, partnerships are critical to the future of our mental health and community services. We have renewed our leadership in the three STP/ICS Boards that we sit on. It is important we represent the voice of community and mental health services at these forums and bring new ideas for improvement across the whole health and care spectrum.

We are also involved in discussions in three areas to develop provider partnerships. All have the focus on improving services and reducing unwarranted variation:

a) The Community Services Partnership in Mid and South Essex seeks to ensure a consistent protocol as patients move between with the three hospitals managed by the MSE Group and community physical health services. The partnership with Provide and North East London Foundation Trust will improve the experience for patients and healthcare professionals using our services. In order to aid the improvements the partnership will be advertising for a Director of Transformation.
b) In north east Essex we are discussing with alliance partners an innovative new partnership to provide community services in this area. We hope to think very differently so that we can deliver the best possible service for the populations in that area.
c) Our specialist Mental Health services are forming a partnership across the East of England to harness the expertise in each of the Mental Health Trusts to improve and standardise care across the geography. We hope to formalise this agreement in the new calendar year.

We will continue to seek new partnerships that bring benefit to our patients and population. One key partnership is with patients and carers. We know we can do better in co-designing services with them and we will be seeking views on how to do this in the near future.

Supporting Economic Recovery Post Covid-19

We know that the Covid-19 has had a devastating impact on the local economy. We know that employment, housing and education are key determinants of health. We are the only pan Essex (and beyond) healthcare organisation and we have the ability, and the

responsibility, to use this status to support the recovery of the Essex economy. We will be seeking new partnerships with employers, educational facilities, housing associations and other public sector organisations to encourage innovation and investment to support our population in the future.

We have more to do to explore the possibilities in this area and we are keen to build a dialogue with local communities and organisations about how we can best make an impact and support others.

Appendix A

Service Visits by Chief Executive Paul Scott

25 August	• Rainbow Unit • Edward House
26 August	• FRT • Essex Perinatal MH Team • Beech Ward • Beech Health based Place of Safety • ESTEP Early Intervention
27 August	Basildon MHU • CRHTT • Mental Health Liaison Team – Basildon West • Basildon Assessment Unit • Thorpe, Grangewaters, Hadleigh Sankey House • Basildon Older Adult CMHT • Immunisation Nurses • Eating Disorders • Crisis 24/7 111 Service
28 August	Latton Bush Centre • Community Matrons • Life Limiting Conditions • Respiratory Team • Cardiac Team
02 September	• Wood Lea Clinic • Robin Pinto
03 September	• St Aubyn Centre
07 September	• North East STaRS, • Marginalised Vulnerable Adults (MVA) • Special Allocation Service (SAS)
10 September	• Senior Leaders • Modern Matrons / DNs / HCAs • SWIFT • UCRT • Community Discharge Team • Care Coordination • Podiatry • Podiatric Surgery
11 September	Derwent Centre • Adult Inpatient Services • Urgent Care Pathway including Crisis 24/7, Home First and A&E Liaison St Margaret's Hospital • Older Adult Inpatient Services • Community MH Services
14 September	• Immunisations (visited Team whilst delivering immunisations to school age children)
16 September	• Linden Centre The Lakes • Urgent Care Pathway incl Crisis 247, Home First and A&E Liaison • Adult Inpatient Services • Dementia Services

17 September	Unit 8 • Community OT • Wheelchair Service • Adult Continence • Adult S&LT • Wound Care
02 October	The Lakes
02 October	Thurrock Hospital • Finance • Human Resources
05 October	• Essex STaRS, Chelmsford Team
07 October	• C&E Centre • Crystal Centre • Linden Centre
12 October	• Independent Living Centre
16 October	• Poplar Ward, Rochford
19 October	• Psychology Heads of Services (via Teams)
05 November	• Family Group Conference Team (via Teams)

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 November 2020**

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

Purpose of the Report

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

Performance Reporting

This report presents the Board of Directors with a summary of performance for month 7 (October 2020).

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

Key matters discussed at the Committee included issues with CPA 12 month reviews, mental health in-patient capacity, admissions to mental health facilities, in particular for under 16s and also mandatory training. The Committee also discussed waiting lists and waiting times, including psychology services.

In October 2020 there were 23 Indicators reported within target (24 in September) whilst a number of areas have been identified for further review and improvement. These areas included temporary staffing utilisation levels, data quality/documentation compliance and the staff survey.

On financial matters the consequences of the adapted financial regime were reported and considered along with the significant increase in the level of capital resources available to the Trust, now totalling £17.3m. This follows national approval of the bid to eliminate mental health dormitories. The updated capital programme was discussed by the Committee following Executive Team agreement and is attached as an appendix for approval by the Board.

There are no inadequate indicators which are Oversight Framework indicators for October

Summary of Key Issues
2020. There are no inadequate indicators in the EPUT Safer Staffing Dashboard for October 2020. This CQC Reset action plan is summarised in the CQC Scorecard. The plan has now been completed with all actions having been met; the final actions were marked as complete at the Executive Steering Group on the 25th September. A new action plan will be developed following the conclusion of the next CQC inspection. One unannounced inspection was undertaken in October with feedback received in November. In October 2020 there are two inadequate indicators identified within the Finance scorecard; • Cost improvement Programmes • Capital Expenditure (CDEL) Where performance is under target, action is being taken and is being overseen and monitored by standing committees of the Board of Directors.

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

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

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

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

Acronyms/Terms Used in the Report			
ALOS	Average Length Of Stay	FRT	First Response Team
AWoL	Absent without Leave	FTE	Full Time Equivalent
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies
CHS	Community Health Services	MHSDS	Mental Health Services Data Set
CPA	Care Programme Approach	NHSI	NHS improvement
CQC	Care Quality Commission	OBD	Occupied Bed days
CRHT	Crisis Resolution Home Treatment Team	OT	Outturn
CWP	Connecting with People	YTD	Year To Date
EIP	Early Intervention in Psychosis	PHSO	Public Health Service Ombudsman
FEP	First Episode of Psychosis	PICU	Psychiatric Intensive Care Unit
FFT	Friends and Family Test	RAG	Red-Amber-Green
RWB	Recovery & Well-Being Team	RTT	Referral to Treatment
RD	Recovery Date		

Supporting Documents and/or Further Reading
Board Integrated Quality & Performance report

Lead
Name Paul Scott **Job Title** Chief Executive

NHS
Essex Partnership University
NHS Foundation Trust

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

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

Report Guide

Use of Hyperlinks

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

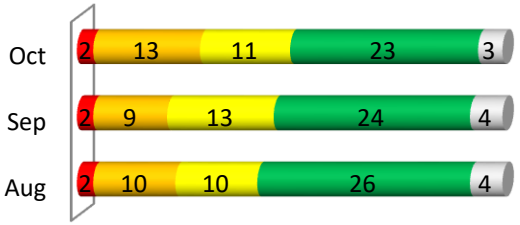
How is data presented?

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

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

SECTION 1 - Performance Summary

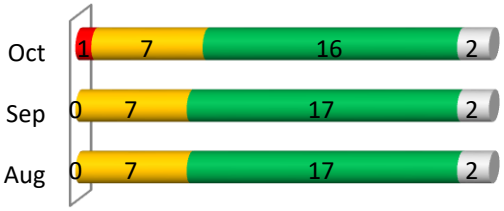
Summary of Inadequate Quality and Performance Indicators (Pg 6)



October Inadequate Performance

- 1.15 Admissions to Adult Facilities of under 16's
- 5.4 Mandatory Training

Summary of Oversight Framework Indicators (Pg 9)



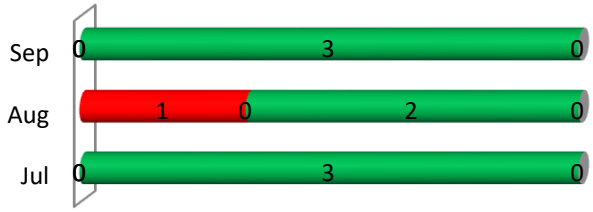
October Inadequate Performance

- 1.15 Admissions to Adult Facilities of under 16's

Summary of Safer Staffing Indicators (Pg 19)

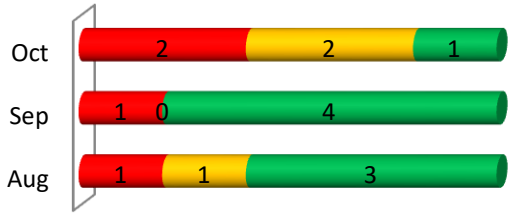
No risks identified within the Safer Staffing section.

CQC Summary (Pg 21)



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

Finance Summary (Pg 23)



October Inadequate Performance

- Cost improvement Programmes
- Capital Expenditure (CDEL)

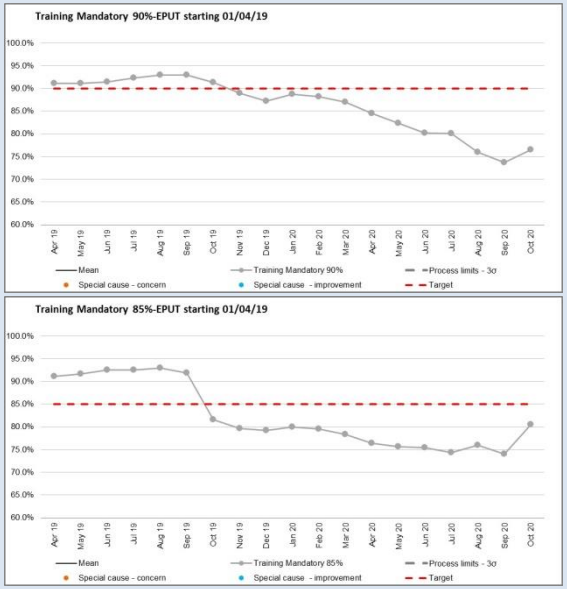
SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

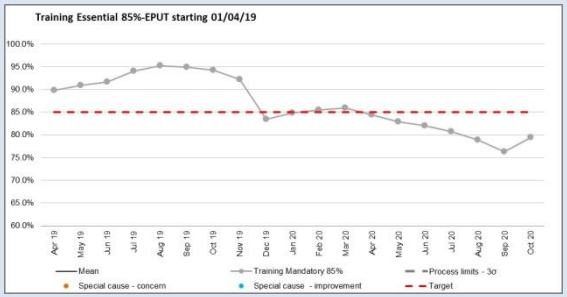
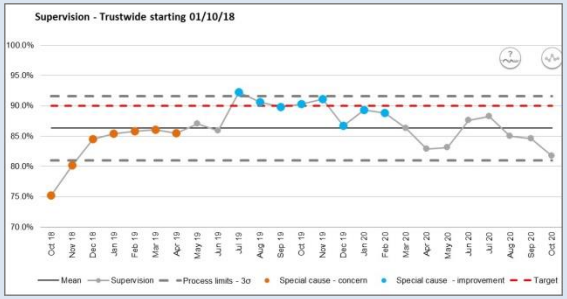
Click here to return to Summary

For Note:

- MH Serious Incidents: In October there were 9 Mental Health serious incidents within the Trust, this represents a small increase from our position in September and overall EPUT is continuing to see a reducing trend.
- CHS Serious Incidents: Zero Community Health serious incidents were reported in October and year to date.

Safe Indicators							
RAG	**Ambition / Indicator**	**Position M7**		**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**	**Inadequate** Any admissions of under 16's is reported to the CQC. ET have requested a piece of work to look at the history of admissions for under 16's required to support discussions with the Mental Health Partnership Board about the system looking at a solution to address the issues that lead to our organisation having to accept under 16's whilst appropriate care/beds is being sourced.						
	0 admissions to adult facilities of patients under 16	1	●	One admissions in October and YTD.	●	Patient registered with NHS East & North Hertfordshire CCG admitted to Stort. Admitted due to no available CAMHS beds, patient remained on the HBPoS on Stort, necessary documentation was completed and CQC were notified.	N/A

Well-Led Indicators							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.4 Training, Supervision and Appraisal Committee: FPC Indicator: Oversight Framework Data Quality RAG: TBC	**Inadequate** EPUT has now begun to encourage completion and compliance with these targets in preparation for them being reinstated. Gold Command monitor uptake weekly and have requested that there is a deep dive on the training that supports the patient safety strategy to ensure compliance in these areas is addressed. From October EPUT has now implemented a new training tracker system that streamlines the previous process. This migration to a new system has resulted in an improved quality of data which has been reflected in this months figures. Whilst this is a great improvement and the new system is working well there are still some changes to be made within reporting processes and this work remains ongoing. EPUT continues to operate with extended periods for training; all courses other than those that are statutory or high risk (Fire, Food Hygiene, Infection Prevention, Information Governance) have had the update period extended by 1 year. Face to face training was previously suspended however most courses have now returned to usual delivery in covid secure environments although spaces are limited within each course to allow appropriate distancing. Primary focus is currently on new recruits to the Trust however arrangements will be made for this groups who are now coming out of compliance. Appraisal deadlines have also been extended to 18 months from the original 12 month timescale.						
	5.4.1 % Staff Training – Mandatory Courses **Target 90%** **Target 85%**	76.5% 80.5%		Above Target = Good 		Mandatory Training is continuing to fall below target. Face to face training has commenced however with limited spaces per course.	

Well-Led Indicators							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	5.4.2 % Staff Training – Essential **Target 85%**	79.4%		Above Target = Good 			
	5.4.3 % Staff Supervision **Target 90%**	81.7%		Above Target = Good 		Common Cause – no significant change Variation indicates inconsistently hitting and passing and falling short of the target	

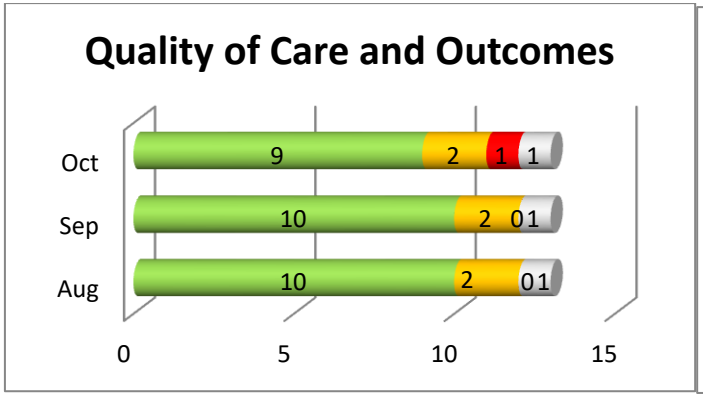
[Click here to return to Summary]

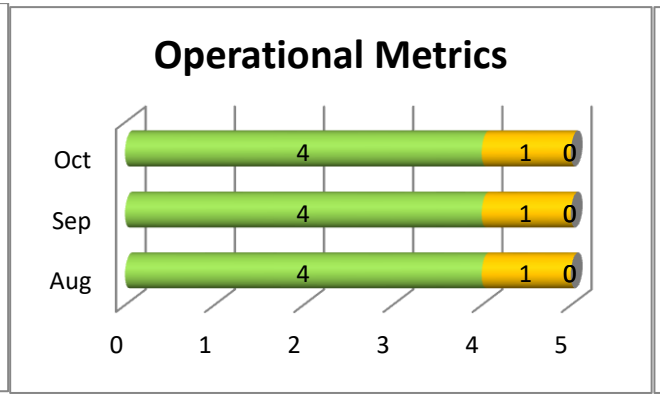
SECTION 3 – Oversight Framework

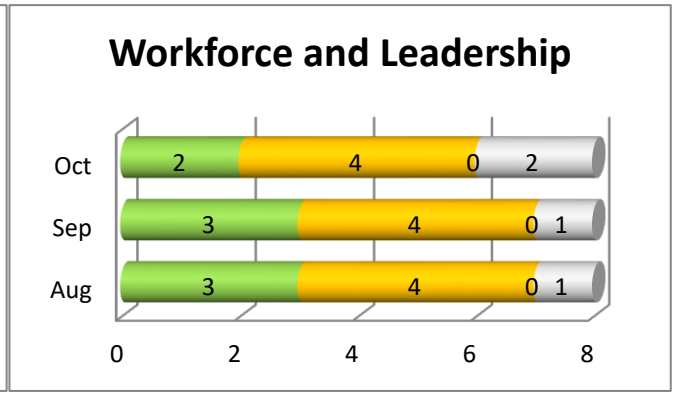
Click here to return to Summary

Summary

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





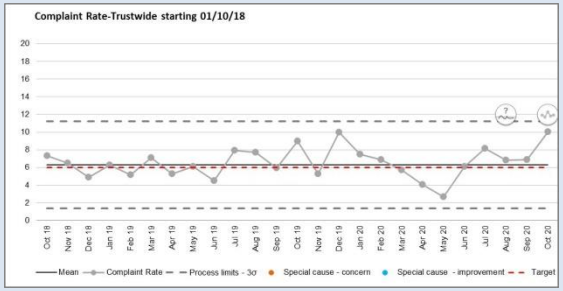


Inadequate

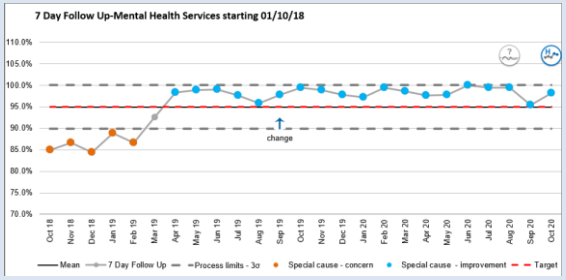
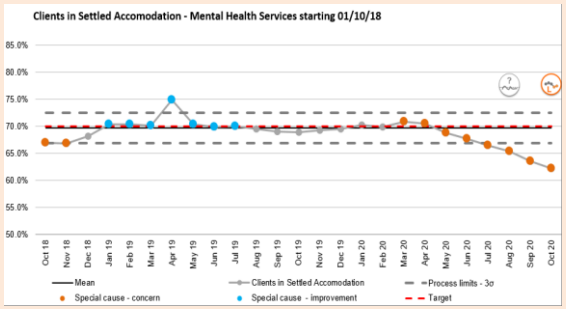
- Admissions to Adult Facilities of under 16's

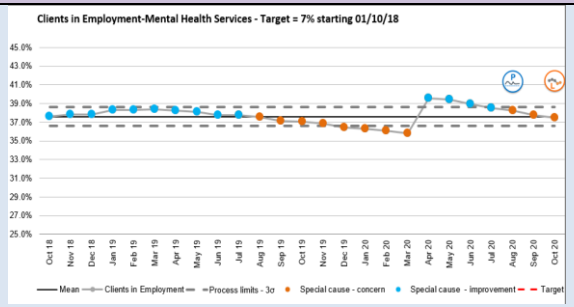
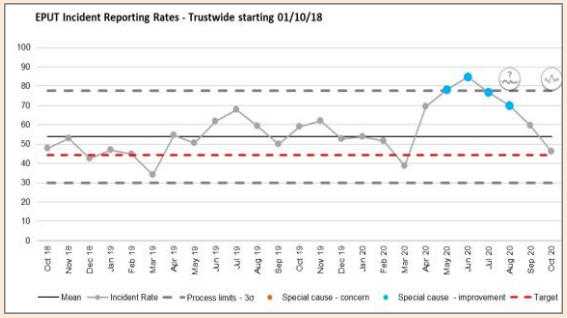
Requires Improvement

- Complaint Rate
- Clients in Settled Accommodation
- Out of Area Placements
- Staff Survey indicators (4 indicators)

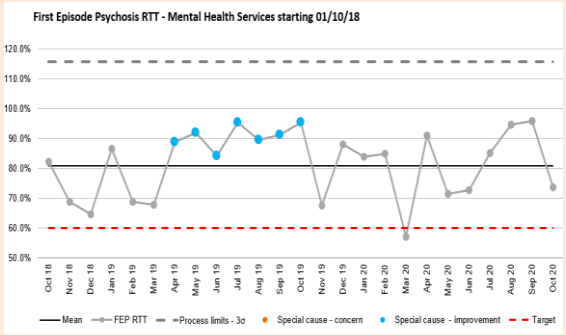
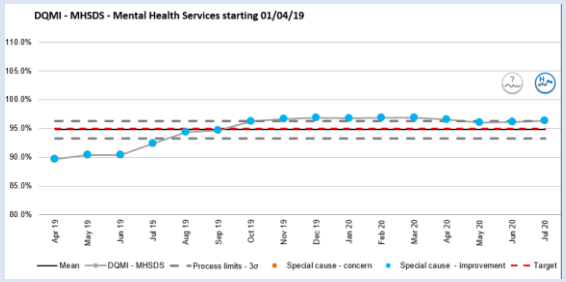
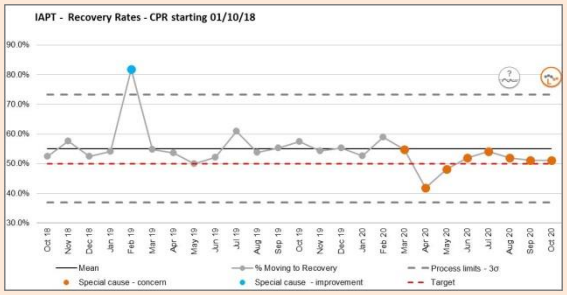
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1 CQC Rating Committee: FPC Data Quality RAG: **Green**	CQC rating of Good or above (no target set)	Good	●	CQC Unannounced Inspection (July – August 2019)			N/A
4.1 Complaints Committee: FPC Data Quality RAG: **Green**	4.1.1 Complaint Rate **OF Target TBC** Locally defined target rate of 6 each month	10.04	●	Below Target = Good 	●	Performance remains inconsistent	N/A
5.6 Staff FFT Committee: FPC Data Quality RAG: **Green**	Staff Friends and Family Test % recommended – care (extremely likely or likely to recommend) **Target 74%**		●		●	Indicator suspended nationally over Covid period	N/A
1.1 Never Event Committee: Quality Indicator: Oversight	0 Never Events 2019/20 Outturn 0	0	●	Year to Date 0	●	Monitored over six-month rolling period	N/A

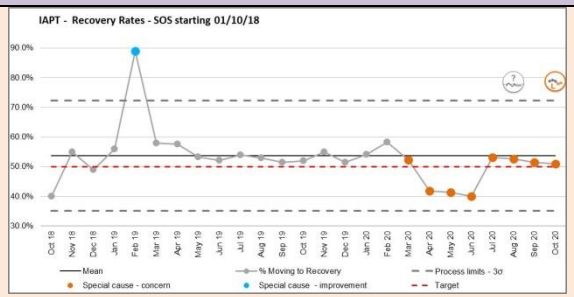
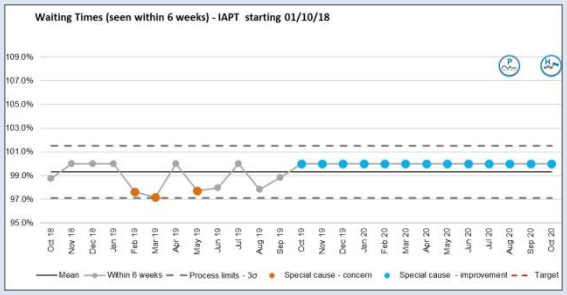
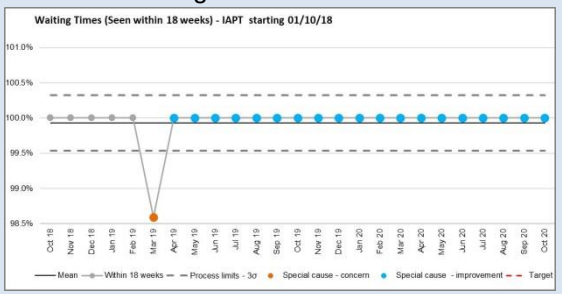
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Framework Data Quality RAG: **Blue**							
1.6 Safety Alerts Committee: Quality Indicator: OF Data Quality RAG: **Green**	There will be 0 Safety Alert breaches **2019/20 Outturn 0**	0	●	Year to date there have been no CAS safety alerts incomplete by deadline.	●		N/A
3.1 Patient MH Survey Committee: Quality Data Quality RAG: **Green**	Positive Results from CQC MH Patient Survey		●	EPUT achieved the same or better in all 11 domains in the 2019 survey	●		N/A
3.3.1 Patient FFT MH Committee: Quality Data Quality RAG:	Mental health scores from Friends and Family Test – % positive (extremely likely or likely to recommend) **Target = 88.3%**	90.0%	●	NHS England have confirmed that Data collection for the Friends and Family Test (FFT) will resume from December 2020. Since April 2020 all forms were updated to ask a new mandatory standard question "Overall, how was your experience of our service". From December 2020 any old forms submitted will be disregarded. New forms can be obtained from the Patient Experience Team.	●	Very low number of responses for October. 10 total for MH 1 rated as Neither Good nor Poor.	N/A

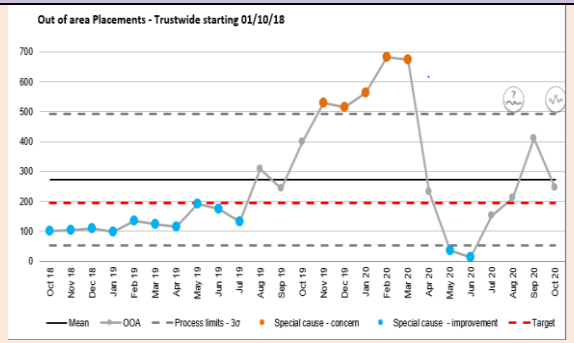
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Green							
3.3.2 Patient FFT CHS Committee: Quality Data Quality RAG: **Green**	Community scores from Friends and Family Test – % positive (extremely likely or likely to recommend) **Target = 96%**	100%	●		●	Very low number of responses for September. 4 total for CHS	N/A
2.8.1 7 Day Follow Up Committee: Quality Data Quality RAG: **Blue**	95% of people on Care programme approach (CPA) are followed up within 7 days of discharge from hospital **Target 95%**	98.2%	●	Below Target = Good 	●	Special Cause of improving nature due to (H)igher values. Discharge follow up forms part of EPUT's "10 ways to improve safety" initiative.	N/A
2.4 Settled Accomodation Committee: Quality Data Quality RAG: **Green**	% clients in settled accommodation (no target set) **LA Target 70%**	62.2%	●	Trend above Target = Good 	●	Reduction in Paris data noted (62.2% in October) Special cause of concern due to seven months of decline.	N/A
2.5 Employment	% clients in employment (no target set)	37.5%	●	Trend above Target = Good	●	Assurance indicates consistently Passing target.	N/A

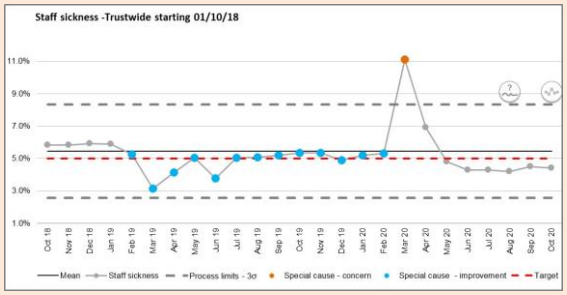
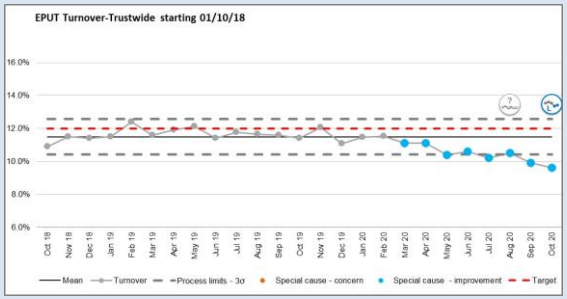
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Data Quality RAG: **Green**	**LA Target 7%**					Decline in performance noted	
Committee: Quality Data Quality RAG: **Amber**	**1.8 Patient Safety Incidents** Potential under-reporting of patient safety incidents **Target >44.33**	46.1	●	Trend above Target = Good 	●	No significant trend noted however performance is inconsistent.	N/A
Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	**1.15 Under 16 Admissions** 0 admissions to adult facilities of patients under 16	1	●	One admissions in October and YTD.	●	Patient registered with NHS East & North Hertfordshire CCG admitted to Stort Admitted due to no available CAMHS beds, patient remained on the HBPoS on Stort, necessary documentation was completed and CQC were notified.	N/A

Click here to return to Summary

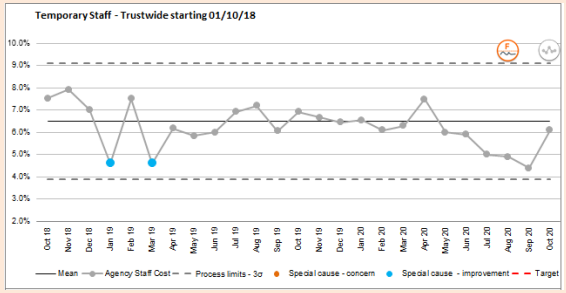
Operational Metrics							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.6 First Episode Psychosis Committee: Quality Data Quality RAG: **Green**	All Patients with F.E.P begin treatment with a NICE recommended package of care within 2 weeks of referral **Target 60%**	73.7%	●	Trend above Target = Good 	●	Target change effective April 20 (from 56% to 60%) October performance represents: 14 / 19 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%**	96.3%	●	Trend above target = good 	●	Latest published figures are for July 20	N/A
2.16.3/4 IAPT Recovery Rates Committee: FPC Data Quality RAG: **Green**	Improving Access to Psychological Therapies (IAPT) /talking therapies 50% of people completing treatment who move to recovery **Target 50%**	CPR 51.2%	●	Trend above target = Good 	●	In April the IAPT service saw a higher than usual rate of self-discharges mid therapy. This was due to patient concerns around Covid-19.	
		SOS 51.0%	●	Trend above target = Good	●	The IAPT service for Southend saw a higher than usual and more sustained rate of self-discharges mid therapy (Apr-Jun). This was due to patient concerns around Covid-19.	

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
							
2.16.5/6 IAPT Waiting Times Committee: FPC Data Quality RAG: **Green**	Improving Access to Psychological Therapies (IAPT)/talking therapies b. waiting time to begin treatment: i) 75% within 6 weeks ii) 95% within 18 weeks	i) 100%	●	Trend above target = Good 	●	Consistently passing target	N/A
		ii) 100%	●	Trend above target = Good 	●		
4.5 Out of Area Placements Committee: FPC	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by 2021**	247	●	Below Target = Good	●	Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. In October EPUT placed 12 new clients out of Area (11 Adult & one PICU), 11 remain (11 Adult) OOA at the end of October. 14 patients were repatriated in October (12 Adult & two PICU). The total Occupied bed days for all out of	N/A

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: Amber						area placements in October was 247. OAP's for locked Rehab patients have been excluded (2 patients) as EPUT do not provide these bed types, therefore these would need to be placed out of area, this was discussed and agreed at ET in July 2020.	

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3.1 Staff Sickness Committee: FPC Data Quality RAG: TBC	Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**	Sep 4.5% Oct Draft 4.4%		Below Target = Good 		*Please note sickness is reported in arrears to allow entry in to ESR.	N/A
5.2.2 Turnover Committee: FPC Data Quality RAG: TBC	Staff Turnover (Benchmark 2017/18 MH 12% / CHS 12.1%) **OF Target TBC** **Target <12%**	9.6%		Below Target = Good 		Special Cause of improving nature of lower pressure due to (L)ower values. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.	N/A

<table>
<tr><th colspan="7">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M7
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td>5.7.3 Temporary Staff

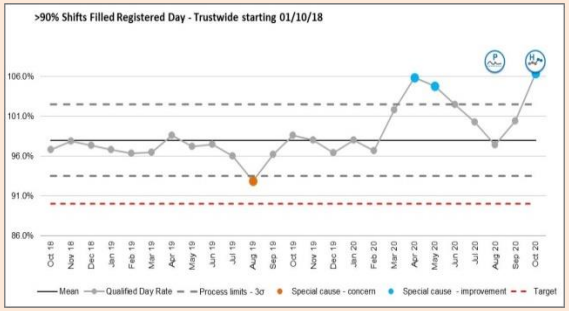
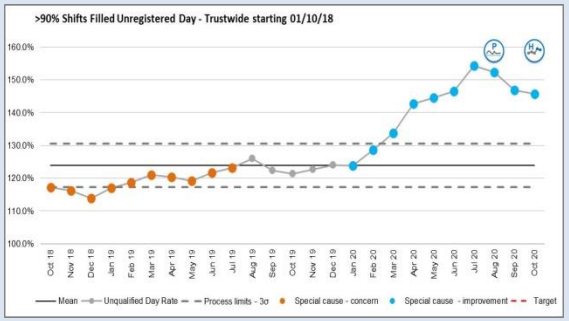
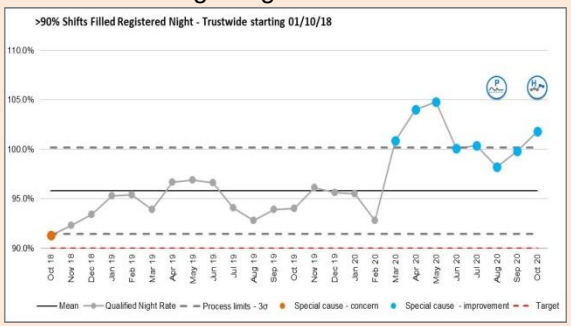
Committee: FPC
Data Quality RAG: TBC</td><td>Proportion of temporary Staff (Provider Return)
OF Target TBC</td><td>6.1%</td><td>●</td><td>Below Target = Good
 
</td><td>N/A</td><td>Increase in temp staff usage in October however this brings performance back in line with average and pre-covid levels.</td><td>N/A</td></tr>
<tr><td rowspan="2">5.5 Staff Survey

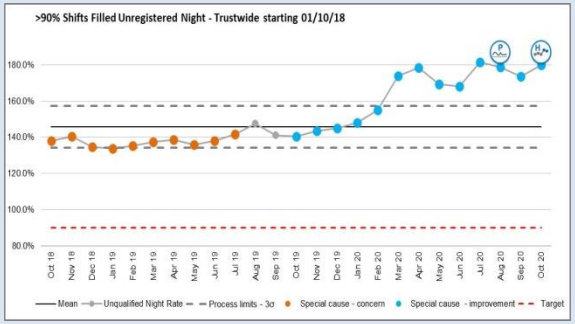
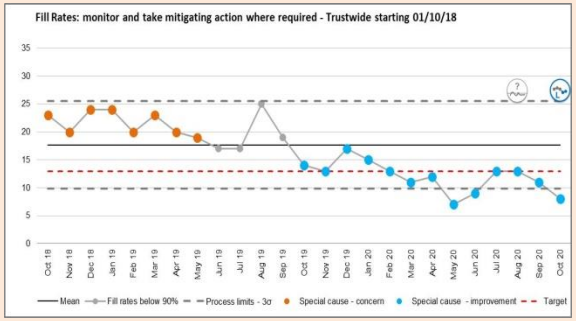
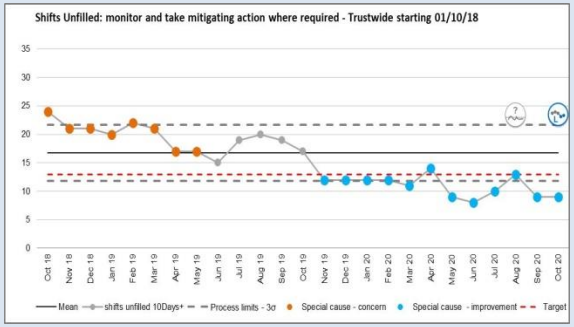
Committee: FPC
Data Quality RAG: Green</td><td colspan="6">The Staff Survey is currently underway for 2020 and will close on 27th November. As at 6th November 42% of staff have completed their survey, this is in line with 41% at this point in the 2019 survey. The aim this year is to reach a response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

<table>
<tr><th colspan="7">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M7
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td rowspan="3"></td><td>Team Work</td><td colspan="6">Teamwork Average of:
• % agreeing that their team has a set of shared objectives
• % agreeing that their team often meets to discuss the team's effectiveness
<table><tr><th>Staff Survey 2019</th><th>EPUT</th><th>National Average</th><th>Comments</th><th></th></tr><tr><td>Q4h The Team I work in has a set of shared objectives</td><td>75.4%</td><td>73.7%</td><td>Better than average and better than last year.</td><td>●</td></tr><tr><td>Q4i The Team I work in often meets to discuss the team's effectiveness</td><td>68.5%</td><td>69.1%</td><td>Below Average better than last year</td><td>●</td></tr></table>Trusts in lowest third across the sector will represent a concern</td></tr>
<tr><td rowspan="2">Inclusion</td><td colspan="6">Inclusion (1) Average of
• % staff believing the trust provides equal opportunities for career progression or promotion
• % experiencing discrimination from their manager/team leader
or other colleagues in the last 12 months
Requires Improvement
<table><tr><th>Staff Survey 2019</th><th>EPUT</th><th>National Average</th><th>Comments</th><th></th></tr><tr><td>Q14 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age</td><td>82.4%</td><td>85.1%</td><td>Below Average</td><td>●</td></tr><tr><td>Q15b Discrimination at work from manager / team leader or other colleagues in last 12 months</td><td>8.1%</td><td>6.4%</td><td>Above average</td><td>●</td></tr></table></td></tr>
<tr><td colspan="6">Inclusion (2)
The BME leadership ambition (WRES) re executive appointments.
Later this month EPUT will be publishing its latest Workforce Race Equality Standard (WRES) data, followed by a presentation at the Board meeting on 30th September. The figures show a positive story, as EPUT has improved in a number of areas, but further work is still needed to improve the experiences of our Black, Asian and minority ethnic colleagues. EPUT's action plan for the next year will re-emphasise our zero-tolerance of racism in all its forms.</td></tr>
</table>

SECTION 4 – Safer Staffing Summary

Click here to return to summary page

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M7**		**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.	106.4%	●	Trend above target = good 	●	The following wards were below target in October: Adult: Ardleigh CAMHS: Poplar - Rochford Specialist: Dune Nursing Home: Clifton Lodge	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	145.8%	●	Trend above target = good 	●	The were no wards below target in October	N/A
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	101.8%	●	Trend above target = good 	●	The following wards were below target in October: Older Adult: Kitwood, Henneage & Beech - Rochford Nursing Homes: Rawreth Court	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts	179.9%	●	Trend above target = good 	●	No wards were below target in October.	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required	8	●	Below Target = Good 	●	The following wards had fill rates of <90% in October: Adult: Ardleigh Older Adult: Beech – Rochford, Henneage & Kitwood Nursing Homes: Clifton Lodge & Rawreth Court Specialist: Dune CAMHS: Poplar – Rochford	N/A
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	9	●	Below Target = Good 	●	The following wards had more than 10 days without shifts filled in October: Adult: Gosfield Older Adult: Kitwood, & Hennage Nursing Homes: Clifton Lodge & Rawreth Court CAMHS: Poplar - Rochford Specialist: Edward House CHS: Avocet LD: Heath Close	

SECTION 5 – CQC

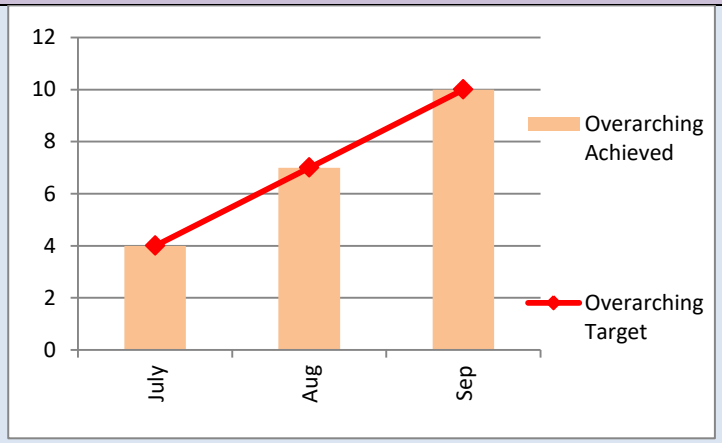
Click here to return to summary page

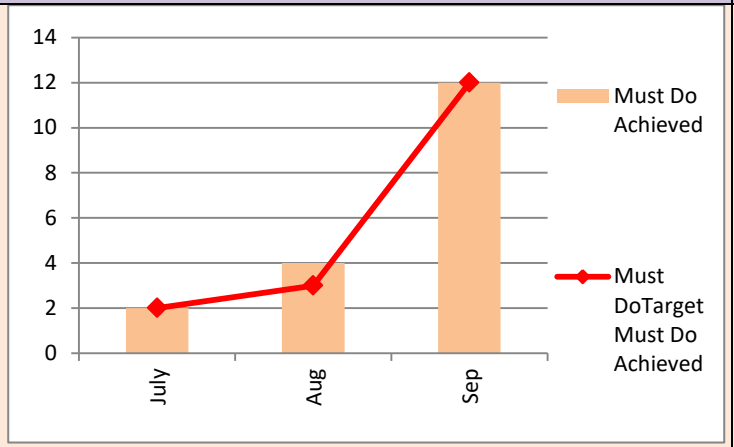
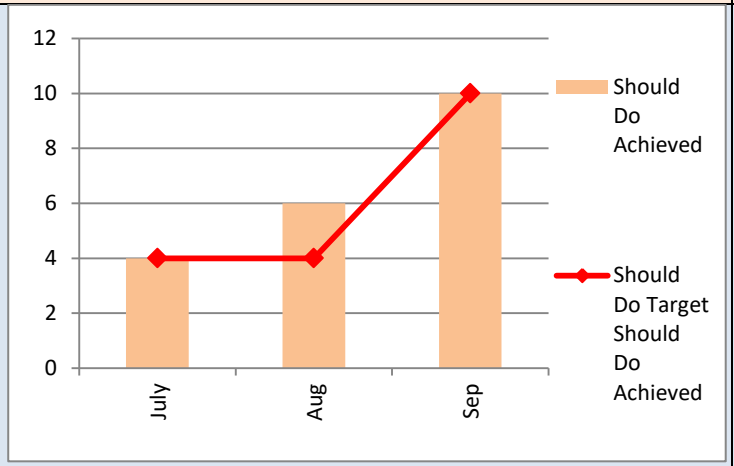
The CQC Reset Action plan has now been completed with all actions having been met; the final actions were marked as complete at the Executive Steering Group on the 25th September. A new action plan will be developed following the conclusion of the next CQC inspection.

The CQC completed an unannounced inspection on the 29th October focusing on Finchingfield Ward following a series of incidents that took place on the 23rd October. The CQC provided high-level verbal feedback immediately following the inspection.

As part of the CQC inspection to Finchingfield, the CQC have sent in a raft of information requests and undertook a remote audit of patient records supported by operational staff and the Compliance team.

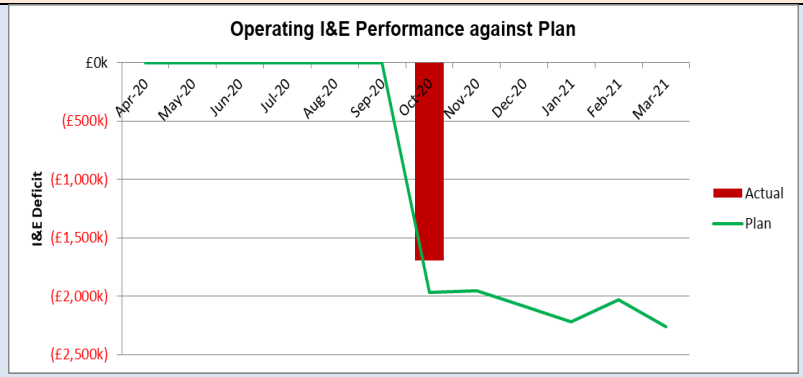
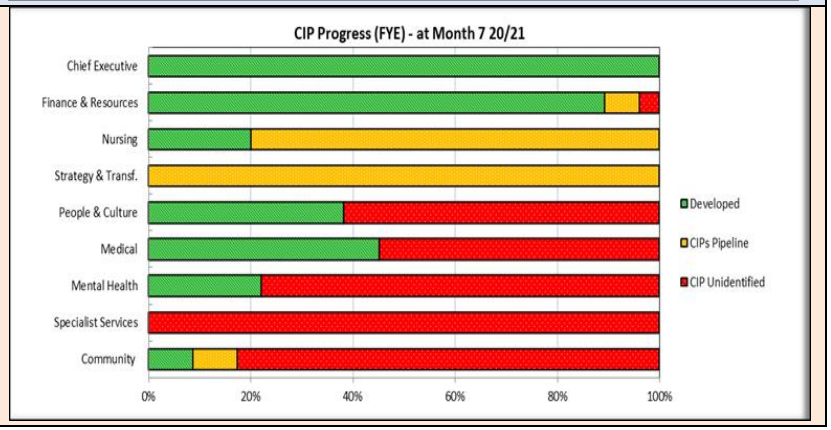
The CQC provided a high level feedback letter on the 3rd November and this has been developed into an Intensive Clinical Support Plan to begin addressing the concerns. This will be used to prepare for the final inspection report and the action plan that will need to be provided to the CQC following their publication of the final inspection report.

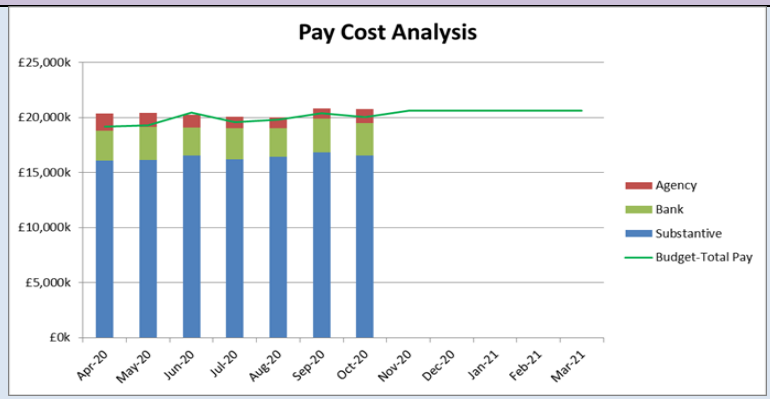
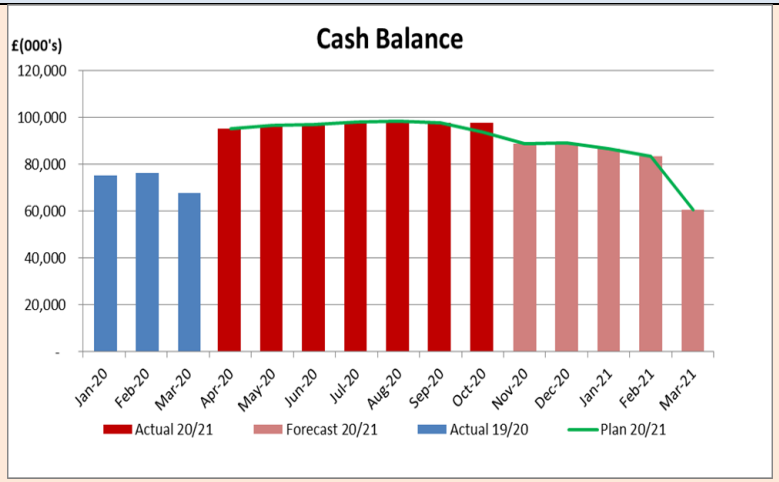
RAG	Ambition / Indicator	Position	Trend (below target = good)	Narrative
CQC Over-arching Actions	There will be 0 CQC Overarching Must Do and Should Do actions past timescale	-		The Reset CQC Action Plan is complete as at 25th September.

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

SECTION 6 - Finance

Click here to return to summary page

RAG	Ambition / Indicator	Position	Trend
Capital Expenditure (CDEL)	Maximising Capital Resources	Having successfully secured additional funds to eliminate mental health dormitories, the Trust's Capital programme has significantly increased this year to £17.3m. The Trust is currently mobilising a significant number of schemes to make sure the resources are fully utilised; this represents a significant investment and spend in the latter part of this financial year.	The Capital Programme has been attached as an appendix to the Finance Report.
Trust I&E 2020/21	Operating Income and Expenditure	The Trust continues to operate within the adapted financial regime; this includes national income allocations for months 7 to 12. The year-to-date £1.7m deficit is broadly in line with the submitted plan. During the first 6 months of the year income and expenditure have been matched under the adapted regime.	
Cost Improvement Programmes	Planned improvement in productivity and efficiency	The Trust's CIP target for 20/21 is £11.7m, including the 19/20 recurrent CIP shortfall brought forward of £5.1m. In Year savings of £7.8m have been agreed with £0.8m identified as in pipeline. Recurrent savings at Month 7 are £3.6m have been agreed.	

RAG	Ambition / Indicator	Position	Trend
Temporary Staffing	Level of Temporary Staffing Costs	The Trust has made good progress in reducing its historic reliance on agency staffing. Overall temporary staffing costs for the month of £4.3m including Bank usage (£3.0m) remain significant (20% of total pay spend M7).	
Cash Balance	Positive Cash Balance	The cash balance at the end of October £97.9m is better than planned £93.7m. The variance is mainly due to: capital spend less than anticipated; less trade creditor payments than anticipated and less Pay expenditure than anticipated. The supplementary national payment is also still to unwind and will be reflected in future months.	

END

		Agenda Item No: 7b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 November 2020**

Report Title:	**Update on Quality Improvement Framework**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Gill Mordain, Strategic Advisor					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	

Purpose of the Report		
This report provides: • The Board of Directors with an overview of the action that is underway currently and that which is planned going forward to embed a culture of quality improvement across all services in a drive to continuously improve patient safety and quality of the care we provide for our patients.	**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 provides a summary of:

- Feedback from Care Quality Commission
- Progress against Board Assurance Frameworks
- Assurance on current work stream activity incorporating:
  - Governance arrangements in place
  - Development of QI Hubs
  - Quality improvement, innovation and research
  - QI tools and techniques
  - Patient safety collaboratives
  - Making data count
  - Training
  - Learning lessons
  - Recognition and celebration schemes

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

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk	32
Do you recommend a new entry to the BAF is made as a result of this report?	

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
 Natalie Hammond Executive Nurse

Agenda Item 7b
Board of Directors Part 1
25 November 2020

UPDATE ON QUALITY IMPROVEMENT FRAMEWORK

1 Purpose of Report

The purpose of this report is to provide the Board of Directors with an overview of the action that is underway currently and that which is planned going forward to embed a culture of quality improvement across all services in a drive to continuously improve patient safety and quality of the care we provide for our patients.

2 Introduction

This year has seen the NHS as a whole and EPUT as an organisation face substantial organisational and humane factors that have impacted deeply on the lives of our populations; affecting factors that are essential to healthy lives such as health and wellbeing, income, job security and social contact. The provision of care in these circumstances alongside the recognition of the impact on our workforce has been difficult. As an organisation the need to reshape service delivery and enhance patient safety has been paramount and has been delivered through an approach that recognises that quality improvement is based on timely, inclusive and person centred improvements. EPUT's response to the pandemic has demonstrated that capacity for improvement is held at a systems, organisational and individual level and that engagement, empowerment and support can enhance and change the delivery of services at pace. Review of improvements initiated is taking an adopt, adapt or abandon approach through the second wave of the pandemic and into the post coronavirus era.

EPUT's ambition is that it will embed a quality improvement strategy through comprehensive and sustainable structures and processes in order to monitor, deliver and integrate the approach in clinical practice and system transformation. Research has shown the impact of quality improvement is often greatest when it forms part of a coherent organisation-wide approach, as opposed to discrete time-limited projects, and in recognition of this, steps are being taken to embed quality improvement within current systems and use it as a tool to deliver against key priorities and objectives. BAF32 Quality Improvement (2020/21) action plan sets out the series of actions underway in delivering this ambition and mitigating the associated risks. It is acknowledged that embedding a culture of quality improvement, supported by clear processes and systems will enhance delivery of strategic and corporate objectives in line with the Trust values of open, compassionate and empowering.

This report provides the Board of Directors with an update of the actions that are underway and those that are planned to embed a quality improvement strategy. It explores the factors that are supporting the organisation to embed its quality improvement framework, and the key enablers for sustaining a focus on continuous quality improvement.

3 Independent Assurance – Care Quality Committee (CQC)

The CQC have identified the following evidence as being required to demonstrate that a provider meets the criteria for a well led organisation:

1. Quality strategy available on website and intranet that explicitly mentions quality improvement and sets the organisation's quality improvement goals
2. Quality appears to be the priority at the Board from agenda and minutes, with a specific report on quality that is accessible publicly
3. The Board looks at data as time series analysis, and makes decisions based on an understanding of variation
4. Clear and consistent improvement method for the organisation, and demonstrable across all areas/operations of the organisation
5. Presence of a central team dedicated to supporting quality improvement, with expertise in the improvement method and tools
6. Plan for building improvement skills at all levels of the organisation, with a large proportion of the organisation (and at all levels) having developed improvement skills
7. Structures in place to oversee quality improvement work, with multiple Executive Directors involved in regular provider-level overview
8. Robust, regular and local support in place across all areas of the organisation to support teams using QI to solve complex quality issues
9. Quality improvement work across the organisation demonstrates alignment – projects at team level align with strategic objectives for the organisation
10. Demonstrable use of measurement on a routine basis to monitor progress of QI work against outcomes and ensure sustainable improvement
11. All executive team and clinical leaders are able to talk about their role in leading quality improvement, supporting teams in their quality improvement work and developing a context and culture within the organisation for quality improvement to occur
12. A majority of staff across multiple areas of the organisation and from a variety of backgrounds are able to talk about the provider's quality improvement approach, how they have been involved and the difference it has made

As previously reported, the CQC carried out an inspection of Trust services in July/ August 2019 and the report of findings gave the following feedback associated with quality improvement within the Trust:

- "There was a fully embedded and systematic approach to improvement, which made consistent use of improvement methodology. Improvement methods and skills were available and used across the organisation. Staff was empowered to lead and deliver quality improvement activities."
- "Staff participated in clinical audit, benchmarking and quality improvement initiatives."
- "All staff was committed to continually learning and improving services. They had a good understanding of improvement methods and skills to use them. Leaders encouraged innovation and participation in research."

4 Current Progress Activity

Governance Arrangements

The organisation recognises the value of quality improvement as an enabler to providing quality services and high levels of patient safety, but is aware that this is not a quick fix and that a QI approach will take time to embed across the organisation whilst structures, processes, skills and capacity are put into place. The Executive Nurse leads the quality improvement agenda supported by all Executive level colleagues.

Following completion of NHSI's Leadership for Improvement programme in March 2020, it was agreed that delivery against the Quality Improvement Framework was a priority as an enabler to the achievement of organisational goals. Governance arrangements with a QI, Innovation and Research Sub-Committee accountable to the Quality Committee, were put in place to embed and drive system wide improvement supported by Directorate Hubs that are increasingly focusing on quality improvement, innovation and transformation. The Sub-Committee has clear terms of reference and representation from across the organisation and individual QI Directorate Hub.

Improving quality of care and patient safety are a priority and are core items on Trust Board, Quality Committee and reporting sub-committee structures. Quality reports across all committee structures are increasingly using time series analysis for decision making and assurance purposes. As an early adopter of the new national Patient Safety Incident Response Framework the Trust is reviewing its systems and processes to build stronger mechanisms for enhanced learning that will be fed into QI arrangements to drive continuous improvement.

The Trust has in place both a Quality Strategy and Quality Improvement Framework that are underpinned by comprehensive action plans. Both documents are available on the Trust website and intranet site. The Quality Strategy is currently under review and it is recognised that this will operate as a live document as we strive to deliver the highest quality healthcare services in the current unprecedented times. It is focused on delivery of our quality priorities 2020/21 which relate to improvement, innovation and transformation.

Directorate Hubs

In recognition of varying population and service needs across the Trust's footprint, different hub arrangements have been put into place to address local requirements and transformation agendas. The Specialist Service Hub is the most advanced with improvement embedded within directorate structures supporting arm's-length hub arrangements for specialist areas e.g. STARS. Structured meeting arrangements are scheduled, tools, methodologies and data are accessible, and patient engagement is in place with the majority of improvement activities. To support development of other hubs representatives have attended specialist hub meetings to learn from their approach.

Across mental health services, prior to the pandemic, a QI hub was operating with multi professional attendance. Due to operational pressures, meeting arrangements were postponed although it is recognised that widespread improvements and innovations

continued to take place. Recent discussions have taken place with agreement that there will be closer alignment between QI and the Transformation agenda. To support this and promoting working arrangements with system partners, it has been agreed that there will be two mental health QI Hubs; one covering north Essex and the other covering mid and south Essex. Locality QI Hubs will be supported corporately to re-establish and reset hub arrangements early in 2021.

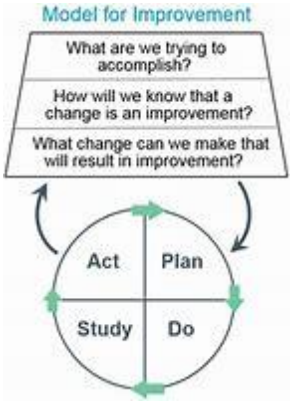
Community Services have closely aligned QI with the Transformation agenda. Both south east and west Essex have identified a lead for QI who will oversee the development of the agenda within the current structural arrangements supporting transformation.

A Corporate Services QI Hub has been newly established with representation from all corporate teams. This hub will drive forward improvement at a corporate level and will also provide support to each of the operational hubs increasing the level of support and alignment across services.

QI Tools and Techniques

The Trust has a clear and consist improvement method that is built into the QI Framework, collaborative improvement events and all training programmes. The 'Model for Improvement' is used as the basis for most quality improvement programmes to trial and measure progress.

A handbook has been developed and is available on the Trust intranet site along with a number of presentations to support use of a number of tools and techniques associated with delivery of the 'Model for Improvement'. All staff also has access to a comprehensive handbook developed by NHSI that provides practical advice on the use of a wide range of tools and techniques at different stages of an improvement project.



Circa 600 Quality Champions undertaking the internal QI programme have been trained in 'Lean' techniques alongside the 'Model for Improvement', and staff within the Service Development Team have received training to an advanced level and use the techniques to deliver against transformation programmes.

Patient Safety Collaboratives

As an organisation our intention is that patient safety should always come first. Improvement in patient safety is a continuous process with improvement areas identified through a range of mechanisms including review of incidents, performance reporting and staff and patient feedback.

The Trust has engaged in a number of external collaboratives facilitated by NHSI/E and the Royal College of Psychiatrists on a range of topics including falls, restrictive practices, sexual safety, recruitment and retention and supportive observations and engagement. Within these the Trust has been recognised for delivery of practices enhancing patient safety with work being presented and circulated nationally.

Patient safety collaboratives have been introduced providing a unique position to connect teams to identify, improve and spread good patient safety practice. As part of the Trust's Quality Improvement strategy, the Quality Team are using internal collaboratives to address key areas of patient safety and increase engagement, ownership and cascade learning. A recent 8 week collaborative in relation to restrictive practice has supported improvements in practice with reduction in prone restraints being recorded, changes to IM injection site and a review of the use of global restrictions. A further collaborative has commenced in relation to physical health which is being delivered across locality footprints with input from inpatient and community services, with the addition of wider system engagement. It is envisaged that QI collaboratives will be used to drive improvement priorities identified within the Trust adopting an inclusive approach with staff, service users and system partners.

Making Data Count

To measure improvement steps have been taken to ensure that we make the best use of data in decision making. Statistical process control (SPC) has been introduced to track improvement in all key areas of patient safety.

Dashboards have been introduced at ward, directorate and Trust wide levels to inform decision making and give assurance that appropriate actions are being taken to drive continuous improvement throughout the organisation.

Quality Improvement, Innovation and Research (QIR)

Following discussions at the Quality Committee, discussions are taking place using a strawman model to bring closer integration between quality improvement, research and innovation. A number of workshops have taken place and work is developing through a task and finish group. The overarching aim is to produce a business proposal for consideration by the Executive Team that will produce seamless process to facilitate QIR process that will continually enhance delivery of high standards of patient safety and standards of care.

Training

During 2019/20 the Trust Board undertook NHSI's Leadership for Improvement programme. Learning from the programme has informed both governance and reporting arrangements across the organisation.

The Trust currently has in place a bronze, silver and gold award system to recognise staff

participating in quality improvement training and leading initiatives and it has been agreed that the awards will represent staff involvement as follows:

QI Bronze award – staff, service users and carers participating in improvement and training through introductory and one day programmes.

QI Silver award – individuals who have completed the internal 5 day Quality Champion Programme or NHSI's Quality Improvement and Service Redesign Programme (QSIR) delivered internally by accredited practitioners and have worked on a quality improvement project.

QI Gold award – individuals who have implemented significant improvements and have the capability to coach/mentor individuals and teams in relation to quality improvement.

Over 600 staff have been trained in improvement tools and methodologies since the formation of the Quality Academy, with a number achieving a silver award following completion of a project. Approximately 20 experienced Quality Champions have received additional training with regards to coaching and mentorship skills, and can support new Quality Champions with delivery of projects. Currently the Trust has 36 staff undertaking QSIR training, which due to COVID, is being delivered virtually across 8 sessions supported by café events and virtual learning sets. The Trust has seven members of staff approved by NHSI to deliver the QSIR programme with representatives from mental health, community, quality, service development and strategy and business development. A further cohort is due to commence in January 2021. The aim is to train a minimum of 10% of the organisation's (circa 520) staff as Quality Champions by 31 March 2022, who will support delivery of improvement projects within QI Hubs. All Quality Champions are encouraged to participate in a project of their choosing or engage with others to support delivery of another project in line with organisational objectives.

In January 2021, QI training will be linked to the Trust's Induction programme with all new members of staff receiving an introduction to the QI programme. The introductory programmes are also available to existing members of staff with the aim that by 2023, all staff will have undertaken an introductory programme in quality improvement.

Quality improvement has been introduced into the Trust's Management Development programmes and once staff has progressed through the Mary Seacole Leadership Programme, they will be invited to undertake an internally developed Leadership for Improvement programme and support delivery of a project in-line with Trust priorities.

There are a range of options including partnership arrangements to provide advanced level training to staff within the Trust. It is proposed that an options appraisal will be undertaken and developed into a business case to be considered by the Executive Team.

Learning and Recognition

The Trust has in place an annual recognition and celebration event. This provides the opportunity to showcase improvement and to give recognition to individuals and teams. Support will also be given to Quality Champions to publish their findings in relation to improvement activities and to apply for local and national awards. Work is planned with the Communications Team to develop the intranet site and put in place further opportunities to cascade learning and celebrate success.

Learning Lessons

At its most successful, quality improvement needs to be embedded within an organisation's culture alongside its systems and processes making it core to day to day service delivery. The Trust is taking steps to build a 'Just culture'. To support this, human factors training is being embedded in Management Development programmes and team away days, establishing the principle that whilst errors may occur, the route to their reduction is building a safe reporting environment and establishing structures where lessons are learnt so continuous improvements in patient safety can be made.

5 Next Steps

To continue the Trust's journey to embed a culture of quality improvement and a number of actions are proposed:

- Re-engagement with Directorate QI Hubs working within agreed governance arrangements
- Implementation of a Training Strategy that supports QI being everyone's business inclusive of capacity and approach
- Completion of a business model that supports closer alignment between QI, innovation and research
- Increased alignment of patient safety, risk and performance to QI agenda
- Develop of internal and external communication systems supported through an internal platform demonstrating QI activity
- Consideration of a partnership approach with a QI leadership organisation
- Options appraisal of QI technologies in place to support delivery against the agenda

6 Action Required

The Board of Directors is asked to:

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

Report prepared by:

Gill Mordain, Strategic Advisor

On behalf of:
Natalie Hammond, Executive Nurse

		Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTRORS PART 1**	**25 November 2020**

Report Title:	**Staff Flu Vaccination Programme Self-Assessment**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Angela Wade Director of Nursing, Infection Prevention and Control and Kim Shaw, Head of Infection, Prevention and Control					
Report discussed previously at:	Executive Committee					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	

Purpose of the Report		
This report provides: • Details of the Staff Flu Vaccination Programme Plan	**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

In August 2020, a request was issued by NHS England for trusts to complete a self-assessment against a best practice checklist, based on key components of developing an effective flu vaccination programme. The completed checklist should be published in public board papers by December 2020.

EPUT's self-assessment, in accordance with the best practice guidance, creates the basis of the Trust's Flu Vaccination Programme Plan for delivery to EPUT staff for 2020. The plan has 4 key elements as detailed in the report.

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

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

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

Agenda Item 7c
Board of Directors
25 November 2020

EPUT STAFF FLU VACCINATION PROGRAMME PLAN

1 Purpose of Report

The purpose of this report is to provide a detailed outline of the 2020 Staff Flu Vaccination Programme.

2 Outline

In August 2020, a request was issued by NHS England, for trusts to complete a self-assessment against a best practice checklist, based on key components of developing an effective flu vaccination programme. The completed checklist should be published in public board papers by December 2020.

EPUT's self-assessment, in accordance with the best practice guidance, creates the basis of the Trust's flu vaccination programme plan for delivery to EPUT staff for 2020. The plan has 4 key elements as detailed.

A Committed leadership

A1: Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers

The flu vaccination for all EPUT staff is a key annual priority for the Trust. This year there is a national expectation for patient facing healthcare workers to receive flu vaccination. This expectation has received commitment from the Executive Team during the Covid-19 pandemic in order to protect our patient population, workforce and service provision, and reduce the risk of overwhelming NHS services whilst seasonal flu and Covid-19 are presenting a combined risk.

A2: Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers

Sufficient inactivated quadrivalent flu vaccines has been ordered to vaccinate a target of 95% of patient facing healthcare staff and 70% of non-patient facing roles. The supply of the vaccine is confirmed to be received in a phased delivery commencing the end of September 2020 with a caveat of final delivery end of November 2020, through application to the regional supply.

Pharmacy pathways are developed to ensure supply and monitoring of distribution to multiple areas across the Trust in order to support vaccination clinics and local peer vaccination. This development is as a result of a review of previous staff flu vaccination campaigns and acting upon lessons learnt as historical Peer Vaccinators had to travel to a central location in order to collect their vaccinations which resulted in inefficient use of vaccinator time and additional delays in vaccination delivery.

A3: *Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt*

Throughout the flu campaign of 2019/20, the Executive Team received weekly updates, including an evaluation at the end of the campaign. The annual Infection Prevention and Control Board paper included a summary of the 2019/20 flu programme and presented final data and programme evaluation.

The campaign for 2020/21 differs in some elements due to lessons learned and feedback received following 2019/20, but also due to significant challenges placed on the delivery of the programme this year during the Covid-19 pandemic.

A4*: Agree on a board champion for flu campaign*

The Board Champion for flu is Natalie Hammond, Executive Nurse.

A5: *All board members receive flu vaccination and publicise this*

All EPUT staff, including Board members are invited to receive their flu either by attending a scheduled vaccination clinic or by a Peer Vaccinator. Requests for Board members can be made via the Chief Executive's office to the Head of IPC; as the local Peer Vaccinator for Trust Headquarters.

Following the programme starting on the 1st October 2020, the Executive Team led by example and received their vaccines on the same day. This supported the Trust's flu Communication Plan with the provision of photographs which are publicised widely on a variety of communication forums such as social media, the flu intranet page and staff briefings.

The CEO launched the Trust's flu campaign as part of the weekly CEO live event programme where the Trust Director of Infection, Prevention and Control joined the presenting panel to highlight importance of having a flu vaccine, with particular focus during the current Covid-19 pandemic, and to inform staff how they can have their jab and direct them to intranet's dedicated flu page.

A6: *Flu team formed with representatives from all directorates, staff groups and trade union representatives*

The Flu Project Team is formed with Trust-wide representation of key stakeholder roles and convened regular meetings which commenced in June 2020. A request was made through HR representation to extend an invitation to Trade Union representatives in accordance with guidance. The meeting structure was agreed in-line with best practice management guidance, chaired by the Trust Director of Infection, Prevention and Control and meeting governance recorded through minutes and action log completion. Since the programme commenced, weekly reporting and escalation papers are presented to the Executive Committee.

A7: *Flu team to meet regularly from September 2020*

The meeting schedule commenced monthly through June-August 2020.
The frequency of the project team meetings was then increased to weekly throughout September 2020 in order the support the final preparatory actions of the plan prior to the

programme going live on 1st October 2020. The project team meeting continues on a fortnightly frequency during the live programme.

B Communications plan

B1: *Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions*

The Communications Plan outlines the variety of communication delivery methods. National and local resources have been utilised to explain the underpinning rationale and importance of the Flu Vaccination Programme for 20/21. Due to the important link to management during the Covid-19 pandemic, the Gold Command structure has been utilised to ensure that senior clinical leaders and trade unions are informed and can cascade the importance of the flu programme and rationale through their Bronze Command structures.

B2: *Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper*

Due to infection, prevention and control restrictions during the Covid-19 pandemic, drop in clinics could not be held this year; therefore the Programme requires a booked appointment approach.

An alternative solution was sought to provide an electronic booking and clinical recording programme. Shift partner was suggested following feedback at the project meeting from staff who had used it when supporting the system response to Covid-19 antibody testing, and it was confirmed that circ. 3000 EPUT staff had an existing account for Covid testing. A scoping and contract exercise was completed and the platform confirmed as suitable for flu vaccination as the MSE group as a system partner had had already added a flu vaccination process to the platform that EPUT could partner. This platform was both the booking portal for static booked clinics and accessible for Peer Vaccinator use.

The clinic schedule and the full list and locations of the 180 Peer Vaccinators are published on a dedicated Flu page within the EPUT intranet and the EPUT Facebook page.

The Trust SnapComms Service is pushed daily to remind staff and inform when new additional clinic slots are made available. Physical posters are posted in clinical and work areas as a further visual reminder, in particular for staff who do not have daily access to PCs.

B3: *Board and senior managers having their vaccinations to be publicised*

Following the October Executive Committee, the Executive Team led by example and received their vaccines on the same day. This supported the Trust's Flu Communication Plan with the provision of photographs which were publicised widely on a variety of communication forums such as social media, inform pages and staff briefings.

B4: *Flu vaccination programme and access to vaccination on induction programmes*

Historically, vaccination clinics have always been held at Induction events but this year, due to the pandemic, restrictions are in place and all Inductions are being held virtually via Teams Meetings, so vaccinations have not been offered via this route.

However, the Head of the IPC Team delivers a session on the Induction Programme and the importance of vaccination is stressed, as well as how staff can access vaccination within the Trust.

B5: *Programme to be publicised on screensavers, posters and social media*

The Communications Plan includes a variety of publicity routes for the flu programme to be featured on including screensavers, posters, social media, Snapcomms messages, newsletters and the dedicated intranet flu page.

B6: *Weekly feedback on percentage uptake for directorates, teams and professional groups*

Weekly uptake data is easily accessible via Shift partner and this is included within a weekly uptake report to the Executive Committee. On a monthly basis an additional report is presented to the Executive Committee that provides the data submitted to PHE which breaks down staff groups within patient facing and non-patient facing roles.

The staff newsletter 'Wednesday Weekly' includes a standing Flu section which provides an infographic "fluometer" to give the total staff % vaccinated each week.

Further work is being developed with Shift partner and the Trust's Information Team to support local teams and the Peer Vaccinators with role and location specific data.

C Flexible Accessibility

C1: *Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered*

The Executive Nurse has received assurance from the service Directors of their commitment to the flu immunisation programme and confirmation of the empowerment of Peer Vaccinators to support at least 1 for each service area.

At least 180 staff, based in teams and clinical areas across all areas of the Trust, have signed up and completed training to deliver vaccines to their colleagues for 2020.

C2: *Schedule for easy access drop in clinics agreed*

As previously confirmed, drop in clinics have not been arranged this year due to the infection, prevention and control requirement during the Covid-19 pandemic.

There are pre-arranged, diarised, static bookable clinics, run by the Infection Control Team, Optima Occupational Health staff and Bank staff support. These are scheduled daily for the first 6 weeks across all areas of the Trust, primarily to support those staff working from home that do not have easy and regular access to clinical areas and a Peer Vaccinator.

This schedule will be added to after the initial 6 week schedule, following review and extended where a need has been identified from data/gap analysis and/or feedback requests from staff.

C3: *Schedule for 24 hour mobile vaccinations to be agreed*

The Peer Vaccinators will deliver mobile vaccinations within the plan. They are empowered to work directly with their local teams to provide vaccinations in a flexible manner so that staff who work on 24 hour rotation, will be able to receive their vaccine conveniently whilst at work. This approach extends across the Trust in both inpatient and community settings. It is noted that this year's plan has delivered significantly increased number of Peer Vaccinators to support this approach in comparison with previous years.

D Incentives

D1: *Board to agree on incentives and how to publicise this*

Incentives this year are to be offered to primarily Peer Vaccinators. They will receive shopping vouchers depending on the number of vaccines given; give 10 and they will receive a £10 voucher, give another 20 and they will receive a further £20 voucher.

Further incentives have been given executive approval when key trajectory milestones are achieved both for teams and vaccinators.

D2: *Success to be celebrated weekly*

Successes will be published via the intranet and via weekly ET report circulations.

3 Action Required

The Board of Directors is asked to:

1. Consider the content of this report
2. Identify any further information and/or actions required

Report prepared by:
Angela Wade, Director of Nursing, DIPC
Kim Shaw, Head of IPC

On behalf of:
Natalie Hammond, Executive Nurse

November 2020

	Agenda Item No: 7d
SUMMARY REPORT / **BOARD OF DIRECTORS PART 1**	**25 November 2020**

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

Purpose of the Report

This report provides:

- The Trust Board of Directors with an overview of EPUT's Freedom to Speak Up Guardian Service for April to September 2020.

Approval	
Discussion	✓
Information	✓

Recommendations/Action Required

The Trust Board of Directors is asked to:

1. Note the content of this report.

Summary of Key Issues

Members of the Board are aware that EPUT's Freedom to Speak Up Principal and Local Guardians complement other arrangements already in place in the Trust for staff to raise concerns such as the Trust's Raising Concerns (Whistleblowing) Policy and Procedure.

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

The guardian role is not an easy role but a rewarding one. The expectation of the National Guardian Office (NGO) is high and broad, as patient safety and staff well-being is at its heart.

The overall purpose of the Guardian Service is to:

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

This report provides details on:

- Activity and progress.
- Concerns raised and themes noted.
- Challenges.
- Successes.

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

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

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

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

Acronyms/Terms Used in the Report			
MDP	Management and Development Programme	TASI	Therapeutic and Safe Intervention

Supporting Documents and/or Further Reading

Lead

Sean Leahy Executive Director of People and Culture

Agenda Item 7d
Trust Board of Directors
25 November 2020

EPUT

FREEDOM TO SPEAK UP GUARDIAN SERVICE

1.0 PURPOSE OF REPORT

This paper outlines the activity from the Freedom to Speak Up Guardian service from April to September 2020.

2.0 EXECUTIVE SUMMARY

2.1 EPUT's Freedom to Speak Up Guardian Service

The Trust Board of Directors will recall I was elected and commenced in the role of EPUT's Principal Guardian in November 2019, dedicating 2 days per week to role while my substantive role of community psychiatric nurse working for the Trust's Access and Assessment Team is backfilled. Since the pandemic and with the increased amount of activities and concerns raised, the Executive Team agreed for the role to become full time.

EPUT's vision for Freedom to Speak Up is 'Supporting compassion, openness and empowerment'. We aim to continue to grow the number of Local Guardians in the Trust. Due to the current pandemic it has been difficult to do so however this remains firmly on the agenda. We have had 2 new members of staff join us since the last report in May 2020. Unfortunately due to staff turnover as well as job changes and staff not feeling able to continue to commit to be a Local Guardian we have had staff who are no longer to be a guardian. At the time of writing this report the total number of Local Guardians is 10. We continue to promote the agenda and in doing so we encourage people to consider becoming a Local Guardian.

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

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

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

- Support the organisation in further developing a culture of openness and freedom for staff to raise concerns about patient safety and anything that gets in the way of delivering high quality care as part of everyday practice.
- Support staff to raise concerns directly with their line manager/supervisor.
- Work in partnership with managers where staff are unable to raise concerns themselves.

- Escalate raised concerns that are not acted upon by managers with the Chief Executive.
- Where concerns raised by staff are not acted upon internally, the Principal Guardian is expected to take the matter externally to the National Guardian for investigation.
- Provide training across the organisation on the raising concerns agenda.

2.2 Corona virus Pandemic

Since becoming the Trust's Principal Freedom to Speak Up Guardian, the role has become more relevant for staff who through fear or their health and safety have approached the platform. Initially in the pandemic, staff were approaching regarding concerns for shielding, as they felt they were not being allowed to do so, and also about redeployment issues, as well as not enough personal protective equipment (PPE). As the pandemic took a sharp rise, the issues re PPE and social distancing continued to be reported to Freedom to Speak Up. It soon became apparent that not just issues about PPE but a number of concerns started coming through regarding bullying and harassment in general not necessarily due to the pandemic. The role of the guardian therefore has become very much about supporting staff and providing up to date information we have with the ever changing climate with the pandemic. As such I have been invited to attend silver command and return to the workplace meetings in order to keep abreast of what is happening in the Trust, as well as listening to all government guidelines which seems to be ever changing. Some staff have felt very overwhelmed and not knowing where to go and felt that by approaching the Freedom to Speak Up platform, they were listened to and signposted to relevant teams appropriately.

2.3 Overview of activity/progress 1 April 2020 to September 2020

- Training of new Local Guardians has continued.
- Continuation of meetings with Board representatives including the Non-Executive Director and Executive Director for the Freedom to Speak Up agenda, the Chief Executive and Chair.
- Continuation of the Communications strategy to raise awareness of the agenda in 2020/21 and beyond.
- Continuation of visits to services and teams in the Trust to develop/increase awareness of the Freedom to Speak up process and Guardian service, particularly those highlighted as 'hotspot' areas.
- Working closely with Organisational Development (OD) and Staff Engagement Teams.
- Leadership engagement representation.
- Working closely with education and training to identify gaps → closer engagement with TASI training. Due to the pandemic and with social distancing in place, it has not been possible to attend but this remains on the agenda.
- Principal Guardian attending EPUT's Learning oversight Sub Committee and the Workforce Transformation Group.
- Working with Estates and Facilities to ensure colleagues working in this area of the Trust are aware of the agenda.
- As part of Covid-19 attending silver command to discuss with senior leaders how the Guardians can support colleagues to continue to work and improve services and work experience for staff.
- Supporting the anti-bullying ambassadors in creating a better working experience for our workers.
- We continue to reflect with colleagues learning from serious incidents meeting.

2.4 Concerns Raised April 2020

From April 2020 to September 2020 80 concerns were raised with the Guardian Service (this does not include details of concerns raised through the Trust Whistleblowing process, but does include all concerns diverted from the previous 'I'm Worried About' system). The table below provides details of the method used to raise these:

Method Used	**Number**
Email/ F2SU intranet link	58
Telephone	22
Face to face	0

2.5 Number of staff who have received training is below:

The following table details training activities that have taken place in respect of the agenda from April 2020 until September this year:

Training Type	**Approximate Number of attendees**
Induction	314
Student nurses The most popular times for induction is normally January and February time. The plan is for 66 students for Mental Health in January 21	5
Junior Doctors South North	37 47
Associate practitioners EPUT delivered- HND Assistant Practitioner Anglia Ruskin University Healthcare assistant practitioner	11 1

2.6 Emerging Themes

The following themes have been noted from the concerns raised from 1 April 2020 to 30 September 2020. Please note that individuals may have raised more than one issue as part of their 'raised concern':

Concern Theme	**No of concerns since April/May/June 2020**
Patient Safety/Quality	1
Staff Safety	9
Bullying/Harassment/Discrimination	15
Infrastructure/Environmental	3
Other	2
Total	**30**

	No of concerns July/Aug/Sept 2020
Patient safety	4
Staff safety	8
Bullying and harassment	24
Infrastructure/Environmental	4
other	10
Total	50
From April 20 to September 2020	**80**

Bullying and harassment remains the top theme reported since the last report presented to the Board in May 2020. The law makes clear that all employees have the right to work in a safe environment. In conjunction with Human Resources, the Guardian Service supports staff members who feel they are being bullied and harassed. Sometimes people who use the Guardian Service do not wish to take things further, however the service has provided a platform where they feel they are being listened to. I will continue to encourage people to come forward to hear their stories so that issues get addressed and we can support each other in creating and maintaining a safe workplace, free from bullying, intimidation and harassment. With the Speak up Month of October and the fact that we have continued to raise awareness and meet different teams (via MST), this has resulted in a number of staff coming forward and make their concerns known.

The main professional background where concerns are raised from is nursing and support workers. As yet no concerns have been raised from Doctors. I am aware that they have another platform /guardian service in place. We did have a junior doctor who was a local guardian who has moved on as part of their training. This is something that I am keen to look into and encourage in the last two quarters of 2020/21. In addition, we will also look to recruit some Doctors as Local Guardians. I have been in contact with Dr Karale and he is keen to support this and training has already started for junior doctors.

In term of geography the concerns appear to be fairly spread out across the Trust, with a couple of areas where more concerns have been raised. I have been working with the senior leaders in those areas to see how we can continue the support staff to feel safe in raising concerns and evidence that when genuine concerns are raised that these are listened t o and acted on and that feedback is given in a timely manner. I will continue to identify areas where common themes occur in the last two quarters of 2020/21, using other data from the Learning Oversight Group, where we have the opportunity to reflect and identify any further training needs for staff and learning from incidents, and the Workforce Transformation Group in terms of employee relations data.

One of our local guardians is a psychologist, who has been supporting staff as well as look at ways of improving learning and practice.

With regards to the recording of those raising concerns who have protected characteristics, currently the only data collected is in respect of race and it is optional for people to do so or not. Again this is not an area showing any trends to report. Most reported issues have been from colleagues from the white British background although there have also been a number of issues reported by the BAME staff members and we have been working with our colleagues from HR as well as the BAME network to support individuals.

2.7 Challenges

As previously reported some of the challenges that exist in the Trust will not change, like the physical size of it and the task of getting around the Trust to continually increase visibility and awareness is ongoing. The recruitment of Local Guardians is a way of managing this challenge. During ‘speak up month’ we have had people making contact enquiring about being a freedom to speak up Guardian and we hope to train staff to support the agenda.

Once business as usual resumes with the support of the Executive Director of People and Culture we plan to grow this number further in the last two quarters of 2020/21.

A continuing challenge in the process of raising concerns has been related to timings. Some managers/leaders have been very quick in responding and taking action when a concern has been raised, whilst for others it can be weeks before a response is received which can extend the process. As previously noted this was highlighted at a leadership event in October 2019, and is a discussion point during the MDP sessions. It is an area which will continue to be monitored. If progress is slow the sense for staff raising concerns is that nothing has or will happen, and is a major deterrent for others to speak up. Timeframes and the escalation process for concerns raised with the Guardian Service will be added to the Trust's Raising Concerns (Whistleblowing) policy and procedure to support this further.

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

As noted in the report presented to Trust Board in May 2019 patient safety concerns are raised regularly during training sessions. As part of my clinical work, I have attended TASI training previously and also attended personal safety training. This is a great opportunity to meet people from different areas and have discussions around patients' safety. The aim is to continue to work with colleagues from other departments to ensure that we have this valuable opportunity to reflect on practice and learn from other people's experiences and continue to improve on the quality of service we deliver and allow our staff to express themselves and continue to promote the speaking up culture. The current pandemic does mean that we now deliver most sessions via MST and in some ways it has actually made these easier for people to attend and have a larger number of people at a time.

2.8 Successes

The profile of the Freedom to Speak Up service has been raised significantly through the support of the Communications Team and the concerted effort during the National Speak up month in October.

We will continue to publish 'you said we did' for concerns raised, once business as usual resumes. These provide high level information on concerns raised and the action taken by the Trust to resolve them and detail the improvements put in place as a result. They can be located on the Freedom to Speak Up intranet page and are mentioned as part of my regular blog.

We have taken steps to set up a more robust communication structure for the Local Guardians as it was noted that this was required to provide support to one and another and to generally keep in contact. We communicate with each other through the Pando app as well as emails and now with MST.

We have recently updated the Freedom to Speak Up page as well making it more user friendly and having more information on our local guardians, giving individuals a choice to which guardian they want to approach.

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

We have plans to further develop awareness of freedom to speak up and developing OLM training for staff as well as making a more in depth induction on Freedom to speak up for our new starters including temporary workers.

2.10 Feedback

Feedback from people who have used the Guardian Service is critical to the Freedom to Speak Up agenda and we will have to continue to create this culture of openness. Feedback is requested at the end of each quarter from people who have raised a concern. A survey link is sent asking the individual to answer two questions; 'Given your experience, would you speak up again?' and 'Would you recommend to someone else to use the Freedom to Speak Up Guardian Service?' Of the 80 individuals sent the survey link 25 people responded. The table provides the feedback given.

	Given your experience, would you speak up again?	**Would you recommend to someone else to use the Freedom to Speak Up Guardian Service?**
April20-September 20	Yes 21 May be 0 Don't know 0 No 4 No response 0	Yes 22 Maybe 0 Don't know 0 No 0 No response 0

The survey also provided the opportunity to provide written comments. The majority of comments reflected a positive experience of the service, however there were some responses from people who felt that nothing had changed for them. As noted in section 2.7 timeliness of response continues to play a huge part in staff feeling that something has changed for them as well as detailed responses from managers on how they looked into the matter and any actions taken. We will continue to survey people at the end of each quarter in.

I have had a lot of people who said that they would be happy to share their story of raising concerns.

2.11 Conclusion

As previously noted EPUT has good processes in place to manage concerns raised by staff and this service is an addition to the Raising Concerns (Whistleblowing) Policy and Procedure. The challenge is to continue to raise awareness and understanding of the Freedom to Speak Up process. As noted the key issue is culture, both of people feeling able to raise concerns and then managers to act on them in a timely manner.

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

The Board will be aware that listening to and acting on concerns is key to the success of this initiative and it is pleasing that all concerns raised in 2019/20 have now been closed, and of the 80 concerns raised in quarters 1 and 2 only 15 remain open.

As noted the pandemic has unfortunately slowed some of our promotional work down, however we continue to provide support to staff during this time. 18 concerns relating to the pandemic have been received to date and all have been resolved.

2.12 Actions planned 2020/21:

In my report provided in May 2020 I advised that the following actions were planned for 2020/21 many of which have been noted in the report:

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

3.0 ACTION REQUIRED:

The Board of Directors is asked to:

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

Report prepared by:

Yogeeta Mohur, EPUT Principal Freedom to Speak Up Guardian

On behalf of:

Sean Leahy, Executive Director of People and Culture

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 7e
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 November 2020**

Report Title:	**Final EPUT Quality Account 2019/20**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Susan Barry, Head of Assurance					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides the Board of Directors with the final EPUT Quality Account 2019/20 for approval, submission to the Secretary of State and publication on the EPUT website	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

- Approve the EPUT Quality Account 2019/20 for submission to the Secretary of State for Health and Social Care via NHS Choices and publication on the EPUT public website

Summary of Key Issues

Background

On 1 May 2020, regulations revising Quality Account deadlines for 2019/20 came into force. While primary legislation continues to require providers of NHS services to prepare a Quality Account for each financial year, the amended regulations meant there was no fixed deadline by which providers must publish their 2019/20 Quality Account. NHS England and NHS Improvement recommended to NHS providers that a revised deadline of 15 December 2020 would be appropriate, in light of pressures caused by Covid-19.

Board decisions

- The Board of Directors agreed in May 2020 to continue with the original timetable except for partner consultation and submission to the Secretary of State in order to discharge its responsibility to our public for reporting on quality.
- The Board of Directors approved an Interim Quality Account in July 2020 and made available to the public on the EPUT website.

Partner commentaries

A letter sent to partners on 15 October invited comments on the final draft Quality Account and the responses received at the time of writing this report are included in the version for approval. The Board of Directors will receive any late responses (up to the date of the Board meeting) virtually at its meeting.

Submission and publication

- Following Board approval, the Secretary of State for Health and Social Care will receive the EPUT Quality Account 2019/20 via NHS Choices by 15 December.
- Members of the public will then be able to access the Quality Account via NHS Choices or through our public website.
- Partner organisations will receive a final approved version.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓

SO 3: Valued system leader focused on integrated solutions	✓

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk	BAF 9 No Force First BAF35 Culture of Fairness and Learning Lessons BAF32 Quality Improvement through Innovation BAF10 Ligature Reduction
Do you recommend a new entry to the BAF is made as a result of this report?	No

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

Acronyms/Terms Used in the Report			
EPUT	Essex Partnership NHSFT	NHSE	NHS England
CCG	Clinical Commissioning Group	NHSI	NHS Improvement
QC	Quality Committee	NHSI/E	NHS England / Improvement
		BAF	Board Assurance Framework

Supporting Documents and/or Further Reading
Final EPUT Quality Account 2019/20

Lead
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Essex Partnership University
NHS Foundation Trust

Interim Quality Account 2019/20

"Working to improve lives"

Contents

Part 1: Statement on quality

"I am taking this opportunity to record how extraordinarily proud I am of our staff for their outstanding delivery of care and services during the Covid-19 pandemic. We will never be able to thank them enough. Even in an unprecedented global health emergency, they worked together brilliantly, pulling out all the stops to deliver care for our patients and in wider local communities. This Quality Account was prepared in the midst of the pandemic. My heart goes out to all those across the world who have lost loved ones during this time."

This Quality Account for 2019/20 shows how Essex Partnership University NHS Foundation Trust (EPUT) met our quality commitments for 2019/20, our third as a newly merged organisation, and it outlines our quality priorities for 2020/21.

Each year, we set ourselves different quality priorities to help us to achieve our long-term quality goals. We base these annual priorities on the feedback about our services we have received during the previous year from our service users, carers, staff and stakeholders. We also use findings from our Trust-wide learning from incidents, complaints and Care Quality Commission (CQC) inspections. Finally, as EPUT's senior leadership team, we bring our own knowledge of our services to bear.

During this year, the CQC rated our services as 'Outstanding' overall for Caring. As CEO, I have visited many Trust services at all times of the day and night. This is one of the most rewarding parts of my job. I have always been welcomed and made to feel at home on the frontline of our care provision, even when I have startled staff by popping into their ward unexpectedly in the early hours! I am delighted their care of the people using our services is recognised and, as ever, I am extremely proud of them.

We set ourselves eight quality priorities for 2019/20. In line with NHS England/ Improvement guidance, we ensured these priorities covered indicators from the three areas of service user quality – safety, effectiveness and patient / carer experience. To ensure quality is core to running EPUT, we align our quality priorities with our corporate objectives.

We check in throughout the year on how we are doing in meeting our quality priorities. We have a range of forums and events, which promote and maintain engagement between our service users, carers, staff, Board of Directors, Council of Governors, NHS Foundation Trust membership and stakeholders. At these, we have monitored progress against our current quality priorities and sought views on proposed quality priorities for 2020/21.

Most of our priorities for 2019/20 related directly to improving the care we provide in our services. Our top quality priority was to provide harm-free care. This reflects our determination that our services will improve sufficiently to be rated as 'Good' overall for Safety at our next Trust-wide CQC inspection. A number of sub-priorities were set here, covering areas such as reducing pressure ulcers and falls, patients missing fewer doses of their medication, improving the physical health of

our mental health patients and introducing new ways to support our staff in picking up early warning signs that a patient's condition may be deteriorating.

In addition to this harm-free care top priority, we also set ourselves direct patient care priorities on reducing restrictive practices in mental health services; rolling out comprehensive suicide prevention training to our community mental health teams and improving the care we provide for people at the end of their lives.

I am pleased to report that we achieved all these quality priorities, sometimes by exceeding our ambitious achievement targets. For instance, I am particularly pleased that the CQC rates our End of Life services as 'Outstanding' overall.

Our remaining four quality priorities supported our determination to improve patient safety and our ambition to enable our staff to develop their innovative skills for their patients' benefit. Developing collective leadership means EPUT is not 'top-down' but we work together as leaders to enhance performance and improve practices. Continuous improvement means we never rest on our laurels, but are always on the lookout for ways to make our best even better. Effectively using modern technology is central to transforming outcomes for our patients. It enables us to find, use and share more and better data quickly, safely and widely across EPUT. Embedding a just and learning culture at EPUT means individuals, teams and the organisation as a whole learns more widely and deeply from mistakes, which leads to us being able to make real life improvements to the safety of our patients.

I am pleased to report we achieved these quality priorities too. I am particularly pleased with our growing cohort of homegrown Quality Champions, rising to those challenges often faced by trailblazers and are a significant influence on our quality improvement programme.

This report details many more achievements of which EPUT is justifiably proud. It also details our improvement plans for this year. I hope it gives a clear understanding of how seriously we take our responsibilities and how determined we are to provide safe, effective, caring, responsive and well-led NHS services.

Statement of Accuracy

I confirm that to the best of my knowledge, the information in this document is accurate.

Sally Morris
Chief Executive
Essex Partnership University NHS Foundation Trust

Part 2: Our Quality Priorities for improvement during 2020/21 and Statements of Assurance from the Board

What services did EPUT provide in 2019/20?

During 2019/20, we provided hospital and community-based mental health and learning disability services across Essex as well as a small number of specialist mental health and/or learning disability secure services in Essex, Bedfordshire and Luton. We also provided community health services in South East Essex and West Essex as well as some specialist children's services Essex-wide.

How have we prepared this Quality Account?

The Quality Account has been prepared in accordance with the national legislation and guidance relating to the preparation of Quality Accounts in the NHS. The legislation and national guidance on Quality Accounts specifies mandatory information that the Quality Account must report and local information that EPUT can choose to include. In addition, Trusts must follow a process of seeking comments from partner organisations (Clinical Commissioning Groups, Healthwatch organisations, and Local Authority Health Overview and Scrutiny Committees) and the Council of Governors on their draft Quality Account.

On 1 May 2020, regulations revising Quality Account deadlines for 2019/20 came into force. While primary legislation continues to require providers of NHS services to prepare a Quality Account for each financial year, the amended regulations meant there was no fixed deadline by which providers must publish their 2019/20 Quality Account. NHS England and NHS Improvement recommended to NHS providers that a revised deadline of 15 December 2020 would be appropriate, in light of pressures caused by Covid-19. EPUT's Interim Quality Account sent to stakeholders (for 'document assurance' as required by the Quality Accounts regulations) on 15 October allows for scrutiny and comment. Responses received are included in Annexe A.

EPUT agreed to continue with its original timetable except for the partner consultation and submission to the Secretary of State for Health and Social Care. In this way, we have discharged our responsibility to our public in terms of reporting on quality and the final draft version approved at the May Board meeting by publishing an Interim Quality Account on our website. This final Quality Account has Board approval as at 25 November.

This Quality Account would normally align itself to the Quality Report section of our Annual Report. Due to the Covid-19 pandemic, no Quality Report appears in the EPUT Annual Report thus, there is no external audit of the Quality Account this year.

2.1 Key actions to maintain and/or improve the quality of services delivered in 2020/21

How have we developed our priorities for the coming year?

Each year we set annual Quality Priorities to help us to achieve our long-term quality goals. We identify them through feedback from service users, carers, staff and partners, as well as information gained from incidents, complaints and learning from Care Quality Commission findings.

Our Quality Priorities represent the greatest pressures that EPUT is currently facing. Following the unprecedented period of Covid-19, there are changes to the healthcare system on a macro and micro scale that impact on quality priorities moving forward. The Covid-19 pandemic brought with it potentially disruptive transformation of services. However, together with system partners EPUT has implemented many transformation initiatives at pace and made significant adaptions and improvements to services.

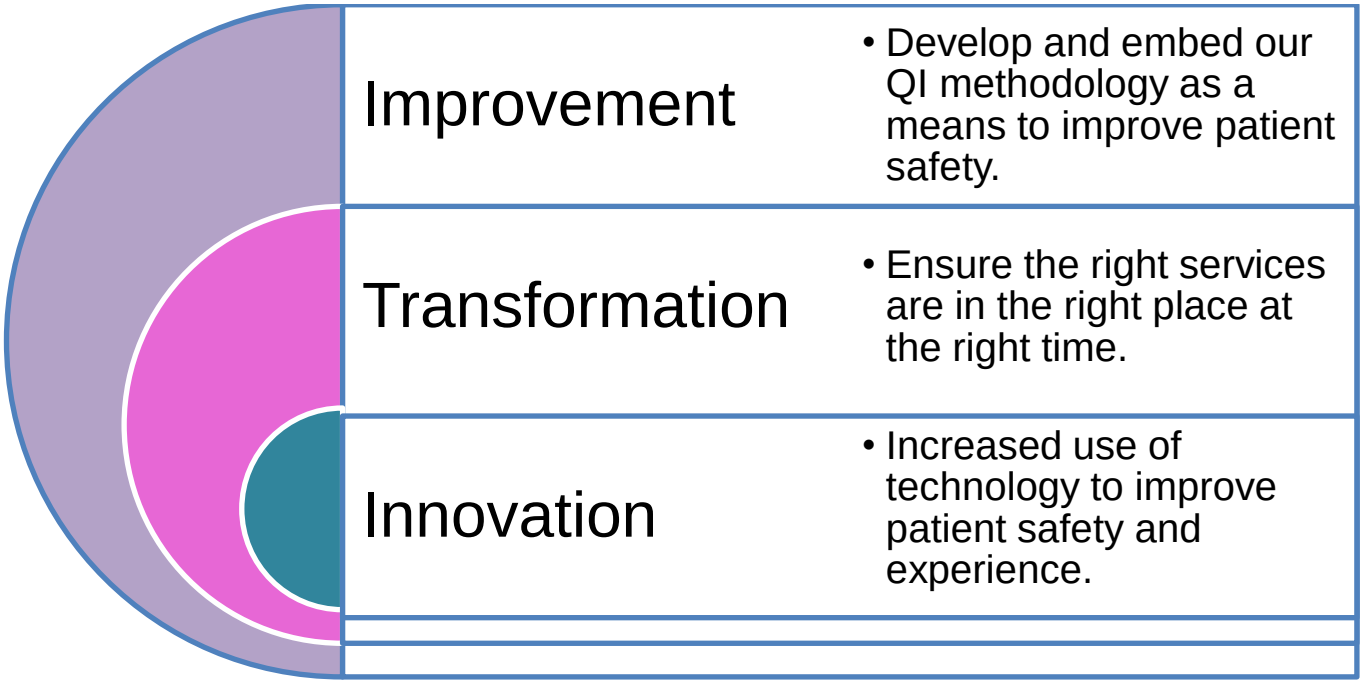
As an organisation, moving forward through the recovery from the first wave of the Covid-19 pandemic EPUT is seeking to use this phase as an opportunity to transform and reform services while learning from the improvements, innovations and adaptions that introduced at speed to protect both our communities and our workforce. As a mental health and community service Foundation Trust, we are aware that this pandemic will have an unprecedented impact on our communities moving forward.

We will build on the changes brought about by the pandemic to enhance patient care and lock in operational improvements, whilst also identifying the longer-term challenges to protect and improve the wellbeing of our communities. As a result, our strategic quality priorities relating to innovation, improvement and transformation are the best fit for EPUT now. Due to the unprecedented changes required, we acknowledge that the content of our quality priorities will respond to the needs of our communities and our workforce; EPUT will ensure processes are in place to adapt to the challenges we face.

We have provided an in year update of progress against our quality priorities. Through a range of forums and engagement events incorporating EPUT Board, governors, service users, carers and staff we have monitored the progress against the 2019/20 quality priorities and sought views on proposals for new quality priorities driving progress into 2020/21.

In line with NHS Improvement / England guidance, our priorities cover indicators from each of the three areas of service user quality – safety, effectiveness and experience that align with EPUT corporate objectives.

The quality priorities for 2020/21 agreed by the EPUT Board of Directors are as follows:



2.1.1 Priority 1 – Develop and embed QI methodology as a means to improve patient safety

EPUT sees quality improvement as a key enabler to transform services and bring about changes to deliver person centered care that is better, safer, more effective and efficient. The goal is to standardise best practice, ensuring that the workforce have the skills, resources and capabilities to implement proven and better ways of delivering care. The impact of Covid-19 has seen the introduction of quality improvements across all services in extremely accelerated timeframes due to the need to build improvements and solve problems at pace.

During this year, we will evaluate and learn from improvements made during this unprecedented time, leveraging our connectivity to identify new solutions to providing healthcare. We will build on our current approach to improving quality and patient safety, delivering a mixture of centrally commissioned projects in line with EPUT priorities and service/individual level initiatives delivered through Directorate QI Hubs. We will test, refine and continue the journey of embedding a quality improvement methodology based on well-established continuous improvement techniques. This will support the delivery of sustainable improvements at scale and pace.

- **Directorate Improvement Hubs**
- Identify, and delivery of, a minimum of three quality improvement projects
- Identification of 20 Quality Champions per hub to undertake QSIR
- Engagement of service users and carers in QI initiatives

- **Development of QI Training Directory**
- Delivery of four cohorts of QSIR training
- Delivery of one day QI training across all improvement Hubs (120) people
- Embed QI in leadership and induction programmes

- **Sharing best practice and learning lessons**
- Ensure all QI initiatives have clear outcomes and data measures
- Use data and learning from incidents to identify QI projects
- Develop systems for sharing and celebrating best practice

- **Accreditation Programme**
- Develop accreditation programme across inpatient services
- Embed principles of Just Culture and Human Factors
- Develop internal recognition system to support levels of accreditation

2.1.1 Priority 2 – Transformation: Ensure the right services are in the right place at the right time

Covid-19 has brought about the need for a redesigned healthcare system with system partners identifying new solutions at unprecedented speed to address operational challenges. This situation is likely to lead to a fundamentally different healthcare system. The pandemic has indicated where systems are defective and shown how technological innovation can be used to move away from institutionally based healthcare and that along with the rapid education and role adaptation within the workforce has enhanced our ability to provide care in different ways. It is a challenge that requires input from all, co-producing healthcare to meet personal and individual needs within our population, therefore EPUT will continue to work with system partners to ensure seamless integration of recent and future developments. The current situation has demonstrated the importance of flexibility within our programme plans to align with ongoing national and local priorities.

Currently, the Mental Health and Community Health Services Transformation Programme (STP) covers three STP areas and within them seven CCGs, two local Unitary Authorities and one County Council.

The Mental Health and Community Transformation Portfolio comprise four major programmes and within these, 18 projects and over 20 programmes in community services. Since the implementation of the STPs some of these programmes have remained broadly, Essex wide whilst others will reflect the 'PLACE' based care and the individual needs of each locality.

Within each STP the four major programmes for mental health transformation are:

Emergency Response and Crisis Care Service:

People facing a mental health crisis should have access to care 7 days a week and 24 hours a day in the same way that they are able to get access to urgent physical health care. Getting the right care in the right place at the right time is vital. Analysis of RAID and occupied bed days data indicates an increasing system pressure for acutely unwell mental health patients. The ambition for implementing the MH5YFV is that by 2020/21:

- All areas will provide crisis resolution and home treatment teams (CRHTTs) that are resourced to operate in line with recognised best practice – delivering 24/7 community-based crisis response and intensive home treatment as an alternative to acute inpatient admissions
- Out of area placements will essentially be eliminated for acute mental health care for adults
- All acute hospitals will have 'all-age' mental health liaison teams in place, and at least 50% of these will meet the 'Core 24' service standard as a minimum

Personality Disorders:

The Business Case for this programme of work proposes a Personality Disorder and Complex Needs pathway, which integrates with wider primary care services and provides evidence-based interventions and enhanced self-care. It emphasises prevention of crisis episodes through linking with both urgent care and primary care pathways, delivering multiple benefits for patients and the system.

Key actions are as follows:

- Development and delivery of a bespoke training programme to improve awareness and ensure the diagnosis of Personality Disorder is provided
- Remodeling of current psychotherapy and Personality Disorder services into an Essex-wide specialist MDT
- Expansion of Personality Disorder treatment interventions
- Enhanced clinical skills training
- Enhance integration with system partners

The outputs expected are an improvement in service user feedback, clinical improvements, positive attainment of specific individual goals using GAS goals, reduction in hospital stays (reduction in admissions, and length of stay) and improved movement through services in the system, and reduction in waits for treatment.

Older People and Dementia:

This programme was first introduced in Mid and South Essex STP. It is a model of dementia care that ensures early diagnosis and good post-diagnostic support. It is an optimum community model with system partners in primary care, and is able to respond proactively to those with dementia or suspected dementia and their carers in their own homes and community settings. S dementia inpatient model provides for those with the most complex needs. To embed and expand we will

take the following actions:

- Implementation of new ways of integrated working
- Increased use of telemedicine
- Introduction of collaborative assessment, review, treatment and care interventions
- Embed inpatient service model
- Develop systems to enhance carer support

The outputs expected are an increase in dementia diagnosis rates, a reduction in inpatient admissions, and reduced length of stay in inpatient settings and improved service user experience and outcomes.

Community (Primary) Care:

This programme will deliver on a locality basis ensuring services meet the needs of local populations.

Across **Community Health Services** in both South East Essex and West Essex, a range of transformations will deliver in partnership. EPUT alongside system partners has developed a road map with clear milestones for all transformation projects.

Key programmes - EPUT is developing 'system' programme documentation to support transparent and shared control documents for the future ensuring implementation is in line with agreed timescales and success measures which incorporate the following:

- **Community Crisis Response:** Enhance the SWIFT Crisis response team established in 2019/20 to align with the Intermediate Care Transformation programme to improve integration and collaboration across all Intermediate Care services

To enhance the current service provision work will be undertaken with NELFT and PROVIDE with SWIFT team member attending EEAST hub to deliver Category 3/4/5 calls direct to community services. The outputs expected are significant admission avoidance activity, reduction in falls and neutropenic sepsis response.

- **Comprehensive Community Palliative Care Offer in South East Essex:** Establish a comprehensive population-health management model for Community Palliative Care/EOL Services that includes management of an EOL register and delivery of high quality front line EOL care**.**

This will require a consolidated service focus delivering on achieving a 1% population target for End of Life Register meeting all challenging contractual KPIs and work with community care and local hospices to develop pathways that maximise access to new hospice beds scheduled to open during 2020.

- **Case Management of Frail and Complex Patients:** In West Essex, a programme to standardise the system offer/ specification for case management links directly with services

across the system. Work with system partners will reduce A&E attendance and non-elective admissions.

- **Development of West Essex Intermediate Care:** A business case includes a full options appraisal to develop systems that reflect the needs of local populations.

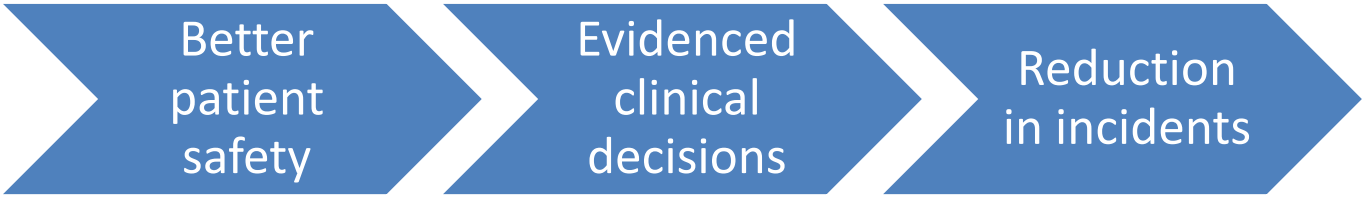
EPUT is working with system partners to build a transformation model that meets the needs of local populations. At this stage that some of the transformations set out may develop or transform into different specifications through engagement with system partners and stakeholders.

2.1.1 Priority 3 – Innovation: Increased use of technology to improve patient safety and experience

EPUT has been extremely innovative at developing and using technology to improve services. Through EPUT Lab, clinicians have been empowered to identify technology that improves clinical decision-making, supports individuals to manage their own health and frees up clinical time to allow smarter working across services. The pandemic has brought the use of technology to the forefront of the organisation supporting new ways of working and providing care.

EPUT Lab is in place as one forum to present and evaluate innovative treatment solutions and staff have the opportunity to receive credit for their solutions and sponsor any projects that emerge.

EPUT has an ambition to engage with the Model Hospital in order to provide the best patient care in the most efficient way. EPUT will review, access and implement a range of digital tools that will compare productivity and identify opportunities to make improvements to clinical services. During 2020/21 EPUT Lab will identify a range of technological innovations for evaluation in respect of the following areas:



2.2 Statements of Assurance from the Board for 2019/20

2.2.1 Review of services

During 2019/20, EPUT provided and/or sub-contracted 141 relevant health services.

EPUT has reviewed all the data available to them on the quality of care in 141 of these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 represents 94% of the total income generated from the provision of relevant health services by EPUT for 2019/20.

The data reviewed aimed to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. During 2019/20, monthly data quality reports produce a consistent format across all services. These reports monitored timeliness of data entry and data completeness. There has been excellent clinical engagement with a clear understanding of the importance of good data quality across the clinical areas. Further information about data quality is included in the data quality section 2.2.7.

2.2.2 Participation in clinical audits and national confidential inquiries

Clinical audit is a quality improvement process undertaken by clinicians, doctors, nurses, therapists and support staff that seek to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change (NICE 2005). Clinical audit is a tool to assist in improving services; robust programmes of national and local clinical audit result in clear actions to improve services are a key method of ensuring high quality. EPUT participates in all relevant National Clinical Audit Patient Outcome Programme (NCAPOP) audit processes. Additional national and locally defined clinical audits are important for the people who use our services.

During 2019/20 11 national clinical audits and 2 national confidential inquiries covered relevant health services that EPUT provides

During that period EPUT participated in 100% national clinical audits and 100% national confidential inquiries of the national clinical audits and national confidential inquiries, which it was eligible to participate in

The national Clinical Audits and national confidential inquiries that EPUT was eligible to participate in during 2019/20 are as follows:

National Audit of Care at the End of Life Round 2(NACEL)
National Sentinel Stroke National Audit Programme Round 6 (SSNAP) 2019/20
UK Parkinson's Audit 2019
National Audit of Cardiac Rehabilitation (NACR)

National Asthma and COPD Audit Programme (NACAP) National Audit of Inpatient Falls (NAIF) - National Falls and Fragility Audit Programme (FFFAP) National Diabetes Foot Care Audit Round 5 (NDFA) 2019/20 POMH-UK Topic 19a: Prescribing for depression in adult mental health services POMH-UK Topic 17b: Use of Depot/LA antipsychotic injections for relapse preventions POMH-UK Topic 9d: Antipsychotic prescribing in people with learning disability National Clinical Audit of Psychosis 2019/20 (EIP)

National Confidential Inquiries:

- CAMHS
- National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)

The national clinical audits and national confidential inquiries that EPUT participated in during 2019/20 are as above.

The national clinical audits and national confidential inquiries that EPUT participated in, and for which data collection completed during 2019/20, are below alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of that audit or inquiry:	
National Clinical Audits **POMH - Prescribing Observatory for Mental Health*	No. of cases submitted as a % of the number of registered cases required by the terms of the audit/ inquiry
National Audit of Care at the End of Life Round 2 (NACEL)	100% of required cases had information provided to national organisers
National Sentinel Stroke National Audit Programme Round 6 (SSNAP) 2019/20	Data collection is on-going and continuous
UK Parkinson's Audit 2019	100%
National Audit of Cardiac Rehabilitation (NACR)	Data collection is on-going and continuous
National Asthma and COPD Audit Programme (NACAP)	Data collection is on-going and continuous
National Audit of Inpatient Falls (NAIF) - National Falls and Fragility Audit Programme (FFFAP)	100% of required cases had information provided to national organisers
National Diabetes Foot Care Audit Round 5 (NDFA) 2019/20	Data collection is on-going and continuous
POMH-UK Topic 19a : Prescribing for depression in adult mental health services	100% of required cases had information provided to national organisers
POMH-UK Topic 17b : Use of Depot/LA antipsychotic injections for relapse preventions	100% of required cases had information provided to national organisers
POMH-UK Topic 9d : Antipsychotic prescribing in people with learning disability	100% of required cases had information provided to national organisers.
National Clinical Audit of Psychosis 2019/20 (EIP)	100% of required cases had information provided to national organisers

The reports of nine national clinical audits were reviewed by EPUT in 2019/20 and we intend to take the following actions to improve the quality of healthcare provided (examples listed)

NACEL 1

- Complaints related to EoLC to be quarterly reported to EPUT wide EoLC Group
- Care of the Deceased Patient Guideline revised to include domiciliary teams. Information included in the leaflet relating to Last Days of Life
- Tools/prompts to recognise and provide palliative care for patients whose recovery is uncertain (e.g. AMBER Care Bundle)
- Processes to create personalised recommendations for a person's clinical care in a future emergency (e.g. ReSPECT)
- Opportunities for staff to reflect on emotional aspects of their work (e.g. Schwartz rounds)
- Guidelines for referral to 'Pastoral care/Chaplaincy team'
- Guidelines to promote dignity evidenced within the EoL Care Guideline around holistic individualised care with dignity and compassion
- End of Life Care Clinical Lead developed a leaflet to be included in EPUT wide Induction
- Department of Work and Pensions (DWP) leaflet 1027, 'What to Do After a Death in England and Wales' included in EoL and Bereavement leaflets
- Carers are provided with information on bereavement services

SSNAP Round 5

- Working relationship between CICC and Essex ESD Team to be robust
- Team to ensure timely submission of complete data set to SSNAP
- Close working relationship with Beech Ward (St Margaret's Hospital) and West Essex ESD Team and timely submission of complete data set sent to SSNAP
- Project Group to contact SSNAP regarding incorrect patient data allocation

NAIC 2018

- IT issues at CICC to be resolved; relocation from CICC to Rochford site and training will solve the access problems to SystmOne
- More feedback to be collected from service users; PREM to be completed in CICC, MNC, SWIFT service and ESD teams
- Review the Caseload for Home based teams; Review of the therapy caseload in June

NDFA Round 4

- Provide faster expert first assessment in SE and SW Essex Team
- Work with CCG to increase accuracy and appropriateness of referral from General Practice
- Discuss findings at the Diabetes network meetings
- Promote timely electronic referrals
- Implementation of the Hot Foot tool (System wide stratification tool for referral of urgent foot problems)

POMH Topic 18a

- Clinicians to ensure all necessary documentation including discussion with the patient and/or carers completed for off label prescription and to discuss in the annual review
- Clinicians to make sure all patients on Clozapine have annual general physical examination with BP, body weight, glycemic control and plasma documented on notes
- Physical Health forms in Mobius and Paris to be updated/modified to record annual checks
- Pharmacy to ask CCG's to remind GP's to add Clozapine information to Summary Care Record (SCR)

POMH Topic 6d

- Inpatient service ward managers to review existing processes to ensure reviews take place
- Community Deputy/Associate Directors with responsibility for community services to initiate with Team Managers/Leads a review of processes in depot clinics/ administration to enable regular monitoring of physical health to take place
- Inpatient service ward managers to review use of checklists or side effect rating scales (physical health monitoring tool for patients on psychotropic medication)
- Community Deputy Directors/ Team Managers to work with community team managers /leads to ensure Lunsers checklists or other rating scales as part of depot clinic/ depot administration processes incorporated into clinical reviews.

POMH Topic 7f

- Community team managers/leads review of processes and availability of equipment to enable regular monitoring of physical health
- Patients are reviewed with checks undertaken and recorded
- Use of checklists or rating scales as part of physical health clinic administration processes
- Feedback to NPSA re current information packs to patients to be reviewed
- NPSA packs to be re issued to all community clinics and re-order packs when low

POMH Topic19a

- Comprehensive treatment histories to be undertaken and clearly documented for all patients referred into EPUT services, to include any comorbid conditions, alcohol and substance use, physical and psychiatric disorders
- Crisis/care plans for patients with depressive illness to have potential triggers/ stressors identified with strategies identified incorporated within the patient's management plan
- Annual reviews undertaken and recorded for patients managed long term by the CMHT; including assessment of symptoms, severity and frequency of their depressive episodes, responses, adherence and side effects to medication

NCAP EIP Spotlight Audit

- All service users allocated to care co-ordinator within 48 hours of referral acceptance
- Care co-ordinator to make contact within 12 days and agree a plan for further engagement
- Conduct gap analysis and discuss results with commissioners to agree an approach to address any shortfall in family interventions

- Obtain feedback from service users/ families on hesitance to receive family interventions
- Look at adaptations that can be made to interventions to accommodate the feedback
- Revisit the option of family interventions with each service user and their family
- Ensure that teams have sufficient staff trained to deliver family interventions
- All service users to have a full physical health assessment based on the Lester Tool
- Service users to receive annual physical health check if in the service for >1 year
- Physical health data to be shared with service user's GP
- Team now has 2 x Wellbeing Clinics which will increase compliance
- Team to have sufficient equipment to undertake physical health checks
- Systems and processes in place ensuring that clinical staff identify triggers for physical health screening and provide interventions appropriately
- Electronic tools available for staff to collect outcome measures for HoNOS, DIALOG, QPR
- Operational managers to ensure that care coordinators carry out a baseline and subsequent score every six months for at least two of the EIP outcome measures

(Note: All national clinical audit reports go to relevant Quality and Safety Groups at a local level for consideration of local action in response to the national findings.)

The reports of 28 local clinical audits were reviewed by the provider in 2019/20, and EPUT intend to take the following actions to improve the quality of healthcare provided (examples only are listed)

- Achieve 100% compliance in notifying relative / carer / NOK on each episode of seclusion
- Medical and multidisciplinary reviews to take place in line with policy requirements
- Relevant paper work to be completed by staff with scanning ability
- Care plans to include specific care requirements during each episode of seclusion
- Task and Finish Group convened to support Longview in achieving overall compliance
- MH Inpatient Safety and Quality Group to work with individual Teams
- Monthly data submission to Clinical Audit Department from all adult MH to be consistent
- Restrictive Practice Grp members to advise on terminology and consider raising awareness of BSP's and potential use across wider practice areas
- Staff competencies and training in end of life care
- SystmOne review of end of life care data recording, templates and care plans
- Redesign of last days of life care plan to include robust training and implementation plan
- Seek assurance from our partners and learn from system approaches to care
- Ensure staff record information given to patients
- Provide process for staff to ensure patient handheld records of administration of medications scanned into SystmOne following their death for future audit/review
- Audit/review of patient's medication charts and symptom management post death
- Project lead/ audit team liaise with business analysis / performance team re finance data
- ECG's carried out and recorded as routine on admission and repeated quarterly
- Debrief arranged, followed through and document following each episode of RT
- Ensure physical observations documented; document refusal on Datix/ Nursing shift noted
- Standardisation of EoL care across services to update systems to record DNACPR status
- Ensure DNACPR is included in End of life training

- Clinical supervision to ensure all EOL patients on caseloads have a DNACPR in place
- Ensure DNACPR reviewed for all patients admitted to community hospital for both step down and step up beds
- Raise awareness in medical teams to complete the delirium screening tool on admission
- The medical team on Roding/ Kitwood wards to use inpatient admission assessment form
- Delirium screening tool to be added to SystmOne electronic records
- Staff to screen all patients on admission for continence problems using EPUT screening tool and if applicable, complete full continence assessment form, and record on SystmOne
- Clear documentation that a medication review for falls risk has been carried out
- Nursing and therapy staff to be reminded to do lying and standing BP
- CHS Nursing staff to document falls advice given to patients, relatives/ carers
- Ensure relevant records completed and updated as required by the Record Keeping Policy
- Rainbow Ward manager to address lack of carer involvement / crisis planning in care plans
- Team Managers to address issues relating to involvement of carers and Crisis planning through supervision with their staff teams
- MH Inpatient Safety and Quality Group to work with individual Teams (Gosfield, Grangewaters, Ipswich Road, Kelvedon, Peter Bruff, Stort and Hadleigh)
- Ward level Audit findings to be shared with respective team at Team Meetings for discussion and team level consideration on how to improve their performance
- Monthly dashboard discussed as standing agenda item at monthly Community Services Safety and Quality Group meeting

2.2.3 Clinical Research and Innovation

We offer opportunities for patients and staff to take part in research studies relevant to them, enabling us to support the NHS to improve the current and future health of the population together with providing an evidence base for ongoing better healthcare. EPUT is committed to being a research active organisation providing a balanced portfolio of interventional, observational, large-scale surveys, commercial and non-commercial studies across Essex.

The total number of patients receiving and staff delivering relevant health services provided or sub-contracted by EPUT in 2019/20 recruited during that period to participate in research approved by a Research Ethics Committee and the Health Research Authority (HRA) was 669. This number of recruits was from participation in 33 research studies opened to participation at EPUT in 2019/20.

Our research portfolio 2019/20 included the National Confidentiality Inquiry into Suicide and Safety in Mental Health (NCISH), recruiting 42 participants, and suicide by middle-aged men study, recruiting six participants.

EPUT aligns with the National Institute for Health Research (NIHR) Clinical Research Network (CRN) North Thames (NT). It provides regional support for researchers and funds a number of EPUT research delivery staff to run studies on the NIHR CRN portfolio, a database of high quality peer reviewed clinical research studies meeting CRN eligibility criteria and expected to lead to significant changes in the NHS within five years.

EPUT continues to collaborate locally with Anglia Ruskin University (ARU), University of Essex (UoE), University of Hertfordshire, University of East Anglia (UEA), University of Bedfordshire and acute Trusts through University College London Partners (UCLP), the Eastern Academic Health Science Network (EAHSN) and the NIHR North Thames Applied Research Collaborative (ARC).

In 2019/20, we have submitted two NIHR Research for Patient Benefit (RfPB) grants as follows:

- The development of a patient and public involvement framework for acute mental health inpatient settings – collaborating with UoE
- Implementing a new specialist community mental health team for preconception advice for women with severe mental illness (SMI) - collaborating with RAND Europe

EPUT is working on a partnership research proposal with NIHR to fund the commissioning of a joint project between adult health and social care organisations in Camden, Essex and Edinburgh to promote and evaluate Family Group Conferencing. EPUT is supported by Professor Martin Webber at the University of York with whom we have developed a close alliance following successful completion of the evidence-informed social intervention research study based in the psychosis service pathways known as 'connecting people'.

In February 2020 EPUT commenced the one year ODESSI research trial of the newly delivered treatment in Thurrock known as Peer Open Dialogue (POD); the trial is being conducted in close association with UCL and will consider how POD compares to 'Treatment as usual'. Research in Finland, where it originated, has shown that patients who were under POD needed significantly fewer admissions and in some cases came off their medication and remained stable, for example patients with psychosis.

2.2.4 Goals agreed with Commissioners for 2019/20 (CQUINs)

The CQUIN (Commissioning for Quality and Innovation) payment framework aims to support a cultural shift towards making quality the organising principle of NHS services, by embedding quality at the heart of commissioner-provider discussions. It continues to be an important lever, supplementing Quality Accounts, to ensure discussion and agreement at Board level and between organisations of local quality improvement priorities. It makes a proportion of the provider's income dependent on locally agreed quality and innovation goals.

A proportion of EPUT's income (1.25% of contract value) in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between EPUT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. ***In light of the Covid-19 pandemic, the Commissioners have stated that they will be making payments for all the 2019/20 CQUINs.***

Our CQUIN programme for 2019/20 included schemes negotiated with commissioners across the areas in which we operate services on their behalf. The CQUIN programme consisted of mainly national schemes and valued at just under £3 million, which represents 1.25% of contract value for

EPUT. This compares to the 2018/19 CQUIN programme, which represented 2.5% of contract value equating to just under £6 million. Although these CQUINs were nationally mandated, there is local agreement on quarterly milestones Trusts need to meet on the journey to achieving the final CQUIN requirement. This supported the need for different Trusts to work in different ways over the duration of the CQUIN, while working towards a common goal.

Our CQUIN programme included:

- staff flu vaccinations
- alcohol and tobacco screening
- alcohol and tobacco - tobacco brief advice
- alcohol and tobacco - alcohol brief advice
- 72hr follow up post discharge
- mental health data quality - quality maturity index
- mental health data quality – interventions
- use of anxiety disorder specific measure IAPT
- three high impact actions to prevent hospital falls
- six month review for stroke survivors
- healthy weight in adult secure mental health services
- tier four CAMHS staff training
- provision of a catheter care passport (local CQUIN agreed with South Essex Community CCG)

Our dedication to continually improving services endures; and teams have proven to be committed to and adept at managing resources to meet the stretching goals for quality improvement within the national CQUINs that have been set by commissioners in previous years as well as locally negotiated schemes.

2.2.5 Stretching goals for quality improvement – 2020/21 CQUIN programme for EPUT

Commissioners have incentivised us to undertake 15 CQUIN projects in 2020/21. The value of our 2020/21 CQUIN scheme will equate to 1.25% of Actual Annual Contract Value, as defined in the 2020/21 NHS Standard Contract.

The schemes agreed for 2020/21:

- CCG2: Cirrhosis and fibrosis tests for alcohol dependent patients
- CCG3: Malnutrition screening
- CCG4: Oral health assessments
- CCG5: Staff flu vaccinations
- CCG6: Use of anxiety disorder specific measures in IAPT
- CCG7a: Routine outcome monitoring in CYP and community perinatal MH services
- CCG7b: Routine outcome monitoring in community MH services
- CCG8: Biopsychosocial assessments by MH liaison services
- CCG11: Assessment, diagnosis and treatment of lower leg wounds
- CCG12: Assessment and documentation of pressure ulcer risk

- CCG17a: Data security protection toolkit compliance
- CCG17b: Reported access to NHS mail
- PSS2: Adult Secure healthy weight
- PSS3: CAMHS Tier 4 Needs Formulations
- PSS5: Outcome reporting in Perinatal services (Mother and Baby Unit)

All national CQUINs have now moved over to using denominator and numerator figures to calculate percentages of achievement, measured against a minimum and maximum achievement threshold.

Note on the impact of Covid-19:
Commissioners have confirmed that they are standing down 2020/21 CQUINs until July 2020 because of the Covid-19 pandemic. EPUT will receive the value of the 2019/20 CQUIN scheme in full.

2.2.6 What others say about EPUT

Care Quality Commission

Essex Partnership University NHS Foundation Trust (EPUT) is required to register with the Care Quality Commission and its current registration status is 'registered with conditions'. EPUT has the following conditions on registration in relation to Clifton Lodge and Rawreth Court (Nursing Homes):

- A requirement to have Registered Managers
- A limitation on the number of beds provided by the services

Essex Partnership University NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2019/2020.

The Care Quality Commission completed two inspections during 2019/2020:

CQC Focused Inspection (April 2019)

The CQC completed an unannounced inspection of Adult Acute Inpatient services on three and 11 April 2019. The CQC completed the inspection following a number of concerns raised by various sources to the CQC about care and treatment of individuals on acute wards. The concerns included how staff managed patient risk and how staff supported patients when they were ready for discharge from hospital.

The inspection too place on seven wards across three sites:

Basildon Mental Health Unit (Basildon Assessment Unit, Grangewaters Ward, Thorpe Ward)
The Derwent Centre (Chelmer Ward, Stort Ward)
The Linden Centre (Finchingfield Ward, Galleywood Ward)

The report confirmed that the inspection did not affect the overall rating of EPUT. The report

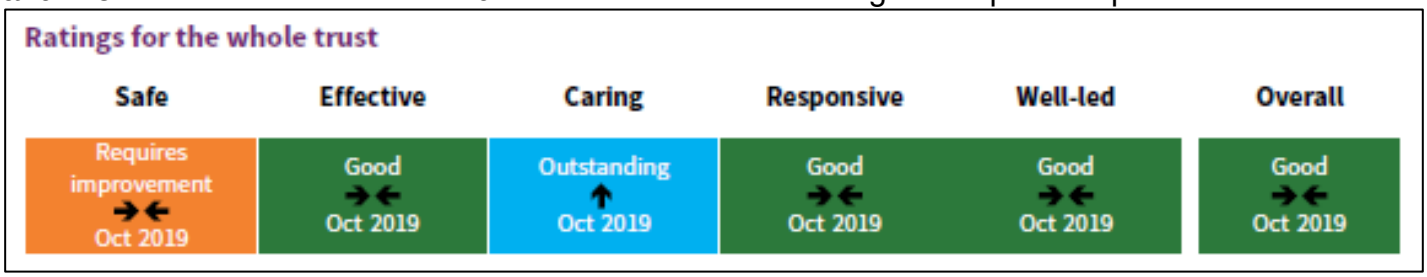
provided positive assurance in relation to the reasons why the inspection was completed, including:

- Staff worked in collaboration with patients to plan their discharge and started discharge planning at the right time. The CQC saw examples of robust and detailed discharge plans.
- EPUT employed staff specifically to support patients moving on from hospital and the CQC saw evidence of staff supporting patients with visits to the community in relation to their housing.
- Staff completed detailed and individualised risk assessments and care plans with patients and patients were involved in creating 'my care, my recovery' plans to manage their own risks.
- All staff spoken with, including agency staff, took time to make themselves aware of patient risks and needs by looking at care notes and receiving thorough handovers.

However, the report identified five 'Must Do' and two 'Should Do' actions that EPUT needed to address. An action plan identified 69 individual internal actions addressed by end December 2019.

CQC Well Led Inspection (July-August 2019)

The CQC completed an unannounced inspection of six core services within EPUT over a three-day period commencing 29 July 2019 and carried out the planned 'Well Led' inspection 19 – 22 August 2019. The report confirmed that EPUT had upheld the overall rating of 'Good' and had achieved a rating of 'Outstanding' for the Caring domain and 'Good' in the Effective, Responsive and Well-Led domain. The 'Safe' domain has received a rating of 'Requires Improvement':



This is an improvement from the previous rated inspection in April – May 2018 with one domain (Caring) moving from 'Good' to 'Outstanding'. The ratings for the other four domains have remained the same.

During this inspection, the CQC visited the following core services:

- End of life care
- Child and adolescent mental health wards
- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems
- Specialist mental health services – substance misuse

Out of the six core services inspected, three (50%) have improved, two (33%) have remained the same and one (17%) has declined. CAMHS and End of Life Service have improved to an overall 'Outstanding' rating, with End of Life moving from 'Requires Improvement' to 'Outstanding' overall.

The CQC report confirmed that inspectors found a number of examples of outstanding practice across EPUT:

- They identified that staff respected and valued patients as individuals and empowered them to be partners in their care.
- Staff promoted people's dignity and offered care that was compassionate, supportive, and person centred. Staff went the extra mile to care for patients and feedback from families and carers indicated that the care exceeded their expectations.
- Staff were committed to working in partnership with patients, and their carers to achieve positive outcomes, they made this a reality for each person and staff consistently displayed EPUT values in the care they delivered.
- Staff valued the emotional and social needs of their patients and embedded them in care and treatment. For example in end of life services, staff had gone food shopping for the relative of a person who had lost weight because they would not leave home in case their relative died whilst they were out. Staff made such offers effortlessly and did so with the sole aim of ensuring the people they looked after, and those important to them, were cared for.
- The CQC identified that staff recognised that patients need to have access to, and links with, their advocacy and support networks in the community, and they supported patients to have easy access to independent advocates.
- Staff involved patients and carers in risk assessment and care planning to ensure treatment addressed patient need, in a way that was preferable to them.
- Staff demonstrated a strong person-centred culture and inspired to offer care that was kind and promoted dignity.
- Leaders valued the strong, caring and supportive relationships formed between staff, patients and relatives.
- On the children and adolescents' wards, staff identified areas on the ward where patients could express their feelings including via blackboards and white boards. Staff issued patients with a resource box on admission whereby the patients could personalise the content of their resource box and use the chosen items when upset or anxious. Patients had led the redesign of an area of the ward, staff and patients now use this area for de-escalation, and patients refer to this area as 'the snug'. Patients had completed 'patient reported outcome measures', which led to meaningful involvement and co-production. The areas covered in the patient reported outcome measure were: 'having hope', 'having an equal say in my care', 'being a part of improving the service', 'understanding my mental health and how to manage it' and 'feeling good about myself'
- EPUT valued feedback on the services they received from patients and carers. Staff monitored responses and took steps to change services based on feedback provided, to overcome obstacles to delivering care. Staff empowered people who used the services to have a voice and to realise their potential.

Community Health Services (CHS):

Community end of life care	Good → ← Oct 2019	Good ↑ Oct 2019	Outstanding ↑↑ Oct 2019	Outstanding ↑ Oct 2019	Good ↑ Oct 2019	Outstanding ↑↑ Oct 2019
Overall*	Good → ← Oct 2019	Good → ← Oct 2019	Outstanding ↑ Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019

Mental Health:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Requires improvement → ← Oct 2019	Requires improvement ↓ Oct 2019	Requires improvement → ← Oct 2019
Long-stay or rehabilitation mental health wards for working age adults	Good ↑ Oct 2019	Requires improvement ↓ Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Good ↑ Oct 2019	Good ↑ Oct 2019
Wards for older people with mental health problems	Requires improvement ↓ Oct 2019	Good ↑ Oct 2019	Good → ← Oct 2019	Requires improvement ↓ Oct 2019	Good → ← Oct 2019	Requires improvement ↓ Oct 2019
Child and adolescent mental health wards	Good ↑ Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑ Oct 2019	Outstanding ↑ Oct 2019
Substance misuse services	Requires improvement → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Requires improvement ↑ Oct 2019	Requires improvement → ← Oct 2019
Overall	Requires improvement → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019	Good → ← Oct 2019

The report also contained a number of positive themes throughout the inspection, including where EPUT:

- Addressed many of the issues identified at the last inspection in May 2018
- Increased the oversight, monitoring and recruited leaders in service such as end of life care and substance misuse
- Staff confidently described knowledge of risk areas in services such as acute mental health wards, they described areas of risk and how they mitigated it to increase patient safety
- Made improvements to medicines management processes and resolved issues with stock rotation
- Staff ensured that they applied for deprivation of liberty safeguard applications in good time and assessed patient's mental capacity where appropriate
- Leadership was strong and had a clear sense of direction. The leadership and governance of EPUT promoted the delivery of high quality, person centred care
- Took opportunities to improve services and provide better care and outcomes for people using services
- Had a clear and robust governance structure to oversee performance, quality and risk.
- Used a variety of tools to monitor and assess risk
- Staff assessed the needs of patients in a timely way and used information to develop holistic, person centred care plans
- Staff cared for patients in line with national guidance and best practice
- Staff had access to regular supervision and specialist training
- Staff respected and valued patients as individuals and empowered them to be partners in their care.
- Valued feedback on the services they received from patients and carers

The CQC inspection report identified four key areas where EPUT must improve:

- Learning lessons
- Equalities
- Data quality
- Restrictive practice

The report identified 18 'Must do' and 29 'Should do' actions that EPUT needed to address. An action plan identified 223 individual internal actions.

As at the end of March 2020, 193 internal actions were completed (87%) which confirms that progress continues with the actions agreed to address the findings of the inspection.

2.2.7 Data quality

Our ability to have timely and effective monitoring reports, using complete data, is a fundamental requirement in order for us to deliver safe, high quality care. The Board of Directors strongly believes that all decisions, whether clinical, managerial or financial, reflect information that is accurate, timely, complete and consistent. A high level of data quality also allows us to undertake meaningful planning and alerts services to any deviation from expected trends.

Internal audit carried out a data quality audit on randomly selected KPIs across EPUT during October 2019 and advised there was 'moderate assurance' on the controls that were in place.

EPUT achieved an average Data Quality Maturity Index score of 90.1% for Q1, 93.8% for Q2, 96.5% for Q3, and 93.7%* for Q4 compared to the NHSI Oversight Framework target of 95%. *Q4 figure below target due to introduction of seven new indicators in March 2020.

EPUT's Information Governance Data Security and Protection Toolkit (DSPT) overall score for 2019/20 was compliant across all assertions.

Essex Partnership University NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission.

Essex Partnership University NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses Service. These are included in the Hospital Episode Statistics and the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number was:

- 99.8% for admitted patient care (Apr 19 – Mar 20)
- 100% for outpatient care (Apr 19 – Mar 20)
- N/A for accident and emergency care

The percentage of records in published data, which included the patient's valid General Medical Practice Code was:

- 96.0% for admitted patient care (Apr 19 – Mar 20)
- 99.12% for outpatient care (Apr 19 – Mar 20)
- N/A for accident and emergency care

We will be taking the following actions to improve data quality:

- Awareness raising throughout EPUT of importance and impacts of data quality

2.2.8 Learning from deaths

1. Background and context

The effective review of mortality is an important element of our approach to learning and ensuring the quality of our services continually improves. 'National Guidance on Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care' was published by the NHS National Quality Board in March 2017 and set out extensive guidance for Trusts in terms of approaches to reviewing mortality, learning from deaths and reporting information. Its aim was to help initiate a standardised approach that would evolve as national and local learning in respect of mortality review approaches increases.

During 2019/20, we continued to strengthen our approaches to mortality review in line with national guidance. We take every death of a person in our care very seriously. We expect our staff to be compassionate and caring at all times. The aim of reviewing the care provided to people who have died is to help improve care for all our patients by identifying whether there were any problems, understanding how and why these occurred and taking meaningful action to implement any learning. The reporting of mortality data is part of this review process and continues to be an evolving, challenging, process across the whole NHS both nationally and locally, to gather and analyse the data. The review of mortality and reporting of data will continue to evolve over time to become more meaningful as we learn from our own experiences and those of other NHS Trusts.

As Trusts have been able to determine local approaches to undertaking mortality reviews and defining deaths that should be in scope for review, mortality data is not comparable between Trusts. As such, we use data locally to monitor the review of mortality and to assist in the ultimate aim of learning from deaths and improving the quality of services. Due to the nature of the services we provide, there will be a number of deaths that will be 'expected'. Nevertheless, we are always mindful that even if the person's death was 'expected', their family and friends will feel deeply bereaved by their loss, and we strengthened our processes to support those people. We undertook a review of a sample of 'expected' deaths to identify any learning on the quality of the care we provide to people at the end of their lives.

2. Explanatory notes

* Please note, all figures stated in the section below relate to deaths 'in scope' for mortality review. EPUT's Mortality Review Policy deaths 'in scope' as all deaths:

- That have occurred within our inpatient services (this includes mental health, community health and learning disability inpatient facilities and within the prison)
- In a community setting of patients with recorded learning disabilities
- Meeting the criteria for a serious incident, either within our inpatient services or in a community setting
- Any other deaths of patients in receipt of our services not covered by the above that meet the Grade 2 case note review criteria. These are identified on a case-by-case basis and include:
- Any patient deaths in a community setting which have been the subject of a formal complaint and/or claim by bereaved families and carers
- Any patient deaths in a community setting for which staff have raised a significant concern about

the quality of care provision

- Any deaths of patients deemed to have a severe mental illness in a community setting. For the purposes of this policy, this is any patient with a psychotic diagnosis (schizophrenia or delusional disorder) recorded on electronic clinical record systems that are recorded as having been under the care of EPUT for over two years
- Any deaths identified for thematic review by the Mortality Review Sub-Committee (including a random sample of 20 expected inpatient deaths per annum). Please note, information relating to these deaths is reported separately in section 9 below

Figures reflect Q1 – Q3 of 2019/20. Information in relation to Q4 reports to the Board of Directors in June 2020. Q4 2019/20 information reports in EPUT's Quality Account for 2020/21. The reporting schedule was the same last year; and, therefore, information relating to Q4 2018/19 reports in this Quality Account.

At the time of preparing this Quality Account, the thematic reviews and expected inpatient death review sample for 2019/20 are in the process of being defined and commissioned and figures are therefore not included within the data below. Information in relation to thematic reviews of 2019/20 deaths will therefore be reported in EPUT's Quality Account for 2020/21. Information relating to the thematic reviews of 2018/19 deaths (which have been undertaken during 2019/20) is included in this Quality Account.

The figures contained in this section of the Quality Account are consistent with the agreed approach for reporting quarterly information to the Board of Directors as at 4 March 2020.

3. National Guidance Ref 27.1 - Number of deaths in scope for mortality review

2018/19 Q4: The number of deaths within scope for mortality review in Q4 2018/19 was 65.

2019/20 Q1 – Q3: During 2019/20 (Q1 – Q3*), 162 EPUT patients died. This comprised the following number of deaths occurring in each quarter of that reporting period:

Q1	53	Q2	56	Q3	53

4. National Guidance Ref 27.2 - Number of these deaths subjected to case record review/investigation

2018/19 Q4:
By 4 March 2020, 3 Grade 2 case note reviews and 16 Grade 4 Serious Incident investigations took place in relation to 19 of the Q4 2018/19 deaths. Note: In addition, one case record review and zero Serious Incident investigations are in progress.

For the full year 2018/19, by 4 March 2020 12 Grade 2 case note reviews and 69 Grade 4 Serious Incident investigations reflect 81 of the 235 2018/19 deaths. Note: In addition, seven Grade 2 case record reviews and zero Grade 4 Serious Incident investigations are in progress.

2019/20 Q1 – Q3:
By 4 March 2020, 2 Grade 2 case record reviews and 41 Grade 4 Serious Incident investigations

reflect to 43 of the Q1 – Q3 2019/20 deaths included above.

Note: in addition to the above, three Grade two case record reviews, 1 Grade 3 Critical Incident review and 13 Grade 4 Serious Incident investigations are in progress.

The number of deaths in each quarter 2019/20 with a case record review or an investigation (including those in progress) was:

Q1 18 Q2 27 Q3 15

The grade of review for 41 of the 162 deaths is under determination.

Explanatory note:

- 61 closed reviews at Grade 1 (do not fall within the category of case note reviews/ investigations)
- 43 closed reviews at Grade 2 - 4 (case note review/investigation)
- 17 reviews in progress at Grade 2 - 4 (case note review/investigation)
- 41 final grade of review still under determination

Total = 162 deaths

5. National Guidance Ref 27.3 - Deaths judged more likely than not to have been due to problems in care

2018/19 Q4:

- One, representing 1.5%, of the patient deaths during Q4 2018/19 are judged more likely than not to have been due to problems in the care provided to the patient.
- Please note, three reviews are still in progress as well as a judgement in terms of problems in care at the date of preparing this information.
- For the full year 2018/19, by 4 March 2020, six (representing 2.5%) of the patient deaths during the reporting period are judged more likely than not to have been due to problems in the care provided to the patient.

Please note, for the full year 2018/19, 21 reviews are still in progress as well as a judgement in terms of problems in care at the date of preparing this information.

2019/20 Q1 – Q3:

Three, representing 1.8%, of the patient deaths during the reporting period are more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- zero - representing 0% for the first quarter
- three - representing 5.3% for the second quarter
- zero - representing 0% for the third quarter

Please note 63 reviews are still in progress or is a judgement in terms of problems in care is at the date of preparing this information.

The above judgements use a tool designed locally by EPUT, based initially on the Royal College of Physicians Structured Judgement Review tool/methodology and revised to take account of the

tool/methodology published by the Royal College of Psychiatrists in November 2018.

6. National Guidance Ref 27.4 - Examples of learning derived from the review/investigation of deaths judged more likely than not to have been due to problems in care

The following are examples of learning derived from the investigation of deaths judged more likely than not to have been due to problems in care provided to the patient:

- A communication plan, including contact with next of kin, should be agreed prior to a patient's discharge
- Clinical teams must ensure follow up with patients 48 hours after discharge; and undertake a further risk assessment if contact is not achieved
- The Glasgow Coma Scale (GCS) Observations competency should be added to the induction of bank and agency registered nursing staff
- Guidance on the use of high/low and floor line beds should be added to EPUT's Falls Guideline
- A revised bedrail risk assessment form should be uploaded onto the clinical system, including mental capacity questions
- Guidance for staff completing care plans for patients at risk of ligature. This should explain key elements and minimum standards for consideration within these plans to aid in their formulation and recording
- The Basic Life Support training programme includes identification of all equipment contained in the emergency grab bag to ensure that all staff are familiar.

7. National Guidance ref 27.5 - action taken in consequence of the learning above

We have taken the following actions from the examples of learning detailed above:

- Reviewed the processes used for follow up of patients after discharge and introduced new enhanced protocols. These include the community teams undertaking follow up to ensure this occurs on a timely basis as well as actions to take if contact attempts have been unsuccessful. Compliance with the new protocols monitors achievement.
- The induction for bank and agency registered nursing staff now includes competence in Glasgow Coma Scale (GCS) Observations.
- Guidance on the use of high/low and floor line beds added to EPUT's Falls Guidelines.
- The revised 'bedrail risk assessment form' includes the addition of mental capacity questions, and uploaded onto the clinical system.
- At the time of writing this report, enhanced guidance in terms of care plans for patients at risk of ligature is under development.
- EPUT's Basic Life Support training includes information in terms of EPUT's emergency grab bags and their contents.

8. National Guidance Ref 27.6 – Impact of the actions described above:

The impact of the example actions described above is as follows:

- A strengthened process for following up patients discharged from inpatient units after 48 hours includes actions if contact has been unsuccessful. It is anticipated that this will assist the effective discharge of patients successfully into the community with appropriate support
- All bank and agency registered nursing staff are required to be competent in Glasgow Coma Scale (GCS) observations if working within EPUT

- There is clear written guidance for staff enabling them to act appropriately in terms of high/low and floor line beds
- Comprehensive bed rail risk assessments can be undertaken utilising the form available electronically for all clinical staff
- On completion, there will be detailed guidance available for staff in terms of care plans for patients at risk of ligature to ensure care plans are of a high standard
- Via completion of EPUT's Basic Life Support training, all EPUT staff will be familiar with the contents of EPUT's emergency grab bags and thus be able to identify contents and take appropriate action in the event of any emergency

9. Learning from other deaths subjected to mortality review/investigation

We identify any appropriate learning from all mortality reviews undertaken and agree actions irrespective of whether the death is more likely than not to have been due to problems in care provided to the patient. Examples of such learning include the following issues:

- Risk assessment
- Documentation/record keeping
- Communication
- Discharge and assertive follow up
- Disengagement
- Family and carer involvement
- End of life care / physical healthcare

In addition to the individual mortality reviews outlined in the sections above, during 2019/20 we undertook the following thematic reviews of deaths occurring in 2018/19:

- A sample of expected inpatient deaths
- A sample of EPUT's nursing homes patient deaths (Clifton Lodge and Rawreth Court)
- A sample of deaths classified as serious incidents

A review of a sample of deaths of patients diagnosed with a Severe Mental Illness and not classified as serious incidents occurring in 2018/19 was also underway at the time of writing this report.

The above reviews have resulted in 45 deaths subject to overarching thematic review. We have also undertaken an audit of a random sample of seven deaths closed at Grade 1 review (desktop review).

We have shared the learning from these reviews with teams and our Mortality Review Sub-Committee is overseeing its implementation. Examples of learning and actions as a result include:

- Inclusion of a separate specific end of life care plan on patient's records accessible by all staff involved in decision making for the patient
- Review of record systems to ensure all records are easily accessible on electronic systems
- Ensuring that the discussion and agreement of Do Not Attempt resuscitation (DNACPR) with patient / family is appropriately documented in clinical records as per EPUT guidance
- Exploring further the reasons for transfer of patients from EPUT inpatient units to the acute Trusts in the final phases of their lives to identify whether there is any learning for EPUT in terms of being able to meet the patient's preferred place of death request
- Strengthening communication between the acute Trust and EPUT inpatient units when deaths occur within the acute Trust following discharge from EPUT to ensure timely notification of

deaths, thus improving the support that EPUT can offer to bereaved families / carers

10. National Guidance ref 27.7 – 27.9 - Mandated information that will be reported in 2020/21 Quality Account

We are unable to report on the following mandated information in the Quality Account 2019/20; we will report on this in the Quality Account 2020/21:

- The number of case record reviews or investigations finished in 2020/21 which related to deaths during 2019/20 but were not included in the Quality Account for that previous reporting period (Q4 information)
- An estimate of the number of deaths included above which we judge as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this (Q4 information)
- A revised estimate of the number of deaths during the previous reporting period taking account of the deaths referred to in the point above (Q4 information)

Larkwood Ward

A huge thank you to you all for looking after my daughter and being the people to ignite her recovery.

She was a very poorly, sad girl when she came to you and I am now seeing my girl again, trying so hard and taking responsibility, which is all down to you.

Please give my thanks also to the OTs, school, and Danielle. What you are able to do is a wonderful and life-affirming change to kids who cannot see the light at the end of that tunnel.

My gratitude also, for how supportive you have been to me and other family and friends.

2.2.9 National mandated indicators of quality

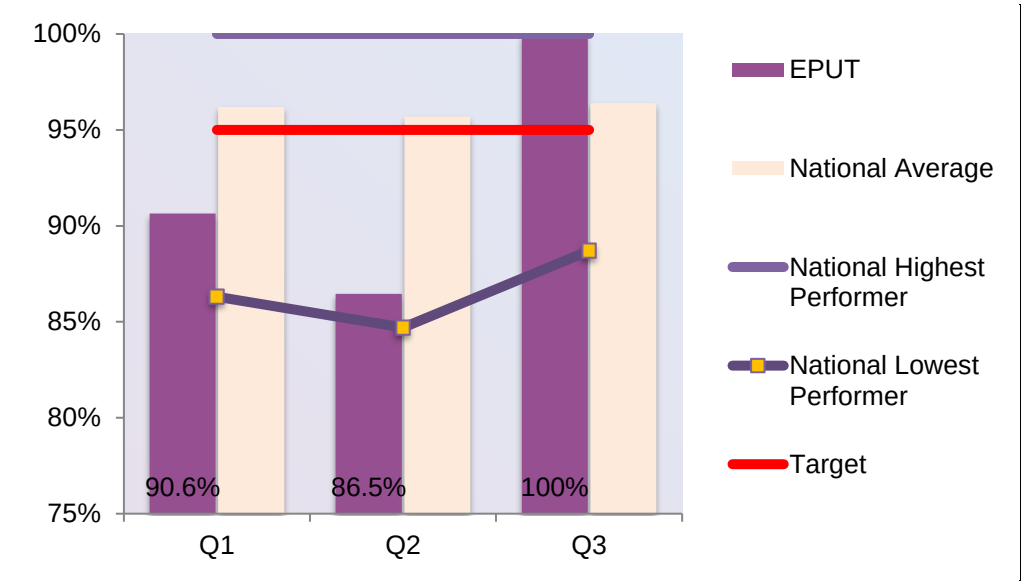
Since 2012/13 NHS Foundation Trusts have been required to report performance against a set of core indicators, using data made available to EPUT by NHS Digital. This section outlines how we have performed as a Trust along with data for the highest and lowest performing Trusts and the National average, where available.

The information presented extracts from nationally specified datasets and reported at an EPUT-wide level.

1. Patients on Care Programme Approach (CPA) followed up within seven days of discharge from psychiatric inpatient stay

This indicator measures the percentage of patients followed up (either face to face or by telephone) within seven days of their discharge from a psychiatric inpatient unit.

Data source: NHSD Strategic Data Collection Service (SDCS) – MHPrvCom via NHS Digital
National Definition Applied: Yes



2019/20	Q1	Q2	Q3
EPUT	90.6%	86.5%	100%
National Average	96.2%	95.7%	96.4%
National Highest Performer	100%	100%	100%
National Lowest Performer	86.3%	84.7%	88.7%

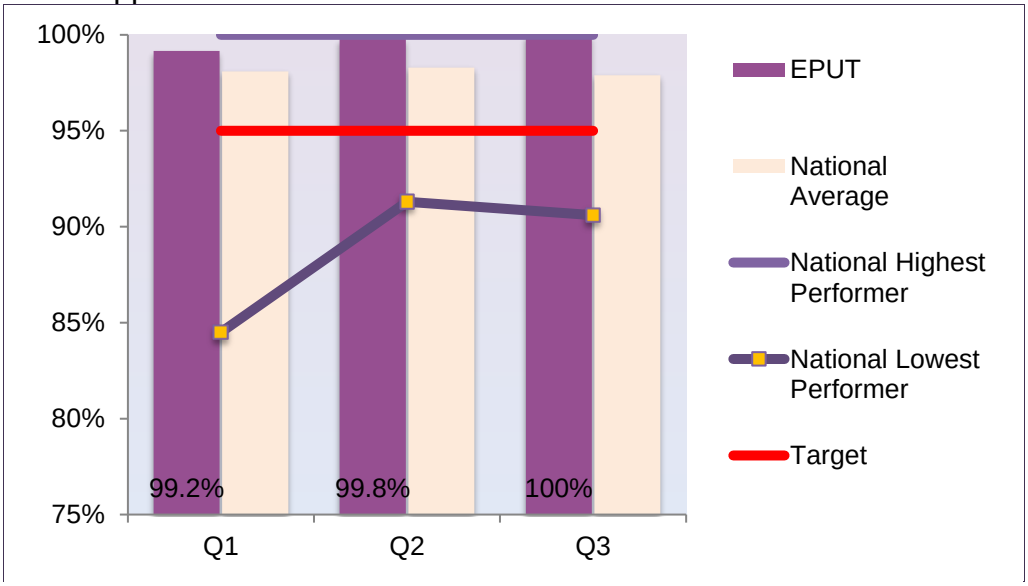
EPUT has achieved this target in Quarter 3 however; EPUT failed to achieve the target in Quarters 1 and 2 and performed below the National average for the same period. This was due to a change in internal monitoring to bring indicator construct in line with national constructs. A Rapid Response Action plan ensured compliance achieved consistently throughout Quarter 3. In Quarter 4, the submission and publication of this National data ceased due to Covid-19 to release capacity across the NHS to support the response.

We have taken a number of actions to improve service quality for this indicator including provision of a live dashboard for operational services to self-monitor and enhanced data quality checking with routine reporting. There is sharing of learning across all appropriate services.

2. Admissions to acute wards gate kept by Crisis Resolution Home Treatment Team

This indicator measures the percentage of adult admissions gate kept by a crisis resolution and home treatment team.

Data source: NHSD Strategic Data Collection Service (SDCS) – MHPrvCom via NHS Digital
National Definition Applied: Yes



2019/20	Q1	Q2	Q3
EPUT	99.2%	99.8%	100%
National Average	98.1%	98.3%	97.9%
National Highest Performer	100%	100%	100%
National Lowest Performer	84.5%	91.3%	90.6%

In 2019/20 EPUT consistently surpassed the target of 95% and performs above the National average for each quarter. There is routine monitoring and reporting of performance on this indicator as part of our Quality and Performance reporting.

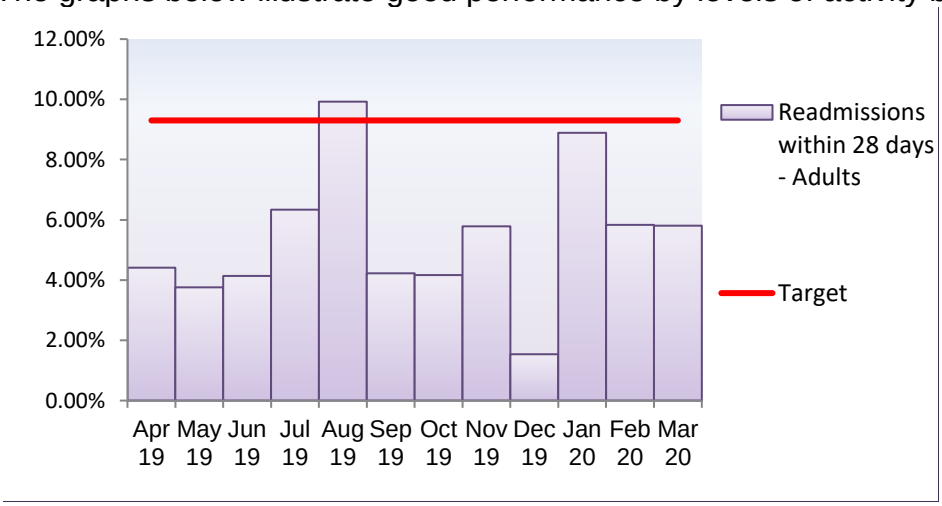
Quarter 4 data is unavailable due to the suspension of this submission and its publications; this submission was paused due to Covid-19 to release capacity across the NHS to support the response.

3. Readmissions

This indicator measures the percentage of adults and older adults readmitted to EPUT within 28 days. There is no set national target for readmission rates; therefore, the MH benchmarking average sets appropriate EPUT targets.

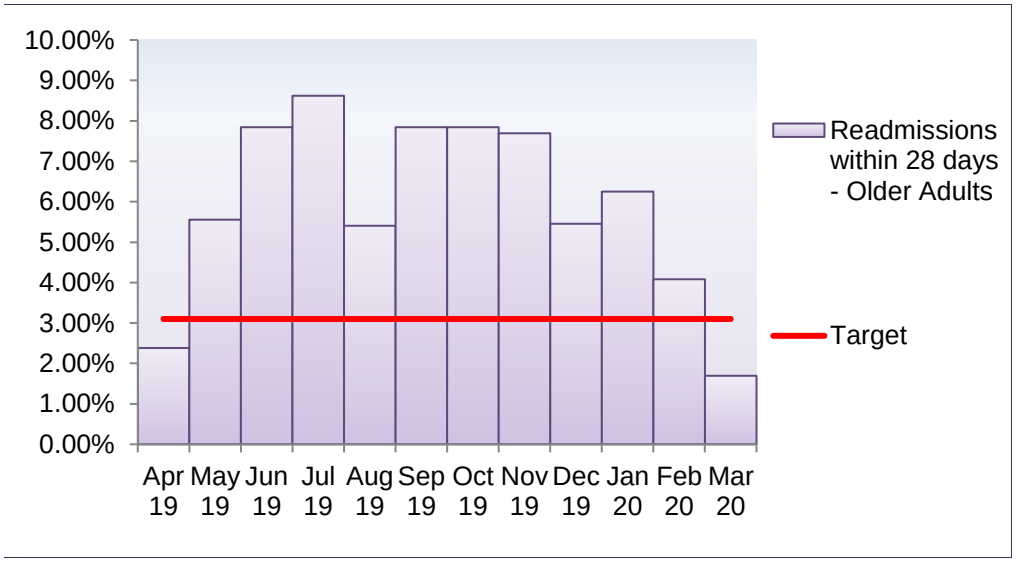
Data Source: EPUT systems (Mobius and Paris)
National Definition applied

The graphs below illustrate good performance by levels of activity below the target line.



The percentage of adults readmitted within 28 days has performed below the target of less than 9.3% for all months with the exception of a surge in August 2019. In August 2019 performance rose to just above target at 9.9%.

The percentage of older adults readmitted within 28 days has breached the target of less than 3.1% for all months with the exception of April 2019 and March 2020.



In 2019/20 EPUT was consistently below national target of 9.3% for Adults with the exception of one month in August 2019.

In 2019/20 EPUT was almost consistently above the national target of 3.1% for Older Adults.

Analysis looks at why Older Adult readmission rates are above national average and a high proportion of the discharges and readmissions relate to acute hospital care.

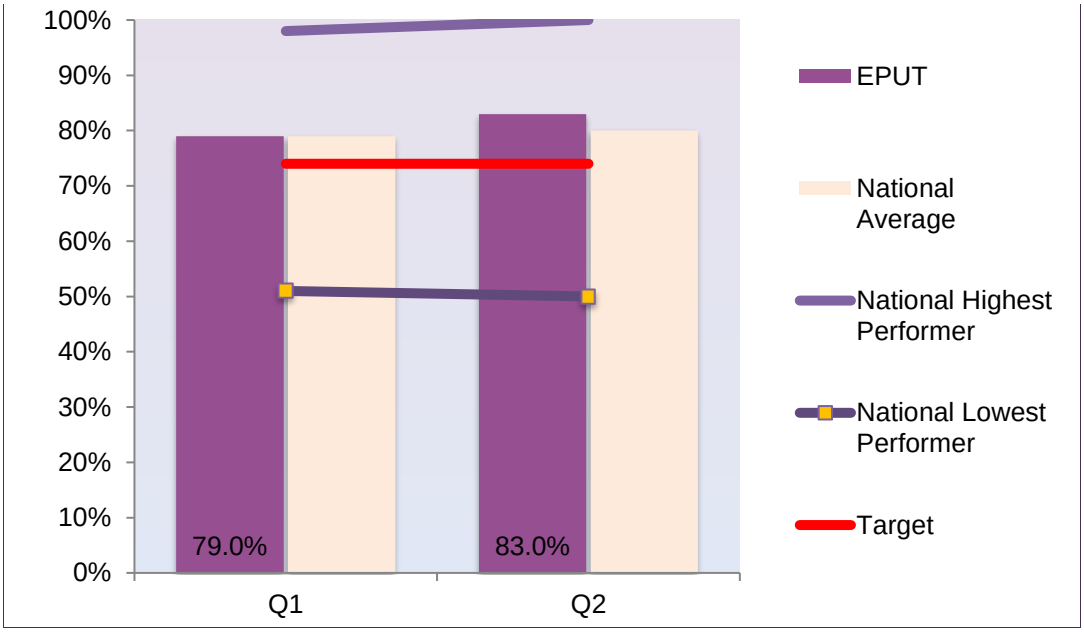
Routine monitoring and reporting of performance on this indicator takes place as part of our Quality and Performance reporting.

4. Staff recommended score of EPUT as a place to receive treatment

The Friends and Family Test is available to staff anonymously records whether they would recommend EPUT to their family or friends, as a place to work or as a place to receive care. This section details what percentage of staff would recommend EPUT as a place to receive treatment. The aim of the Staff Friends and Family Test is for all staff to have the opportunity to feed back their views on their organisation at least once per year.

Our staff were able to record their views from 1 April 2019 to 31 March 2020, however please note that there are no responses reported for Q3 as this coincides with the National NHS Staff Survey. Due to the Covid-19 outbreak, this submission ceased to release capacity from March 2020 and we therefore do not have Quarter 4 information.

Data source: Staff Friends and Family Test (FFT) survey **National definition applied: Yes**



2019/20	Q1	Q2
EPUT	79%	83%
National Average	79%	80%
National Highest Performer	98%	100%
National Lowest Performer	51%	50%

The above information outlines that EPUT has performed in line and above average in Quarters 1 and 2. The Staff Friends and Family Test (SFFT) is helping to promote a big cultural shift in the

NHS, where staff have both the opportunity and confidence to speak up, and where the views of staff are increasingly heard and are acted upon. EPUT produces regular reports following each publication of the survey results and works to introduce measures for improving our scoring.

5. Patient experience of community mental health services

The Care Quality Commission (CQC) conducts an annual survey for clients who have received care from community mental health services in England. In this section, you will find the results of the 2019 EPUT survey.

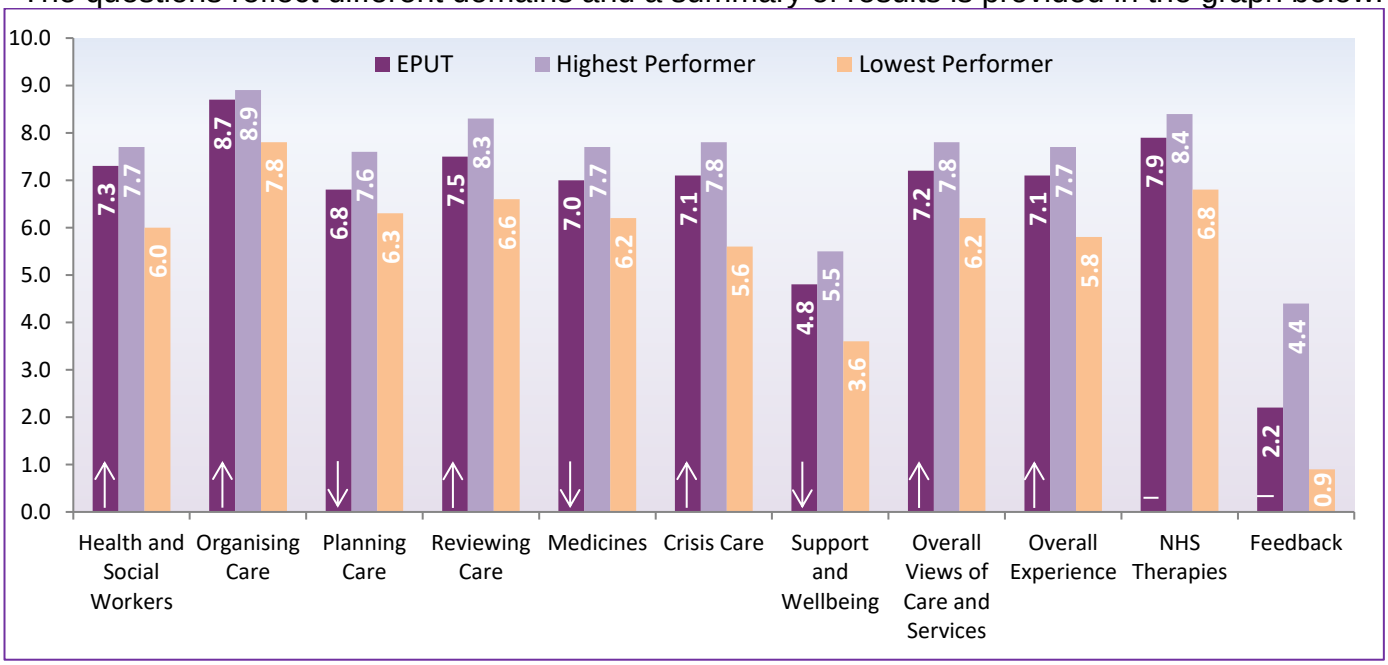
EPUT is continuously working to improve our service and client feedback drives a large part of that work, so that we can understand what clients think about their care and treatment.

The survey, commissioned by the CQC, resulted in responses from 12,551 people, a response rate of 27%.

Our 2019 report shows how we scored for each evaluative question in the survey, compared with the lowest and highest Trusts. Scores are on a scale of 0 to 10.

Data source: CQC Community Mental Health Services Survey
National Definition Applied: Yes

The questions reflect different domains and a summary of results is provided in the graph below:



Arrows in the above graph highlight which domains have improved or declined from the 2018 survey results. Comparing the 2018 and 2019 scores, EPUT improved in six domains and declined in three. There are two new domains for 2019 and comparison analysis therefore cannot be undertaken.

A full action plan includes making improvements in all areas below national average and all areas

where a decline is noted.

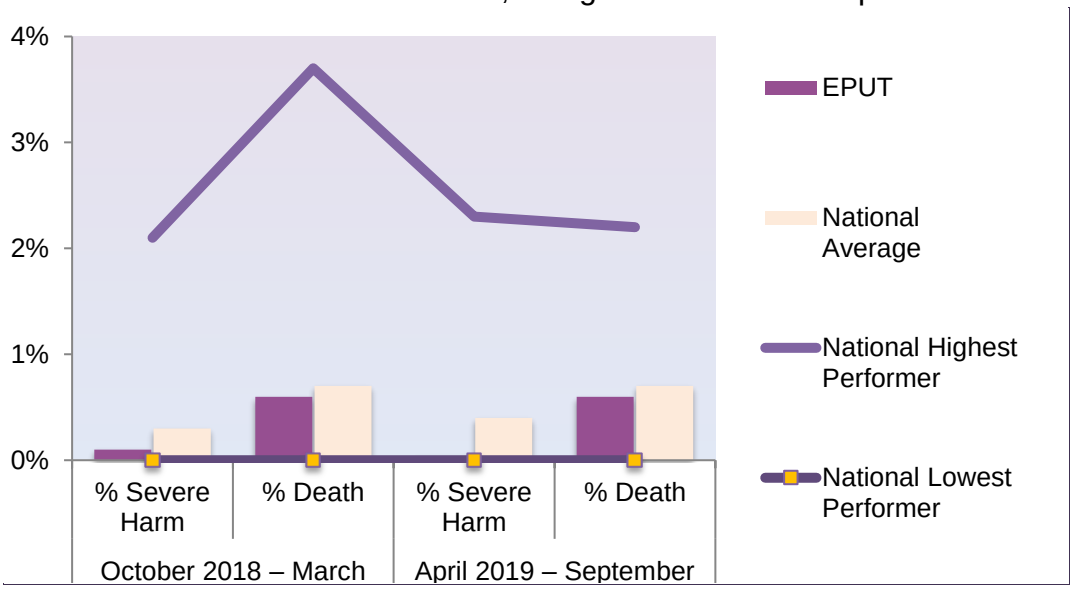
6. Patient safety incidents and the percentage that resulted in severe harm or death

This indicator measures the number of incidents to occur in EPUT and the percentage of those that result in severe harm or death.

Data source: NRLS NPSA Submissions *National definition applied: Yes*

Reporting Dates	1st October 2018 - 31st March 2019 (Published September 2019)			1st April 2019 - 30th September 2019 (Published March 2020)		
	All incidents	Severe harm	Deaths	All incidents	Severe harm	Deaths
EPUT	7,603	5	43	8,170	3	48

The graph below shows the percentage of all incidents we reported to the NRLS that resulted in severe harm and those which resulted in death, along with National comparisons.



2019/20	October 2018 – March 2019			April 2019 – September 2019		
	Incident Rate	% Severe	% Death	Incident Rate	% Severe	% Death
EPUT	70.6	0.10%	0.60%	64.2	0.04%	0.60%
National Average	57.3	0.30%	0.70%	62.9	0.40%	0.70%
National Highest Performer	118.9	2.1%	3.7%	130.8	2.3%	2.2%
National Lowest Performer	14.9	0%	0%	17.2	0%	0%

The above graph and table highlights that EPUT has consistently performed below the national average for patient harm resulting in severe harm or death. EPUT has however performed above the National average in overall incident rates per 1,000 bed days.

There is robust governance within EPUT to ensure no harm/ low harm rates including benchmarking ourselves against national averages and other Trusts within our cluster group.

We are taking the following actions to improve our incident reporting rates by:

- Training ward managers in the running of their own incident reports for monitoring purposes of their respective area
- Routine reporting of incident rates and patient harm through a number of internal reports
- Undertaking six monthly auditing of incident reporting to ensure all Patient Safety incidents are on the incident recording system.

Incident system training is ongoing, and work is planned (once the Covid-19 threat has passed) to work with Service Managers to improve the quality of lessons learned from incidents. Quality Priorities for the coming year have been set to improve patient safety.

2.2.10 Doctors' Rota Gaps

Annual Report on Safe Working of Junior Doctors 2019/2020

This section provides assurance that doctors in training are safely rostered and that their working hours are compliant with the terms and conditions of their contract.

Doctors in Training Data:

Number of doctors in training (total inclusive of GP and Foundation)	122
Number of doctors in psychiatry training on 2016 Terms and Conditions (average)	50
Total number of vacancies (average over reporting period)	31
Total vacancies covered by LAS and MTI (average over reporting period)	21

Annual data summary:

Trainees within EPUT

Specialty	Grade	Q1	Q2	Q3	Q4	Total gaps (average WTE)
Psychiatry	CT1-3	32	31	31	29	13.25
Psychiatry	ST4-6	22	18	18	19	17.75
Total		54	49	49	48	31

Trainees outside EPUT overseen by the LET guardian

Specialty	Grade	Q1	Q2	Q3	Q4	Total gaps (average WTE)
GP trainees	ST1	13	13	13	15	1.75
Foundation	FY1	12	12	12	12	0
Foundation	FY2	12	12	14	14	2

Agency Usage:

EPUT does not use agency workers and relies on the medical workforce to cover out of hours i.e. 5pm to 8:30am at internal locum rates. There are varied reasons for covering out of hours ranging from sickness, the additional out of hours that less than full time trainees cannot contractually cover, and vacant posts.

The total number of shifts covered in reporting period:

Locum bookings (internal bank) by reason					
Reason	No. of shifts requested	No. of shifts worked	No. of agency shifts	No. of hours requested	No. of hours worked
Vacancies/ Maternity Leave/ Sickness/ LTFT cover	471.5	471.5	0	5054.5	5054.5
Total	471.5	471.5	0	5054.5	5054.5

Exception Reports:

Trainees via the Allocate reporting system from April 2019 to March 2020 raised 15 exception reports.

Issues Arising

- Gaps in rota from April 2019 – March 2020
    - Core Trainee (CT) Grade – total of 30 WTE
    - Specialty Trainee (ST) Grade – total of 89 WTE
- Filling of gaps at CT level is with internal doctors paid an internal locum rate. The gaps at ST level are unfilled; on occasions Consultants, especially in the North of EPUT, had to step down to cover the gap. We generally avoid the use of Agency locums. There are no particular reasons or patterns observed for these gaps and national recruitment seems to be the issue.
- Junior doctors expressed concern at lack of facilities in on call rooms especially at Colchester, Epping and Gloucester Ward.
- Junior Doctors requested an updated 'Stepping Down Policy'.
- Health Education England has granted £30,000 to our Junior Doctors.

Actions taken to resolve issues

- Rolling adverts on NHS jobs are in place and EPUT has recruited a number of MTI and LAS doctors who are covering the gaps in the rota.
- GPs and FY2s have the opportunity to express an interest in joining the bank to participate in on-call when they leave EPUT.
- Facilities in on calls rooms at various sites have improved after escalating the issues to the relevant Managers.
- The HEE funding amount has now been finalised and signed off at the Junior Doctors Forum; Junior Doctors have decided on how they are going to utilise the money to improve the facilities at their work site.

Key issues from host organisations and actions taken

- There are no specific key issues within EPUT with regard to vacancy rates. There is a National recruitment issue.

At the Junior Doctors Forum, Doctors have raised the following issues:

- Facilities in on call rooms and doctor's room
- Lack of rooms and facilities to carry out their daily tasks at Gloucester ward at Thurrock
- Doctors requested access to blood results from pathology labs

- Senior Doctors requested laptops

Issues addressed are as follows:

- Facilities in their on call and doctors' room have improved
- Gloucester Ward Doctors have been identified a room to carry out their tasks
- Laptops have been distributed to the Senior Doctors
- More improvements to their working environment are in progress via the HEE funding, which Doctors had autonomy to decide on how to use the money. This has been finalised and signed off at the last Junior Doctors Forum.

EPUT had a very good pass rate in the last MRCPsych examination and there is hope that these Doctors will become Senior Trainees in the near future.

2.2.11 Staffing in adult and older adult community mental health services

The long-term implementation plan for the NHS 2019/20 to 2023/24 set out a proposal to transform mental health services. A ring-fenced local investment fund worth at least £2.3 billion a year in real terms by 2020/24 aims to ensure the NHS provides high quality, evidence-based mental health services to an additional two million people. For EPUT this translates into five primary strands

Perinatal Services

EPUT perinatal services have received additional funding that has increased staffing. This is progressing well ahead of an agreed business case. Better quality services have resulted from system working with midwifery and integrated physical and mental health pathways

Perinatal Mental Health

By 2023/24:

- At least 66,000 women with moderate to severe perinatal mental health difficulties will have access to specialist community care from pre-conception to 24 months after birth with increased availability of evidence-based psychological therapies. Their partners will be able to access an assessment for their mental health and signposting to support as required;
- Maternity Outreach Clinics will be available across the country, combining maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience.

Community (Primary) Care

There are a small number of Trusts acting as early implementers and West Essex is one of these. An evaluation of this model should result in a roll out between 2021 and 2024. EPUT is a leader in delivery and other pilots will take place in Southend, Castle Point and Thurrock, operated by senior clinical staff. Again, this is whole system working between physical and mental health, including GPs. Mid/South Essex and Brentwood/Basildon will come on line in Quarter four with a full roll out the following year. There are exceptional calls on this funding.

Personality Disorders

For people with a diagnosis of personality disorder there is an agreed business case for an Essex

system wide model funded by three System Transformation Partnerships (STPs). However, it should be noted that only Mid/South Essex have agreed funding at present, with West Essex withdrawn for 2020/21 and North Essex still negotiating. This has resulted in the need to review the start and rollout of this major model. Training, consultation and a special case holding team aims to reduce out of area bed number. The model will reduce admissions and provide care that is more effective locally rather than out of area.

Adult Severe Mental Illnesses (SMI) Community Care

By 2023/24:

- All STPs/ICSs will have received funding to develop and begin delivering new models of integrated primary and community care for adults and older adults with severe mental illnesses, incorporating care for people with eating disorders, mental health rehabilitation needs and complex mental health difficulties associated with a diagnosis of a 'personality disorder', among other groups. These new models of care will span both core community provision and also dedicated services, where the evidence supports them, and they will be built around Primary Care Networks. By the end of 2023/24 every STP/ICS will have at least one new model in place, with care provided to at least 370,000 adults and older adults per year nationally, giving them greater choice and control over their care, and supporting them to live well in their communities.
- A total of 390,000 people with SMI will receive a physical health check.
- A total of 55,000 people a year will have access to Individual Placement and Support services.
- The 60% Early Intervention in Psychosis (EIP) access standard will be maintained and 95% of services will achieve Level 3 NICE concordance.

Urgent and Emergency Care

Three services have launched in North Essex, West Essex and Mid/South Essex. A 24-hour public facing crisis helpline is now in place, enabling mental health assessment and safe tele coaching. This has involved an additional 50 staff across Essex and recruitment continues.

Mental Health Crisis Care and Liaison

By 2023/24:

- There will be 100% coverage of 24/7 age-appropriate crisis care, via NHS 111, including:
  - 24/7 Crisis Resolution Home Treatment (CRHT) functions for adults, operating in line with best practice by 2020/21 and maintaining coverage to 2023/24;
  - 24/7 provision for children and young people that combines crisis assessment, brief response and intensive home treatment functions [see also *Children and Young People's Mental Health*];
  - A range of complementary and alternative crisis services to A&E and admission (including in VCSE/local authority-provided services) within all local mental health crisis pathways;
  - A programme for mental health and ambulances, including mental health transport vehicles, training for ambulance staff and the introduction of nurses and other mental health professionals in Integrated Urgent Care Clinical Assessment Services.
- All general hospitals will have mental health liaison services, with 70% meeting the 'core 24' standard for adults and older adults.

Additionally, appropriate access and waiting time standards for urgent and emergency mental health care will be field tested during 2019/20, with trajectories for introduction over the course of the LTP to be confirmed thereafter.

Older People and Dementia/Frailty

New, fully integrated health and social care and frailty models are in place in Mid and South Essex and are having a positive impact on admission rates. Two wards closed as a direct result of this integration. Agreement with Clinical Commissioning Groups through business cases will improve and roll this out in due course.

Older People's Mental Health

The implementation of the Long Term Plan provides a unique opportunity to ensure consistent access to 'functional' mental health support for older adults and address the mental health needs of older adults wherever they may arise or present[1]. Older people's mental health (OPMH) is embedded as a 'silver thread' across all of the adult mental health ambitions, including IAPT, community-based services for people with severe mental illnesses (SMI) and crisis and liaison mental health care.

Note on the impact of Covid-19:

Although the current Covid-19 pandemic may divert attention away from these transformation projects, they will continue and the impact may be a slight pause or slowing down rather than any cessation.

2.2.12 Whistleblowing

At EPUT, we are creating an environment where our staff are able to speak up and raise concerns about poor practice without fear of victimisation. We want to encourage staff to express any concerns in a constructive way and to put forward suggestions in order to contribute towards the delivery of care and services to patients, service users and carers.

A 'standard' integrated policy was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS aimed at improving the experience of whistleblowing. The policy (produced by NHS Improvement and NHS England) to be adopted by all NHS organisations in England as a minimum standard will help to normalise the raising of concerns for the benefit of all patients and service users. EPUT took this recommendation forward in 2017, and our approach and local process reflected in EPUT's Raising Concerns (Whistleblowing) policy and procedure, which provides more detail about how we will look into a concern.

The policy and procedure does not replace existing policies and procedures regarding grievance or complaints, or dealing with patient events as described in the 'Being Open and Duty of Candour policy', nor is it intended to replace the normal lines of communication between staff and their managers. Matters of concern should still be dealt with through normal management and/or clinical advisory channels

If an individual raises a genuine concern under this policy, they will not be at risk of losing their job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully an individual into not raising any such concern as this behaviour is a breach of our values as an organisation and, if upheld following investigation could result in disciplinary action. Provided an individual is acting honestly, it does not matter if they are mistaken or if there is an innocent explanation for their concerns.

We are committed to the principles of the 'Freedom to Speak up' review and its vision for raising concerns, and will respond in line with them.

We are committed to listening to our staff, learning lessons and improving patient care. On receipt, we record the concern and the individual will receive an acknowledgement within two working days.

We will tell the individual who will be handling the matter, how to contact them, and what further assistance required. If required, we will write summarising the concern and setting out how we propose to handle it and provide a timeframe for feedback.

Individuals can raise concerns about risk, malpractice or wrongdoing in connection to any harm to the service we deliver. Just a few examples of this might include (but are by no means restricted to):

- unsafe patient care
- unsafe working conditions
- inadequate induction or training to staff
- lack of, or poor, response to reported patient safety incident
- suspicions of fraud (which can also be reported to our local counter fraud team)
- a bullying culture (across a team or organisation rather than individual instances of bullying)

How does the Freedom to Speak Up agenda support staff?

Freedom to Speak Up is a national agenda and an elected Principal Guardian is in place for EPUT. We have a number of mechanisms in place to enable staff to raise issues, for example a designated facility on the intranet and the 'Raising Concerns' policy and procedure. The idea of the 'Freedom to Speak Up' Principal Guardian is that they facilitate discussions between staff and management. Local Guardians are also in place to support the Principal Guardian.

Roding Ward

To all the nursing staff on Roding ward, a very big thank you!

You all were so very kind to me, especially Jenny - so very patient! I miss having you all around, although it is lovely to be home again.

I would also like to thank all the staff in the kitchen, who were never impatient with me.

Part 3: Review of quality performance 2019/20

3.1 Progress against the quality priorities we set for 2019/20

Quality priority 1: EPUT will aim to achieve a minimum 95% harm free care through the national Safety Thermometer data collection with the aim to drive continuous improvement to move towards zero:

- Pressure ulcers
- Avoidable falls
- Medication omission
- Physical health of mental health patients and
- Early warning systems for deteriorating patients

AREA	PRESSURE ULCERS
Why did we set this priority?	• Pressure ulcers represent a major burden of sickness and reduced quality of life for people and their carers with the most vulnerable people being aged 75 • The presence of a pressure ulcer creates a number of significant difficulties psychologically, physically and clinically to patients, their families and their carers. They have a profound impact on a person's overall wellbeing and can be both painful and debilitating • Pressure ulcers can be serious and lead to life-threatening complications
What were our aims?	• Develop a trajectory for a reduction in category 2 pressure ulcers (2018/19 outturn 669) • Zero category 3 and 4 pressure ulcers acquired as a result of omissions in care with a 50% reduction in year against current performance (2018/19 outturn 6)
What actions did we take?	• Developed trajectory for reduction in category 2 pressure ulcers • Developed and embedded RCA Pressure Ulcer Guidelines across all clinical services • Rolled out NHSI recommendations in relation to the revised definition and measurement of pressure ulcers • Reviewed incident reporting system to ensure consistency in reporting • Reviewed and revised guidelines on prevention and management of pressure ulcers to ensure consistency and standardisation of practice across EPUT • Revised training programmes and information packs cascaded to all teams with face to face training to support implementation of NHSI recommendations
Future actions	• Further update of PU guidelines required to clarify and simplify some key areas (reporting process and frequency of risk assessments) • Develop quick reference and FAQ guide for the PU reporting process • Develop minimum data set guide for frequency of risk assessments as a resource for EPUT teams • Undertake 'deep dive' of all pressure ulcer incidents to identify themes, trends and lessons learned

AREA	FALLS
Why did we set this priority?	• Across England and Wales, over 36,000 falls are reported from mental health units and 28,000 from community hospitals • They are the most commonly reported type of incident in community hospitals and the third most commonly reported type of incident in mental health hospitals • Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged over 75 in the UK
What were our aims?	• 15% reduction in all falls against 2018/19 outturn 1620 (2017/18 1552) • 10% reduction in the number of falls resulting in a serious incident against 2018/19 outturn 7 • 50% reduction in the number of falls as a result of omissions in care against 2018/19 outturn 6
What actions did we take?	• Reviewed Falls Guidance and provided clarification regarding the requirement to complete a Falls Risk Assessment in people under the age of 65 • Introduced Falls: Supportive and Safe Observation Guidelines and output measures in relation to a reduction in the number of falls • Implemented a procedural guideline for Delirium • Continued participation in the National Audit of Inpatient Falls • Undertook learning events with falls champions • Reviewed guidance in relation to safe use of bedrails
Future actions	• Continued participation in the National Audit of Inpatient Falls to include mental health wards • Implement the Delirium Guideline to include a Delirium Pathway • Undertake a local audit to examine post-falls management

Byron Court

I would like to take the opportunity to extend my appreciation to the entire staff Team at Byron Court for all their hard work and dedication in supporting JR through his treatment while an inpatient. The time and diligence demonstrated through their collaborative partnership working instilled the processes to establish effective transition and discharge planning thus ensuring the successful outcome that JR presently enjoys within the community to date.

AREA	Omitted Doses
Why did we set this priority?	• Over the last 12 months omitted doses have featured within the top three subcategories of medication incidents, both for mental health and community health services • A review of medication incidents by the National Patient Safety Agency (NPSA) identified that omitted and delayed medicines was the second largest cause of medication incidents reported to the National Reporting and Learning System (NRLS) • Omitted doses affect patients by reducing chances of successful treatment and tend to increase length of stay that affects financially on EPUT.
What were our aims?	• To reduce the incidence of omitted doses by 50% where no reason code is annotated • To provide assurances that medicines are being used safely and effectively across EPUT
What actions did we take?	• Recruitment of a Trust Medication Safety Officer (MSO) in Q1 of 2019/20 • Thematic analysis of incidents relating to omitted doses and identification of high risk medications • Omitted doses captured on inpatient units as part of a weekly pharmacy checklist and auditor is required to report this using the DATIX incident reporting system • An annual omitted doses audit is undertaken as part of the pharmacy audit programme • The MSO works with the risk management colleagues to improve usability of the DATIX system for staff when submitting medication-related incidents • Reinvigoration of EPUT Medication Safety Group in quarter two 2019/20 at which omitted doses is a standing item on the agenda • Funding for EPMA secured with a plan to roll out to start in 2020/21
Future actions	• Development of an algorithm for staff on the actions to be taken if a dose is missed • The Medication Safety Group will update guidance on time critical medicines to improve the understanding of staff on the impact of omitted doses • The MSO will continue to follow up DATIX reports of medication incidents involving a delayed or omitted dose to ensuring appropriate action has taken place

Holly Wheelchair Team

I am writing to thank you so much for your efforts on my behalf with the wheelchair, which are much appreciated.

It is so much more manageable than the previous one, besides giving me more control.

AREA	PHYSICAL HEALTH OF MENTAL HEALTH PATIENTS
Why did we set this priority?	• It has been shown that the most successful systems for improving physical health care of patients with serious mental illness are those where physical and mental health care is integrated
What were our aims?	• To support nursing and support staff in the development and maintenance of physical health competencies • To implement the competency framework
What actions did we take?	• Put in place physical health training programme based on competency framework incorporating management of diabetes and Coronary Vascular Disease • Reviewed and implemented physical health audit incorporating a qualitative outcome baseline
Future actions	• Continued delivery of physical health training to nursing and support staff

Robin Pinto Unit

To all the wonderful staff at Robin Pinto

Thank you so much for the exceptional care and support you have given to Adam over the last two years.

We are truly grateful from the bottom of our hearts.

AREA	EARLY WARNING SYSTEMS FOR DETERIORATING PATIENTS
Why did we set this priority?	• The Modified Early Warning System has been implemented within EPUT inpatient services to support staff in the detection of physical deterioration
What were our aims?	• To ensure that patients physical health is monitored and deterioration is recognized and treated promptly
What actions did we take?	• Audit of MEWS charts and review of findings
How well did we do?	• The audit findings indicate that MEWS recording is accurate across the inpatient setting. Improvement from previous audit is evident
Future actions	• Action plan to be developed to improve escalation/recording of raised MEWS scores • Delivery of face-to-face training on vital signs monitoring across inpatient areas where areas for improvement have been identified • Review early warning scoring systems to ensure compliance with most appropriate model

Quality priority 2: No Force First. We will seek to embed the principles of No Force First in order to reduce restrictive interventions

AREA	NO FORCE FIRST
Why did we set this priority?	• 'No Force First' was originally an initiative within mental health inpatient units in the United States to dramatically reduce the number of, and ultimately eliminate dangerous restraint and seclusion events • It has a proven record of success in transforming healthcare environments and enhancing safety for service users and staff
What were our aims?	• EPUT has agreed to adopt No Force First as its restrictive practice reduction programme following significant success as a strategy in other mental health inpatient environments • The impact of No Force First on wards had shown to reduce conflict and restraint and associated work related sickness with significant benefits for service users and staff • In addition, two wards were selected to take part in a two year collaborative working with Royal College of Psychiatrists on restrictive practices • Through the Restrictive Practice Steering Group comprehensive and sustainable structures will be established to monitor, deliver and integrate the approach in clinical practice
What actions did we take?	• Introduced ward level system ensuring compliance with new national data set • Active participation by two wards in RCP reducing restrictive interventions collaborative • Implemented a range of tools and techniques e.g. safety crosses and safety pods across a range of inpatient areas • Implemented a debriefing protocol at ward level and developed a psychological debriefing support system for staff • Held a reducing restrictive practice conference • Scoping exercise led by Executive Nurse across inpatient areas informing further actions • Reviewed in-house training programmes and undertook BILD accreditation • Developed dashboards from ward to board • Change in practice in relation to pharmaceutical management of restraint supported by training programmes
Future Actions	• Appointment of QI Facilitators working with front line teams to cascade implementation of a range of tools and techniques to change practice • Roll out learning from RCP collaborative • Roll out of OLM and BILD new training criteria

Access and Assessment Team
I want to tell you how very much I have appreciated what you have done for me over the last several months. More than anything, though, I have so valued your warmth and sincerity. Since we first met, I have felt I had a friend on my side, which is something I have not been accustomed to.

Priority 3: Suicide/Unexpected Deaths: Following the publication of the NHS Zero Suicide Alliance EPUT has revised its Suicide Prevention Strategy taking recommendations from working groups to identify priorities for action

AREA	SUICIDE/UNEXPECTED DEATHS
Why did we set this priority?	• Suicide is a significant public health problem and reduction and prevention is a major part of our role • The number of unexpected patient deaths (including deaths by suicide, neglect and misadventure has increased across mental health Trusts

What were our aims?	• As a result of the publication of EPUT's Suicide Prevention Strategy and recommendations from working groups the following priorities have been identified to ensure successful implementation and embedding of the strategy into EPUT services:
	  • Suicide Prevention Safety Tools and communication
	  • Suicide Prevention Learning Culture
	  • Suicide Prevention Family and Carer Involvement

What actions did we take?	• Appointed a dedicated suicide prevention trainer and are in the process of rolling out a comprehensive training programme • Revised Suicide Prevention Group underpinned by 3 work streams: clinical, Family and Carer Engagement and Learning Lessons Culture • Development of a dashboard to drive performance • Work streams have been established for Family and Carer Engagement and Learning Lessons Culture • Review of suicide and self-harm policy • Work undertaken with system partners to develop an integrated suicide plan • Membership of Zero Alliance • Partnership with Samaritans • Introduction of Staying Alive Suicide Prevention app on all EPUT mobiles • Three audits undertaken linked to Suicide Prevention Strategy – DNA, Meds on discharge and risk assessment prior or inpatient leave
Future actions	• Workshop to cascade learning for development of a learning culture • QI approach to be taken to reduction of self-harm • Audit and dashboard to inform future actions.

Priority 4: Collective Leadership

AREA	COLLECTIVE LEADERSHIP
Why did we set this priority?	• It is recognised that in order to operate as an outstanding organisation it is essential that EPUT works collectively with its staff, service users and system partners to plan, deliver and evaluate the quality of care and associated outcomes that is provided
What were our aims?	• To develop and embed systems of collective leadership to enhance EPUT performance and improve practices for staff and patients
What actions did we take?	• System involvement in NHSI Transforming Change through System Leadership • Collective working to identify key transformation projects • Staff involvement in transformation and QI programmes

	• Collective leadership embedded in OD Frameworks • Review of leadership forums supporting wider engagement
Future Actions	• Further work will be undertaken to develop and embed EPUT Organisational Development programme

Priority 5: Continuous Improvement

AREA	CONTINUOUS IMPROVEMENT
Why did we set this priority?	• Nationally and internationally a case has been made to change the way patient safety is approached in the NHS • QI provides a methodology to drive continuous and sustainable improvements in relation to patient safety
What were our aims?	• Our aim is to embed continuous improvement within the culture of the organisation and empower all staff, service users and carers to work together to enhance the reliability of service provision
What actions did we take?	• EPUT board completed NHSI's Leadership in Improvement programme • Directorate QI Hubs introduced • Gained accreditation to deliver QSIR and implemented first cohort alongside other training programmes • Developed Gold level Quality Champions to provide coaching/mentorship • Develop dashboards against quality priorities
Next Steps	• Further development of QI Hubs • Development of training strategy • Ward accreditation schemes • Closer integration with research and innovation

Priority 6: Effective Use of Technology

AREA	Effective use of technology
Why did we set this priority?	• As set out in national guidance and strategy published by National Information Board data and technology are central to transforming outcomes for patients and local populations
What were our aims?	• Through the effective use of technology, EPUT will implement improved mechanisms of acquiring, reviewing, understanding, analysing and exchanging patient safety data and knowledge.
What actions did we take?	• Through EPUT Lab developed and reviewed and implemented a number of technological systems • Development of a dashboard against quality priorities • Strengthening of ward to board use of data to inform decision making • Introduction of Perfect Ward app to strengthen audit and systems of assurance • Implementation of SafeCare to improve Safer staffing
Next Steps	• Technological innovations driven through EPUT Lab to deliver against the Model Hospital

Priority 7: A Just and Learning Culture

AREA	A JUST AND LEARNING CULTURE
Why did we set this priority?	• Patient Safety is of primary concern • Delivery is dependent on the development of a Just, and Learning Culture where individuals and organisations can learn from mistakes improving systems and processes to enhance patient safety
What were our aims?	• A just and learning culture will be developed to embed EPUT's agreed approach in response to incidents and errors to protect both staff and people that use our services.
What actions did we take?	• Principles of just and learning culture and human factors embedded into induction, leadership and quality champion training • Process reviewed and enhanced to share 72 hour review of serious incidents within one week to relevant teams • Key messages and lessons learnt distributed monthly • Developing Learning Culture Group established to develop work plans and cascade learning. • Datix training and risk training updated to enhance focus on learning lessons.

Priority 8: End of Life Care

AREA	END OF LIFE CARE
Why did we set this priority?	• Supportive End of Life care is critical for people in the last months or years of their life • Following a CQC inspection it was reported that some improvements could be made to Trust services
What were our aims?	• EPUT is committed to the provision of the very highest quality of care for people with advanced life threatening illnesses • They and their families should expect good end of life care, whatever the cause of their condition and all those identified as end of life should have the opportunity to discuss, plan and identify their preferences for their care at end of life and their preferred place of death
What actions did we take?	• Implemented 'national ambitions' through EPUT End of Life Care framework • Developed and implemented competency framework to enhance knowledge, develop skills and promote positive attitudes and behaviour in the delivery of care to patients at the end of life • Participated in National Audit for Care and End of Life for inpatient services • Undertook local audits relating to care at end of life and Do Not Attempt Cardiopulmonary Resuscitation • Developed dashboard to develop a set of measureable, person centred outcomes to ensure EPUT has a greater understanding of the impact of the care being delivered by teams and to monitor quality and performance • Developed information leaflets for Life Limiting and End of Life conditions, and Care in the Last Days of Life to supplement information for patients and carers • Participated in the national Dying Matters Campaign • Implemented the role of End of Life Champion across all teams

Future actions	• Undertake an analysis of audit findings to determine actions and implement recommendations • Strengthen feedback from carers by the development of a questionnaire • Explore options for a forum for carers • Continued working with system partners to develop a standardised approach to EoL care and frailty

Beech Ward (Essex)

Thank you for all the help you give
Thank you for being there
Thank you for all the things you do
Thank you for all your care
Thank you for standing by my side
Thank you for staying true
Thank you for giving me the strength
Thank you for being you!

Did we achieve the priority?

The Board of Directors considered the strategic context, their knowledge of EPUT and the feedback from staff and stakeholders during the planning cycle and identified eight Quality Priorities for 2019/20.

RAG (Red Amber Green) ratings have been applied to provide an accessible method of understanding the levels of performance. RAG ratings should be used in conjunction with the actual levels of performance which are also quantified in the charts that follow.

RAG rated RED to indicate that performance has not met the target by a significant margin.

RAG rated AMBER to indicate that performance is close to target.

RAG rated GREEN to indicate that performance has met or exceeded the target %.

AMBITION		YEAR END POSITION	
1	Achieve 95% harm free care through the national Safety Thermometer data collection	• March 2020 Performance 95.7%	
1a	Reduce the number of avoidable category three and four pressure ulcers acquired in our care	• At year end there have been 6 Cat 3 / 4 pressure ulcers as a result of omissions in care (18/19 OT = 6)	
1b	Reduce the number of avoidable falls that result in moderate or severe harm and a 15% overall reduction in falls	• Not in performance report. The reduction in all falls is 8% at year end and reduction in avoidable falls was 60% with 4 at year end compared to 10 18/19 OT)	
1c	Reduce the number of omitted doses of medication across our services	• MH/LD - During the audit period, there were omissions of 5% of prescribed doses. However, we exclude doses omitted for a valid clinical reason and the omission rate falls to 1%. Therefore, 99% of doses were administered as intended • CHS - During the audit period, there were omissions of 2.3% of prescribed doses. However, we exclude doses omitted for a valid clinical reason and the omission rate falls to 0.5%. Therefore, 99.5% of doses were administered as intended	
1d	To improve the physical health of mental health patients	• 85.9% of SMI inpatients had a physical health assessment • 91.8% of EIP patients had a physical health assessment • 39.1% of SMI community patients (in care + 1 year) had a physical health assessment in last 12 months • 45.7% of SMI community patients (in care <1 year) have had a physical health assessment • Please note physical health assessment does not include all requirements of a Cardio Metabolic Assessment	
1e	Ensure early warning systems for deteriorating patients are in place	• The audit findings indicate that MEWS recording is accurate across the inpatient setting. Improvement from previous audit is evident	
2	Implement 'No Force First' to reduce the number of restrictive practices including restraints	• 20% reduction in use of seclusion • 12% reduction in restraints and 7% reduction in prone restraints	
3	Roll out suicide prevention training to community mental health teams	• 587 contact with Samaritans • Dashboard developed	

AMBITION		YEAR END POSITION	
4	To develop and embed systems of collective leadership	• Completion of NHSI leadership programmes • System transformation partnerships in place • Improvement in staff survey results	
5	To embed continuous improvement	• Directorate Improvement Hubs in place • QSIR training in place with further cohorts planned • 120 Quality Champions trained, bronze level • 30 Quality Champions Coach/Mentors in place	
6	Effective use of technology	• EPUT Lab review and implementation of a number of technological advances • Implementation of Perfect Ward to provide increased assurance of practice • Roll out of SafeCare to increase accuracy of staffing levels in relation to patient acuity	
7	To embed a just and learning culture	• Staff survey results demonstrated improvement in patient safety, reduction in discrimination and respect at work	
8	To improve End of Life Care	• EPUT received CQC 'outstanding' rating in relation to End of Life Care in the Well Led Review 2019	

3.2 Overview of the quality of care offered in 2019/20 against selected local indicators

As well as progress with implementing the quality priorities identified in our Quality Account last year, EPUT is required to provide an overview of the quality of care provided during 2019/20 based on performance against selected quality indicators. EPUT has selected the following indicators regularly monitored by the organisation. There is some degree of consistency of implementation across our range of services. They cover a range of different services and there is a balance between good and under-performance.

Data for two indicators, Readmissions and IAPT Recovery Rates are in the National Mandated and Key National Indicator section of this report.

PATIENT SAFETY

3.2.1 Restraints

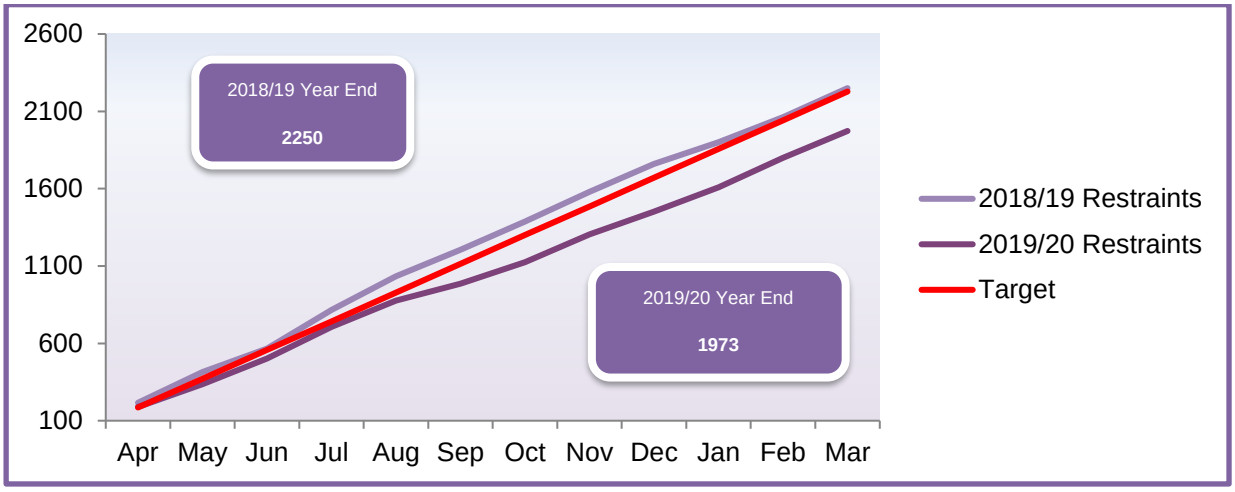
Restraints

EPUT monitors the use of restraints by inpatient ward on a monthly basis, including the reason for restraint and the type of restraint. The most common reasons for restraint are self-harm, physical assault, anti-social behaviour and clinical care. The most common types of restraint are patient standing and in a supine position. We monitor the use of prone position restraints in detail.

The total number of restraints in 2019/20 was 1973; this is a positive reduction on year-end position

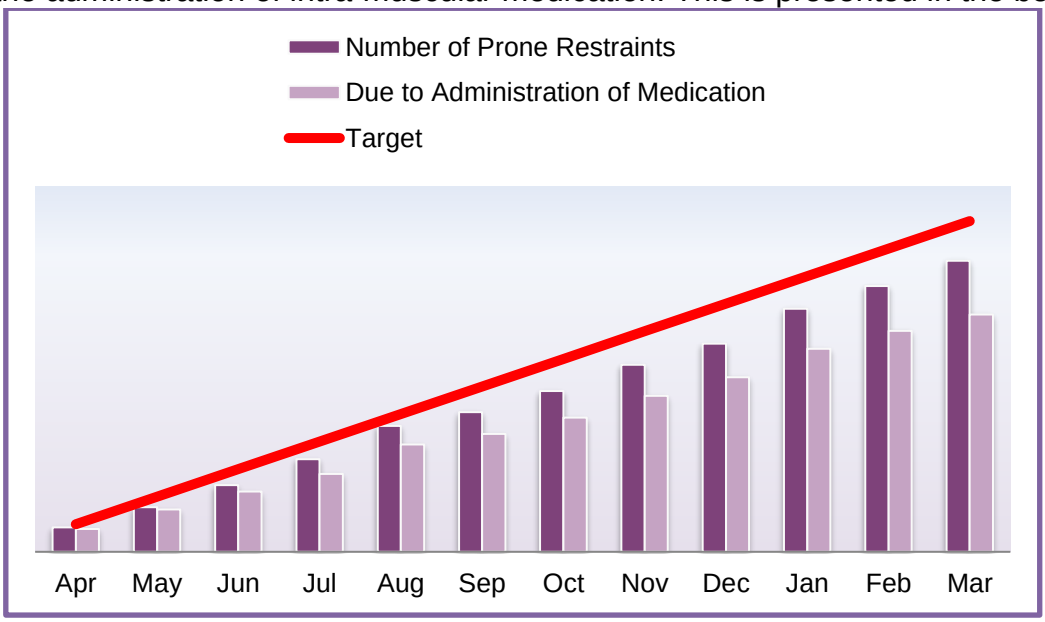
for 2018/19 which was 2256 (please note 2251 restraints were reported in the 2018-19 report however a further five incidents were identified after publication date). EPUT is also pleased to report that the rate of restraints per 10,000 beds is lower than the national benchmark.

The graph below demonstrates the reduction target set by EPUT against 2018/19 out turn and the 2019/20 performance against this target. Reduction started in July 2019 and shows sustainability across the year.



Prone Restraints

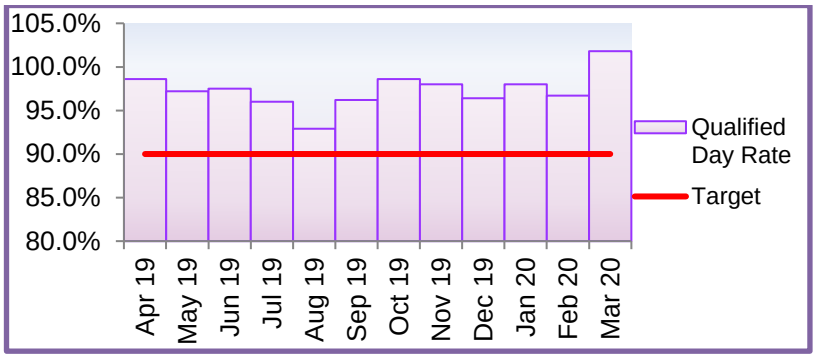
In 2019/20 EPUT achieved a reduction in the number of prone restraints with the largest portion facilitating the administration of intra-muscular medication. This is presented in the below graph.



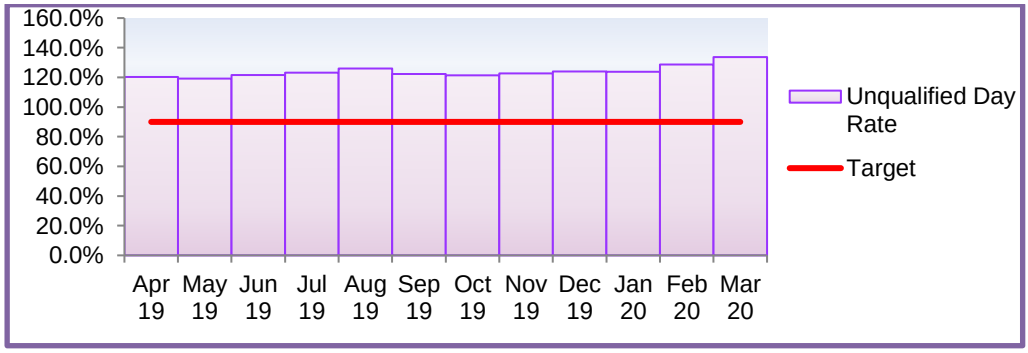
Reducing restrictive practices forms one of EPUTs Quality Priorities and shown in more detail in section 2.1.2.

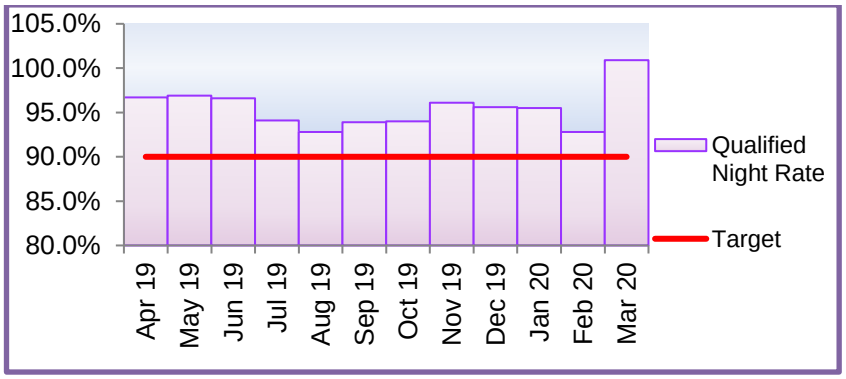
3.2.2 Safer Staffing

All Trusts are required to publish information on nursing staffing levels in ward based clinical areas, along with the percentage of shifts filled that meet safe staffing guidelines. EPUT monitors the actual levels of staffing compared to the established levels on a shift-by-shift basis.

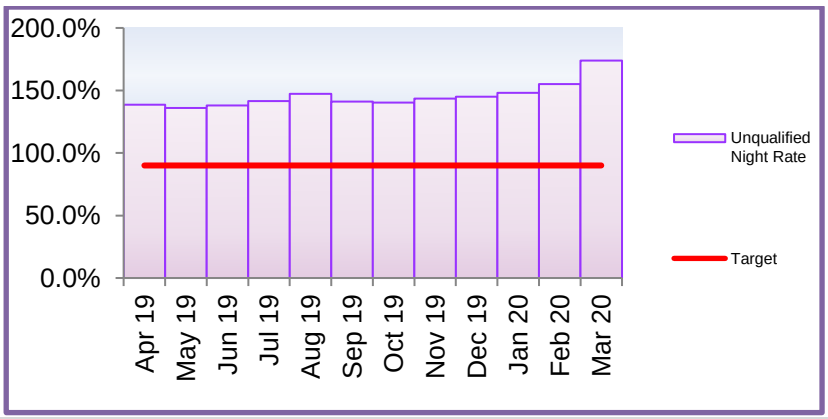


In 2019/20 EPUT consistently surpassed our 90% target for four indicators





Daily sit rep calls take place with all wards to review current staffing levels and risks.



3.2.3 Serious Incidents

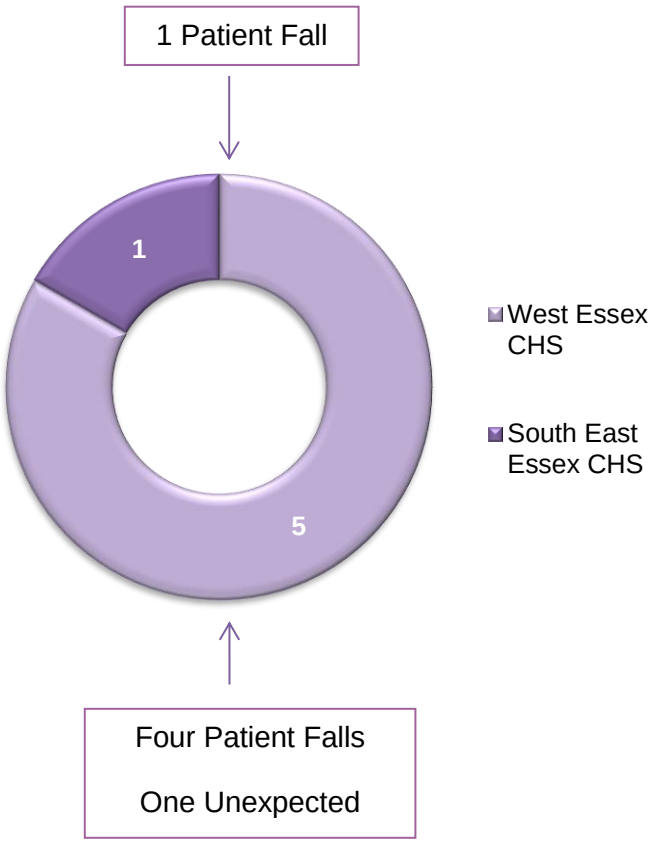
Data Source: Datix

National Definition applied: East of England and Midland's definition applied

A key part of EPUT's patient safety systems is the monitoring we undertake on all serious incidents; we learn from lessons and share following each incident to ensure we embed learning into clinical practice.

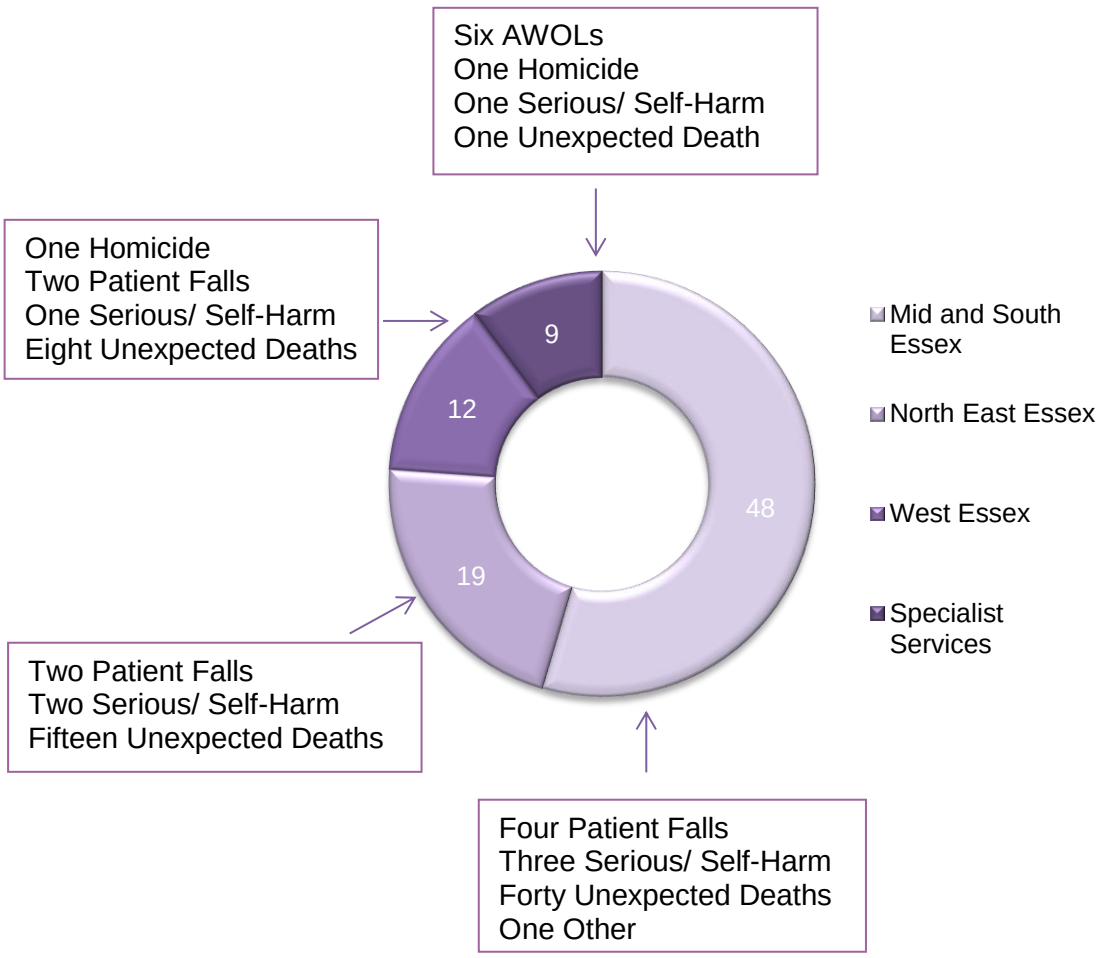
EPUT reported six serious incidents in Community Health Services in 2019/20 representing no change from the six reported in 2018/19.

The diagram below details the number of serious incidents by area and the type of incident for Community Health Services.



In Mental Health Services we reported 88 serious incidents (SIs) in 2019/20, which is a positive reduction on the 109 reported in 2018/19 (please note that 113 SIs were reported in 2018/19 but 6 were downgraded following investigation after publication date).

The next diagram details the number of serious incidents by area and the type of incident for Mental Health services:



There were six avoidable pressure ulcers reported in 2019/20 and four avoidable patient falls.

The most common type of serious incident is an unexpected death. EPUT had 65 unexpected deaths in 2019/20. EPUT has committed to reducing this number through its Suicide Prevention Strategy and set as a Quality Priority ambition, more details of which can be found in the Quality Priorities section of this report.

3.2.4 Complaints

Data source: Datix

National definition applied: only to K041-A submissions to the Department of Health

Complaints referred to the Parliamentary and Health Service Ombudsman

During 2019/20, we referred 19 complaints to the Parliamentary and Health Service Ombudsman (PHSO). Of these 19 referrals, the PHSO decided not to investigate in 10 cases. Two cases closed with financial redress of £500 and £100 respectively, one is awaiting a final report and the remaining six are ongoing at either assessment stage or under investigation.

In addition to the 19 cases received this year, five cases from 2018/19 remained open at the start of this year and carried over. Of these, three closed with one of them receiving financial redress.

Provisional reports received for the remaining two and EPUT is awaiting final reports. One case upheld with recommendations, referred from the previous North Essex Trust prior to the formation of EPUT.

Complaints closed within timescales

The percentage of complaints resolved within agreed timescales' indicator is a measure of how well the complaints-handling process is operating. The agreement of a timescale for the resolution of a complaint is in the NHS Complaints Regulations; however, these do not stipulate a percentage target. EPUT believes that in adherence to commitments to complainants and aims for 100% resolution of all complaints within the agreed timescale with the complainant.

This year EPUT has achieved 93.1% for complaints closed within agreed timescale.

Non-Executive Director Reviews

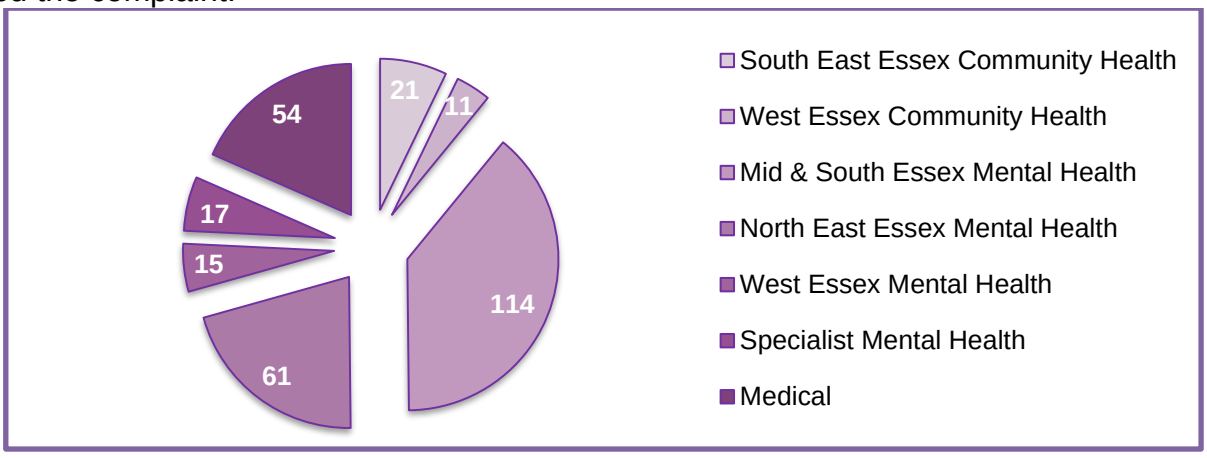
An important part of the complaints process is the independent review of closed complaints by the Non-Executive Directors (NEDs). We select complaints at random each month. The reviewer will take into consideration the content and presentation of the response, whether they feel EPUT has done all it can to resolve the complaint and if they think anything else could have been done to achieve an appropriate outcome. During 2019/20, the NEDs reviewed 27 complaint responses. The majority received a good or very good rating for how we handle the investigation and the quality of the response.

Formal complaints received

Please note: The figures stated in this section of the report (and those reported in EPUT's Annual Complaints Report) do not correspond with the figures submitted by EPUT to the Health and Social Care Information Centre on our national return (K041A). This is because EPUT's internal reporting (and thus the Quality Account and Annual Complaints Report) is based on the complaints closed within the period whereas the figures reported to the Health and Social Care Information Centre for national reporting purposes have to be based on the complaints received within the period.

Complaints Received by Locality

In 2019/20 EPUT received 293 complaints against numerous services across EPUT, eight of which were withdrawn. At year-end, the number of active complaints was 49. The next diagram represents the number of complaints received by EPUT. The complaints are by the locality and service that received the complaint.



Number of complaints upheld/ partially upheld:

We closed 288 complaints during the year.

Upheld	Partially Upheld	Not Upheld	Not Investigated	Withdrawn
24	177	69	10	8

Patient Advice and Liaison Service queries and locally resolved concerns:

EPUT received 959 Patient Advice and Liaison Service queries and 110 locally resolved concerns in 2019/20.

Nature of complaints received:

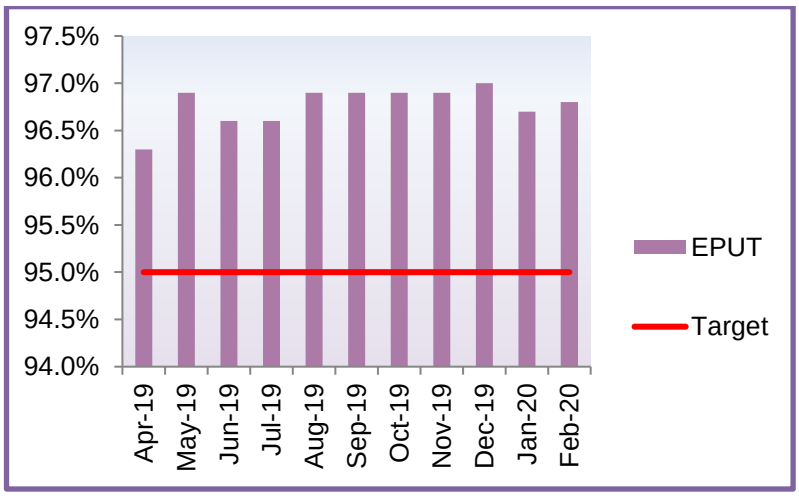
The top three themes for complaints for both mental health and community during 2019/2020 were Staff Attitude, Unhappy with Treatment, and Communication. The table below shows the outcomes of the closed complaints for each of these three themes:

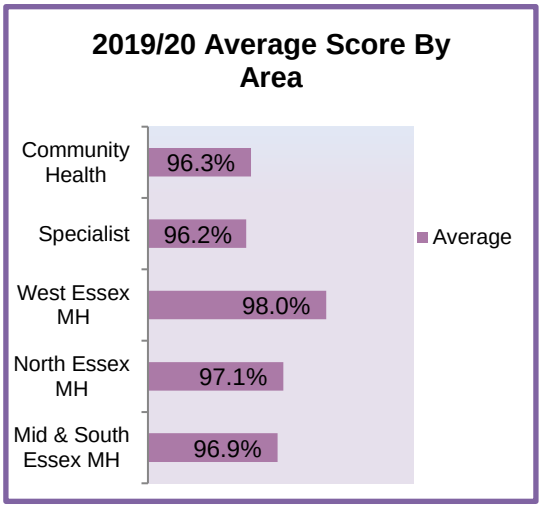
2019/20	Staff Attitude	Unhappy with Treatment	Communication
Complaints Closed	85	24	28
Upheld	5	1	6
Partially Upheld	56	17	18
Not Upheld	16	5	3
Not Investigated	2	1	1
Withdrawn	6	0	0

3.2.5 Patient Environment

EPUT measures the environment of each inpatient ward and assigns monthly scores following these audits. In 2019/20 EPUT achieved the target of 95% for each month in the year, and no individual area fell below this target. A review undertaken of all EPUT cleaning schedules in accordance with the National Standard of Cleanliness 2019 concluded that EPUT met all National standards. The below graphs details EPUT's overall scores throughout the year as well as the average score for each individual area.

Please note that due to the Covid-19 pandemic, audits were not carried out in March 2020.



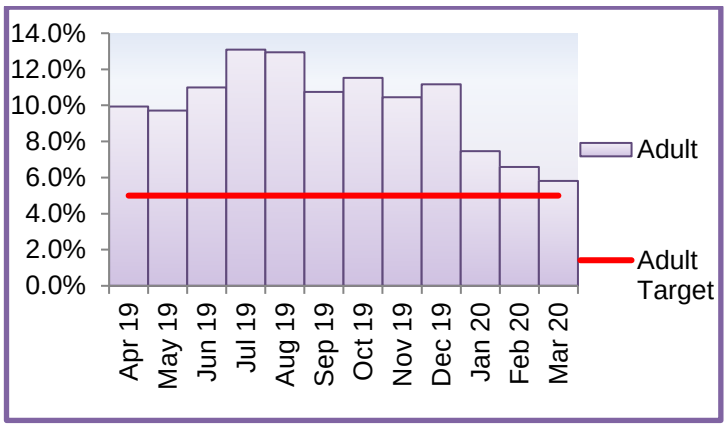


CLINICAL EFFECTIVENESS

3.2.6 Delayed transfers of care

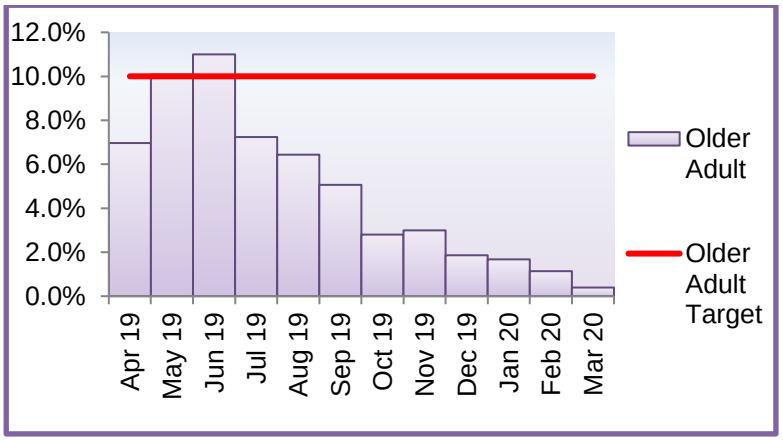
Data Source: EPUT systems (Mobius and Paris) *National Definition applied: Yes*

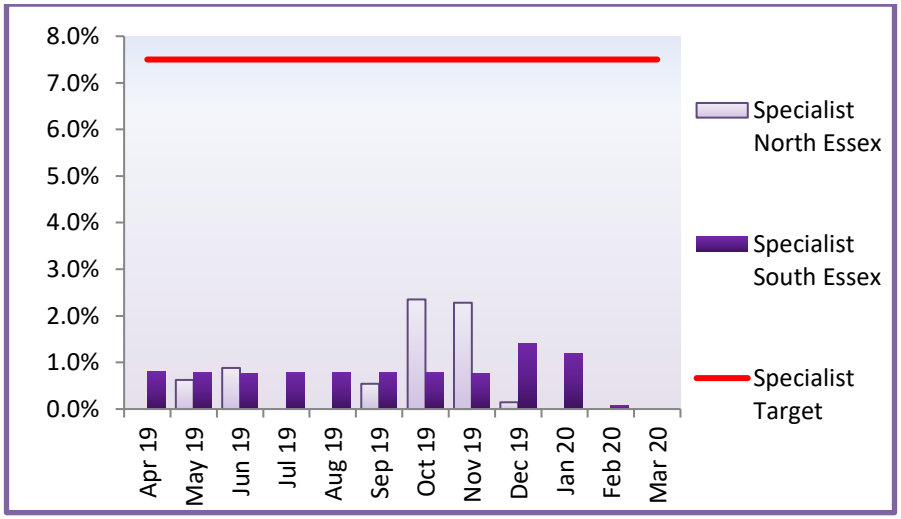
EPUT undertakes monitoring of delayed transfers of care in weekly and monthly reporting as well as in daily sit rep calls. EPUT continues to take improvement measures to reduce the delay rate.



EPUT's adult delayed transfers of care have consistently been above the target of less than 5%, however, work remains ongoing to reduce this and an improvement in performance is emerging.

EPUT has also been working to improve older adult delayed transfers of care and achieved this since July 2019 with performance below the target of less than 10%.





Specialist delayed transfers of care remain low and EPUT can consistently been below the target of less than 7.5% throughout 2019/20.

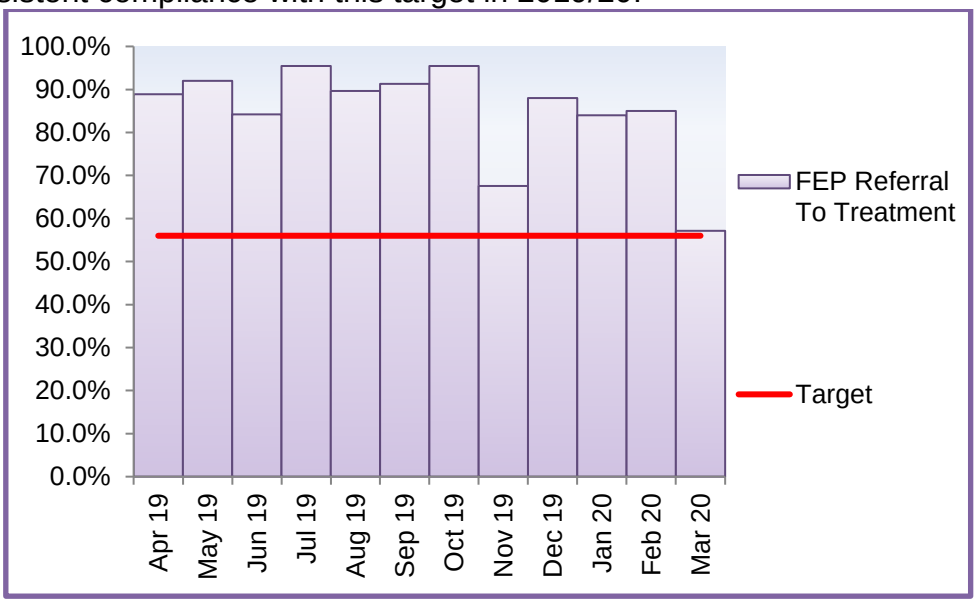
3.3 Performance against key national priorities (NHS oversight framework)

This section provides an overview of performance in 2019/20 against key national targets relevant to EPUT's services, contained in NHS Improvement's (NHSI) Oversight Framework in accordance with the national guidance issued by NHSI for Quality Accounts.

Data for one indicator, 'Patients on Care Programme Approach (CPA) followed up within seven days of discharge from psychiatric inpatient stay' is in the mandatory indicator section of this report.

3.3.1 First Episode Psychosis: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral

This indicator measures the percentage of referrals for people with a first episode of psychosis treated within two weeks. The current target measured against is performance above 56%. We achieved consistent compliance with this target in 2019/20.

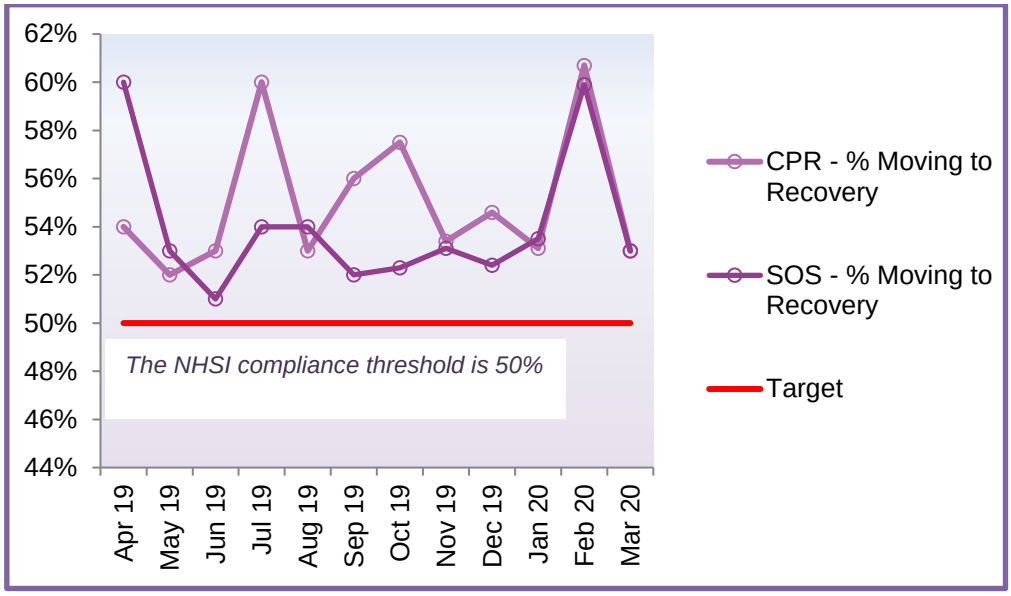


3.3.2 Improving Access to Psychological Therapy Services: Recovery Rates above 50% and Access Targets

Recovery Rates:

This indicator measures the percentage of patients discharged from IAPT services who have moved to recovery. Two CCGs namely Castle Point and Rochford CCG, and Southend on Sea CCG commission IAPT services from EPUT.

Both of these CCG's have consistently surpassed the 50% threshold in 2019/20:

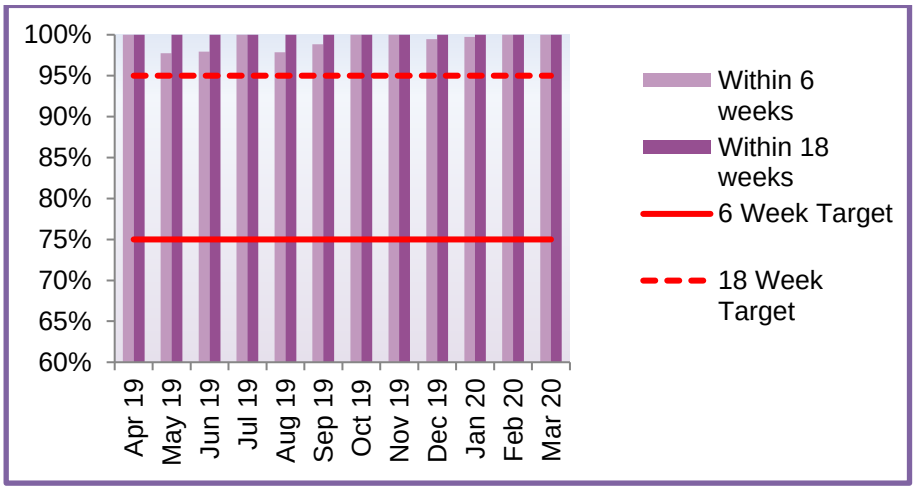


Access Rates:

This indicator measures the percentage of referrals to IAPT services where treatment commences within: 6 weeks (Target 75%) 18 weeks (Target 95%). We achieved consistent compliance with both of these targets throughout 2019/20.

EPUT achieved an average of 99% for those starting treatment within 6 weeks

EPUT achieved an average of 100% for those starting treatment within 18 weeks

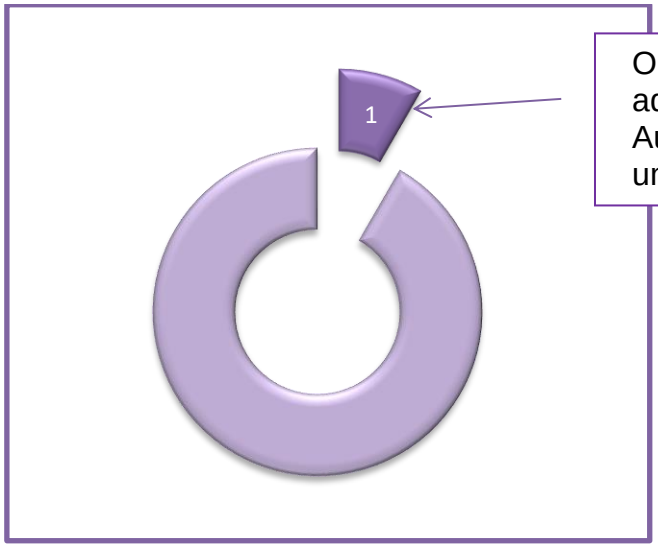


3.3.3 Under 16 Admissions to Adult Wards

This indicator measures the number of admissions to Adult Mental Health Wards where the client is aged less than 16 years old.

In 2019/20 EPUT witnessed one under 16 year old admitted to one of its Adult Wards:

No further child or adolescent clients admitted to an adult ward in 2019/20.

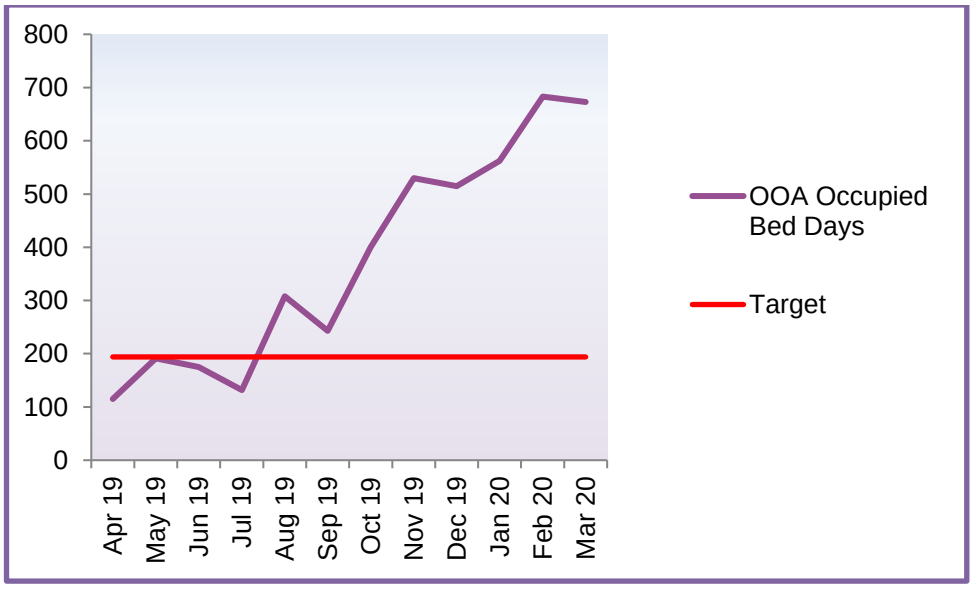


One under 16 year old admitted for one day in August 2019 due to unavailability of a bed.

3.3.4 Out of Area Placements

This indicator has formed part of the NHS Oversight Framework since November 2017. The indicator measures the number of days that patients have spent in in-patient facilities that are out of area and therefore not part of our Trust.

EPUT has seen an increase from its 2018/19 position and a gradual increase month on month in 2019/20 resulting in failure to achieve the reduction target. Significant work has been undertaken to improve OOA rates with the establishment of a new Capacity and Flow work stream.



The average number of days EPUT clients spent in an out of area bed each month for 2019/20 was 377 days

2019/20 Year End

3.4 Listening to our patients and service users

We believe that receiving and acting on feedback from our service users is crucial to maintaining the high quality standards we set ourselves and work continues to increase the feedback received.

This section of our Quality Account outlines some of the ways in which we capture feedback from people who use our services together with some examples of changes we have made and outcomes resulting from that feedback. Information in terms of the results of the Friends and Family Test (FFT) is included in the local quality indicators of this report.

Patient Survey Feedback

EPUT has in place a unified patient survey. This draws together the national NHS Friends and Family Test (FFT) and a further series of local questions around key areas we identified together with people who use our services. Surveys go to all patients recently discharged, from either inpatient services or community caseloads as well as some patients who have chronic long-term conditions to ensure they continue to receive a good service. Carers may complete the survey for those unable to fill it in themselves.

In 2019/20 EPUT introduced online dashboards for Managers to access their service FFT results. They are then able to discuss feedback with their team or individuals, where appropriate, using it as an opportunity to reflect on practice and look for improvements. Managers are encouraged to use positive feedback to share and reinforce good practice, as well as encourage further participation in the survey.

Question	EPUT Scores 2019/20
To what extent did you feel you were listened to?	9.3
To what extent did you feel you understood what was said?	9.3
To what extent were staff kind and caring?	9.6
To what extent did you have confidence in staff?	9.4
To what extent were you treated with dignity and respect?	9.5
To what extent did you feel you were given enough information?	9.2
How happy were you with the timing of your appointments?	9.2
How would you rate the food?	7.7
To what extent would you say the ward/clinic was comfortable?	8.8
To what extent would you say the ward/clinic was clean?	9.3

We received 5,447 responses to the Survey in 2019/20. The results of the answers to the local questions are detailed in the table above (figures denote average score out of 10).

The lowest scoring area with an average of 7.7 was food. The Patient Experience Team attends Open Inpatient Meetings in order to listen to concerns from service users, and an item that does feature in some meetings is food. The Team contacts the Facilities Department to discuss any issues brought forward. This has led to menu changes in some areas. In addition, the Facilities Department undertakes their own surveys and audits in relation to food to try to improve the patient experience.

EPUT also participates in the National Community Mental Health Survey. The Community Mental Health Patient Survey 2019 went to patients who received treatment from EPUT from September to November 2018 to complete and return.

Other Key Patient Experience Engagement Activities

'Your Voice': The aim of these events is to give service users, carers, members of EPUT and

Governors as well as the public a chance to speak directly to the Chief Executive about the services provided by EPUT. They take place across all localities and include different presentations from teams relevant to the locality. The events also provide an opportunity to update everyone on EPUT's planning process. Feedback from these events is generally positive, although attendance does vary considerably from locality to locality.

Community Mental Health Forums: These are public forums, their purpose to provide the opportunity for service users, carers and staff to discuss services in their area and share feedback with EPUT. A locality lead for EPUT chairs the forums and supported by operational staff. These Forums are now in place across EPUT and well received by members of the public whose attendance continues to grow. Some smaller forums act more as discussion groups, which include patients, carers and local voluntary organisations.

Stakeholder Reference Group: One of EPUT's strategic objectives is to involve service users and carers more to play a meaningful role in current services and the future of EPUT services. The Stakeholder Reference Group was initially set up to discuss the merger and engage on Mental Health transformation work. This group remains in place and members receive updates on developments from operational leads. Many attendees continue in smaller working groups looking at specific service areas of transformation. The Stakeholder Reference Group offers the opportunity for attendees to feedback to others on the discussion topics.

Training: EPUT continues to involve both carers and service users at corporate induction. They present with a member of the Patient Experience Team to share their lived experiences. This session is a positive experience for both attendees and volunteers. In addition, service users give talks at the mental health first aid training, and service users and carers take part in some clinical staff interview panels. Service users also share their lived experiences with EPUT Health and Social Care Apprentices in the form of a workshop.

Co-production: The Patient Experience Team is responsible for driving EPUT's work to support co-produced projects. These include supporting operational services to set up Service User Groups and collaborate on projects such as 'Always Events'.

Open Inpatient Meetings: These are now in place across all mental health wards and work is ongoing to implement these in our Community Health wards. These meetings allow managers the opportunity to gather feedback from patients and relatives to improve services. We record good practice in order that it can be cascaded as learning throughout EPUT. As much as possible we encourage patients/service users to lead the meetings.

'Buddy' Scheme: The scheme seeks to empower both service users and our future healthcare workers by increasing understanding of mental health through true partnership-based work and education. It gives mental health nursing students an opportunity to engage with an identified service user who acts as a 'Buddy' in a series of structured meetings and provides an opportunity to learn from carers, gaining insight into their experience. The scheme encourages students to enquire with sensitivity and respect about service user and carer experiences of living with mental illness within the context of family, work and the wider community.

Outpatient Surveying: This attempts to increase FFT returns by service users who attend community based outpatient clinics and appointments. A member of the Patient Experience Team together with a volunteer, where appropriate, will proactively hand out FFT surveys for service users to complete on arrival or on leaving the outpatient centres. The presence of a volunteer assists this as they can often engage with service users who may not wish to engage with someone from EPUT and are more comfortable talking to a person with lived experience.

Patient Experience Framework: During 2019/20, the Patient Experience Team undertook a project to engage with people who have lived experience in order to co-produce the new Patient Experience Framework for 2020-2023. Workshops took place across EPUT's footprint with people who have lived experience invited and a working group set up to draw this up. This project is currently ongoing.

Valuing people who have lived experience: During 2019/20 EPUT made a commitment to reach best practice guidelines on valuing the contribution made by people who have lived experience by recompensing them for their time. A working group was set up including operational staff, support services and people with lived experience to draw up this policy. This project is currently ongoing.

Targeted engagement: The Patient Experience Team has traditionally held events that allow people who have used services to attend and feedback. We recognised in 2019/20 that this approach might miss people who would not normally attend these types of events. To alleviate this, the Team proactively seeks feedback from services by visiting places where people who use services attend, such as community centres and events.

Examples of actions we have taken/ outcomes from service user feedback we have received

The table below details some examples of the 'You Said, We Did' feedback gathered by the services. These are actions we have taken and outcomes achieved by listening to feedback from our patients, service users and carers over the past year. The Patient Experience Team collects this information on a monthly basis.

You Said	We Did
You asked for subtitles on TV as you were hard of hearing	We are putting up a notice advising that patients can ask for the subtitles to be used on the TV
You asked for a relaxation room for when you are stressed	We have changed the purpose of the Quiet room to a Relaxation room. It has bubble lights, relaxing chairs, soft floor, and relaxing music can be played
You would like to do some more cooking sessions	We provided some baking sessions with support staff
Improve choice of sandwiches, desserts and availability of squash and fruit juice	We are organising regular three monthly reviews of the menu choice with Facilities Team
Patients asked for more access to their bedrooms	Bedrooms are now open 24/7 with access throughout the day

Closing statement from Chief Executive

Thank you for your time and interest in reading EPUTs third Quality Account and my last one before I retire from EPUT at the end of November. I hope you have found it a clear, straightforward and informative report.

I have always valued highly the opportunities to meet with you directly but of course, under current national Coronavirus pandemic restrictions we cannot hold our public meetings. We hope to resume a schedule of engagement events in due course but, meanwhile, please share any quality improvement suggestions with us by contacting our Trust Secretary. We will take these forward as EPUT returns to 'business as usual'.

Thank you for supporting EPUT and other local NHS services while we are continuing to deal with this unprecedented global health emergency. On my retirement, EPUT's new Chief Executive will inherit a thriving Trust, with exemplary staff of whom I could not be more proud. Their services will remain essential as we help local people and communities to recover from the effects of this pandemic. Please continue to support them, as we could not do it without you.

Keep safe and keep looking out for one another. I send my very best wishes to you, your families and friends for the future.

[Sally's signature]

Sally Morris
Chief Executive
Essex Partnership University NHS Foundation Trust (EPUT)

Please send any questions or comments about this Quality Account to:
Trust Secretary

Email: epunft.trust.secretary@nhs.net
Post: Essex Partnership University NHS Foundation Trust
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Annexe 1:
Comments on the Quality Account

EPUT Council of Governors' Statement on the Quality Account 2019/20

We have been invited to review the draft Quality Account for 2019/20. This has been undertaken by the Lead Governor co-ordinating thoughts and ideas from colleagues. This provides Governors with an opportunity to assure members of our Trust, via the Annual Report to Members that quality is at the heart of what EPUT does and will not be compromised. We have to ensure that the priorities which were set for 2019/20 have been met and are continuing to be taken forward.

We are pleased to note that the independent inspection by CQC has rated the in-patient CAMHS and End of Life services as 'Outstanding', and that for the whole Trust Care was 'Outstanding'. This is very heartening and reflects the efforts put in by all the staff involved.

We continue to be concerned that Safety is still rated as Requires Improvement. We notice that there has been a reduction in Serious Incidents from 109 in 2018/19 to 88 during this year, and that prone restraints continue to fall (anticipated at 6%) and, although it is not clear from the graph as to the actual numbers, there is still some way to go before the Board's target of zero prone restraints is achieved. We are aware of the introduction of some 'pods' to assist in the administration of medication for those patients who are reluctant to co-operate and this has a significant effect on the prone restraints required, as the majority are for this purpose. We have been able to monitor these during our regular 'Quality Visits' to EPUT's facilities.

We do note that the other safety concerns of Omitted Doses are down, as are Avoidable Falls (down from 10 to four during the year to date), with All Falls showing an 8% reduction. Grade 3/4 Pressure Ulcers total six, which is the same as last year, against an ambition to reduce year on year.

We are pleased to see the mention in Priority 2 Transformation of 'co-producing healthcare to meet personal and individual needs of our populations.' We expect this increased focus on co-production to produce an increase in the quality of care.

We also note that out-of-area placements, which were at a high level of nearly 700 occupied bed days in March 2020 (average for the year was 377), have been reduced to zero since, following the request to reduce occupancy during the Covid-19 pandemic. It is now (as at April 2020) at 65%. This is a major factor in a patient's recovery journey and the staff are to be congratulated on this remarkable achievement. This issue of capacity for in-patient MH adults, which the Governors have raised during the year, appears to have been addressed as a result of the pandemic pressure on beds and we look forward to EPUT maintaining this position. Cardio-metabolic assessment targets, which have been a hotspot for some time, also appear towards the end of the year to have been resolved.

We look forward to the other hotspots mentioned being addressed in the coming months, including

timeliness of data entry and Care Programme Approach, and these improvements in quality and particularly in patient safety being maintained.

We are aware that patients regularly bring up the issue of food quality and that steps have been taken to try to address these. The Governors have been active in undertaking PLACE visits during the year when food is sampled and I can report that Governors were generally impressed with the quality offered.

The Governors hold the view that EPUT's Board engages in the processes relating to quality in EPUT, and treats 'Quality' as a top priority. We have attended EPUT stakeholder events, alongside service users and their carers, members of staff and senior staff from Local Authorities and Clinical Commissioning Groups, when time was spent considering the priorities for the coming year.

We appreciate the good working relationship which exists between the Board (both Executive and Non-Executive Directors) and the Council and the regular attendance and input that we have received from Directors, whose standard of reporting continues to be generally very high. We are also pleased that the Chief Executive, Sally Morris, uses the occasion of each of the Council meetings to address the Governors on an issue of interest. Her close involvement with the Council is much appreciated.

We have been pleased to continue, on your behalf, to undertake 'Quality Visits' to a wide range of Trust facilities. These have enabled us to talk to staff as well as patients and to listen to any concerns there may be about quality. We can report that when these have been raised they have been immediately considered.

A basic tenet for any hospital trust is that a service user's physical condition should not be worsened by being in its care. We can give an assurance that the Quality Account is an honest commentary on the last year which shows a Trust which continues to be high performing, and the Board of EPUT have agreed a set of priorities which will continue to support the essential requirement that safety and quality comes first.

John Jones
Lead Governor

June 2020

Essex Partnership University
NHS Foundation Trust

Working together for better health and care

NHS
Thurrock
Clinical Commissioning Group

BY EMAIL ONLY

Civic Offices
2nd floor
New Road
Grays
Essex
RM17 6SL

12.11.20

Paul Scott
Chief Executive
Essex Partnership University NHS Trust
Head Office
Runwell Chase
Wickford
Essex
SS11 7XX

Dear Paul

I am pleased to forward to you, the Mental Health Mid and South Essex Health and Care Partnership joint response to the Quality Account for 2019/20 Coordinated by Thurrock Clinical Commissioning Group

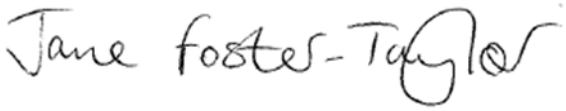
This is the CCG Mandated Summary Statement relating to the Essex Partnership University Trust 2019/20 Quality Account. This summary was ratified by Committee in Common Quality and Patient Safety and Clinical Commissioning Groups Boards on behalf of the commissioning organisation of the Mid and South Essex Health and Care Partnership. The statement is a combined response on behalf of all contributing organisations

Commissioners request if there are any significant or material changes to the draft Quality Account 2019/20 that would require a review of the response prior to publication that Essex Partnership University Trust under take due diligence and notify us prior to publication of the final version in order for the Health and Care Partnership to ensure a consistent response to the final published report.

The Health and Care Partnership has provided a response that summarises commissioners views of achievements in 2019/20 and planned work streams and quality priorities for 2020/21. Commissioners consider that the Quality Account provides an accurate and balanced picture of the reporting period. The Heath and Care Partnership will continue to seek assurance on performance and delivery of care by regular monitoring through its agreed contractual arrangements and via quality assurance visits and triangulation of local intelligence.

I would like to take this opportunity to recognise the significant work of Essex Partnership University Trust in its third year as a merged organisation. We have considerable transformation work to undertake in the coming year and this summary statement reflects our views of the future opportunities for continued development of high-quality patient services and partnership working.

Yours sincerely



Jane Foster-Taylor
Chief Nurse

Castle Point and Rochford
Clinical Commissioning Group

ESSEX PARTNERSHIP UNIVERSITY TRUST COMMUNITY HEALTH SERVICES,

SOUTH EAST ESSEX

EPUT OUALITY ACCOUNT 2019/20 CCG MANDATED SUMMARY STATEMENT

ESSEX PARTNERSHIP UNIVERSITY TRUST COMMUNITY HEALTH SERVICE CONTRACT

Response statement from NHS Castle Point & Rochford Clinical Commissioning Group on behalf of the two South East Essex Clinical Commissioning Groups (the CCG's).

The CCGs welcome the opportunity to review and comment on the Quality Account for Essex Partnership University Trust for 2019/20 and would like to offer the following commentary:

The CCGs are committed to working with Essex Partnership University Trust to develop sustainable and patient-focused services within the Health and Care services within South East Essex, to ensure that patient outcomes are improved by working collaboratively and striving to reduce duplication within the system and that personalisation increasingly becomes central to development of services.

The CCGs support the Trust's priorities for improving the quality of its services for its patients, and have continued to provide support but also challenge and scrutiny through the Clinical Quality Review Group (CQRG) meetings with the contractual monitoring, review and discussion of quality issues.

The opening statement on quality for 2019/20 references NHS England/Improvement guidance outlines, which has determined the development of the eight quality priorities. These priorities incorporated three areas of service user quality – safety, effectiveness and patient / carer experience at the core that aligned the quality priorities with EPUT corporate objectives.

Commissioners acknowledge the CQC ratings from the unannounced 3-day inspection programme of six core services in July 2019 and the well-led inspection in August 2019. The achievement of upholding the overall rating of 'Good' and receiving a rating of 'Outstanding' for the Caring domain and 'Good' in the Effective, Responsive and Well-Led domains, for the End of Life services reflect significant work undertaken. The CCG will continue to work with EPUT; undertaking the continuous improvement journey regarding the safe domain which remains at requires improvement.

In March 2020 193 (87%) of internal actions to address the findings from the CQC inspection had been completed. Commissioner assurance has been provided that a reset and refresh meeting with the CQC has been held with the formulation of an action plan for the remaining outstanding actions signed off by the CQC.

The CCGs welcome the Quality Improvement (QI) methodology that EPUT are implementing to drive continuous and sustainable patient safety improvements.

The CCGs also welcome the development of clinical innovation by the "EPUT Lab" where clinicians and practitioners collaborate to identify technology that can impact on the delivery of care, improves clinical monitoring and decision making, exploring and promoting opportunities for greater independence and self-care models. As with all the organisations within the SEE Health and care systems, the pandemic has forced the use of technology and enabled speedy implementation of systems, which ordinarily would have taken far greater time to introduce. The CCG staff also participate in the forum and have promoted and been party to the development of processes to enhance patient care and safety.

The CCGs acknowledge that EPUT has actively participated in all the National Clinical Audits as well as all the national confidential inquiries appropriate to their organisations. This is also evidenced within the report of the intent to implement the learning to improve the quality of service delivery within the organisation.

EPUT has done well when compared to National statistics for the majority of the National mandated indicators of quality, with the exception of Older adult readmissions and patient harm resulting in severe harm or death. The fully integrated health and Social care models in place in Mid and South Essex as well as current work around improving destination transfers and outcomes associated with Discharge to Assess in SEE will help to address this trajectory.

The CCGs welcome the work undertaken, pre Covid, to align wound care services under one streamlined approach, making referral and triage simpler and enable individuals with wound issues to be assessed by an appropriate practitioner in a more timely manner and supporting the reduction of sepsis

Essex Partnership University Trust has developed it's Quality Priorities for 2020/21 in response to the challenges and opportunities of the COVID19 pandemic these are:

- Innovation
- Improvement
- Transformation

During Q4 of 2019/20 there was significant impact upon the provision and delivery of health and care services, Essex Partnership University Trust have had to reconsider and prioritise service

delivery and introduced technology at pace and to support virtual delivery options in partnership with the CCGs, Primary Care and Adult Social Care to minimise risks to vulnerable patients, whilst still enabling visibility and monitoring. Their community Care Home Support team has been a significant part supporting care homes with education packages around IPC and PPE to try to minimise the risk to the extremely vulnerable residents within the care homes; it is commendable that as well as commencing this programme nearly a month in advance of the NHSE mandate, the impact upon the residents within SEE care homes fared better than the national picture.

During 2020/21 the work commenced during the pandemic and lessons learned during the initial spike will need to continue to inform the transformation of services; greater emphasis on whole person/holistic care with closer integration of physical and mental health services,

as well as rising to the challenge for community services to take the lead with hospital discharge functions via the Discharge to Assess developments to promote safe, effective and efficient service delivery.

EPUT's ambition to continue to improve the nature and delivery of Community health service is evidenced within this report, the pandemic has forced a greater degree of collaboration to improve patient outcomes and whole system working, which continue to be foremost with future development as we move into 2020/21.

Tricia D'Orsi
Deputy Accountable Officer SEE and Chief Nurse
Castle Point & Rochford

NHS
Thurrock
Clinical Commissioning Group

ESSEX PARTNERSHIP UNIVERSITY TRUST MENTAL HEALTH MID AND SOUTH ESSEX

EPUT QUALITY ACCOUNT 2019/20 CCG MANDATED SUMMARY STATEMENT

ESSEX PARTNERSHIP UNIVERSITY TRUST MENTAL HEALTH CONTRACT

Response statement from NHS Thurrock Clinical Commissioning Group on behalf of (Southend Clinical Commissioning Group, Castle Point and Rochford Clinical Commissioning Group, Basildon and Brentwood Clinical Commissioning Group and Mid Essex Clinical Commissioning Group) Mid and South Essex Health and Care Partnership.
The Clinical Commissioning Groups (CCGs) welcome the opportunity to review and comment on the Quality Account for Essex Partnership University Trust for 2019/20 and would like to offer the following commentary:

The CCGs are committed to commissioning high quality services from Essex Partnership University Trust and collaborate diligently to ensure that patients' needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and central to the commissioning decision making and service development.

We have remained sighted on the Trust's priorities for improving the quality of its services for its patients, and have continued to provide robust challenge and scrutiny through the Clinical Quality Review Group (CQRG) meetings with the contractual monitoring, review and discussion of quality issues.

The opening statement from the Chief Executive clearly sets out the EPUT vision and Quality Strategy. It outlines the development of the eight quality priorities for 2019/20 in line with NHS England/Improvement guidance. These priorities incorporated three areas of service user quality – safety, effectiveness and patient / carer experience at the core that aligned the quality priorities with EPUT corporate objectives. The CQRG receive a quarterly quality report that includes narrative and data indicating progress with the identified quality priorities.

Commissioners acknowledge the CQC ratings from the unannounced 3-day inspection programme of six core services in July 2019 and the well-led inspection in August 2019. The achievement of upholding the overall rating of 'Good' and receiving a rating of 'Outstanding' for the Caring domain and 'Good' in the Effective, Responsive and Well-Led domains are to be commended. Commissioner will maintain their commitment to work with EPUT in undertaking the continuous improvement journey regarding the safe domain which remains at requires improvement.

In March 2020 193 (87%) of internal actions to address the findings from the CQC inspection had been completed. Commissioner assurance has been provided that a reset and refresh meeting with the CQC has been held with the formulation of an action plan for the remaining outstanding actions signed off by the CQC.

The Suicide Prevention Strategy in 2019/20 laid the foundation stones for the work that is continuing in 2020/21. There is a comprehensive work plan linked to the National Confidential Inquiry into Suicide and Homicide (NCISH) quality standards identified for 2020/21. It is encouraging that the Trust have set stretch targets this reflects the determination to provide safer services. Forty-eight (48) Serious Incident were reported for Mid and South Essex and of these forty (40) Serious Incident were unexpected deaths. EPUT has committed to reducing this number through its Suicide Prevention Strategy and this is set as a Quality Priority for 2020/21. EPUTs commitment to reducing unexpected deaths is further evidenced by the partnership work with the Samaritans, the implementation of the Grassroots Stay Alive app and the engagement with the work of the Zero Suicide Alliance.

Commissioners endorse the Quality Improvement (QI) methodology that EPUT are in the process of implementing as research evidence specifies that when effectively embedded QI drives continuous and sustainable patient safety improvements. Commissioners have confidence that this combined with the cohort of home-grown Quality Champions will influence and harness the determination, focus and energy on achieving the quality improvement programme in 2020/21.

Commissioners support the development of clinical innovation by the “EPUT Lab” where clinicians are empowered to identify technology that improves clinical decision making, supports individuals to manage their own health and frees up clinical time to allow smarter working across services. The pandemic has brought the use of technology to the forefront of the organisation supporting new ways of working and providing care. Commissioners are engaged in the forum and have witnessed the early benefits of the clinical engagement and technological advances operating symbiotically to enhance patient care and safety.

It is notable that EPUT have participated in 100% of the National Clinical Audits and 100% national confidential inquiries where eligible and applicable to the services delivered by the organisation. The inclusion within the report of a comprehensive schedule of intended actions derived from the audits to improve the quality of healthcare delivery within the organisation highlights EPUTs dedication to learning from research and audit.

Essex Partnership University Trust have developed their Quality Priorities for 2020/21 in response to the challenges and opportunities of the COVID19 pandemic these are:

- Innovation
- Improvement
- Transformation

During Q4 of 2019/20 Essex Partnership University Trust adapted their mental health service delivery to implement technological solutions at pace and to deliver virtual options of care and treatment due to the presenting and prevailing risks to patients and staff from the COVID19 pandemic. During 2020/21 the transformation, reform and innovation required to respond to the needs of the population will undoubtedly continue to grow and test the Trust as we enter the new phases of the pandemic and the post pandemic recovery requirements for psychological treatment and aftercare. Mental Health will be at the core of the essential patient services and the flexibility and dedication of the workforce will be essential to sustaining safe, effective and efficient service delivery.

Overall the report is reflective of the commissioner knowledge of the Trust quality activities and ambitions. A collaborative transformational work programme has been developed in line with the Long-Term Plan (LTP mental Health) and by continuing our strong alliance through the Mental Health Partnership Board and integrating system and PLACE models of mental health service delivery we will to strengthen the quality of Mid and South Essex mental health commissioned services in 2020/21 and beyond.

Jane Foster-Taylor
Chief Nurse

Statement from West Essex Clinical Commissioning Group

West Essex Clinical Commissioning Group is responsible for the commissioning of community and mental health services from Essex Partnership NHS Foundation Trust (EPUT) for the citizens of west Essex.

EPUT provide services across Essex including community and mental health services. Where possible the information in the Quality Account has been divided by locality and type of care, this has helped us to identify elements of the account that are specific to west Essex patients.

NHS West Essex CCG would like to commend and thank all the staff and volunteers that work for EPUT, in relation to their response to the Covid 19 pandemic. Staff responded with professionalism, energy and adaptability. Their team work and continued energy has enabled the care of patients and their families to continue during the challenging time of the pandemic.

EPUT achieved the majority of elements within their quality priorities from 2019/20. There have been some outstanding improvements to care particularly the improvement to the physical health assessment rate for mental health inpatients, the successful implementation of the early warning scoring system and reductions in the use of restraint.

We would like to congratulate the Trust on the developments that have been made to end of life care; this element of care has been recognised by the CQC, in year, as outstanding.

The account includes extensive information on the learning that has been gained from the review of deaths. As a result there have been changes to practice in relation to risk assessment, staff competencies and the use of equipment.

The Priorities for 2020/21 are clearly articulated, the CCG is particularly supportive of the work being undertaken to develop west Essex intermediate care and the case management of frail and complex patients to reduce the need for the use of emergency services.

The Trust is continuing to embed quality improvement methodologies across the workforce. The use of quality improvement methodologies to improve patient's safety is one of the main priorities for 20/21. The engagement of service users in this work demonstrates the Trusts clear commitment to the effective use of improvement science and the need to work together with service users to improve the quality of care.

The CCG fully support EPUTs quality priorities for 2020/21, particularly the focus on improving patient safety using all available means.

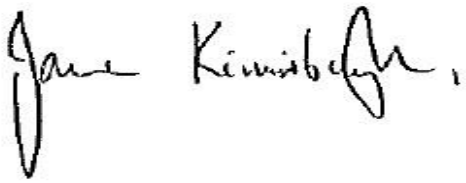
We are grateful that the Trust has included the governance arrangements for producing the quality account; this makes it clear to patients and families how this complex document has been created.

We confirm that we have reviewed the information contained within the Account and checked this against data sources where these are available; it is accurate in relation to the services provided. The explanation by the Trust of why certain data sets are as they are has been fully explained.

We have reviewed the content of the Account; it complies with the prescribed information as set out in legislation.

Whilst the element of care that EPUT deliver for west Essex is only a proportion of their overall care provision, the account demonstrates clearly how care has been delivered by locality for both mental and community health. The account also shows how valuable system collaboration with EPUT continues to be for the west Essex system.

We believe that the Account is a fair, representative and balanced overview of the quality of care at the Trust.



Jane Kinniburgh
Director of Nursing and Quality
Hertfordshire and West Essex Integrated Care System
November 2020

Essex Partnership University
NHS Foundation Trust

North East Essex Clinical Commissioning Group

Essex Partnership University Trust (EPUT)

The Norfolk East Essex Clinical Commissioning Group (CCG) confirms that EPUT have consulted and invited comment regarding the Annual Quality Account for 2019/20. This has been submitted within the agreed timeframe and the CCG is satisfied that the Quality Account provides appropriate assurance of the service.

The CCG has reviewed the Quality Account and, to the best of our knowledge, consider that the data is accurate. The information contained within the Quality Account is reflective of both the challenges and achievements within the organisation over the previous 12 month period. It is recognised that the COVID-19 pandemic has created additional, unprecedented challenges this year, which has made the report more difficult to compile.

The North East Essex Clinical Commissioning Group looks forward to working with clinicians and managers from the service, and with local service users, to continue to improve services to ensure quality, safety, clinical effectiveness and a good service-user experience is delivered across the organisation.

This Quality Account demonstrates the commitment of EPUT to provide a high quality service. The Clinical Commissioning Group endorses the publication of this account.

Lisa Nobes
Chief Nursing Officer

North East Essex Clinical Commissioning Group

22nd October 2020

GLOSSARY

A&E	Accident and Emergency
ARC	Applied Research Collaborate (NIHR)
ARU	Anglia Ruskin University
AWOL	Absent Without Leave
BILD	Bild Association of Certified Training
BP	Blood Pressure
BSP	Behaviour Support Plan
CAMHS	Child and Adolescent Mental Health Services
CC	Community care
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CHS	Community Health Services
CICC	Cumberlege Intermediate Care Centre
CMHT	Community Mental Health Trust
CPA	Care Programme Approach
CRHT	Crisis Resolution Home Treatment
CRHTT	Crisis Resolution & Home Treatment Team
CRN NT	Clinical Research Network – North Thames (NIHR)
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Core Trainee
CYP	Children and Young People
DNA	Did Not Attend
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DSPT	Data Security and Protection Toolkit
DWP	Department of Work and Pensions
EAHSN	Eastern Academic Health Science Network
ECG	Electrocardiogram
EEAST	East of England Ambulance Service Trust
EIP	Early Intervention in Psychosis
EOL	End of Life
EOLC	End of Life Care
EPMA	Electronic Prescribing and Medicines Administration
EPUT	Essex Partnership University NHS Foundation Trust
ESD	Early Supported Discharge
FFT	Friends and Family Test
FFFAP	National Falls and Fragility Audit Programme
FY	Foundation Year (doctor)
GAS	Goal Attainment Scaling
GCS	Glasgow Coma Scale
GP	General Practitioner
HEE	Health Education England
HoNOS	Health of the Nation Outcome Scales

HRA	Health Research Authority
IAPT	Improving Access to Psychological Therapy
ICS	Integrated Care System
KPI	Key Performance Indicator
LAS	Locum Appointment for Service
LD	Learning Disabilities
LTFT	Less Than Full Time Training
LTP	Long Term Plan (NHS)
MDT	Multi-Disciplinary Team
MEWS	Modified Early Warning System
MH	Mental Health
MH5YFV	Mental Health 5 Year Forward View
MNC	Mountnessing Court
MRCPsych	Member of the Royal College of Psychiatrists
MSO	Medication Safety Officer
MTI	Medical Training Initiative
NACAP	National Asthma and COPD Audit Programme
NACEL	National Audit of Care at the End of Life
NACR	National Audit of Cardiac Rehabilitation
NAIF	National Audit of Inpatient Falls
NCAPOP	National Clinical Audit Patient Outcome Programme
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
NDFA	National Diabetes Foot Care Audit
NED	Non-Executive Director
NELFT	North-East London NHS Foundation Trust
NHS	National Health Service
NHSD - SDCS	NHS Digital – Strategic Data Collection Service
NHSFT	NHS Foundation Trust
NHSI	NHS Improvement
NICE	National Institute of Health and Care Excellence
NIHR	National Institute of Health Research
NOK	Next of Kin
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
OD	Organisational Development
ODESSI	Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness
OT	Occupational Therapist
OT	Out-turn
OOA	Out Of Area (placement)
OPMH	Older People's Mental Health
PHSO	Parliamentary and Health Service Ombudsman
PLACE	Patient-Led Assessments of the Care Environment
POD	Peer Open Dialogue
POMH-UK	Prescribing Observatory for Mental Health - UK

PREM	Patient Reported Experience Measures
PU	Pressure Ulcer
QI	Quality Improvement
QPR	Question Persuade Refer (suicide prevention training)
QSIR	Quality, Service Improvement and Redesign
RAID	Rapid, Assessment, Interface and Discharge (team)
RCA	Root Cause Analysis
RCP	Royal College of Psychiatrists
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RfPB	Research for Patient Benefit
RT	Rapid Tranquilization
SCR	Summary Care Record
SFFT	Staff Friends and Family Test
SI	Serious Incident
SMI	Severe Mental Illness
SSNAP	National Sentinel Stroke National Audit Programme
ST	Specialty Trainee
STP	Sustainability and Transformation Partnerships
UCL	University College London
UCLP	University College London Partners
UEA	University of East Anglia
UofE	University of Essex
VCSE	Voluntary, Community and Social Enterprises
YTD	Year to Date

		Agenda Item No: 8(a)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 November 2020**

Report Title:	Board Assurance Framework 2020/21 as at November 2020					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Susan Barry, Head of Assurance					
Report discussed previously at:	Executive Operational Sub-Committee 3 November and 17 November 2020					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

Purpose of the Report

This report presents the Board of Directors with an overview of the Board Assurance Framework, Corporate Risk Register, and Covid19 Gold Risk Register for 2020/21 covering the two month period October and November (Q2) as at 25 November 2020	**Approval**	✓
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Review the risks identified in the BAF 2020/21 November summary and approve the risk scores (Appendix 1) taking account of actions taken by EOSC at its early November meeting (deferred from October)
2 Note the CRR November summary table (Appendix 2) including actions taken by EOSC at its early November (deferred from October) meeting
3 Note the new risks added to the Covid19 risk register
4 Identify any further risks for escalation to the BAF, CRR or Directorate risk registers

Summary of Key Issues

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

Board Assurance Framework

There are now 20 risks on the Board Assurance Framework following some consolidation of risks reported at the last EOSC meeting. There are three risks reported as sitting at a score of 20 (extreme) and these are:

ID	Risk
BAF43	Surge planning
BAF50	New risk: Skills, resource and capacity to deliver business as usual high quality care, manage C19 pandemic and increased variation of demands on corporate services (consolidates BAF31 BAF40 BAF48 and CRR69)
BAF53	New risk: Responding at pace to external feedback and delivery of safety strategy (this risk has replaced the previous HSE BAF15 risk)

The following risk changes are reported since last Board Report

ID	Risk	Change
BAF9	No Force First	Reduction in score to threshold C4 x L2 = 8 (from 12) reflects real changes in outcomes/ full engagement - complete 3 actions
BAF15	HSE	Closed
BAF32	Quality Improvement	Reduction in score to C4 x L3 = 12 (from 16) – complete final action
BAF34	Staffing for New Services	Closed – action plan completed
BAF41	CIPs	Score reduced to C4 x L3 = 12 (from 16) by EOSC
BAF43	Surge planning	Reduction in score to C5 x L3 = 15 (from 20) then increased to C5 x L4 = 20 (from 15)
BAF49	EPUT Leadership	Closed – comprehensive handovers by former CEO & ECFO

Corporate Risk Register

There are currently 26 risks on the Corporate Risk Register

The following new risks were escalated from Directorate Risk Registers since last Board report

ID	Risk
CRR65	If EPUT is unable to deliver ECT to patients in a timely manner due to capacity related to Covid19 then delays in treatment may occur resulting in potential deterioration and poor patient experience Score: C4 x L5 = 20
CRR71	If EPUT experiences issues with the battery life on its stock of McKinley T34 Syringe Drivers then the Trust may not be able to provide effective therapeutic symptom management to service users, resulting in poor patient care, poor patient experience and non-compliance with best practice and national guidelines Score: C4 x L3 = 12
CRR72	If EPUT does not have a suitable IT system in place for its Drug and Alcohol Service then partners may not be able to access clinical records in a timely manner, possible damage to data integrity and excessive prescribing or treatment, resulting in poor system working and patient harm Score: C4 x L3 = 12
CRR73	If EPUT does not have robust systems in place for communicating concerns regarding patients who may be subject to dual diagnosis care then patients may not receive the care they need in a timely manner, or may be put at risk by overtreatment, resulting in patient harm and reputational damage Score: C4 x L3 = 12

Covid19 Risk Register

The following risks have been added to the Covid19 Risk Register since the last BOD Report

ID	Risk
CVS26	Management of business as usual biochemistry blood tests during period of reagent shortage (Roche)
CVS27	Oversight of backlog of Datix incidents
CVS28	Bank staff working in a number of different sites and impact on track and trace
CVS29	Compliance with Covid19 requirement and Covid19 Secure arrangements
CVS30	Management of levels of staff fatigue over pandemic period
CVS45	Clinical waste
CVG41	Staff contacting EPUT Contact Centre if tested positive or contacted by Test & Trace
CVG42	Full national lockdown
CVG43	Skills and competencies to manage second wave (may close in view of BAF risks 50, 51, and 52)
CVG44	Outbreaks of Covid19
CVG46	Delivery of valid server generated emails to staff outlook inboxes
CVG47	Older adult social care flow and capacity
CVG48	Lateral Flow Staff Testing
CVG49	Regional public testing
BAF50	Skills, Resource and Capacity

Directorate Risk Registers

Medical DRR summary and Strategy and Transformation DRR summary were reviewed by EOSC in November

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

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

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

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

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

Supporting Documents and/or Further Reading

Appendix 1 – Summary of BAF as at 17 November 2020
Appendix 2 – Summary of CRR as at 17 November 2020

Lead

Paul Scott
Chief Executive Officer

EPUT

BOARD ASSURANCE FRAMEWORK 2020/21 NOVEMBER 2020

PURPOSE OF THE REPORT

This report presents the Board of Directors with an overview of the Board Assurance Framework and Corporate Risk Register 2020/21 as at 25 November 2020.

UPDATE AS AT NOVEMBER 2020

1. Board Assurance Framework 2020/21

The Board Assurance Framework (BAF) provides a comprehensive method for the effective management of the potential risks that may prevent achievement of the key aims agreed by the Board of Directors. The full BAF and CRR spreadsheets are available on request.

Appendix 1 provides a summary of BAF risks as at November 2020 (and notes of any changes made in early November 2020), including mapping of risks against the 5 x 5 scoring matrix and movement on scoring from January 2019 to November 2020.

2. Recommendations for BAF Closure, Replacement, De-escalation and Revision of Scores

Following earlier November EOSC meetings no further closures and revisions are identified. Head of Assurance and Interim COO are considering BAF20 and BAF47 for consolidation as one risk.

3. BAF Action Plans

Potential risks on the BAF should have (in most cases) a detailed action plan to mitigate risks. EOSC reviewed BAF Action Plans September 20. Standing Committees reviewed their allocated risks in September and November. The table below breaks these down by action plan status for October and November. BAF action plans are available on request.

October 2020 (discussed EOSC 3 Nov 20)			**November 2020**	
Action plans in place			**Action plans in place**	
BAF4	Fire Safety		BAF4	Fire Safety
BAF9	No force first		BAF9	No force first
BAF10	Ligature Reduction		BAF10	Ligature Reduction
BAF20/47	Adult inpatient capacity and bed occupancy		BAF20/47	Adult inpatient capacity and bed occupancy
BAF23	EU Exit (Transition)		BAF23	EU Exit (Transition)
BAF31	Skills and capacity		BAF31	Skills and capacity
BAF32	Quality improvement		BAF32	Quality improvement
BAF34	Staffing new services/ care pathways		BAF36	Female patients with PD
BAF36	Female patients with PD		BAF44	Reset and recovery
BAF44	Learning from Covid19 (to develop)		BAF50	Skills, Resource and Capacity consolidates four risks (BAF48 BAF40 BAF31 and CRR69) all related to skills, resource and capacity – action plans for BAF31 and BAF48 have been combined into one action plan for BAF50
BAF48	Capacity for Mortality Reporting/ Review			
No action plans required			**No action plans required**	
BAF15	HSE (linked to BAF10)			
BAF35	Culture of fairness and learning		BAF35	Culture of fairness and learning

October 2020 (discussed EOSC 3 Nov 20)			November 2020	
BAF38	Emergency planning for Covid19		BAF38	Emergency planning for Covid19
BAF40	Resource and Capacity (Organisational objectives)			
BAF41	CIPs (linked to financial plan)		BAF41	CIPs
BAF42	Financial plan		BAF42	Financial plan
BAF43	Surge planning		BAF43	Surge planning
BAF45	CQC - reset action plan		BAF45	CQC - reset action plan approved
BAF46	Young people with complex care needs		BAF46	Young people with complex care needs
BAF49	Executive Leadership		BAF53	Responding to external reviews

4. Corporate Risk Register

4.1 October 2020 (discussed at EOSC 3 November)

There were 24 risks on the Corporate Risk Register in October.

4.2 November 2020

There are currently 26 risks on the Corporate Risk Register. The summary table of CRR risks is attached as Appendix 2. Table 1 gives a summary of each risk (including notes of any changes made early November 2020), and Table 2 shows the mapping of risks against the 5 x 5 scoring matrix.

5. Covid19 Risk Register

The C19 risk register is now being updated on a rolling basis as far as practicable and is circulated to Silver Command and to Executive Directors via Gold Command for review. The Non-Executive Director responsible for emergency planning receives the risk register at the same time. A summary document for Gold risks is appended to each CEO report on Covid19 presented to Board.

6. Directorate Risk Registers

Work continues to progress on Directorate Risk Register summaries for presentation instead of the spreadsheets.

Medical DRR summary and Strategy and Transformation DRR summary were reviewed by EOSC in November

7. Key Performance Indicators

Key performance indicators will be included in the Q3 and Q4 BAF reports then monthly from April 2021.

8. Recommendations

The Board of Directors is asked to:

1 Review the risks identified in the BAF 2020/21 November summary and approve the risk scores (Appendix 1) taking account of actions taken by EOSC at its early November meeting
2 Note the CRR November summary table (Appendix 2) including actions taken by EOSC at its early November meeting
3 Note the additions to Covid19 Risk Register managed through Command structure
4 Identify any further risks for escalation to the BAF, CRR or risk registers

Report prepared by**:**

Susan Barry
Head of Assurance

On behalf of:

Paul Scott
Chief Executive

Appendix 1 - Table 1 – BAF 2020/21 Summary of Risks as at 17 November 2020

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

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview & scrutiny/ date
Strategic Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe and innovative services - Lead Director: Natalie Hammond - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score							
BAF32	If EPUT does not drive quality improvement through innovation then maintaining 'Good' rating and moving towards an 'Outstanding' rating may be difficult resulting in potential stagnation of services and falling behind in whole system transformation	NH	• There are currently six actions on the BAF action plan • Five actions are completed including one that is ongoing • One action is ongoing with a revised completion date – integration of QI, research and innovation arrangements supported by appropriate governance arrangements • Risk score reduced to threshold by EOSC 3/11 and to remain on BAF for completion	Risk score reduced 4 x 3 = 12	Target ~~September~~ December 20 4 x 3 = 12	Learning Oversight PIT At threshold	PIT Nov 20
BAF23	If EPUT does not assess the potential implications of EU Exit (Transition) as no deal or other then there may be unforeseen circumstances resulting in an impact on service delivery	NL	• An Action Plan is in place from September 2019 that has reviewed and circulated for ongoing updates • EU Exit (Transition) Group met on 21 October and due to meet again on 17 November • A designated lead is in place together with support arrangements • Risk score reduced following EOSC 3/11 in discussion with Exec Director of Strategy and Transformation	Risk score reduced 4 x 4 = 16	Target March 21 4 x 3 = 12	EOSC EU Exit (Transition) Group Board of Directors Above threshold	Will be Finance and Performance Committee (Dec 20)
Corporate Objective 1: To provide safe and high quality services during Covid19 pandemic – Lead: Paul Scott supported by all Executive Directors - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score							
BAF4	If EPUT fire safety systems and processes are not suitable and sufficient there is a potential risk of injury or death to patients, staff and visitors, and that enforcement action could be taken by the Fire Authority in the form or restrictions, forced closure of premises, fines, and prosecution / custodial sentencing for 'Responsible' persons	TS	• The action plan has been reviewed in the light of the BDO audit that received Moderate assurance • The BDO generic action has been removed and new actions added specifically around insufficient Fire Wardens and tracking of fire drills • Following the review there are now eleven actions, six actions completed, three actions in progress to timescale and two overdue (insufficient fire wardens and compliance with fire drills)	Risk score unchanged Current Risk Score 5 x 3 = 15	Target March 2021 4 x 3 = 12	HSSC, EOSC and Board Fire Safety Group Above threshold	Finance and Performance Sept 20

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview & scrutiny/ date
BAF10	If EPUT fails to provide high quality services from premises that are safe, then the risk related to ligatures is not minimised and this may impact on the safety of patients in inpatient services.	NL supported by TS	• There are 43 actions on the BAF action plan (ligature reduction work plan) • 23 actions completed • Three actions are due to be completed this month • Some dates have been revised due to some slippage (original dates are crossed through) • 16 actions in progress to timescale, revised timescale or not due yet (including the three above) • Four actions are now overdue (a) curtain rail testing is considered to be a conflict of interest in that the company contracted will be testing their own work. A request has been made to estates by Deputy Director C&A to access the contract to check the wording (b) comparative audit of ligature inspections 2018 v 2020 (c) involving Consultants in ligature risk assessments (d) report from garden audit with recommendations (costings awaited)	Risk score unchanged Current Risk Score 5 x 3 = 15	Target March 2021 4 x 3 = 12	HSSC Quality Committee EERG LRRG Above threshold	Quality Committee Sept 20
BAF9	If EPUT does not embed a No Force First strategy through comprehensive and sustainable structures to monitor, deliver and integrate the approach in clinical practice then a reduction in conflict and restraint may not be achieved resulting in work related staff sickness and poor patient experience	NH	• 20 actions on BAF Action Plan • 18 actions completed • The additional action added is in relation to achieving Accreditation against National Training Standards as they have been implemented • Two actions in progress to timescale including the new one above • Risk score reduced to threshold 4 x 2 = 8 by EOSC 3/11 as there have been real changes in outcomes as a result of this strategy and engagement has been full and positive • To remain on BAF until completed	Risk score reduced 4 x 2 = 8	Target March 2021 4 x 2 = 8	Restrictive Practice Steering Group At threshold	Quality Committee Sept 20

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview & scrutiny/ date
BAF38	If EPUT does not implement effective emergency planning arrangements for managing the Covid19 outbreak in line with national and local requirements then the ability to deliver services is reduced resulting in a lack of containment of the pandemic.	NL	• Command structure in place with twice weekly Gold, Silver and Bronze command meetings in place. • During Wave 1 Covid19 reorganised corporate services to support operational services. Moved clinical corporate services staff to operational services and to support movement of supplies of PPE • Covid19 secure building programme in place • Reset and recovery group established • Covid19 return to workplace group disbanded and work delegated • Emergency planning tasks being re-allocated for expediency	Risk score unchanged Current Risk Score 5 x 2 = 10	Target Ongoing during Covid19 pandemic 5 x 2 = 10	Board of Directors Covid19 Command Structure At threshold	Live Action Log maintained daily through Command Structure
BAF53	If EPUT does not respond at pace to external feedback from independent reviews of its services then it may not complete required safety actions or effectively shape its safety plans for the future resulting in an undermining of reputation and a failure to deliver our new safety strategy	NL	• This new risk supersedes the closed risk BAF15 HSE • Mitigating actions will include: ○ Establishment of Executive Safety Oversight Group ○ Lead Executive for Patient Safety ○ Implementation plan for patient safety strategy ○ Use implementation plan as BAF action plan	Initial risk score C5 x L4 = 20	Align with implementation plan 5 x 2 = 10	EOSC Trust Board Executive Steering Groups Standing Committees Above threshold	Quality Committee
BAF36	If EPUT continues to experience high numbers of female patients with personality disorders being admitted to inpatient services then there is a risk that the ward environment may become more volatile and difficult to manage, impacting patient safety and length of stay.	AB/AG supported by NH / PS (FS)	• There are now eight actions on the Action Plan • Five actions completed • Three actions in progress to revised timescales • One action has been moved to BAF9 No Force First – advance directives and advocacy support action as not just related to PD patients	Risk score unchanged Current Risk Score 5 x 3 = 15	Target date changed from July to September 2020 5 x 2 = 10	Directorate PST Mid/South Essex funding agreed Above threshold	Quality Committee Sept 20

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview & scrutiny/ date
BAF45	If EPUT does not prepare for an anticipated CQC inspection in 2020 then this may have a negative impact on the outcome of the inspection resulting in not maintaining our 'Good' rating	PS (FS)	• CQC Executive Steering Group is monitoring • The Compliance Team has developed a new work plan that is reported on monthly until such time of a CQC inspection • Work plan monitors progress on ○ Developmental actions identified and closed in the CQC action plan ○ Issues identified when ensuring practice has been embedded and sustained ○ Action plans from internal inspections ○ Development and potential new practices following any new CQC guidance	Risk score unchanged 4 x 3 = 12	Target March 2021 4 x 2 = 8	CQC Exec Steering Group Above threshold	Quality Committee Sept 20
BAF46	If EPUT is unable to secure low secure and other placements for young people with complex care needs then an increase in restraints and assaults may be seen resulting in potential harm to patients and staff	AB/ AG	• Actions logs and feedback from the system wide clinical reference group and associated workstreams as well as clinical design group for clinical care models are used to monitor this risk in conjunction with Specialist Services • Work streams have continued as part of the New Care Models work and have been submitted for inclusion in the business case for CAMHS to go to the Consortia for consideration. At this stage there is no proposed increase in LSU capacity in the system. However, a focus on preventative work across the system is suggested to mitigate escalation and need for LSU	Risk score unchanged Current risk score 4 x 4 = 16	Target March 2021 4 x 2 = 8	PST Above threshold	No action plan required

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview & scrutiny/ date
BAF50	If EPUT does not have the skills, resource and capacity to deliver high quality business as usual care and services, manage the C19 pandemic, and increased variation of demands on corporate services then it may not achieve the deliverables on this wide range of priorities and pressures resulting in not achieving organisational objectives, unsustainability in corporate services, stagnation of risks and failure to maintain our position within the wider health economy	PS and all EDs	• This risk consolidates the following four risks recommended for closure: BAF48, BAF40, BAF31, and CRR69 • Mitigating actions include ○ Ensuring organisational, reporting and governance structures within EPUT are set up to meet the priorities and pressures on it ○ Closely monitor and manage the BAF, CRR and DRRs ○ Central co-ordination point within Strategy and Transformation Directorate • BAF50 action plan combines BAF31 and BAF48 action plans now with 14 actions, five of which are completed and nine in progress to timescale	Initial risk score C5 x L4 = 20	Ongoing during C19 pandemic 5 x 2 = 10	Command structure EOSC Trust Board PIT F&PC Above threshold	PIT
Corporate Objective 3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response – Lead Director: Sean Leahy supported by all other Executive Directors – Impact of not achieving the Corporate Objective 4 x 3 = 12							
BAF35	If EPUT does not develop a culture based on what is morally right and fair in response to incidents and errors, and is unable to demonstrate that lessons are learnt, then protection of both staff and patients is reduced which may result in poor quality services and patient experience together with lack of actions consistent with prevention impacting on CQC rating	SL NH	• This risk is monitored through the People Plan, WRES, Communications and PSIRF implementation plan • A two hour session was held at the October Board Development session to feedback on EPUT's People Plan • PSIRF Project Team in place and meeting weekly	Risk score unchanged Current Risk Score 4 x 3 = 12	Target March 21 4 x 2 = 8	Workforce Transformation Group PIT F&PC Mortality Review Sub-Committee Learning Oversight Group Above threshold	No action plan required

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview & scrutiny/ date
BAF20	If EPUT has insufficient adult mental health capacity then in-patient activity levels may exceed funded capacity and continued bed occupancy levels above 85% with high numbers of out of area placements, this may impact on the quality and effectiveness of services delivered as well as the Trust meeting its statutory financial duties	AG	• There are now ten actions on BAF20 (linked also to BAF47) • Five actions have been completed • Two actions in progress • Three further actions in progress require target dates • Out of area placements remain challenging • Action plan will be reviewed with flow and capacity lead • Discussing with COO the possible consolidation of this risk with BAF47	Risk score unchanged Current Risk Score 5 x 3 = 15	Target date changed from June to March 21 due to Covid19 4 x 2 = 8	Reporting to PST CQC action plan monitored by EOSC Above threshold	F&PC Sept 20
BAF41	If recurrent CIPs for 2020/21 are not identified then delivery of the programme is compromised resulting in a challenge to the sustainability of EPUT going forward	TS (financial monitoring) supported by all Executive Leads	The Trust's Cost Improvement target for 20/21 is £11.7m, including 19/20 £5.1m recurrent shortfall brought forward • Full recurrent delivery of the 20/21 CIP target must be delivered and focus needs to be on the full year recurrent CIP for the Trust due to the current financial regime • **M6** £3.6m FYE CIP schemes agreed and £0.8m of pipeline schemes remain deliverable • This leaves FYE unidentified balance of circa £7.3m • The 2020/21 CIP Deep Dive reviewed at FPC concluded a number of actions which finance, supported by Executive Directors, are working on. The main focus will be to recurrently address the 19/20 recurrent CIP shortfall brought forward, of £5.1m, in advance of setting baseline budgets for 2021/22 • Finance continuing to meet with Directors/ Service Leads to discuss progressing schemes identified, and identify schemes to meet the unidentified target • Emerging risk is the unknown and unconfirmed terms of settlement for the second half of 2020/21 • In operational services CIPs is being taken forward internally, with a different approach linked more to transformation rather than top slicing budgets. To be discussed within PST. • EOSC did not agree to increase the score to 20 and requested TS to review this. Consequence has now been reduced to 3 in view of the proportion of overall cost base	Risk score reduced Current Risk Score 3 x 4 = 12	Target March 2021 4 x 2 = 8	Finance and Performance Committee Board Above threshold	No Action Plan required

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview & scrutiny/ date
BAF42	If the Covid19 crisis continues then EPUT may experience an adverse impact on its financial plan as a knock on from system wide financial planning resulting in additional risk for EPUT to its sustainability	TS	• EPUT continues to operate under a National NHS Emergency Finance Regime as a result of C19. This will change in M7 and a review of this risk will take place • During the first four months of 2020/21 all NHS providers reporting a deficit will receive top up payments to adjust their reported position to breakeven • In September 2020 the Trust recorded a deficit of £6.5m before top up income, including year to date Covid-19 costs of £7.3m. Cash is £28.7m above plan at **M6** • Continued discussions with system regarding allocation of COVID19 funding for M7-12. Early indications are that there will be a system shortfall. • EOSC did not agreed to an increase in risk score and asked TS to review. As a consequence the score remains as previously 4 x 3 = 12 until Region respond on EPUT's plan submission	Risk score unchanged Current Risk Score 4 x 3 = 12	Target March 2021 4 x 2 = 8	Finance and Performance Committee Board Above threshold	No Action Plan required
BAF43	If EPUT does not plan for an expected surge in demand for Mental Health services or physical CHS and rehabilitation during or post C19 then skills and capacity may not be in place resulting in long waiting lists and self-harm in the community	AG	• A phased plan is in place to manage the surge demand alongside winter planning • From October – April 2021 existing capacity, flow and escalation initiative are in place • From November to March 21 winter funding schemes are to be signed off, implemented and monitored, underpinned by MH Winter KLOES • From January to April 21 plan in place for Topaz Ward to be operational mid-January 21 providing additional mental health surge capacity • Contingency plans include exploring opportunities with local private providers to purchase additional inpatient capacity and exploring further use of other estate options for additional beds (Kelvedon) or a Covid19 ward for unwell patients who are not a ligature risk • EOSC 3/11 did not agree to a reduction in score as things have moved on and EPUT is currently at Opel 4	Risk score unchanged Current Risk Score 5 x 4 = 20	Target March 2021 5 x 2 = 10	Command Structure EOSC and Board plus Standing Committees Above threshold	PIT Nov 20

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance	Action Plan overview & scrutiny/ date
Corporate Objective 4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance – Lead: Paul Scott supported by all Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score							
BAF44	If EPUT does not fully capture, review and embed learning from the C19 experience then this may have an adverse impact on Phase 3 planning resulting in missed opportunities in transformation	NL	• There are 10 actions on the BAF action plan with two completed and eight in progress to timescale	Risk Score unchanged Current Risk Score 4 x 3 = 12	Target March 2021 4 x 2 = 8	Above threshold	PIT Nov 20
BAF47	If EPUT limits bed occupancy to 85% on mental health inpatient wards to facilitate social distancing requirements then modelling suggests there will be a shortfall in beds resulting in delays to admissions or an increase in out of area placements	AG	• Linked to reset and recovery group for action planning • This is linked to BAF20 action plan • Discussing with Interim COO the possible consolidation of this risk with BAF20	Risk score unchanged 4 x 4 = 16	Target date March 21 4 x 2 = 8	Reset and Recovery Board EOSC Above threshold	Action plan linked to BAF20
Corporate Objective 2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans - Lead Director: Nigel Leonard supported by all other Executive Directors - impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score							

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

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2				BAF9	BAF38
	3				BAF35 BAF42 BAF44 BAF45 BAF32	BAF4 BAF20 BAF36 BAF10
	4				BAF23 BAF41 BAF46 BAF47	BAF43 BAF50 BAF51 BAF52 BAF53
	5					

Table 3: Movement on scoring –period from January 2019 to November 2020

Risk ID	Initial Score	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	July 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Risk ID
BAF4	15	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF4
BAF5	12	12↔	12↔	12↔																					BAF5
BAF6	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔												BAF6
BAF9	16	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	16↑	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	8↓	BAF9
BAF10	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	BAF10
BAF12	12	16↔	16↔	16↔																					BAF12
BAF13	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	6↓							BAF13
BAF14	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔																BAF14
BAF15	15	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔		BAF15
BAF16	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔																BAF16
BAF18	15	20↔	20↔	20↔	20↔	16↓	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔							BAF18
BAF20	12	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF20
BAF21	15	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔															BAF21
BAF22	16	16↔	9↓	9↔	9↔	9↔	9↔	9↔	9↔	9↔															BAF22
BAF23	15	20↑	20↔	12↓	8↓					20↑	20↔											20	20↔	16↓	BAF23
BAF25	16	12↓	12↔	8↓																					BAF25
BAF26	16	8↓	8↔																						BAF26
BAF27	16	16↔	12↓	12↔																					BAF27
BAF28	16	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔																BAF28
BAF29	12	12	8↓																						BAF29
BAF30	12			New	12	12↔	12↔	12↔	12↔	12↔															BAF30
BAF31	16			New	16	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF31
BAF32	16			New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	BAF32
BAF33	12								New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	6↓							BAF33
BAF34	16									New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	8↓	BAF34
BAF35	16									New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	BAF35
BAF36	15											New	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↓	BAF38
BAF39	20														New	16									BAF39
BAF40	12																New	12	16↑	16↔	16↔	12↓	12↔		BAF40
BAF41	16																New	16	16↔	16↔	16↔	16↔	16↔	12↓	BAF41
BAF42	12																New	12	12↔	12↔	12↔	12↔	12↔	12↔	BAF42
BAF43	20																New	15	20↑	20↔	20↔	20↔	20↔	20↔	BAF43
BAF44	12																	New	12	12↔	12↔	12↔	12↔	12↔	BAF44
BAF45	12																	New	12	12↔	12↔	12↔	12↔	12↔	BAF45
BAF46	16																		New	16	16↔	16↔	16↔	16↔	BAF46
BAF47	16																			New	16	16↔	16↔	16↔	BAF47
BAF48	16																			New	16	16↔	16↔		BAF48
BAF49	15																			New	15	15↔	15↔	8↓	BAF49
BAF50	20																						New	20	BAF50
BAF51	20																						New	20	BAF51

Notes: Risks closed for over two years removed from table

Table 4: Milestones – under development

Risk ID	Initial Score	Length of time on BAF	Apr 19	May 19	Jun 19	July 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Risk ID
BAF4	15	> 2 years																					BAF4
BAF9	16	> 2 years						16↑								12↓						8↓	BAF9
BAF10	12	> 2 years	15↔								20↑					15↓							BAF10
BAF15	15	> 2 years Closed				20↑																Closed	BAF15
BAF20	12	> 2 years	15↓																				BAF20
BAF23	15	> 2 years (intermittent)	8↓					20↑													20 ↔	16↓	BAF23
BAF31	16	> 1 year Closed	16	15↓																		Closed	BAF31
BAF32	16	> 1 year	16																			12	BAF32
BAF34	16	> 1 year Closed						New	16									12↓				Closed	BAF34
BAF35	16	> 1 year						New	16														BAF35
BAF36	15	1 year								New	15												BAF36
BAF38	15	> 6 months											New	15									BAF38
BAF40	12	> 6 months Closed													New	12	16↑			12↓		Closed	BAF40
BAF41	16	> 6 months													New	16					20↑	12↓	BAF41
BAF42	12	> 6 months													New	12					16↑	12↓	BAF42
BAF43	20	> 6 months													New	15	20↑						BAF43
BAF44	12	<6 months														New	12						BAF44
BAF45	12	<6 months														New	12						BAF45
BAF46	16	<6 months															New	16					BAF46
BAF47	16	<6 months																	16				BAF47
BAF48	16	<6 months Closed																	16			Closed	BAF48
BAF49	15	<6 months Closed																	15			Closed	BAF49
BAF50	20	New																				20	BAF50
BAF51	20	New																				20	BAF51

Appendix 2 CRR 2020/21 Summary of Risks as at 17 November 2020

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

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
Strategic Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe and innovative services - Lead Director: Natalie Hammond - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score						
Corporate Objective 1: To provide safe and high quality services during Covid19 pandemic – Lead: Paul Scott supported by all Executive Directors - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score						
CRR 51	If EPUT staff are not alert whilst on duty then high quality care will not be delivered resulting in poor patient experience	AG	• This currently remains a risk • Robust observation protocol in place – for agency staff there is a 'one strike and out' rule in place • Robust performance management of substantive staff in place	Risk score unchanged 3 x 3 = 9	3 x 2 = 6 ~~July~~ Dec 2020	EOSC Above threshold
CRR 58	If EPUT's in-patient wards do not fill shifts consistently to a minimum of 90% then safer staffing is not fulfilled resulting in poor patient experience, low staff morale and non-compliance with standards	AG	• Continues to be monitored due to CQC profile • Unfilled shifts highlighted in performance reports are not aligned with acuity and occupancy. Low occupancy may mean that the ward is still well managed even with unfilled shifts • The view of Operations is that twice daily sitreps ensure that wards are safely staffed • This is not an issue for Community Health Services • Specialist Services and Mental Health have negligible vacancies and recent over-recruitment will show an improvement as aspirant nurses receive PIN nos. • Vacancies out to advertisement. Had to hold aspirant nurse vacancies in North East, distorting figures • Consistent monitoring of shift fill via SafeWards	Risk score unchanged 4 x 2 = 8	4 x 2 = 8 March 2021	Sitreps Quality Dashboard/ CQC compliance Board At threshold
CRR 61	If the CQC investigates recent inpatient deaths then EPUT may receive additional scrutiny during its upcoming inspection resulting in its rating not being improved with the associated reputational damage	AG/ PS	• Leave at threshold as a precautionary measure • No change whilst awaiting CQC inspection • CQC unannounced inspection took place on Finchingfield generating a number of information requests	Risk score unchanged 5 x 2 = 10	5 x 2 = 10 ~~July 2020~~ March 2021	HSE Steering Group At threshold
CRR 65	If EPUT is unable to deliver ECT to patients in a timely manner due to capacity restrictions resulting from Covid19 guidance then patients may experience a delay in receiving treatment, resulting in a poor patient experience, possible patient deterioration or harm and reputational damage to EPUT	MK	• Risk description changed • Two sites are now registered for ECTAS accreditation • ECT Group chaired by Consultant and Associate Director Operations, with regular updates to EOSC on progress with ECTAS accreditation • ECT protocols in place in North Essex, anticipating award of accreditation before end of year	Risk score unchanged 4 x 4 = 16	4 x 2 = 8 ~~September~~ December 2020	TST Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 11	If EPUT fails to implement and embed its Suicide Prevention Strategy into Trust services then it may not track and monitor progress against the ten key parameters for safer mental health services resulting in not taking the correct action to minimise unexpected deaths and an increase in numbers	NH/ MK	• Reviewed Suicide Prevention Strategy • A campaign of awareness took place between 10 September and 10 October with a number of live events that were well supported	Risk score unchanged 4 x 3 = 12	4 x 2 = 8 March 21	Quality Committee and sub-Committees Above threshold
CRR 39	If EPUT does not drive improvement through clinical research then an outstanding rating may not be possible resulting in the Trust not reaching its aspiration in the desired timeframe	MK	• The situation with Covid19 remains fluid at the present time, which may impact on face to face research • As a result of discussion with the Interim Research Manager two new risks are being considered for the Medical DRR, the first around placing emphasis on the adoption of NIHR national studies to ensure performance and finance is not impacted and to ensure a mature clinical research culture; the second around ensuring that the capacity of the research team is not compromised by pressure to participate in clinical trials	Risk score unchanged 3 x 3 = 9	3 x 2 = 6 March 2021	Research and Innovation TST NIHR Clinical Trials Performance (CTP) Team Above threshold
CRR 16	If violence and aggression is not managed there is a risk of severe harm or death, as well as impacting on reputation and staff survey results.	PS	• General workplace risk assessments are in place • Environmental aspects are reviewed to minimise violence and aggression • Violence and aggression task and finish group continues to meet quarterly • Trial of body worn cameras completed with evaluation showing positive staff response • Ongoing work with Essex Police has resulted in improved responses and investigations and a better relationship • Staff are better supported with positive feedback • New lone worker devices in place with more staff using them • Patient acuity is high meaning that this is always going to be a risk • Body worn cameras rolled out to more wards • Evaluation report to Technical T&F group • Possibly one T&F group to be formed for Technical and Oxehealth	Risk score unchanged 4 x 3 = 12	4 x 2 = 8 March 21	Internal audit HSSC Staff survey Task & Finish Group Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 56	If blanket (global) restrictions continue to be operated in in-patient mental health services, then the experience of patients will be impacted and the CQC rating of the Trust / in-patient services is unlikely to improve	AG NH	• Risk assessments continue on wards • 5 steps to managing global restrictions in inpatient wards was introduced • Work ongoing within Older People's wards • It remains the case that EPUT's response to managing higher occupancy levels as a result of C19 pandemic and winter pressures may result in a decision to introduce rules to enforce social distancing on inpatient wards as well as staggered mealtimes. This could result in an interpretation of 'blanket restrictions' but deemed important for staff and patients at the current time	Risk score unchanged 3 x 4 = 12	3 x 2 = 6 March 21	Restrictive Practice Group Quality Committee Above threshold
CRR 64	If there are new serious inpatient patient safety incidents then there is a risk that the Trust could be subject to increased regulatory scrutiny with respect to clinical care and governance processes, impacting the Trust's reputation and CQC rating	AG/ PS	• There have been zero never events reported within EPUT services in the last six months • Risk closely aligned to BAF10 Ligatures and remains high risk with scrutiny by LRRG • Serious incident resulting in death related to an abscond from Finchingfield sees this risk materialise and an unannounced visit from CQC has taken place as a result	Risk score unchanged 4 x 3 =12	4 x 2 = 8 March 21	Ligature Risk Reduction Group HSSC Above threshold
CRR 48	If EPUT is unable to suitably fill consultant vacancies across EPUT mental health adult inpatient wards on a substantive or locum basis then the Trust may not be able to deliver safe and effective services, resulting in poor patient flow and possible patient harm	MK	• The situation is now more complex and activity has increased with cover being maintained by locum and agency • This risk has been reworded to cover inpatient services as recruiting to adult inpatient wards in all areas is challenging • There are 20 Consultant vacancies, of which 16 are covered by Locum posts	Risk score reduced 4 x 4 = 16	4 x 2 = 8 Mar 21	Medical Staffing Committee Above threshold
CRR 68	If EPUT does not complete annual General Workplace Risk Assessments or they are of poor quality then its statutory requirement is not met resulting in non-compliance with CQC well led standards	PS supported by all Executives	• A Task and Finish Group within the Risk, Compliance and Assurance Directorate is currently ongoing including reviewing and simplifying risk assessment paperwork, looking at other Trusts' paperwork as well as HSE guidance • Discussions with other Trusts may lead to a forum working on achieving compliance with GWPRAs • Task and Finish Group on 12 November will agree a final version of the GWPRA template, finalise and email out to HSSC members to test within their teams and feed back	Initial and current risk score 4 x 4 = 16	4 x 2 = 8 October 20	HSSC Quality Committee Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 71	If EPUT experiences issues with the battery life on its stock of McKinley T34 Syringe Drivers then the Trust may not be able to provide effective therapeutic symptom management to service users, resulting in poor patient care, poor patient experience and non-compliance with best practice and national guidelines	AG	• A number of controls already in place • Send out a request to all areas asking that all machines are checked. The battery prongs are to be cleaned and sent for repair if there are still issues. They should be trial tested prior to being applied to any patient. • Duracell batteries in use across Trust • Guidance in place for battery maintenance of Series 2 & 3 devices • 8 devices to be returned from manufacturer, 6 to return to stock following Althea checks	4 x 3 = 12	December 2020 4 x 2 = 8	Above threshold CHS SMT
Strategic Objective 2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts - Lead Director: Paul Scott supported by all other Executive Directors - Impact of not achieving the Strategic Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score						
CRR 40	If the Trust is not adequately prepared, or there is a lack of funding for the cyber team, it could be subject to a cyber-attack that compromises clinical or corporate IT systems, and the consequent cost pressure may result in a financial risk to EPUT	TS	• Whilst this is at threshold, during Covid19 the NHS remains vulnerable to hacking and a potential scam email from a pharmaceutical company has been investigated. Pharmacy staff are aware of this. • There is a need to upgrade Windows 10 by October – this was delayed due to Covid19. Licences have now been ordered.	Risk score unchanged 4 x 2 = 8	4 x 2 = 8 March 20	Cyber Essentials Accreditation PSOG PST At threshold
CRR 53	If the dormitory elimination project plan is not implemented in line with agreed timescales then there could be a delay to providing single bedroom accommodation by 2021 which could potentially impact on CQC ratings and patient experiences.	NL	• Phase 1 completed • Phase 2 completed • Phase 3 Cherrydown and Kelvedon Ward refurbishments design team reviewing current floor plan to include assisted bathroom • An application has been made to Region for central funding to support Phase 3	Risk score unchanged 3 x 4 = 12	4 x 2 = 8 December 21	Capital Group PIT EOSC Above threshold
CRR 34	If there are insufficient suicide prevention trainers and staff are not trained effectively in suicide prevention then there is a risk that staff may not have the necessary skills to safely support a suicidal patient, resulting in self-harm or suicide.	NH MK	• Ligature and training compliance figures were reviewed and decreasing; an improvement is required • This training is not mandatory and an improvement trajectory has been set for specific staff to complete the training as the current uptake is an issue • Training is currently virtual and proposal for delivery submitted to Suicide Prevention Group	Risk score unchanged 3 x 3 = 9	3 x 2 = 6 March 21	Quality Committee Suicide Prevention Group Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 49	If urgent care pathway services receive high levels of referrals which do meet the threshold for secondary services then the ability to respond is reduced resulting in poor patient experience	AG	• Access and assessment services no longer exist in West and North East are moving away from this service to new community assessment model. The new Crisis 24 team are also taking referrals • By April 21 EPUT will have more control over referrals from IAPT into core services • Community transformation is a phased model • Operations leads have reviewed the wording of this risk and cross referenced with surge planning • Community transformation paper signed off in NEE, redesign of CMH pathways and reprovision of IAPT through EPUT • Transparent monitoring through contracting	Risk score unchanged 3 x 3 = 9	3 x 2 = 6 Dec 20 ~~July 20~~	CCG QCPM Board CCGs Above threshold
CRR 72	If EPUT does not have a suitable IT system in place for its Drug & Alcohol Service then partners may be able to access clinical records in a timely manner, possible damage to data integrity and possible excessive prescribing or treatment, resulting in poor system working and possible patient harm	AG	• Escalated from Operations MH Specialist Services • Reinforce importance of Datix recording as part of work to map incidents and build evidence of problems • Theseus does not constitute an official medical record as content may be deleted – numerous difficulties experienced with Theseus • ECC advise Theseus 2.0 in development • Plan to move to SystmOne for prescribing • Auditing and monthly data cleansing exercises in place	4 x 3 = 12	March 21 4 x 2 = 8	SSMG Above threshold
CRR 73	If EPUT does not have robust systems in place for communicating concerns regarding patients who may be subject to dual diagnosis care then patients may not receive the care they need in a timely manner, or may be put at risk by overtreatment, resulting in possible patient harm and reputational damage	AG	• Escalated from Operations MH Specialist Services • Review Dual Diagnosis Policy and Procedure • Theseus does not connect to HIE and MH staff unable to see prescribing activity from drug and alcohol services • Open Road not checking if patient known to MH and vice versa – poor system working and communication • Dual Diagnosis working group restarted • Pilot in West using Pando for Consultants at Derwent Centre to ping each other drug and alcohol cases to check with STaRS	4 x 3 = 12	March 21 4 x 2 = 8	SSMG Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
Corporate Objective 3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response – Lead Director: Sean Leahy supported by all other Executive Directors – Impact of not achieving the Corporate Objective 4 x 3 = 12						
CRR 14	If EPUT staff morale is low then it may not be able to deliver high quality services resulting in a challenge to transformational change, patient experience and outcomes	SL	• Staff are being encouraged to complete the current staff survey • The Pulse survey has had a low take up amongst EPUT staff but there is a theme of tiredness and fatigue emerging • Wobble (chill out) rooms are being set up across inpatient areas	Risk score unchanged 4 x 3 = 12	4 x 2 = 8 March 2021	Workforce Transformation Group Above threshold
CRR 57	If EPUT fails to embed equality and diversity into its culture and conversation then staff and patient experience may be negative resulting in a challenge to the CQC rating for well-led, and exposure to legal challenge for discrimination	SL supported by all Execs	• Be You Week was very successful and staff were encouraged to 'Be You' in the workplace and shared things that were important to them • Various training sessions and live events took place during Be You week • The Executive for People and Culture is formally the Inequalities Executive Lead for EPUT	Risk score unchanged 3 x 4 = 12	3 x 2 = 6 March 21	Equality and Inclusion Committee PIT Board EOSC Above threshold
Strategic Priority 3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve - Lead Director: Nigel Leonard supported by all other Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						
Corporate Objective 2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans - Lead Director: Nigel Leonard supported by all other Executive Directors - impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						
CRR 45	If the revised mandatory training policy requirements are not achieved this could impact on the Trust's ability to maintain a 'good' rating.	SL supported by all Execs	• Gold Command have concerns about compliance levels for mandatory training and the number of staff who are booking on courses and failing to attend or cancelling at short notice. • Training courses are currently running at 30% under capacity as a result of the above • All staff are urged 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 have been reminded to check training trackers and prompt staff whose training is overdue	Risk score unchanged 4 x 4 = 16	4 x 2 = 8 March 21	Training and Development Group Above threshold
CRR 28	If mental health clinical activity is not entered into patient admin systems on a timely basis this could impact on monitoring and reporting key performance measures which could result in breaches on regulatory or contractual requirements	AG/ MK	• No change to this risk: • Timeliness of data entry is still identified as a concern • Works within Operations Mental Health is currently ongoing	Risk score unchanged 5 x 3 = 15	4 x 2 = 8 September 20	PST Performance reports Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR 30	If data entry is incorrect, late or recorded on paper then managers may not have sufficient information for decision making, data from paper records cannot be reported on, impacting on contractual obligations and the risk of financial penalties	TS	• Issues around inequalities are being looked at in relation to EPUT's population and reporting • Data Quality Reports provided to Operations on a regular basis through Crystal reporting in North and Caseload audit reporting in South • Compliance now 97% and target has been met	Risk score unchanged 4 x 3 = 12	4 x 2 = 8 July 20	Internal Audit CCG Assurance IGSC Above threshold
CRR 52	If EPUT, as the lead in the consortium, is unable to manage overruns or delays in the implementation of HSCN, then this may weaken relationships with partners resulting in a threat to reputation and a financial cost pressure	TS	• At threshold but continues to be monitored	Risk score unchanged 4 x 2 = 8	4 x 2 = 8 June 20	C19 Command At threshold
CRR 36	If the provision of primary care services in different areas of the Trust includes a range of varying models then this presents an associated challenge to corporate services in providing performance management information and responding to data requests, resulting in a resource and capacity issue impacting on contract requirements and financial sustainability	TS	• This risk was reviewed with the Directorate and remains a risk for ITT services whilst returning to business as usual, the demands of which may increase the score at some point. • A broader risk was added as CRR69 to reflect the pressures on all corporate services • Consistency is required across the different areas and this remains an issue	Risk score unchanged 4 x 3 = 12	4 x 2 = 8 March 2021	Above threshold
CRR 70	If GPs do not carry out home visits on their end of life care patients then additional work is given to community staff in visiting patients and sending videos to GPs to avoid coroner involvement in unexpected deaths, resulting in a poor experience for patients and low morale of staff	AG	• New CRR risk approved by EOSC September 20 escalated from West Essex Community Health Services • Concerns escalated with examples to CCGs • Engagement with practices on case by case basis in attempt to resolve differences amicably but ensure GPs continue to provide service as expected to patients	Risk Score unchanged 4 x 4 = 16	4 x 2 = 8 Dec 2021	Above threshold
Corporate Objective 4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance – Lead: Paul Scott supported by all Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						

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

	RISK RATING				
	Consequence				
	1	2	3	4	5
Likelihood 1					
Likelihood 2				CRR40 CRR52 CRR58	CRR61
Likelihood 3			CRR34 CRR39 CRR49 CRR51 CRR71 CRR72 CRR73	CRR11 CRR14 CRR16 CRR30 CRR36 CRR64 CRR69	CRR28
Likelihood 4			CRR53 CRR56 CRR57	CRR45 CRR48 CRR65 CRR70 CRR68	
Likelihood 5					

		Agenda Item No: 8 (b)i
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25th November 2020**

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

Purpose of the Report

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

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance provided
3 Agree the updated capital programme 2020/21 (Appendix 1)
4 Request any further information or action.

Summary of Key Issues

The Trust is in the process of updating its Performance reporting and the Committee is supporting the changes which will be implemented through the remainder of this financial year.

Key matters discussed at the Committee included issues with CPA 12 month reviews, mental health in-patient capacity, admissions to mental health facilities, in particular for under 16s and also mandatory training. The Committee also discussed waiting lists and waiting times, including psychology services.

In October 2020 there were 23 Indicators reported within target (24 in September) whilst a number of areas have been identified for further review and improvement. These areas included temporary staffing utilisation levels, data quality/documentation compliance and the staff survey.

On financial matters the consequences of the adapted financial regime were reported and considered along with the significant increase in the level of capital resources available to the Trust, now totalling £17.3m. This follows national approval of the bid to eliminate mental health dormitories. The updated capital programme was discussed by the Committee following Executive Team agreement and is attached as an appendix for approval by the Board.

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
Please see attached Appendix 1,2,3 relating to Financial Performance Report – CAPEX

Lead
Manny Lewis **Chair of Finance & Performance Committee**

Agenda Item 8(b)i
Board of Directors
Meeting: 25 November 2020

FINANCE AND PERFORMANCE COMMITTEE ASSURANCE REPORT

1.0 Purpose of Report

This report is provided by the Chair of the Finance and Performance Committee, Manny Lewis to provide assurance to Board members that the performance operational, financial and governance as at Month 6, September 2020 and Month 7 October 2020 was subject to appropriate and robust scrutiny.

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

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

2.0 Quality and Performance Report

This month's report has been adapted and aligned to CQC classifications in order stratify performance against the key performance indicators i.e. using criteria of Inadequate, Requires Improvement and Good in order to further improve the focus of discussions. This report covers the position of both month 6 and month 7 in line with the agreed bi-monthly Trust Board.

The Committee considered the following key issues over the last two months:

KPIs identified as currently inadequate:

- CPA 12 month reviews
- Mandatory Training and
- Under 16's admission to an Adult Ward

There has been progress on the work addressing CPA 12 month reviews and although there has been an improvement in activity against the target this area continues to be monitored by the service management board.

Mandatory Training is now monitored though the Executive Team on a weekly basis. The Executive Director of People & Culture informed members that a decision had been taken to roster staff on to mandatory training sessions with a view to further improving compliance.

Admissions of under 16's to an Adult Ward was discussed in detail. It explained that collective work across the System needs to take place to ensure this issue is understood and addressed by all parties in order to improve and resolve issues. The matter will also be picked up with the Mental Health Partnership.

The Committee noted that of the 52 KPIs reported there were 13 KPIs that met the category of requires improvement and that the Executive Team had requested that there is a focus on those KPIs through a deep dive process monitored by the Senior Management Team. This is with a view to bringing back improvement plans for those areas. These include mental health in-patient capacity, data quality and documentation, staff survey and temporary staff utilisation.

The Interim Executive Chief Operating Officer updated members on the CAMHS Inpatient Services which was identified as an area that needed to be monitored with high levels of observation due to acuity. It was noted that all other providers in the eastern region were reporting the same challenges. The committee agreed that this should also be included as an area for focus for patient safety.

The Committee also discussed waiting lists and waiting times, including psychology services; this included IAPT first and second appointment waiting times. This service has been affected by COVID but has begun to see an improvement on access and recovery rates since June. There remain concerns that the increasing reliance on this service due to COVID will have further impact on the waiting times for the second appointment. The committee was assured that the service had put measures in to monitor these patients and offered alternative support whilst waiting for the second appointment.

The Interim Executive Chief Operating Officer highlighted areas across the Trust fall into the Good category that have either met or exceeded the targets for their services. The committee noted the good work undertaken by community services on reducing pressure sores and the reduction in the number of falls across the localities. It was also noted that there has been some excellent work by the staff in mental health in reducing the number of Prone restraints

Contract Exception Reporting

Each month EPUT produces a suite of reports for its commissioners and Local Authority partners. These reports are circulated to the relevant Directors for review at the Senior Management Team meetings. Areas of underperformance are highlighted and discussed.
Two Contract Performance Notices issued by Mid & South Essex CCG's continue to be on hold for MH RTT (Patient Referred to the MH First Response Team seen within 28 days), and Community MH service users on CPA with a care plan (assurance accepted by CCG 11/11/20 that performance is at target after September data audit).

3.0 Financial Performance Report

Financial Position: Year-to-date (YTD) deficit £1.7m, broadly on plan with the financial submission.

COVID Spend: The Trust incurred further expenditure of £0.8m in October 20 (year to date £8.1m). Financial recovery of month 7 to month 12 spend is anticipated from Mid & South Essex Health and Care Partnership allocation (with month 1 to month 6 through national reimbursement).

CIP Position: 2020/21 target £11.7m including the 19/20 recurrent shortfall of £5.1m. In Year savings of £7.8m have been agreed with £0.8m identified as in pipeline. Recurrent savings at Month 7 are £3.6m.

Temporary Staffing Spend: Total spend M7 £4.3m, with Bank spend £3.0m (YTD £19.8m) and Agency spend £1.3m (YTD £8.1m). Total temporary staff spend YTD £27.9m with total YTD COVID temporary staff spend £5.2m.

CAPEX: At M7 the Trust has incurred expenditure of £2.7m against capital resources £17.3m. New further schemes (£4.4m) have been identified in order to seek to fully utilise the resource this year. (see appendix 1-3) The programme has been slightly overcommitted due to anticipated slippage.

Cash: The cash balance at the end of October is £97.9m which is better than planned with the supplementary national payment still to unwind.

UoRR: Due to COVID-19 and the Adapted Financial Regime, NHSI is not monitoring against this metric.

Sub Committee Reports

The Committee received 9 sets of Executive Operational Sub-Committee part one minutes for noting:

- 15 September 2020
- 22 September 2020
- 29 September 2020
- 6 October 2020
- 13 October 2020
- 20 October 2020
- 27 October 2020
- 3 November 2020
- 10 November 2020

Policies for Approval

The following Policies and Procedures were approved by the Committee

- Apprenticeship Policy

Progress Against RMAF Development Plan

The Deputy Director of Compliance and Assurance updated the committee on the current position with the progress against the RMAF. The RMAF is a three year document but reviewed annually and presented to the Finance and Performance Committee and the Audit Committee for approval.

There are currently 12 actions, one of which is the responsibility of the Trust Secretary and the remaining 11 the responsibility of the Compliance and Assurance Directorate:

- Seven actions are completed with five in progress to timescale
- Four completed actions are the subject of ongoing and evolving work related to the RMAF.

The recommendations made by BDO (Internal Audit in its Risk Maturity Audit carried out in 2019 have been completed and BDO will be reporting to the Audit Committee on this.

Previously the committee has requested that options for an electronic risk register be considered. The Deputy Director of Compliance and Assurance informed the committee that the Directorate was continuing to explore the potential of an electronic risk register.

The committee was also informed that the decision of the CEO and the Executive Team to devote more EOSC agenda time to the Board Assurance Framework.

The committee supported the move towards electronic risk registers.

Any Risks or Issues

There are no risks and Issues identified.

Report prepared by:

Janette Leonard
Director of ITT, Business Analysis and Reporting
On behalf of:

Manny Lewis
Chair of the Finance and Performance Committee

Appendix 1

2020/21 CAPITAL PLAN

	Project Lead		Forecast Actual 2020/21		*Committed in 2021/22*
ESSENTIAL MAINTENANCE SCHEMES					
ICT					
~ ePrescribing	Hilary Scott		288		*90*
~ ePrescribing Business Continuity Solution	Hilary Scott		220		
~ ICT 2020/21 projects (as per Appendix 2)	Jan Leonard		3,691		
Carbon Reduction					
~ Carbon Reduction LED Lighting (Rochford & Thrurrock Hospitals)	Tim Wheeler		200		
~ Boiler works (The Lakes and Robin Pinto)	Anthony Flaherty		31		
Mems and Other Equipment					
~ COVID 19 i-Stat Equipment	Emma Bullard/Paul Bannister		21		
~ Tovertafel Original for Dementia patients	S Waterhouse/A Kutraite		9		
~ Flat lifting equipment (12 flojacs & 12 scoop stretchers)	A Nugent/J Fisher		99		
~ ECT Equipment for Linden Centre	Lynn McGhee/Ann Nugent		68		
Safety and Ligature (incl. CQC requirements)					
~ Window Replacement b/f	Anthony Flaherty		70		
~ Air Conditioning In-Patient Ward Installation Programme b/f	Anthony Flaherty		26		
~ Bathroom & Shower Door Top Alarm Programme b/f	Anthony Flaherty		80		
~ Cumberledge Nurse Call Replacement b/f	Anthony Flaherty		4		
~ Window replacement programme	Anthony Flaherty		220		
~ South & West Bedroom Door top Alarms	Anthony Flaherty		341		
~ Seclusion Room and Health Base of Safety Units refurbishment	Anthony Flaherty		132		
~ CCTV in ward communal areas	Anthony Flaherty		0		*342*
~ Kitwood & Roding Fencing Works	Anthony Flaherty		71		
~ Airlock Entrances at The Linden Centre & Rochford ~ Hospital	Anthony Flaherty		79		
~ Willow Ward Ligature Works	Anthony Flaherty		55		
~ Patient Safety and Ligature 2020/21 projects - Other	Anthony Flaherty		87		
Backlog Maintenance					
~ BM 2019/20 b/f (as per Appendix 3)	Anthony Flaherty		241		
~ BM 2020/21 projects (as per Appendix 3)	Anthony Flaherty		684		
			6,715		***432***
STRATEGIC SCHEMES:					
~ Dormitory project (Funded by NHSE/I)	Anthony Flaherty		5,749		
~ Topaz Ward Refurbishment (Funded by NHSE/I)	Anthony Flaherty		1,571		
~ Rainbow unit building works	Anthony Flaherty		337		
~ Derwent Centre Garden b/f	Anthony Flaherty		2		
~ Gloucester Ward – Phase 2 Works b/f	Anthony Flaherty		2		
~ Bedford Immunisation Team - Dolittle Mill b/f	Anthony Flaherty		29		
~ Capital Development Fees (PAH Design Fees)	Anthony Flaherty		95		
~ Single Point of Access Refurbishment Project	Anthony Flaherty		40		
~ Construction of ADL kitchen within the Lakes	Anthony Flaherty		25		
~ Rochford Ward Improvements – Beech, Cedar, Poplar and Willow	Anthony Flaherty		2,033		
~ Independent access to rooms for ageing adults	Anthony Flaherty		144		*972*
~ The Lakes Wards Improvement Works	Anthony Flaherty		653		
~ Ipswich Road Extension for Clinic/Treatment Room	Anthony Flaherty		77		
~ Cedar Ward Security Works – Fencing	Anthony Flaherty		40		
~ Project Management	Anthony Flaherty		100		
~ Beverage bays - Cedar, Beech, Willow, and Woodlea wards	Anthony Flaherty		32		
~ Strategic Capex 2020/21 projects - Other	Anthony Flaherty		4		
			10,932		***972***
Gross Capital Expenditure			**17,647**		***1,404***
DISPOSALS					
4 The Glade					
Oxe Health Buyback			(133)		
			0		
PFI RESIDUAL INTEREST					
2020/21			105		
Capital Departmental Expenditure Limit (CDEL)			**17,619**		***1,404***

Appendix 2

IT CAPITAL PLAN 2020/21

Scheme	£
End of life network switch	£5,000
End of life Firewall	£175,000
End of life network switch	£6,000
End of life core network switches	£300,000
End of life backup Data Storage	£150,000
End of life and support live Data Storage	£300,000
HIE STP interoperability	£300,000
Back up Storage - secondary Datacentre	£35,000
HIE Dashboard interoperability	£100,000
Inpatient Wifi Upgrade	£130,000
Security appliance	£85,000
Paris API	£25,000
IT and Estates Service desk replacement	£100,000
New intranet/internet website	£200,000
Wallboard screens for compliance dashboards	£50,000
Bed management app	£40,000
care co software solution	£40,000
Blood analysers	£200,000
Server Blades	£250,000
Server Chassis	£100,000
Replacement Cyber patching system	£40,000
Microsoft Office Update	£829,500
Wound care app - Enterprise subscriptions	£180,000
Room VC solutions - Microsoft teams room based solutions/digital Hubs	£50,000
	£3,690,500

Appendix 3

Backlog Maintenance Listing

Area	*Description*	*2020/21 Allocations*
North	C BM Christopher Unit Sills	£10,000
	C BM Edward Hse Compart Works	£30,000
	C BM Edward House Fire Doors	£60,000
	C BM Herrick Hse Asbestos Work	£27,000
	C BM The Lakes Fire Works	£10,000
	C BM Lakes Bung Asbestos Works	£10,000
	C BM Linden Ctr Lighting Works	£20,000
	C BM Linden Ctr Compart Works	£200,000
	C BM St Aubyns Flooring Works	£7,500
	C BM St Aubyns Fire Works	£10,000
	C BM Northgate Ctr Roof Works	£28,000
	C BM C&E Ctr Car Park	£15,000
	C BM Crystal Cntr Handrail Works	£5,000
		£432,500
South	C BM Thurrock Asbestos Works	£20,000
	C BM Bas MHU Asbestos Works	£60,000
	C BM Bas MHU Compart Works	£245,850
	C BM Rochford Compart Works	£50,000
	C BM The Lodge Asbestos Works	£60,000
	C BM The Lodge Heater Works	£14,000
		£449,850
West	C BM Woodlea Fire Escape Works	£10,000
	C BM Robin Pinto Toilet Refurb	£10,000
	C BM Woodlea Toilet Refurb	£7,500
		£27,500
	Other	£15,000
		£924,850

		Agenda Item No 8bii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 November 2020**

Report Title:	**Board of Directors Quality Committee Assurance Report – October 2020**					
Executive/Non-Executive Lead:	**Amanda Sherlock, NED and Chair of Quality Committee**					
Report Author(s):	**Natalie Hammond, Executive Nurse**					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Purpose of the Report

This report provides assurance to the Board that the Quality Committee is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objectives and impact on quality, are being managed effectively.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance given in respect of risks and actions identified
3 Request further action/information as required.

Summary of Key Issues

At the meeting held on 15 October 2020, the Quality Committee:

- Received a positive patient story regarding the rehabilitation of a patient during the COVID-19 pandemic

Received the following reports:

- Quality Performance Quarterly Report
- Quality Priority Report: Falls
- Mortality Data and Learning Quarterly Report
- CQC Exception Report
- Security Framework
- Dementia and Frailty Transformation Presentation

The Committee reviewed the following policies:

- CP75 Ligature Policy
- RMPG14D Heatwave Policy
- Adverse Incident Policy
- CPG81 Carers Assessment & Support Policy
- CP10 Claims Policy

Risks/Hotspots:

The Committee identified:

- The difficulty securing blood tests in some areas should be escalated to a medium risk on the corporate risk register

- The risk associated with failure to achieve compliance with the Data Security and Protection Toolkit.
- No risks or issues to be raised with other outstanding committees
- No recommendations to the Audit Committee linked to the internal audit programme

The Committee identified the following as areas of good practice:

The Committee identified the following as areas of good practice:

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

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

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	✓
If yes, insert relevant risk: BAF 6 - If EPUT does not develop a just and learning culture to embed it agreed approach in response to incidents and error then protection of both staff and patients is reduced resulting in poor quality services and patient experience. BAF 10 - If the Trust fails to provide high quality services from premises that are safe, then the risk related to ligatures is not minimised and this may impact on the safety of patients in inpatient services. BAF 15 – If the HSE investigations into the actions taken by former NEP in respect of patient safety identify failings in the systems in place prior to merger, this could result in prosecutions and or fines being imposed on EPUT impacting on financial sustainability and reputation. BAF 16 – If the Trust does not take account of current and emerging guidance relating to dormitory accommodation, single sex accommodation, and the size of the wards, then this could impact on privacy and dignity, patient safety and quality and compliance with CQC standards. BAF 30 – If EPUT fails to maintain a 'Good' rating then it may not maintain compliance with CQC standards resulting in a failure to aspire to 'Outstanding' and be unable to compete in a system wide transforming health economy, poor reputation and patient experience. BAF 32 - If EPUT does not drive quality improvement through innovation then maintaining good and moving towards an outstanding rating is more difficult resulting in the potential stagnation of services and falling behind in whole system transformation	
Do you recommend a new entry to the BAF is made as a result of this report?	No

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Committee	DTA	
BAF	Board Assurance Framework		
SPC	Statistical Process Control		

Supporting Documents and/or Further Reading

Lead
 **Amanda Sherlock** **NED and Chair of the Quality Committee**

Agenda Item 8bii
Board of Directors Meeting
25 November 2020

ESSEX PARTNERSHIP UNIVERSITY NHS TRUST

QUALITY COMMITTEE ASSURANCE REPORT

1 Purpose of Report

This report is provided to the Board of Directors by the Chair of the Board of Directors Quality Committee. As an integral part of the Trust's agreed assurance system, the report is designed to provide assurance to the Board that:

- risks that may affect the achievement of the Trust's objectives and impact on quality are being managed effectively. This is an integral part of the Trust's agreed assurance system;
- the Committee is discharging its terms of reference and delegated responsibilities effectively.

2 Executive Summary

2.1 Minutes of previous meetings

The minutes of the Quality Committee meeting held on 15 October 2020 were approved subject to a small amendment.

2.2 Summary of discussions and issues identified as well as assurances provided at the meeting held on

2.2.1 Patient Story: Received a positive patient story regarding the rehabilitation of a patient during the COVID-19 pandemic. A 74 year old female patient was admitted to Beech Ward for ongoing rehabilitation following a right thalamic bleed. On admission, the patient required full assistance for all personal care, hoist transferring and was experiencing extreme low moods due to impact of stroke. She received ongoing rehabilitation with OT, PT and psychology support. An extension request was secured to continue the provision of intensive inpatient rehabilitation to further ensure good outcomes. In March the patient tested positive for COVID and received care on Poplar Ward before being transferred back to Beech Ward were her therapy was resumed. An extension was granted to enable the Early Supported Discharge Team to support the transition home after a long admission building in arrangements to monitor family dynamics. On discharge, the patient was mobilising with a stick, using stairs and completing basic kitchen tasks and some dressing tasks. She had begun to acknowledge her low mood and had started to explore medication options which had been previously refused. The Committee noted the good practice that had taken place.

2.2.2 Quality Performance Report: The Committee received the report which gave an updated August 2020 position. One hotspot identified as performing below target was CPA 12 month reviews. It was noted that a decline in performance was reported in July 2019 but since April 2020 this indicator has seen marked recovery and was progressing towards the required target.

It was noted that a reducing trend in mental health serious incidents was continuing which was against expectations and a caution was noted that due to the pandemic it remained likely that rates could increase.

All safer staffing indicators were achieved in August. It was recognised that there had

been an increase in the number of unqualified staff. This had been introduced to support issues associated with the pandemic such as managing isolation and social distance. The Committee recognized that staff had adapted well to the challenges of the pandemic and increasingly examples of good practice were being shared. An example was shared of a sewing club that was set up in west Essex and it was agreed that the team would be asked to present their achievements at a future meeting.

The Committee was advised that there was difficulty undertaking all aspects of cardio-metabolic assessments due to requirement to operate virtually. It was noted that a proposal was to be considered by the Executive Team for the purchase of a blood nebuliser allowing tests to be undertaken and analysed within the Trust .It was acknowledged that this is likely to become a national issue and should be taken forward as a matter of urgency. Assurance was sought that there are processes in place to stratify patients with access to priority testing where required and arrangements were outlined.

2.2.3 Quality Report: Falls The Committee received an update report in relation to falls. The committee was advised that the causes of falls are multi-faceted and the emphasis requires a multi-professional approach. Falls and harm from falls present a major challenge across the Trusts 'older adult wards with recognition that 30% of people who fracture their hip as a result. The Trust has made the reduction in the number of falls and the degree of harm as a result of a fall a quality priority. It was noted that significant progress had been made and work was ongoing to ensure that this was sustained. The Committee commended the work undertaken and questioned whether a quality improvement approach had been taken to identify actions that were having the largest impact. It was noted that a quality improvement approach had been undertaken at both a national and local level but were advised that the improvement had been due to a multi-faceted approach being taken. This would continue to be driven forward through the introduction of a twelve month whole person collaborative that has been introduced which operate across the Trust on a population centered basis .It was suggested that following the successful roll out of Oxehealth a pilot could be undertaken across older adult wards to support a continued reduction in calls. This was viewed as a positive progression and it was agreed that discussions would take place outside of the Committee meeting to progress.

2.2.4 Mortality Data and Learning Quarterly Report: The Committee Received a report which set out data relating to Q1 2020/21 deaths and associated learning. It was noted that monitoring of deaths within the Trust has continued throughout the COVID-19 pandemic in order to ensure timely identification of any possible problems in care. The Mortality Review Sub-Committee has agreed a dashboard format for collating information on deaths of substance misuse service users. The dashboard had identified no issues to report.

2.2.5 CQC Compliance Report: The Committee received an update on the current position regarding CQC compliance. Confirmation was given that the Towards Outstanding group has been re-established with a wide ranging membership representing different services and professional groups. .The group will focus on 8 key areas where practice has the potential to contribute towards an outstanding rating for the Trust. It was noted that the CQC Chief Inspectors and Deputy Chief Inspector and lead for mental health services have issued a joint statement setting out how they will regulate during the next phase of the coronavirus pandemic. It was confirmed that the Trust had met with registration requirements providing notification of all changes to the Directors and CQC Nominated Individual have been made. Assurance was given that all existing actions had been completed and the plans have been closed.

The Trust Compliance Team will continue to take a full review of new documentation and will propose changes as required to the Trust compliance framework.

2.2.6 Security Framework: The Committee received the Trust's Security Framework which forms part of the Trust's Quality Strategy which sets out in full the Trust's new vision, values and strategic priorities. The Security Framework is a key document that draws together the Trust's approach and priorities in relation to promoting a shared culture, new vision, new values and motivation to deliver corporate and team objectives. It was noted that this Framework had been developed with the input of a range of services across the Trust. The Committee endorsed this Framework responding positively to the underlying principle that people are our most important asset and recognition has been given to ensure their security, safety and welfare.

2.2.7 Dementia and Frailty Transformation: The Committee received a presentation from Spencer Dinnage, Operational Services Manager that outlined progress made against the quality priority transformation agenda. Through the Quality Academy Spencer identified a proposal to remodel dementia services. A system approach has been taken, bridging all environments to improve care that is provided. Working at a neighbourhood level services have been transformed ensuring 24/7 care incorporating a comprehensive single point of access services, inpatient, community, complex and post-diagnostic care. The Committee was delighted to note the transformation that had taken place and noted that the work had been recognized at a regional and national level. It was proposed that Spencer should be invited to present the work undertaken to the Trust Board and this was agreed by the Committee.

2.2.8 Any other Business: The Committee was advised that there had been a failure to sign off the Data Security and Protection toolkit which is a key requirement for the Trust in relation to cyber security. This was due to the Trust not meeting the 900% target for completion of level 2 training in relation to Information Governance, The Trust has been given an extension to meet the target a position that is shared with a number of Trust's across the country. The Committee was informed that failure to achieve the target would have a significant impact for the Trust as it would result in a cyber security fail but were given some assurance that actions had been taken and significant progress had been made. It was agreed that the Committee would receive regular updates on this issue.

2.3 The Committee approved the following policies and procedures:

- CP75 Ligature Policy
- RMPG14D Heatwave Policy
- Adverse Incident Policy
- CPG81 Carers Assessment & Support Policy
- CP10 Claims Policy

2.4 Risks/Hotspots:

The Committee identified:

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

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

The Committee identified the following as areas of good practice:

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

Report prepared by:
Natalie Hammond, Executive Nurse

On behalf of:
Amanda Sherlock, Non-Executive Director Chair of the Quality Committee

		Agenda Item No 8biii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 November 2020**

Report Title:	**Board of Directors Quality Committee Assurance Report – November 2020**					
Executive/Non-Executive Lead:	**Amanda Sherlock, NED and Chair of Quality Committee**					
Report Author(s):	**Natalie Hammond, Executive Nurse**					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**	x	**Level 3**	

Purpose of the Report		
This report provides assurance to the Board that the Quality Committee is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objectives and impact on quality, are being managed effectively.	**Approval**	
	Discussion	x
	Information	x

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance given in respect of risks and actions identified
3 Request further action/information as required.

Summary of Key Issues

At the meeting held on 12 November 2020, the Quality Committee:

- Received a patient story where family experience was unsatisfactory and as a result the organisation was taking forward a number of learning points by co-producing a resource with the patient's family.

Received the following reports:

- Combined Assurance Report from Sub-Committees
- CQC Assurance Report
- Covid 19 Board Assurance Framework
- Draft Patient Safety Strategy
- Mental Health Community Service User Survey 2020 – Management Report

The Committee reviewed the following policies:

- A number of procedures for ratification
- CP24 Equality, Inclusion & Human Rights Extension Request
- CLP66 MH & LD Joint Working Policy Extension Request
- RM21 Operational & Maintenance for the Management & Control of Asbestos.

Risks/Hotspots:

The Committee identified:

- No risks for escalation to the CRR or BAF but there was agreement that systems to further embed learning would be given further consideration following receipt of CQC final report of their unannounced visit on 29 October 2020
- No risks or issues to be raised with other outstanding committees
- No recommendations to the Audit Committee linked to the internal audit programme but a conversation took place to review 2021/2022 programme to ensure if reflects learning emerging from the introduction of the new Patient Safety Strategy.

The Committee identified the following as areas of good practice:

- Recognition was given to the context of the current working environment and the challenges it poses for the workforce. The Committee expressed their thanks to staff going over and above to deliver services at the present time.

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

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	x
If yes, insert relevant risk: BAF 9 – If EPUT does not embed a No Force First strategy through comprehensive and sustainable structures to monitor, deliver and integrate the approach in clinical practice then a reduction in conflict and restraint may not be achieved resulting in work related staff sickness and poor patient experience. BAF 10 - If the Trust fails to provide high quality services from premises that are safe, then the risk related to ligatures is not minimised and this may impact on the safety of patients in inpatient services. BAF 15 – If the HSE investigations into the actions taken by former NEP in respect of patient safety identify failings in the systems in place prior to merger, this could result in prosecutions and or fines being imposed on EPUT impacting on financial sustainability and reputation. compliance with CQC standards. BAF 30 – If EPUT fails to maintain a 'Good' rating then it may not maintain compliance with CQC standards resulting in a failure to aspire to 'Outstanding' and be unable to compete in a system wide transforming health economy, poor reputation and patient experience. BAF 32 - If EPUT does not drive quality improvement through innovation then maintaining good and moving towards an outstanding rating is more difficult resulting in the potential stagnation of services and falling behind in whole system transformation. BAF 45 – If EPUT does not prepare for an anticipated CQC inspection in 2020 then this may have a negative impact on the outcome of the inspection resulting in not maintain our 'Good' rating. BAF 48 – If EPUT has insufficient capacity within the Quality, Risk, Information and Medical Teams then Governance, Data Collation, Analysis and Mortality Review processes (respectively) may become unsustainable resulting in delays in producing mortality reports and reviews.	
Do you recommend a new entry to the BAF is made as a result of this report?	No

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

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			
CQC	Care Quality Committee	FLO	Family Liaison Officer
BAF	Board Assurance Framework	MHA	Mental Health Act
PSIRF	Patient Safety Incident Response Framework	NIHR	National Institute for Health Research
MPET	Multi Professional Education and Training	DWP	Department of Work and Pensions
HEE	Health Education England		

Supporting Documents and/or Further Reading

Lead

Amanda Sherlock
NED and Chair of the Quality Committee

Agenda Item 8biii
Board of Directors
25 November 2020

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 15 October 2020 were approved at the meeting held on 12 November 2020.

2.2 Summary of discussions and issues identified as well as assurances provided at the meeting held on 12 November 2020

2.2.1 Patient Story:

Received a patient story that highlighted learning associated with the death of a female patient who had died unexpectedly. Due to the circumstances of the patient's death a serious incident investigation was commissioned in adherence with the Trusts adverse incident procedure. A lead investigator and medical representative were appointed to commence the investigation. A family liaison officer (FLO) was also appointed to support the family. There were issues associated with the sharing of information with the family particularly her parents who were not her next of kin. As part of learning, and the positive engagement of the patient's father a series of actions are taking place as follows:

1. All patient safety investigations are now supervised by a senior member of the patient safety team who is able to support/ supervise investigators in meeting timescales and in applying robust investigation methodology.
2. An Executive patient safety assurance meeting is now in place where any delays or concerns regarding investigations are escalated.
3. The patient's father is engaging with the patient safety team to produce a learning resource for staff linked to the new PSIRF (Patient Safety Incident Framework) within the patient /family involvement work stream.
4. The treating consultant and investigating consultant have been asked to formally respond to the circumstances and context of the patients discharge from services.
5. The PSIRF patient/family work stream is exploring the possibility of a family support resource.
6. A lunch time learning event is scheduled to take place.

2.2.2 Combined Assurance Report from Sub-Committees

The Committee was presented with a report that gave assurance from all Sub-Committees accountable to the Quality Committee. It was noted that all Sub-Committees were operating virtual arrangements and were meeting on a regular basis. The Committee was advised of risks/hotspots and assured of actions being taken to mitigate risks:

- Restrictive Practices BAF9 (No Force First) – Significant work has been undertaken with positive outcomes and work is on track. A risk has been identified in relation to safety pods and manufacturer specifications. Assurance was given that the Quality Team is leading work with operational teams and the manufacturers to address the problem.

- Information Governance – The Committee received a comprehensive update of work being driven forward. Actions are being taken against all previous hotspots. There was a query in relation to the three month extension given to the Trust to achieve 95% target of staff trained in Information Governance. It was confirmed that the Trust is currently below the compliance level when first submitted as a number of the workforce's compliance rates have lapsed and they are required to recomplete the training. The Committee were assured that all steps were being taken to meet the target which has a further two months to achieve compliance. The Committee acknowledged the significant amount of work undertaken by IM&T teams and the outstanding results being achieved, noting that the Trust was one of only three in the country that had achieved Cyber Essential Plus accreditation. JL accredited the achievements attained due to the hard work of her teams.

- MHA and Safeguarding - In relation to MHA the surge in relation to the number of tribunals has settled but remains high. There remain issues in relation to data quality, completion of documentation and timeliness of the completion of reports. A task and finish group has been established putting in place a partnership approach with operational services to drive improvement. A new issue has arisen in relation to electronic scrutiny and discussions have been scheduled with the Medical Director to resolve.

- Clinical Governance – It was noted that there has been a change to the structure of this meeting building in both assurance and development topics on a monthly basis. A risk was identified in relation to sign off of incidents with 637 due for sign off. This has been discussed with silver and gold command with agreement that the Trust will revert to previous systems for sign off. The other risk highlighted was the specification of safety pods which is incorporated in an alternative section of this report.

- Physical Health – It has been observed that coronavirus may lead to a rise in relation to physical health issues. To counteract this and drive improvement a 12 month physical health collaborative has commenced Trust-wide. It was noted, as with a few other committees, attendance and engagement is an issue. The Committee was advised that in support of this agenda two new roles have been advertised, a Clinical Lead for Diabetes and a Resuscitation Lead.

- Health, Safety & Security – Work is being undertaken to resolve all outstanding hotspots. New hotspots have been identified in relation to fire

wardens/lack of training, hospital entrances without airlocks and the potential for increased costs associated with legal frameworks.

- Research and Innovation – NIHR has reopened research activity focusing on resuming none COVID related research. NIHR guidance continues to develop which the Trust is following to direct internal work programmes.

- Multi-Professional Education – there are a number of positives in relation to MPET. The Trust has been awarded the ability to promote EPUT as a provider of the Clinical Association of Psychology; an application has been submitted to DWP as an approved employer on the Kickstart scheme and through the Health & Care Academy, 8 OT apprentices have been approved for training. Two hotspots have been identified and work is taking place to mitigate associated risks. Universities have recruited over agreed numbers which were already an expansion on previous years which is creating pressure for placements. The Trust is awaiting a meeting with HEE, but in the meantime, are creating virtual placements and looking at simulation to manage the situation and provide support to what could potentially be the organisation's future workforce. Mandatory training remains a risk with some of the most important courses e.g. TASID and grab bag training running around 40%. The risk has been reported to gold and discussions are taking place to find appropriate solutions.

- Mortality – Despite Covid, progress continues to be made with no slippage or concerns. All 2018/19 thematic reviews have been completed and consideration is being given to the inclusion of learning from the reviews. Discussions have commenced in terms of implementation of PSIRF and integration with mortality review processes. The one potential hotspot identified is due to a reduction in attendance at meetings that is a recurring theme across most work streams due to current pressures.

- Quality Improvement – The Sub-Committee continues to meet to drive processes that will embed quality improvement across the organisation. Two cohorts of QSIR training has commenced with all individuals looking to engage in an improvement project. The Corporate QI Hub has recently been developed, however all hubs are demonstrating difficulty in securing the time for meetings, although improvements are continuing to be made supporting service demands.

2.2.3 CQC Assurance Report:
The Committee received an exception report providing an update on the recent CQC risk focused inspection and the internal compliance activity undertaken to support the Trust in maintaining the CQC rating of Good.

It was noted that the CQC had completed an unannounced inspection on 29 October 2020 focusing on Finchingfield Ward following a series of incidents that took place on 23 October 2020. The CQC provided a high level feedback letter on the 3 November 2020 which provided positive areas in addition to issues that they identified as holding the Trust back. The Committee was advised that in response, immediate actions have been taken which includes the establishment of an Intensive Clinical Support Group and development of a comprehensive action plan to provide support to the ward and address wider learning. The intention is to monitor all actions via the Intensive Clinical Support Group and the outcomes will be used to prepare for the final inspection report and the action plan that will need to be provided to the CQC following their publication of the final inspection report.

The Committee were advised that the Compliance Team are currently undertaking a number of table top evidence reviews, virtual interviews and focused site visits to review the following work streams:

- Clinical Intensive Support
- CQC Unannounced Inspection (July- August 2019) Action Plan Testing
- Ligature – CQC Brief Guide to Inspections EPUT Testing
- PHSO/HSE Action Plan Testing.

The Committee noted disappointment at some of the findings and it was confirmed that the findings would be linked with the new Patient Safety Strategy to drive continuous improvement.

2.2.4 Covid Board Assurance Framework:
The Committee received an update on the previous assurance framework which had been amended following a national update in response to emerging Covid-19 evidence and effective infection and control measures. It was noted that the framework is a live and dynamic collection of evidence, risks, gaps and mitigation.

A summary of the key issues given were as follows:

- A task and finish group has been established with IPC attendance to mitigate risk associated with ventilation and air cooling systems. Vented mobile cooling units have been purchased and installed in identified clinical areas of need
- Air changes in areas that undertake an AGP require external guidance to ensure IPC compliance
- Visitor guidance has been reviewed and updated in line with care home visitors and end of life guidance. Visitor logs have been introduced to support contact tracing undertaken by the IPC Team as part of possible outbreak management and nosocomial spread prevention
- Recording of IPC Covid training is now held centrally
- Risk assessment processes have commenced to gain Covid secure status in wider Trust environments monitored through an Executive Lead Task & Finish Group
- Improvement of processes to ensure weekly testing of EPUT staff who visit care homes has been arranged
- A case by case review by IPC of all staff who contact the Trust contact number is in place
- Guidance has been issues and a 24/7 staff contact line is in place following the launch of Test and Trace
- A new swabbing process was agreed with MSE Group effective from 23 October 2020. All inpatient areas will have access to the results portal with results expected within a 5-12 hour period
- Central and local guidance has been issued
- EPUT are participating in the national FFP3 research stage2 programme to support the improvement in fit testing and mask provision.

The Committee acknowledged the significant amount of work that was being required to ensure successful delivery against this assurance framework that is on top of day to day work. Staff welfare and means of supporting teams was discussed with assurance given that where possible actions, however small, were being taken to support staff which had been positively received. It was acknowledged that there was a parallel piece of work that could take place associated with Covid ethics with agreement that this would be discussed with the Medical Director.

2.2.2 Draft Patient Safety Strategy:

The Committee received a draft strategy which aimed at setting out a statement of ambition and high level actions, grouped into seven strategic themes that emerged from interviews with internal stakeholders.

The themes were as follows: Leadership, culture, continuous improvement, wellbeing, innovation, enhancing environments and governance and information.

Following feedback, a more detailed implementation plan will be developed that will incorporate required resources and investment. The aim is to present the final draft to the Trust Board on 25 November 2020 and the full implementation plan in January 2021.

The Committee was informed that the themes had been developed following interviews with a number of staff. The themes are predominantly focusing on inpatient safety which is a priority area for the Trust, but further work would be undertaken to drive the patient safety agenda across the organisation as a whole, embedding 'Safety First, Safety Always'. It was discussed that embedding a culture of empowerment and co-production promoting delivery across all themes would be key to success for the Trust. Steps will be taken to engage and empower from the frontline. Discussions are taking place regarding partnership with a Quality Improvement Company as it was viewed that the Trust is operating within a high risk safety industry and organisations both in the NHS, particularly acute services and manufacturing organisations, have demonstrated that an improvement culture supports delivery of harm free services. The Non-Executives received assurance that delivery against this strategy was an absolute priority and against its delivery all current practices and processes will be reviewed with a view to demonstrating continuous improvement across all areas of patient safety.

2.2.3 Mental Health Community Service User Survey 2020 – Management Report:

The Committee received a report containing the results from the 2020 survey gathered by Quality Health. The sample for the survey was generated at random on the agreed national protocol from all clients on the CPA and Non-CPA Register seen between 1 September and 30 November 2019. The response rate was 27% (327 usable responses from a usable sample of 830). The majority of scores sit within the intermediate 60% of the trusts surveyed by Quality Health. There were four questions where the Trust scored in the top 80% of trusts relating to crisis care, medicines, NHS therapies and support and wellbeing. The Trust has just one score that falls in the bottom 20% range which relates to planning care.

The Committee were advised that current insights were showing that CPA was not necessarily effective in current times. Learning was being absorbed from other care pathways and early discussions are taking place to develop new models. It was confirmed that the Trust could support the embedding of shared care records and technological advancements and the Committee agreed that this should be prioritised for early wins.

2.3 The Committee approved the following policies and procedure:

- A range of procedures for ratification noting that within the majority there were very few changes
- CP24 Equality, Inclusion & Human Rights Extension Request
- CLP66 MH & LD Joint Working Policy Extension Request
- RM21 Operational & Maintenance for the Management & Control of Asbestos. This was approved subject to clarification of telephone contacts across locality footprints.

- CP41 Dress Code & Uniform Policy Extension noting that adaptions were being put in place to ensure staff protection in light of COVID-19.

2.4 Risks/Hotspots:

The Committee identified:

- No risks for escalation to the CRR or BAF but there was agreement that systems to further embed learning would be given further consideration following receipt of CQC final report of their unannounced visit on 29 October 2020
- No risks or issues to be raised with other outstanding committees
- No recommendations to the Audit Committee linked to the internal audit programme but a conversation took place to review 2021/2022 programme to ensure if reflects learning emerging from the introduction of the new Patient Safety Strategy.

The Committee identified the following as areas of good practice:

- Recognition was given to the context of the current working environment and the challenges it poses for the workforce. The Committee expressed their thanks to staff going over and above to deliver services at the present time.

Report prepared by:
Natalie Hammond, Executive Nurse

On behalf of:
Amanda Sherlock, Non-Executive Director Chair of the Quality Committee

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Agenda Item No: 8b (iv)

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	25 November 2020

Report Title:	**People, Innovation & Transformation Committee Assurance Report**					
Executive/Non-Executive Lead:	Dr Alison Rose-Quirie Non-Executive Director and Chair of Committee					
Report Author(s):	Nigel Leonard Executive Director Strategy & Transformation					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report is provided to the Board of Directors by the Chair of the People, Innovation & Transformation Committee. It is designed to provide assurance to the Board of Directors that risks that may affect the identification and/or achievement of the organisation's objectives are being managed effectively.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report.
2 Confirm acceptance of assurance given in respect of risks and actions identified.
3 Request further action/information as required.

Summary of Key Issues

The People, Innovation & Transformation Committee met on 2 November 2020 and discussed the following key issues:

- Strategic Issues:
  - Covid-19 Health Response
- System Update:
  - Transformation Assurance Report
- Strategy Update:
  - Planning Timetable
- People Updates:
  - Workforce Transformation Assurance Report
  - People Plan
- Governance:
  - EU Exit
  - Trust Strategies & Frameworks
  - Corporate and Directorate Objectives Monitoring
  - Board Assurance Framework

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
None

Lead

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

Part 1 Agenda Item: 8b (iv)
Board of Directors
25 November 2020

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PEOPLE, INNOVATION & TRANSFORMATION COMMITTEE

PURPOSE OF REPORT

This report is provided to the Board of Directors by the Chair of the People, Innovation & Transformation Committee. It is designed to provide assurance to the Board of Directors that risks that may affect the achievement of the organisation's objectives are being managed effectively.

EXECUTIVE SUMMARY

People, Innovation & Transformation Committee 2 November 2020

The People, Innovation & Transformation Committee met on 2 November 2020, where Committee members had a successful and positive debate on a number of key areas.

The following matters were considered:

1. Strategic Issues

- **Covid-19 Health Response**
  Committee members received a short presentation on EPUT's response to Winter Pressures and the Covid-19 pandemic.

  Highlights included:

  - National Phase 3 return submitted on 1 September and 21 September 2020.
  - Health organisations have been asked to ensure that the Mental Health Investment Standard targets are met.
  - EPUT was able to establish crisis teams, sanctuaries and NHS111 crisis team service early on in Wave 1 of the Covid-19 pandemic.
  - EPUT stood down no mental health service during Wave 1 of the Covid-19 pandemic.
  - Mental Health Partnership Board will coordinate the response over the coming months whilst reset and recovery is underway.

  Committee members acknowledged that it was a very complex and busy period, and confirmed that Non-Executive Directors were available should they be able to support.

2. System Update

- **Transformation Assurance Report**
  Committee members received an assurance report on the Trust's transformation activity.

  This included an outline of the schemes currently being undertaken by the Trust, together with primary care partners and systems generally.

Committee members agreed that the Trust has a vital role in supporting Primary Care Networks, and ensuring that primary and secondary care services work together effectively.

3. Strategy Update

- **Planning Timetable**
  Committee members received a brief verbal update on planning activities for the Trust.

  Work on producing the Planning Timetable was currently underway. Strategic objectives would be discussed during the ET Away Day on 4 November 2020, and the outcomes of this discussion would be reflected in the finalised timetable.

4. People Updates

- **Workforce Transformation Assurance Report**
  Committee members received an assurance report on the Trust's workforce transformation activities.

  There had been lots of recruitment activity, and the programme was proceeding well.

- **People Plan**
  Committee members received report on the Trust's People Plan.

  The report contained data demonstrating that employees were still motivated, but tired, following the first wave of the Covid-19 pandemic, and the HR team were working on providing support to staff.

  A Staff Engagement Network had been established, and 500 Engagement Champions had been recruited. 'The Grill' also provided employees the opportunity to communicate directly with the Executive Team. Initial feedback had been positive.

5. Governance

- **EU Exit Transition Period**
  Committee members received an update on the Trust's planning for the end of the EU Exit transition period.

  The internal EU Exit Task & Finish Group had reconvened, and planning was underway to prepare for the possibility of no deal being agreed with the European Union. Regular updates were being received by the Centre.

  The Trust was currently in a health position, with a 'Green' RAG rating.

- **Trust Strategies & Frameworks**
  Committee members received a report on Trust strategies.

  The Patient Safety Strategy would be presented to the Quality Committee.

- **Corporate & Directorate Objective Monitoring**
  Committee members received a report on Corporate and Directorate Objectives Monitoring.

- **Board Assurance Framework**
  Committee members received a report on the Board Assurance Framework.

ACTION REQUIRED

The Board of Directors is asked to:

1. Note the summary of the meeting of the People, Innovation & Transformation Committee held on 2 November 2020.
2. Confirm acceptance of assurance given in respect of risk and the action identified.
3. Request further action/information as required.

Report produced by:
Nigel Leonard
Executive Director of Strategy & Transformation

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

		Agenda Item No: 8c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 November 2020**

Report Title:	**EU Exit (Transition) Operational Preparedness**					
Executive/Non-Executive Lead:	Nigel Leonard Executive Director of Corporate Governance and Strategy					
Report Author(s):	Lara Brooks, Head of Risk Management and Legal Services					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report presents an update on preparations being made within the Trust for EU Exit (Transition) and assurance on EPUT's response to these.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Trust Board is recommended to:

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

Summary of Key Issues

- The Trusts EU Exit Task & Finish Group stood its arrangements back up as requested by the Trusts Senior Responsible Officer (SRO) and met on 21 October 2020 and 18 November 2020.

- The Task & Finish Group has comprehensively reviewed local, regional and national guidance that has been received assessing any that may affect the Trusts services. Actions and mitigations taken have been recorded in the BAF action plan where relevant.

- The BAF action plan has been revised and brought up-to-date with the actions identified by the task and finish group and is available on request to Board Members.

- As part of our preparations, all services have been asked to review and update their business continuity plans to ensure potential risks and impacts of the end of the transition period on 31 December 2020 on a 'no deal' basis are mitigated. Services have been asked to ensure that the updates incorporate learning from COVID19 and winter planning 20/21.

Whilst difficult to predict, the Task & Finish Group believe the following to be the main areas of concern:

- Potential fuel shortages including the geographical needs of the Trust, although the current home working regime may mitigate this to an extent. BCPs will consider this and contingency planning will take place in case of a shortage.

- Potential difficulties with travel, particularly on main roads that connect to ports, as any major congestion may impact on community staff.

- EU Settlement Scheme and new immigration system from 1 January 2021 means further checks on staff from EU that have not yet updated information. They have the right to remain until June 2021 and the risk is around operational staff not updating the Trust before June 2021. HR writing to all relevant staff on a regular basis

- Actions around IT systems are being reviewed particularly for any further increase in home working and the system use tolerances for VPN. Stock of IT equipment is now being purchased ahead of transition.

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

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

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

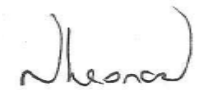
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications: **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			
EU	European Union	SRO	Senior Reporting Officer
BAF	Board Assurance Framework	BCP	Business Continuity Plan

Supporting Documents and/or Further Reading

EU Exit Report attached below

Lead



Nigel Leonard
Executive Director of Corporate Governance and Strategy

Agenda item 8c
Trust Board of Directors
25th November 2020

EPUT

EU Exit (Transition) Operational Preparedness

1.0 PURPOSE OF THE REPORT

This report presents an update on preparations being made within the Trust for EU Exit (Transition) and assurance on EPUT's response to these.

2.0 BACKGROUND

The UK exited the EU on 31 Jan 2020 and is now in a transition period until 31 December 2020. The government has recently confirmed that the transition period will cease as planned on 31 December 2020 and there will be no extension.

All providers must consider and plan for the risks that may arise due to a 'no deal' exit. The Trust Senior Responsible Officer (SRO) requested that the EU Exit work stream be re-established and reported to the Board in September 2020 that this would be done through the following steps:

- Re-establish EU Exit Task and Finish Group
- Review any national changes to guidance
- Consider learning and Trust changes following Covid 19
- Escalate EU Exit back onto the BAF
- Revise the BAF action plan

3.0 Re-establishment of EU Exit Task and Finish Group

3.1 The Trusts EU Exit Task & Finish Group stood its arrangements back up as requested by the Trusts Senior Responsible Officer (SRO) in September 2020 and met on 21 October 2020 and 18 November 2020. Further to discussions in the Task & Finish Group on 18 November alternative options for cascading actions and updating the members are being considered such as use of teams for notifications and having a central repository for members to provide their updates on actions in their respective areas.

3.2 Review of Guidance

EU Exit correspondence has been included in the daily ICC procedures covering the mailboxes between 8am-8pm Monday to Friday. Guidance received is reviewed and escalated to all relevant parties for information or action as deemed appropriate.

3.3 Learning from COVID19

As part of our preparations, all services have been asked to review and update their business continuity plans to ensure potential risks and impacts of the UK leaving the EU on a 'no deal' basis are mitigated. It is also been requested that services also use the opportunity to take into account learning from COVID19 and winter planning 2020/2021 and include these in their updated plans.

3.4 BAF23 Action Plan

The risk was re-escalated to the BAF in September with a score of 5(C) x 4(L) = 20, which was reduced in November to 4(C) X 4(L) = 16 and the action plan has been revised.

The Task & Finish group are able to confirm that it met the majority of requirements for preparedness that NHSE has identified. Whilst difficult to predict, the Task & Finish Group believe the following to be the main areas of concern:

- Potential fuel shortages including the geographical needs of the Trust, although the current home working regime may mitigate this to an extent. BCPs will consider this and contingency planning will take place in case of a shortage.

- Potential difficulties with travel, particularly on main roads that connect to ports, as any major congestion may impact on community staff.

- EU Settlement Scheme and new immigration system from 1 January 2021 means further checks on staff from EU that have not yet updated information. They have the right to remain until June 2021 and the risk is around operational staff not updating the Trust before June 2021. HR writing to all relevant staff on a regular basis

- Actions around IT systems are being reviewed particularly for any further increase in home working and the system use tolerances for VPN. Stock of IT equipment is now being purchased ahead of transition.

5.0 RECOMMENDATIONS

The Trust Board of Directors is recommended to:

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

Prepared by:
Lara Brooks
Head of Risk Management & Legal Services

On behalf of:

Nigel Leonard
Executive Director of Corporate Governance & Strategy

		Agenda Item No: 9 (i)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 November 2020**

Report Title:	**Covid-19 Assurance Report**					
Executive/Non-Executive Lead:	Paul Scott Chief Executive					
Report Author(s):	Jane Cheeseman Head of Compliance and Emergency Planning					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides the Board with assurance in relation to the actions taken in response to the Covid 19 pandemic.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the content of this report.
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3. Note the Covid 19 Gold risk register and summary mitigations (Appendix 1).
4. Request any further information and or action.

Summary of Key Issues

Background

- The country has now been dealing with the corona virus outbreak for 9 months.
- The Trust's arrangements continue to be in place and are working effectively.
- On the 5th November 2020 the Level 3 National Incident was changed to incident response Level 4 with incident response also at Level 4 and the threat level increased to severe. The second lockdown was put in place and will be maintained until 2nd December at which point we will be back to the 3 tier system.
- For EPUT this means we are back under a NHS England national command and control

Command Structure

- The Gold, Silver and Bronze Command meetings have now stepped up in line with the national daily sitrep reporting to 7 days a week.
- The (virtual) Incident Control room operational times have increased to 7 days a week 8am until 8pm
- The Covid Risk Register is regularly reviewed and updated by Gold and Silver Command.

Impact to Date

- The Trust is seeing increasing staffing Covid absences over the last 2 weeks, however Covid sickness rates have remained over around 1%.
- The Trust has declared 3 staff outbreaks. An outbreak is defined where there are 2 of more positive staff based in 1 area at a period of time. All processes for an outbreak were followed as advised through joint meetings with NHSE and PHE where initial feedback has been that we have managed the situation well.

- Learning from all outbreaks has been identified and shared with staff.
- Inpatient Covid positive cases have remained low and are all patients who have been admitted Covid positive.
- Roll out of the lateral flow testing for asymptomatic patient facing staff is imminent. A pilot site has been chosen and tests have been delivered to the site.
- The Trust Committee and Governance Structure have continued through the utilisation of Microsoft Teams to undertake corporate meetings on a virtual basis.

Communication

- The success of the weekly Live events and time hosted by the Chief Executive with the Executive Directors, continues as a means to keep staff updated on the current status and for staff to raise questions directly with the Executives.
- A number of different live events have continued to be held including staff support events

Learning

- Incorporation of staff support offering into reflective learning.
- Learning emerging from all activity being collated for sharing at meetings with acute trusts.
- Daily data analysis at ward level of Staff and Patient Covid sickness/isolation rates
- Following delays in some patient swabbing results the Trust has procured faster patient swabbing from the Lab at Broomfield
- In preparation of the increased Incident Control Centre hours a new staff rota was established to ensure this could be staff 7 days a week and for extended hours.

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

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

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

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

Service impact/health improvement gains			✓
Financial implications			✓
Governance implications **The Government has confirmed any appropriate and reasonable expenditure related to Covid-19 will be supported. All costs identified in year ended 31/3/20 have been agreed and funded.**			
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed?	**~~YES~~/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
PPE	Personal Protective Equipment	IPC	Infection Prevention and Control
MSE	Mid and South Essex	STP	Sustainably and Transformation Partnership

Supporting Documents and/or Further Reading

Covid Assurance Report
Appendix 1 Covid19 Gold Risk Register Summary
Visit the Government website: https://www.gov.uk/coronavirus

Lead

Paul Scott
Chief Executive

ESSEX PARTNERSHIP UNIVERSITY NHS FT

COVID 19 ASSURANCE REPORT

PURPOSE OF REPORT

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

BACKGROUND

Following the previously reported relaxation of many lockdown processes, the recent upturn in Covid case, indicative of the 2nd wave has meant that on the 5th November 2020 the Level 3 National Incident was changed to incident response Level 4 with incident response also at Level 4 and the threat level increased to severe. The second lockdown was put in place and will be maintained until 2nd December at which point we will be back to the 3 tier system. For EPUT this means we are back under a NHS England national command and control.

COMMAND STRUCTURE

The Gold, Silver and Bronze Command meetings have now stepped up in line with the national daily sitrep reporting, with an increase from previously reported twice weekly meetings to 3 days a week for full command structured meetings and 2 days a week escalation meetings. There is also now a combined Silver/Gold escalation meeting each day over the weekends. This arrangement thereby covers 7 days a week and gives the ability to further flex the meetings if demand requires the reinstating of separate Gold and Silver meetings over the weekends.

The (virtual) Incident Control room remains operational 7 days a week and has extended the hours of cover due to the increase in incident level and as the 2nd wave progresses, to be operational from 8am until 8pm for both the week days and weekends to receive, cascade and act on information and guidance, along with managing the daily sitreps required.

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

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

IMPACT TO DATE

Good infection control procedures within our inpatient wards means that we currently only have 2 patients diagnosed with Covid. Both patients were admitted with Covid and are being isolated whilst receiving community health service inpatient support within our Covid-19 designated ward.

Since last reporting in September there have been no further patients pass away due to Covid-19 within our wards, therefore the previously reported total of 18 patients who sadly passed

away since the crisis began (2 in Mental Health services and 16 in Community beds) has not increased.

Covid-19 continues to impact on the Trust and its patients. We have seen an increase in staff off sick with Covid, although a reduction of staff self-isolating. At the time of writing this report we have 64 staff off sick (an increase from 17 at last report), and a significant decrease for 19 self-isolating (compared to 50 self-isolating 2 months ago).

Unfortunately we have now seen an outbreak amongst staff in two of our community health services (Addison House, Podiatry in September and Basildon Sexual Health Clinic in November) along with one of our inpatient CAMHS units at The St Aubyn Centre. An outbreak is classified by PHE when there are 2 or more cases in one area at a period of time, which was the threshold met in each of the teams where the outbreaks have occurred. All processes for an outbreak were followed as advised through joint meetings with NHSE and PHE where initial feedback has been that we have managed the situation well.

The Podiatry team outbreak was closed with no requirement for media escalation and no further positive cases within the team. The Sexual Health Clinic team outbreak remains open and if we remain with no further identified cases we will be able to close on 9th December as per the national 28 day process. The CAMHS unit remains under close observation and exploration of any further potential cases. There have been commonalities of lessons learnt from each of the outbreaks that have occurred and these have been shared with staff, namely the main risks being the identified breaching PPE in staff to staff contact and attending work with symptoms.

Roll out of the lateral flow testing for asymptomatic patient facing staff is imminent with the delivery of the first of the 7,000 boxes to the Trust Thurrock Hospital site. Priority for the use of these self-testing kits will be given to our staff from the CAMHS unit where the outbreak has occurred. This will be treated as a pilot site in order to ascertain the best process for the testing. All staff who self test will report their test results into a system that feeds into the national lad results.

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

COMMUNICATIONS

The success of the weekly Live events and time hosted by the Chief Executive with the Executive Directors, continues as a means to keep staff updated on the current status and for staff to raise questions directly with the Executives. In addition to this there has also been the implementation of numerous virtual events made available to support staff and their wellbeing. Recent sessions have included tips on creating a healthy routine, how to practice mindful relaxation, healthy eating and improve sleep during lockdown.

Non-Executive Directors continue to receive a weekly briefing via Microsoft Teams from the Chief Executive, as well as ad hoc briefings when necessary

RISKS

In the September 2020 paper a number of risks/hotspots were identified: -

1. Care Home Testing
2. Return to work and social distancing Covid
3. Surge Planning

The risks are constantly being updated to reflect the changing environment and are detailed in the summary Covid Gold Risk Register in Appendix 1. From this it can be seen that major risks currently facing the Trust are: -

1) Skills, Resource and Capacity

We have consolidated a number of risks on the BAF and one of the highest risks is EPUT having the skills, resource and capacity to deliver the following:

- High quality business as usual care,
- Manage the C19 pandemic,
- Increased variation of demands on corporate services to deliver a wide range of priorities and pressures as well as meet its organisational objectives.

2) Managing outbreaks
Outbreaks are occurring mainly because of staff breaching Covid rules among themselves as opposed to when they are caring for patients. This may also affect reporting to the IPC team and continuous reminders are being cascaded to all staff to report any outbreaks or positive test results or Covid symptoms.

3) Lateral staff testing
With the start of lateral staff testing EPUT must manage staff levels, staff engagement and input for recording of lateral staff testing

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

5) Regional Public Testing
EPUT needs to manage the impact of regional public testing in Essex to ensure staff remain Covid19 free

LEARNING

Learning continues to be a key part of the Trust response to Covid 19 and a number of activities as reported previously are continuing to take place, alongside some new initiatives:

- COVID-19 Deaths Review Working Group, reporting to mortality review sub-committee
- Incorporation of staff support offering into reflective learning.
- Learning emerging from all activity being collated for sharing at meetings with acute trusts.
- Daily data analysis at ward level of Staff and Patient Covid sickness/isolation rates
- Following delays in some patient swabbing results the Trust has procured faster patient swabbing from the Lab at Broomfield
- In preparation of the increased Incident Control Centre hours a new staff rota was established to ensure this could be staff 7 days a week and for extended hours.

ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report,
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks
3. Note the Covid 19 risk register and mitigations
4. Request any further information and or action

Report prepared by:

Jane Cheeseman, Head of Compliance and Emergency Planning

On behalf of:

Paul Scott, Chief Executive

Appendix 1
COVID19 Gold Command Risk Register Summary of Risks as at November 2020

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

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
BAF 38	If EPUT does not implement effective emergency planning arrangements for managing the COVID19 outbreak in line with national and local requirements then the ability to deliver services is reduced resulting in a lack of containment of the pandemic.	NL	• Command structure in place with twice-weekly Gold, Silver and Bronze command meetings in place. Currently stepped up to 7 days a week • During Wave 1 COVID19 reorganised corporate services to support operational services. Moved clinical corporate services staff to operational services and to support movement of supplies of PPE • COVID19 secure building programme in place • Reset and recovery group established • COVID19 return to workplace group has completed and moved to BAU • Emergency planning tasks being re-allocated for expediency	Risk Score unchanged 5 x 2 = 10	Target Ongoing during COVID19 pandemic 5 x 2 = 10	Gold, Silver and Bronze Command Structure Board of Directors COVID19 Command Structure updated daily Risk at threshold

BAF 50	If EPUT does not have the skills, resource and capacity to deliver high quality business as usual care and services, manage the C19 pandemic, and increased variation of demands on corporate services then it may not achieve the deliverables on this wide range of priorities and pressures resulting in not achieving organisational objectives, unsustainability in corporate services, stagnation of risks and failure to maintain our position within the wider health economy	PS and all EDs	• This risk consolidates the following four risks recommended for closure: BAF48, BAF40, BAF31, and CRR69
			• Mitigating actions include
			  ○ Ensuring organisational, reporting and governance structures within EPUT are set up to meet the priorities and pressures on it
			  ○ Closely monitor and manage the BAF, CRR and DRRs
			  ○ Central co-ordination point within Strategy and Transformation Directorate
			• Full action plan with 14 actions, five of which are completed and nine in progress to timescale in place
				New risk
				
				Initial risk score
				
				C5 x L4 = 20
					Ongoing during C19 pandemic
					
					5 x 2 = 10
						Command structure
						
						EOSC
						
						Trust Board
						
						PIT
						
						F&PC
						
						Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
BAF 42	If the COVID19 crisis continues then EPUT may experience an adverse impact on its financial plan as a knock on from system wide financial planning resulting in additional risk for EPUT to its sustainability	TS	• EPUT continues to operate under a National NHS Emergency Finance Regime because of C19. This will change in M7 and a review of this risk will take place • During the first four months of 2020/21 all NHS providers reporting a deficit will receive top up payments to adjust their reported position to breakeven • In September 2020, the Trust recorded a deficit of £6.5m before top up income, including year to date COVID19 costs of £7.3m. Cash is £28.7m above plan at **M6** • Continued discussions with system regarding allocation of COVID19 funding for M7-12. Early indications are that there will be a system shortfall.	Risk score unchanged Current Risk Score 4 x 3 = 12	Target March 2021 4 x 2 = 8	Finance and Performance Committee Board Above threshold
BAF 43	If EPUT does not plan for an expected surge in demand for Mental Health services (or physical CHS) during or post C19 then skills and capacity may not be in place resulting in long waiting lists and self-harm in the community	AG	• A phased plan is in place to manage the surge demand alongside winter planning • From October – April 2021 existing capacity, flow and escalation initiative are in place • From November to March 21 winter funding schemes are to be signed off, implemented and monitored, underpinned by MH Winter KLOES • From January to April 21 plan in place for Topaz Ward to be operational mid-January 21 providing additional mental health surge capacity • Contingency plans include exploring opportunities with local private providers to purchase additional inpatient capacity and exploring further use of other estate options for additional beds (Kelvedon) or a COVID19 ward for unwell patients who are not a ligature risk	Risk score unchanged Current Risk Score 5 x 4 = 20	Target March 2021 5 x 2 = 10	Command Structure EOSC and Board plus Standing Committees Above threshold
BAF 44	If EPUT does not fully capture, review and embed learning from the C19 experience then this may have an adverse impact on Phase 3 planning resulting in missed opportunities in transformation	NL	• A full action plan is in place with 10 actions (two completed and eight in progress to timescale)	Risk Score unchanged Current Risk Score 4 x 3 = 12	Target March 2021 4 x 2 = 8	Command Structure EOSC and Board plus Standing Committees Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
BAF 52	If EPUT does not ensure that staff have the skills and competencies to manage a second wave of C19 then appropriate care may not be delivered to patients or staff resulting in potential harm and failure to contain the virus	NH AG	• Mitigation will include: ○ Increase in command frequency to monitor daily risks	New risk Initial risk score C5 x L4 = 20	Ongoing during C19 5 x 2 = 10	Command Structure EOSC Quality Committee Trust Board Above threshold
CVG 19	If EPUT does not manage Infection and Prevention Control (IPC) during COVID19 then infections may increase resulting in a negative impact on the pandemic	NH	• Assurance visits being undertaken and clinically held action plans • IPC Board Assurance Framework (national document) updated bi-monthly • New guidance reviewed and implemented through Command structure as received • National recommendations derived from other organisations during C19 to be reviewed against EPUT measures • Ensuring C19 secure procedures in line with IPC guidance	Risk Score unchanged 4 x 2 = 8	Ongoing for duration of crisis 4 x 2 = 8	Command Structure IPC Board Assurance Framework - EPUT response At threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 20	If EPUT has insufficient PPE available, then the spread of the COVID19 virus to staff and patients cannot be fully contained resulting in EPUT not being able to deliver a service.	NH	• PPE sit rep provided daily to Silver and Gold Command. • PPE contingency plan in place. • Gap identified with a need for clear masks to assist people who are deaf. There are no clear masks being issued on a national scale. EPUT procurement is leading on supply of clear masks regionally – quotes being gathered for local supply of clear masks • Differences between organisations to be escalated at regional level • No current concerns	Risk Score unchanged 4 x 2 = 8	Ongoing for duration of crisis 4 x 2 = 8	Gold, Silver and Bronze Command Structure Board of Directors Monitored daily - live action log Regular auditing of stock Letter to CEOs stating that staff without PPE will not be forced to treat patients Mutual aid - 30,000 masks from MSE and 10,000 via emergency NSDR route At threshold
CVG 33	If EPUT does not ensure that staff are Fit Tested for the variation of FFP3 masks coming through the PPE push system then it may delay the utilisation of these masks resulting in lack of PPE for aerosol generating procedures	NH	• Supplies of certain masks taken out of use and stock due to expiry dates. This will require re-fit testing staff, as we anticipate no new stocks of the same mask. Plans are being put in place to schedule this process. • Plan for the ongoing requirement for fit testing was approved at EOC in November 2020	Risk Score unchanged 4 x 3 = 12	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 35	If EPUT does not implement guidance on face masks and face coverings from 15 July in all buildings then people with mild or no respiratory symptoms may transmit the virus to others resulting in a further spread of COVID19	NH	• Updated guidance provided to all Trust staff and all areas asked to review Covid Secure Building Risk Assessment • All staff at The Lodge advised to wear masks in communal areas and clear guidance issued • Staff must only work from a Trust location if it is absolutely necessary for them complete their job effectively	Risk Score unchanged 4 x 2 = 8	Ongoing for duration of crisis 4 x 2 = 8	Command Structure At threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 37	If EPUT is unable to ensure that premises are COVID19 secure then community based services cannot restart resulting in further delays in service delivery	PS/ TS	• COVID19 Secure guidelines – differences between organisations being escalated to region • Taking forward concerns raised by teams working in NELFT buildings • Any concerns are being identified via command structure	Risk Score unchanged 4 x 3 = 12	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 10	If EPUT is unable to maintain its planned capital programme through lack of contractor access then delays or deferments may occur resulting in increased pressure on the capital programme in recovery	TS	• Second lockdown impacting on capital programme	Risk Score unchanged 3 x 2 = 6	Jul-20 3 x 2 = 6	Command Structure At threshold
CVG 34	If EPUT staff are not identified as a contact of a positive patient when working in the community through the PHE track and trace system then other means of patient identification of positive COVID19 status must therefore be obtained resulting in potential delays in self-isolation	NH	• Processes in place to screen patients prior to community visits and COVID19 test results to be checked through SystmOne • Regularly reminding and updating staff on processes to be followed	Risk Score unchanged 4 x 2 = 8	Jul-20 4 x 1 = 4	Command Structure Above threshold
CVG 38	If EPUT is unable to maintain the provision of self-testing kits for staff due to delays by the Local Authority and/or Public Health England then weekly testing for staff visiting care homes cannot take place resulting in non-compliance with national requirements and an outbreak affecting staff and patients	NH	• Supplies of kits currently in place for both of EPUTs nursing homes • Lateral flow testing being rolled out	Risk Score unchanged 4 x 3 = 12	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 39	If EPUT does not maintain its bed occupancy levels below the target of 85% then its ability to manage a COVID19 or other outbreak is impacted resulting in the potential for unsafe admission or discharges	AG	• Review of all wards to ascertain safety at running above 85% undertaken as part of winter planning surge planning. • Dormitory wards to maintain below 100% occupancy to ensure social distancing. Some beds closed. • Some beds closed on larger wards where social distancing would not be possible in communal areas. • Decision making on closure of beds to be closely monitored and communicated accurately for sit reps	Risk score unchanged 4 x 3 = 12	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 40	If EPUT does not have clarity on the definition of aerosol generating procedures then staff may not follow the correct guidance resulting in potential infection and spread of COVID19	NH	• Guidance updated on aerosol generating procedure for children	Risk score reduced 4 x 2 = 8	Ongoing for duration of crisis 4 x 2 = 8	Command Structure At threshold
CVG 41	If staff do not call the EPUT Contact Centre if tested positive or contacted by the NHS Test and Trace Services, then management and reduction of the risk of healthcare spread of COVID19 is compromised resulting in a potentially unsafe workplace and delays in adhering to outbreak management guidance	NH	• Instructions going out regularly in briefings • Clear messaging on COVID19 page and front page on InPut • Gold has asked for assurance that track and trace database is robust and that all managers are completing health roster appropriately	New risk Initial risk score 4 x 4 = 16	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 42	If EPUT does not prepare for full national lockdown related to COVID19 wave 2 then the ability to deliver services is reduced resulting in a lack of containment of the pandemic.	NL	• EPUT is prepared for lockdown by utilising learning from phase 1 and applying appropriate guidance	New risk Initial risk score 5 x 2 = 10	Ongoing for duration of crisis 5 x 1 = 5	Command Structure Above threshold
CVG 44	If EPUT does not manage outbreaks of COVID19 within its services then there is the potential for spread of the virus resulting in a lack of containment of the pandemic and potential harm to patients and staff	NH	• Continuous reminders going out to staff to report any outbreaks (more than one constitutes an outbreak) – gold agreed strong communications required around learning and outbreaks • Daily sitreps in place, monitored and reported • New electronic outbreak tool planned to go live 25 November – link person NJ	New risk Initial risk score 5 x 3 = 15	Ongoing for duration of crisis 5 x 1 = 5	Command Structure Above threshold
CVG 45	If EPUT does not manage clinical waste during COVID19 then hazardous material may be stored longer at a local level resulting in the potential for spread of infection and harm to patients and staff	TS	• Procurement putting in place alternative storage arrangements whilst there is an issue with the contractor • Contact being maintained with contractor • Environment agency are aware of the issue and understand the necessity to store waste on site in locked cages	New risk Initial risk score 4 x 3 = 12	December 20 4 x 2 = 8	Command Structure Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 48	If EPUT does not manage staff levels, staff engagement and input for recording of lateral flow staff testing then resource requirements may not be met resulting in failure to deliver the staff testing project and asymptomatic testing	NH	• Gold supported the brief for lateral flow testing but there is a need to look at costing due to the likelihood of having to use a locum for hard to recruit ICP Nurse Band 7 • Range of learning from other Trusts and will be produced regionally • AW attended NHS Lateral Flow Testing Webinar 18 November	New risk Initial risk score 4 x 3 = 12	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 24	If EPUT does not ensure that staff have the new range of skills required to deal with the C19 crisis then appropriate care may not be delivered to patients resulting in potential harm to patients and challenges for staff	NH AG	• Competency skills assessment carried out in wave 1 under review	Risk score unchanged 5 x 3 = 15	Ongoing for duration of crisis 5 x 2 = 10	Command Structure Above threshold
CVG 43	If EPUT does not ensure that staff have the skills and competencies to manage a second wave of C19 then appropriate care may not be delivered to patients or staff resulting in potential harm and failure to contain the virus	NH AG	• Risk being reviewed together with other staff capacity risks to look at consolidated risk and action plan (Consider closing this risk in view of the BAF risks 50, 51 and 52)	New risk Initial risk score 5 x 3 = 15	Ongoing for duration of crisis 5 x 2 = 10	
CVG 32	If EPUT does not develop a systematic application of a risk reduction framework to protect its vulnerable workers then those staff may be disproportionately affected by increased morbidity and mortality from COVID19 resulting in EPUT breaching its duty of care in securing the health, safety and welfare of its employees	SL	• Patients risk assessed in wave 1 • Risk assessments being updated	Risk Score unchanged 4 x 2 = 8	Jul-20 4 x 2 = 8	Command Structure At threshold
CVG 14	If EPUT does not manage its cyber security then systems may be interrupted or compromised resulting in a failure of business continuity	TS	• No further updates on this risk – maintain watching brief	Risk Score unchanged 4 x 3 = 12	5 x 2 = 10 Ongoing for duration of crisis	Command Structure Above threshold Six issues covered off with centre and copied to CEO

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 46	If EPUT does not manage the delivery of valid server generated emails to staff outlook inboxes then important or urgent COVID19 emails may be missed resulting in a delay in information cascade or the submission of urgent returns (risk following NHS Mail national update)	TS	• ITT working with NHS Digital to resolve this issue for EPUT • Staff have been reminded to check their junk email boxes for any important missed information • National problem and all efforts being made to resolve	New risk Initial risk score 4 x 4 = 16	Dec 20 4 x 1 = 4	Command Structure Above threshold
CVG 47	If EPUT does not manage flow and capacity through older adult social care then patients may not be moved to care homes resulting in bed blocking and challenges to containing COVID19 pandemic	AG	• Currently being monitored via Command Structure • EPUT will support opening additional Covid beds if approached by the system	New risk Initial risk score 4 x 4 = 16	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 49	If EPUT does not manage the delivery of regional public testing in Essex then staff may acquire COVID19 from family resulting in the potential increase in self-isolation	NL	• Risk being reviewed together with other staff capacity risks to look at consolidated risk and action plan	New risk Initial risk score 5 x 4 = 20	Ongoing for duration of crisis 5 x 2 = 10	Command Structure Above threshold

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

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2			CVG10	CVG35 CVG19 CVG20 CVG34 CVG32	BAF38 CVG42
	3				BAF44 CVG33 CVG37 CVG38 CVG39 CVG40 CVG45 CVG48 BAF42 CVG14	CVG44 CVG24 CVG43
	4				CVG41 CVG46 CVG47	BAF50 BAF43 BAF51 BAF52 CVG49
	5					

		Agenda Item No: 9ii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 November 2020**

Report Title:	**Covid 19 IPC Board Assurance Report**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Angela Wade, Director of Nursing and Infection Prevention and Control					
Report discussed previously at:	Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides:

- An update following the previous report submitted to give assurance to the Board on the Trust position regarding infection, prevention and control during Covid-19 Pandemic. Following the first presentation, the assurance template was updated nationally in response to emerging Covid-19 evidence and the effective infection prevention and control measures. The framework is a live and dynamic collection of evidence, risks, gaps and mitigation.

Approval	
Discussion	
Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance given in respect of risks and actions identified
3 Request further action/information as required

Summary of Key Issues

- Ventilation and air cooling are Trust-wide issues and a task and finish with IPC attendance was convened to mitigate risk and find alternative solutions. Vented mobile cooling units purchased and installed in identified clinical areas of need
- Air changes in areas that undertake AGP will require external expert guidance to ensure IPC compliance
- Visitor guidance was reviewed and updated in line with care home visitors guidance and end of life guidance. Visitor logs have been introduced to support contact tracing undertaken by the IPC Team as part of possible outbreak management and nosocomial spread prevention
- Recording of IPC Covid training was not initially held centrally. This has now been resolved through training and development, and confirmation received that OLM and attendance to MS Live events are recorded
- The Trust has commenced risk assessment processes to gain Covid secure status in wider Trust environments in order to reduce the risk of nosocomial spread. There is an Executive Lead Task & Finish Group to ensure processes are confirmed and achieved. CEO sign off required once the Risk Team have signed off the process
- Improvement of processes to ensure weekly testing of EPUT staff who visit care home. Community nursing staff are now accessing weekly testing via local pillar 1 labs and receiving confirmation results via the MSE Shift partner platform. Wider EPUT staff are either accessing key worker testing at St Margaret's or Suffolk sites, or accessing local authority approved testing via the national pillar 2 postal/regional sites.

Group convened to establish a weekly process

- Case by case review by IPC of all staff who contact the Trust contact number
- Guidance issued following the launch of Test and Trace, with a 24/7 staff contact line and management flow charts to support management and practice. Communication directly to IPC if potential of outbreak management and utilisation of PHE outbreak flowchart in place
- As of 23 October 2020, new swabbing process agreed with MSE Group whereby all inpatient swabs are sent to Broomfield Hospital for processing and assurance has been given that results will be received within 5-12 hours. All inpatient areas will have direct access to results portal to access results
- Central guidance regarding some procedures that are not specified in the WHO and NERVTAG AGP guide has been issued, and EPUT have issued guidance and fit testing processes as appropriate
- EPUT are participating in the national FFP3 research stage 2 programme to support the improvement of fit testing and mask provision
- EPUT commence planning for asymptomatic staff testing rollout following communication from NHSE regarding their approval and availability for NHS rollout to patient facing roles. The purpose of their use is to support the reduction of Nosocomial spread and outbreak management. An initial pilot will commence at St Aubyn centre on 19 November 2020.

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

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	✓
If yes, insert relevant risk	Covid-19
Do you recommend a new entry to the BAF is made as a result of this report?	No

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

Visit GOV.UK following the Covid-19 links

Lead

Natalie Hammond
Executive Nurse

Publications approval reference: 001559

Infection prevention and control board assurance framework

19 November 2020, Version 1.5

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection prevention and control board assurance framework

1. Systems are in place 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 posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission • compliance with the national guidance around discharge or transfer of COVID-19 positive patients • all staff (clinical and non- clinical) are trained in putting on and removing PPE; know what PPE	Process and practice assurance in place: • Swabbing on admission/ transfer/ discharge flow chart https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/Coronavirus%20patient%20testing%20flow%20chart.pdf • Summary inpatient and community guidance documents https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/GUIDANCE%20Basic%20Infection%20Control%20Guidance%20for%20INPATIENT%20and%20OUTPATIENT%20(MH%20and%20Community%20services)%20Staff.pdf https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/GUIDANCE%20%20Basic%20Infection%20Control%20Guidance%20for%20COMMUNITY%20(MH%20and%20Comm%20services).pdf • In patient risk assessment https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/GUIDANCE%20-%20COVID-19%20care%20pathways%20for%20people%20using%20EPUT%20inpatient%20services.pdf • IPC isolation process https://input.eput.nhs.uk/DocumentCentre/_layouts/15/WopiFrame.aspx?sourcedoc={C7DA9EBC-9FA2-47EB-A7B4-C7D41755E058}&file=ICPG1%20-%20Section%203%20-%20Infection%20Prevention%20%26%20Control%20in%20Clinical%20Practice.pdf&action=default	• Nil	• Daily review of national guidance and update of Trust Process. • Actions and evidence logged through Silver/Gold command then cascaded through Bronze and staff briefing.

they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance • national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the board assurance framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	https://input.eput.nhs.uk/DocumentCentre/_layouts/15/WopiFrame.aspx?sourcedoc={872BFD17-3ADC-4EC5-9C24-E78B2D93E467}&file=ICPG1%20-%20Section%202%20-%20Standard%20Precautions%20of%20Infection%20Control.pdf&action=default • Operational links with IPC to ensure patient movement limited and promote cohorting when necessary • Swabbing flow chart includes discharge guidance https://input.eput.nhs.uk/covid19/_layouts/15/WopiFrame.aspx?sourcedoc={7d614a38-a298-451a-9838-fce7fd68ec64}&action=edit&source=https%3A%2F%2Finput%2Eput%2Enhs%2Euk%2Fcovid19%2FPages%2FHome%2Easpx • Trust summary of national PPE guidance in place https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/GUIDANCE%20-%20PPE%20summary%20guidance%202%20April%202020.pdf • Ward posters https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/EPUT_PPE_Poster_Door.pdf https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/EPUT_PPE_Poster_Isolation.pdf https://input.eput.nhs.uk/covid19/DocumentLibrary/POSTER%20-%20back%20to%20basics%20IPC%20A3.pdf • Training resources in place https://input.eput.nhs.uk/covid19/Pages/Home.aspx • Daily notification alerts received through GOV.UK and via Covid incident box. • Updated guidance is presented at silver for gold command approval and then cascaded via bronze control and via staff briefings. All communications are then accessible		

	via the Covid intranet pages • The Covid risk register is reviewed and escalated through the incident command structure and monitors on the command calls • All non-Covid infections are managed through the existing IPC policies and processes with direct support from the IPC team and Microbiologist as required. Policies available on the trust's IPC pages https://input.eput.nhs.uk/DocumentCentre/_layouts/15/WopiFrame.aspx?sourcedoc={C7DA9EBC-9FA2-47EB-A7B4-C7D41755E058}&file=ICPG1%20-%20Section%203%20-%20Infection%20Prevention%20%26%20Control%20in%20Clinical%20Practice.pdf&action=default https://input.eput.nhs.uk/DocumentCentre/_layouts/15/WopiFrame.aspx?sourcedoc={872BFD17-3ADC-4EC5-9C24-E78B2D93E467}&file=ICPG1%20-%20Section%202%20-%20Standard%20Precautions%20of%20Infection%20Control.pdf&action=default		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas • designated cleaning teams with appropriate training in required techniques and use of personal protective equipment (PPE), are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation	Processes and guidance in place: • Covid 19 Care Pathway developed by Public Health Consultant, in conjunction with national guidance, and guidance from specialist teams and partner Acute Trusts. https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/GUIDANCE%20-%20COVID-19%20care%20pathways%20for%20people%20using%20EPUT%20inpatient%20services.pdf • IPC guidance on isolation and cohorting in place (see previous links), direct IPC team support to initiate cohorting as required • All points in National Guidance regards cleaning and decontamination have been assessed, reviewed, and where relevant to service areas, have been included in summary guidance sheets to staff. This includes frequencies, products to be used and PPE required.	• Trust accommodation is varied and there are issued with ventilation, air conditioning and cooling in some of the environment • Location that undertake AGPs on sessional basis require external expert review to ensure compliance with IPC guidance	• IPC and Estates and Facilities collaborative review of policies and practices in accordance with national guidance pertaining to Covid -19 as it is issued or updated. Actions recorded through silver command log • Air conditioning group was convened and reviewed ventilation and cooling across all clinical areas in the Trust. Vented cooling units purchased and installed in identified high temperature areas. • ECT management team seeking external air-conditioning expertise to guide practice

	20200326 Covid 19 - FACILITIES Staff Bas • Estates and Facilities have implemented procedural guidance in accordance with national guidance and implemented throughout facilities teams • Continue with existing trust policy. • Continue with existing trust policy. • Guidance issued relating to fans and air conditioning units. • Exec led Air conditioning group to ensure the best ventilation and cooling approaches for service areas, led by director of estates and facilities		

rooms or cohort areas is carried out in line with PHE and other national guidance • increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance • Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses. • Manufacturers' guidance and recommended product			

‘contact time’ must be followed for all cleaning/disinfectant solutions/products. • As per national guidance – ‘frequently touched’ surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids; – electronic equipment e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned a minimum of twice daily – rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods			

immediately after PPE removal by groups of staff (at least twice daily). • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken • single use items are used where possible and according to single use policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance • ensure the dilution of air with good ventilation e.g. open windows in admission and waiting areas to assist the dilution of air			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Processes and guidance in place: • Antibiotics prescribed as per Antimicrobial Formulary https://input.eput.nhs.uk/TeamCentre/pharm/TeamDocuments/Section%2018%20-%20Antimicrobial%20Prescribing%20(Sep%202020).pdf#search=antimicrobial%20prescribing • Board reports continue following agreed governance processes	• Nil	• antimicrobial stewardship quarterly report presented at the IPC group meeting July 2020

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			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	Processes and guidance in place: • National guidance implemented for visitors to all care settings. https://input.eput.nhs.uk/covid19/DocumentLibrary/GUIDANCE%20-%20visiting%20within%20inpatient%20settings.pdf • Communication guidance issued to support staff messaging • For community home visits issued	• Nil	• Guidance reviewed locally for LD patients to further enhance trust wide guidance. • Visitor guidance update 27/07/2020 following guidance issued on 22/7/2020 for care home visitors • Further confirmation

	containing relevant and appropriate summarised guidance https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/GUIDANCE%20%20Basic%20Infection%20Control%20Guidance%20for%20COMMUNITY%20(MH%20and%20Comm%20services).pdf • Trust guidance in place for visiting patients at EOL https://input.eput.nhs.uk/TeamCentre/cg/EOL/Pages/Home.aspx • Posters designed and circulated for display in patient locations and on every ward entrance , including PPE guidance for the location https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/EPUT_PPE_Poster_Door.pdf https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/EPUT_PPE_Poster_Isolation.pdf https://input.eput.nhs.uk/covid19/DocumentLibrary/POSTER%20-%20back%20to%20basics%20IPC%20A3.pdf • Covid 19 dedicated page on the Intranet which includes links to training videos, and relevant websites. Daily updates in staff brief when changes are made https://input.eput.nhs.uk/covid19/Pages/Home.aspx • Trust website link to national site where easy read documents are located • Covid status in included in the patient Discharge summary and telephone discussions re: risks as required.		trust guidance in line with national update October 2020

• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access • information and guidance on COVID-19 is available on all trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved			

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			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non-COVID-19 cases to minimise the risk of cross- infection as per national guidance • mask usage is emphasized for suspected individuals. • ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Processes and guidance in place: • Guidance in place for admitting consultant and assessment units/other admission routes to ensure cross infection minimised https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/GUIDANCE%20-%20COVID-19%20care%20pathways%20for%20people%20using%20EPUT%20inpatient%20services.pdf • Mask usage is risk assessed on an individual basis with case by case review by MDT and IPC where necessary • Operational services undertake risk assessment on admission to ensure cross infection is minimised following IPC isolation guidance and swabbing flow chart • Ethics approval of flow chart to support patients who are not compliant with Covid isolation, accessed via covid-19 intra net page and laminated in clinical areas • All patients isolated and then screened on admission. Swabbing guidance and processes issued to staff via swabbing SOP and		• Case by case review involving senior management with IPC to minimise risk.

• patients with suspected COVID-19 are tested promptly • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Swabbing Flow chart https://input.eput.nhs.uk/covid19/_layouts/15/WopiFrame.aspx?sourcedoc={7d614a38-a298-451a-9838-fce7fd68ec64}&action=edit&source=https%3A%2F%2Finput%2Eeput%2Enhs%2Euk%2Fcovid19%2FPages%2FHome%2Easpx • All patients with suspected symptoms are isolated and then swabbed. Isolation protocol issued as per national guidance. • Contact tracing instigated by IPC following national guidelines • Patients on Outpatient and Community caseloads have all been informed of reduced services/visits/clinic appointments. Where possible either postponed, carried out remotely using virtual technologies. If present with symptoms, are asked to either go home immediately, or isolated in an appropriate area until transport can be arranged • Following release of updated IPC guidance in		

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			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it • a record of staff training is maintained • appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	Processes and guidance in place: • Training includes on-line webinars, issuing of guidance documents, flow charts and templates. • Regular site visits carried out by IPC team to re-enforce good IPC practice and PPE use on wards. • Staff directed to donning and doffing training videos on Covid page on the Intranet. https://input.eput.nhs.uk/covid19/Pages/Home.aspx. • Guidance charts issued which clearly identify what PPE is required for the different scenarios and service areas in the Trust. https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/EPUT_PPE_Poster_Door.pdf https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/EPUT_PPE_Poster_Isolation.pdf https://input.eput.nhs.uk/covid19/_layouts/15/WopiFrame.aspx?sourcedoc={3fcfc602-3ba9-4383-a905-81a5186ef2b0}&action=view&source=https%3A%2F%2Finput%2Eeput%2Enhs%2Euk%2Fcovid19%2FPages%2FHome%2Easpx • Regular IPC MS live events to reinforce PPE donning and doffing	• This recording of IPC training wasn't initially held, this has now be resolved through training and development, but there is retrospective data to be captured. • Regular Trust IPC hand hygiene which were audits paused in phase 1 of pandemic management have now been recommenced. • OLM and Live events now captured via training and development records	

any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions • The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas • staff understand the requirements for uniform laundering where this is not provided for on site	with live demonstration and staff Q&A. • Training records now held through OLM. • Reuse of PPE limited to visors with clear guidance issued to staff regarding use and decontamination  GUIDANCE - PPE eye protection use an • Datix system captures all PPE issues, periodic thematic review for assurance via silver command. • PPE role modelling and professional challenge through the corporate nursing and IPC teams. • Hand hygiene audits are completed quarterly. Posters displaying hand hygiene techniques available in clinical areas • Covid risk assessments undertaken to ensure hand dryers are not in clinical areas. The Covid secure sign off process in non-clinical areas mitigates risk by limiting occupancy to single use at a time. • Staff have been provided with guidance on how to manage their work clothes and the requirement to change before and after work. Alginate bags provided where requested. • Scrubs have been issued to staff		

all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	who do not normally wear uniform and Polo shirts for community teams. • Staff are regularly provided with any updated information pertaining to self-isolation either due to symptoms or family members with symptoms. All staff have access to testing both at local and national sites. • Record held for all staff who have been fit tested for FFP3 masks for Aerosol generating procedures. • Covid incident room ensures CAS alerts are circulated and responded to via Datix. • Datix system captures all PPE issues, periodic thematic review for assurance via silver command. • PPE role modelling and professional challenge through the corporate nursing and IPC teams. • Staff have been provided with guidance on how to manage their work clothes and the requirement to change before and after work. Alginate bags provided where requested. Scrubs have been issued to staff who don't normally wear uniform and Polo shirts for community teams. • Staff are regularly provided with any updated information pertaining to self-isolation either due to symptoms or family members with symptoms. All staff have access to		

	testing both at local and national sites. • Guidance issued following the launch of test and trace, with a 24/7 staff contact line and management flow charts to support management and practice. Communication directly to IPC if potential of outbreak management and utilisation of PHE outbreak flowchart in place https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/Test%20and%20trace%20flowcharts.pdf https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/GUIDANCE%20NHS%20Test%20and%20Trace%20for%20COVID-19%20-%20NHS%20workers.pdf		

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7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed	Processes and guidance in place: • Suspected/confirmed patients with Covid 19 symptoms are isolated most often in individual side rooms. Where not available on wards with bays, the bay would be cohort isolated as a Covid 19 bay. IPC process guidance in place. • IPC policies in place. https://input.eput.nhs.uk/DocumentCentre/_layouts/15/WopiFrame.aspx?sourcedoc={C7DA9EBC-9FA2-47EB-A7B4-C7D41755E058}&file=ICPG1%20-%20Section%203%20-%20Infection%20Prevention%20%26%20Control%20in%20Clinical%20Practice.pdf&action=default https://input.eput.nhs.uk/DocumentCentre/_layouts/15/WopiFrame.aspx?sourcedoc={872BFD17-3ADC-4EC5-9C24-	• Nil	

	E78B2D93E467}&file=ICPG1%20-%20Section%202%20-%20Standard%20Precautions%20of%20Infection%20Control.pdf&action=default IPC guidance in place, links with Microbiologist and the health protection team at PHE for case by case guidance.		

COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement			
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Processes and guidance in place: • Swabbing SOP developed and circulated widely to all staff, and available on the Intranet. https://input.eput.nhs.uk/covid19/Infection%20prevention%20and%20control%20guidance/GUIDANCE%20-%20swabbing%20for%20COVID-19.pdf • Fully equipped swab kits provided to ensure correct procedure is followed. • Trust uses PHE testing at Addenbrookes however; this can be variable in timeliness for result returns. • Existing infection screening continues as per trust guidance.	Gaps: Delays in delivery of care home swab packs from PHE supply and process required to ensure weekly test of EPUT staff who visit care homes •	Mitigating Actions: • 23/10/2020 – new swabbing process being moved over to MSE group who have advised swab results will be received back within 5-12 hours. • System wide approach to ensure the weekly testing of staff who visit care homes currently in progress to ensure this can continue on a weekly basis.

	• Revised Swabbing SOP and internal processes now in place to receive results to a central point and cascade towards via dedicated Covid swab result in boxes 7 days a week. Alternative transport contained and regular supply of swabs from MSE have now mitigated the risk of swab resource issues https://input.eput.nhs.uk/covid19/testing/Pages/Home.aspx • EPUT care homes completing staff swabbing weekly and resident swabbing 4 weekly. • Existing policies in place to screen for and manage other potential infections		

• screening for other potential infections takes place			
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Processes and guidance in place: • Twice weekly bronze calls to support the use of and questions arising. • IPC ward visits. • PIC fortnightly IPC Q&A via MS live event. • All changes communicated via daily staff briefing, bronze cascade and accessible via the intranet. • Facilities teams provide service to remove waste in accordance with guidance. • Trust wide distribution programme in place with key PPE distribution sites. Stock control managed through a stock audit process.  PPE - How and where to access - clin • Ward safety huddle includes PPE monitoring at ward level.  Covid 19 Safety Huddle Template Ver	Gaps: • Lack of central guidance regarding some procedures that are not specified in the WHO and NERVTAG AGP guide. •	Mitigating actions: • PPE sit rep completion. • Central guidance regarding some procedures that are not specified in the WHO and NERVTAG AGP guide has been issued , and EPUT have issued guidance and fit testing processes as appropriate.

• PPE stock is appropriately stored and accessible to staff who require it			
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Processes and guidance in place: • HR process for individual risk assessment, management of high risk and shielding staff in place. • BAME and vulnerable staff risk assessment in place. • FFP3 fit testing programme roll out and records held. More than 80 Fit testers have been trained by an accredited trainer and are fit testing key identified staff who carry out Aerosol generating procedures within their role. Use of positive pressure hoods if required. • HR process in place to contact staff whilst Covid sick. • Management process in place to identify all staff for testing with SOP s for both national and local testing sites. • Guidance in place when to return to work. • Operational teams review of rotas to ensure staff are not working in multiple locations including bank staff		• Gold command issued confirmation that the Shielding staff are supported by national guidance issued on 1/8/2020. • Letter from NHSE received 9/11/2020 confirming that lateral flow testing for Asymptomatic staff will be rolled out across the NHS for patient facing roles, the will be 34 trusts initially piloting and then further rollout across the NHS. EPUT have commenced planning and rollout strategy. There will be an initial pilot commencing at St Aubyn Centre on 20/11/2020. Patient facing staff are required to self-test twice a week for 12

	• Operational teams review of environments and break times to enable staggering of breaks • RIDDOR process in place for those testing positive. • Exec led task and finish group convened to agree processes for Covid secure environments , creation of manager toolkit guidance, risk assessment tool and CEO sign out once risk team assurance confirmed resources include: signage, estates and facilities actions e.g. hand sanitiser instillation, consumables e.g. disinfectant wipe, screens, workforce arrangements • Vulnerable worker risk assessments revisited in July to ensure HR hold a completed record for the organisation		weeks, submitting their results which are reportable to PHE and will require internal management and contact tracing when positive the project is being wed by the DIPC and directly impacts on the reduction of nosocomial spread and outbreak management. Project briefing paper supported by Covid-19 Gold command 18/11/2020

• Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance • all staff should adhere to national guidance on social distancing (two metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas • Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas. • staff absence and well-being are monitored and staff who			

are self-isolating are supported and able to access testing • staff who test positive have adequate information and support to aid their recovery and return to work.			

		Agenda Item No: 10a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**20 November 2020**

Report Title:	**COVID-19 Mass Vaccination Programme**					
Executive/Non-Executive Lead:	Nigel Leonard Executive Director of Strategy & Transformation					
Report Author(s):	Nigel Leonard Executive Director of Strategy & Transformation					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides the Board of Directors with a brief update of the COVID-19 Mass Vaccination Programme.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

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

Summary of Key Issues

Members of the Board will be aware that the Department of Health and Social Care have made a number of recent positive announcements on the trials for potential vaccines to combat the coronavirus.

While we don't expect a COVID-19 vaccine to be widely available until 2021, the Government has asked the NHS to be ready to deliver a vaccination programme from December, so that those who need it most will be able to access vaccinations as soon as they are available. Planning is underway building on the expertise and track record the NHS has for delivering the annual flu vaccination programme. Further announcements are anticipated from NHS England and NHS Improvement shortly.

EPUT, working with colleagues across Essex and Suffolk, is taking steps to consider the implications of a vaccination programme and the arrangements required for delivery. Further information will be made available to the Board shortly on the programme and the role EPUT may undertake in supporting this programme.

Relationship to Trust Strategic Objectives

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

Which of the Trust Values are Being Delivered

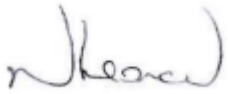
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

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

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

Nigel Leonard **Executive Director of Strategy & Transformation**

		Agenda Item No: 11a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25 November 2020**

Report Title:	**Safe Working of Junior Doctors Quarterly Report**					
Executive/Non-Executive Lead:	Dr Milind Karale					
Report Author(s):	Dr Sethi					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	√	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides: • 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	√

Recommendations/Action Required

he Board of Directors Committee is asked to note the following:

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

Summary of Key Issues

None

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

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**	None

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead

Add signature

Name. Dr Milind Karale
Job Title .Executive Medical Director

Part 1 Agenda Item:11a
Board of Directors
25 November 2020

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 thirteenth quarterly report submitted to the Board on safe working of junior doctors for the period 1 July to the 30 September 2020. The Trust has established robust processes to monitor safe working of junior doctors and report any exceptions to their terms and conditions.

Exception Reporting: (8 Exception reports in this quarter)

Four exception reports were raised for working additional hours. Leave in lieu provided. .

21-23 August 2020: A trainee raised 3 Exception reports during her weekend on call, due to lack of rest and food facilities on site. This matter has been addressed, a temporary alternate room has been identified for on call doctors to rest at Linden Centre and appropriate facilities made available in the room.

23 September 2020: A senior trainee raised an issue about lack of a dedicated on call cover between 9-5pm for section 136 suite. The DME and the tutors are reviewing the rota to address the matter. Meanwhile, the support to 136 suite, if required will be provided by one of the ward doctors.

Work Schedule Report

Work schedules were sent out to all trainees who were employed by the Trust on the 5th August 2020.

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	58
Total number of vacancies	24
Total vacancies covered LAS/ MTI/Agency (there are 4 MTI's who are due to start in the coming weeks but have included in this line)	17
Total gaps	7

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 N.B. increase in shifts because of covering doctors who were absent due to COVID :

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	164	164	0	1650.5	1650.5
Total	164	164	0	1650.5	1650.5

414 hours were covered because of COVID related absence

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 recruited several LAS doctors to cover from August 2020
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:

1. Trainees have been advised regarding the arrangements for the transportation of blood samples.

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2. A concern was raised by a Trainee at Linden Centre; there were no on call doctor available between 9-5pm, this lead to lack of medical input at S136 suite. The cover for 136 suites, interim will be provided by the ward doctors on site.

3 Action Required

Board is asked to note the findings of the report and the concerns raised by doctors at the Junior Doctors Forum.

Report prepared by

Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours
26 October 2020

		Agenda Item No: 11(b)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**25th November 2020**

Report Title:	**CQC Update**					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive					
Report Author(s):	Amanda Webb, Compliance Officer					
Report discussed previously at:	Executive Committee (in part) 17th November Quality Committee (in part) 12th November					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

Purpose of the Report

This report provides an update on the recent CQC risk focused inspection and the internal compliance activity to support the Trust in maintaining the CQC rating of Good.	**Approval**
	Discussion ✓
	Information ✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report.
2 Identify any further action that is required to be taken.

Summary of Key Issues

CQC Unannounced Inspection (October 2020)

The CQC completed an unannounced inspection on the 29th October focusing on Finchingfield Ward following a series of incidents that took place on the 23rd October.

The CQC provided a high level feedback letter on the 3rd November which provided positive areas in addition to issues that they identified as holding the Trust back:

- There were examples of poor record keeping, one being the MHA status of patients, and there was a lack of quality assurance processes to ensure medical records were accurate.
- Multi-disciplinary meeting notes were added to the patient record post serious incident and were not completed in full.
- Clinical decisions had been made by staff who were not of the right grade according to Trust policy. This example related to the reduction of patient observation levels. The rationale was not recorded in the patient record.
- Observations were not carried out as prescribed. Patients were not observed, as required, in the garden area which may have contributed to one incident of a patient jumping the garden fence.
- Observation records did not support staff to accurately reflect the time they observed patients as they were pre populated with hourly intervals.

Immediate actions were taken following the incidents and following the CQC inspection including the establishment of an Intensive Clinical Support Group. An action plan has been developed to address immediate concerns, clinical support needed for the ward and wider learning. The actions will be monitored via the Intensive Clinical Support Group and will be used to prepare for the final inspection report and the action plan that will need to be provided to the CQC following their publication of the final inspection report.

Internal Compliance Team Support

The Compliance Team is currently undertaking a number of table top evidence reviews, virtual interviews and focussed site visits to areas where there actions or concerns relating to following work streams:

- Clinical Intensive Support
- CQC Unannounced Inspection (July - August 2019) Action Plan Testing
- Ligature - CQC Brief Guide to Inspections EPUT Testing
- PHSO / HSE Action Plan Testing

Preparing for Annual Inspection

The CQC Chief Inspectors, and Deputy Chief Inspector and lead for mental health services, issued a joint statement setting out how they will regulate during the next phase of the coronavirus (COVID-19) pandemic.

Ligature Inspection Criteria

On the 20th August the CQC issued an update for NHS MH Trusts from Dr Kevin Cleary, Deputy Inspector Mental Health and Community Services and a new 2020 brief guide for inspection teams was published for the CQC inspectors.

Action has started to review the EPUT position against the criteria set however due to the Unannounced CQC inspection, there has been a slight delay. More data needs to be obtained in order to gain a greater understanding Trust wide in order to agree any further actions.

CQC Guidance/Updates

A range of new publications have been issued by the CQC over this reporting period. Key publications to the Trust Board are:

- CQC draft strategy 2021 on beyond which set out how the CQC plans to develop its approach in line with the changing health and care landscape
- Evaluation of healthcare services well-lead framework (WLF) published by the University of Manchester in partnership with Deloitte who were commissioned to evaluate the WLF.

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

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

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	YES
If yes, insert relevant risk	BAF45
Do you recommend a new entry to the BAF is made as a result of this report?	No

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission		
EERG	Estates Expert Reference Group		

Supporting Documents and/or Further Reading
CQC Compliance Update

Lead
Paul Scott **Chief Executive**

Agenda Item 11(b)
Board of Directors
25 November 2020

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Compliance Update

1.0 Introduction

This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and requirements and to support the Trust's ambition of achieving an outstanding rating by 2022.

1. CQC Unannounced Inspection (October 2020)

2.1 Inspection Findings

The CQC completed an unannounced inspection on the 29th October focusing on Finchingfield Ward following a series of incidents that took place on the 23rd October. The CQC provided high-level verbal feedback immediately following the inspection.

The CQC also provided a high level feedback letter on the 3rd November which identified the following positive areas:

- Patients gave positive feedback on the ward staff and environment. They did not raise any concerns relating to their safety or the way they were treatment by staff.
- The Trust ensured there was support available to patients and staff following the evening of Friday 23 October. This included access to senior leaders and de-briefs from Psychologists.

However, there were also issues identified within the feedback letter; that they identified as holding the Trust back:

- There were examples of poor record keeping, one being the MHA status of patients, and there was a lack of quality assurance processes to ensure medical records were accurate.
- Multi-disciplinary meeting notes were added to the patient record post serious incident and were not completed in full.
- Clinical decisions had been made by staff who were not of the right grade according to Trust policy. This example related to the reduction of patient observation levels. The rationale was not recorded in the patient record.
- Observations were not carried out as prescribed. Patients were not observed, as required, in the garden area which may have contributed to one incident of a patient jumping the garden fence.
- Observation records did not support staff to accurately reflect the time they observed patients as they were pre populated with hourly intervals.

All of these areas have been considered by the Intensive Clinical Support Group (see below) and actions identified. The actions will be monitored via the Intensive Clinical Support Group and will be used to prepare for the final inspection report and the action plan that will need to be provided to the CQC following their publication of the final inspection report.

2.2 Immediate Action Taken

Following the incident on the evening of Friday 23rd October a number of immediate actions were taken including reflective investigation with staff to understand the root cause of the incidents, the removal of the smoking shelter in the garden and upgrading of the lock at the front entrance of the Linden Centre. Support was given to staff and patients following the incident and this support is continuing.

An Intensive Clinical Support Group has been established and has met twice to identify appropriate support for the unit, further actions to be taken and wider organisational learning. This is a MDT group with support from different corporate services.

An initial support plan has been developed; this will continue to be revised as we work through our intensive clinical support programme and following the receipt of the CQC inspection report. The plan has been developed using a quality and improvement collaborative approach with a focus on understanding root causes and staff education. In addition opportunities for wider organisation learning are being captured.

Since the CQC visit to the unit the following actions have been undertaken:

- Reflection on record keeping with the team (at Team Huddle and in Team Meeting). This lead to a change in process for completion of handover sheet which is now electronic and kept centrally so all staff can access. In addition the monthly handover audit is being changed to a weekly audit. Change in practice has been initiated around copying and pasting in the clinical record with a safety alert sent out trustwide to highlight the need to cease this practice.
- A review of the Trust Engagement and Supportive Observation Policy and Procedure has been undertaken to ensure this does not support the pre-population of observation times. Reflection has been undertaken with the clinical team on ensuring recording is to the minute.
- Confirmation that the Trust incident reporting system does date and time stamp incident reports
- Additional clinical support has been identified from Practice Development Team who are working with the ward

Our Intensive Clinical Support Group is continuing to meeting regularly to support the unit in making required improvement and taking forward the improvement plan. The group is also identifying opportunities for wider organisational learning.

2. Internal Compliance Team Support

2.1. Clinical Intensive Support

The Compliance Team have facilitated the establishment of the Intensive Clinical Support Group and Action Plan. Due to the findings from Finchingfield, the Compliance Team have undertaken an inspection at Galleywood Ward to identify if the issues found by the CQC were present elsewhere at the Linden Centre. Finding from the inspection are currently being analysed and will be reported in the next report to committee. Further internal inspections will be undertaken within a selection of Adult Acute Admission wards across the Trust.

2.2. CQC Unannounced Inspection (July - August 2019) Action Plan Testing

The action plan and reset action plan developed as a result of the CQC unannounced inspection (July – August) was reported as complete at the end of September. The Compliance Team collated evidence as the action plan progressed to confirm that the action was completed as reported.

The Compliance Team is currently undertaking a further testing regime using a mix of table top evidence reviews, virtual interview and focussed site visits to confirm that actions have been embedded and sustained.

A report of the findings will be presented in December and will identify if any further actions are required to ensure any identified gaps are resolved in addition to what support is required to progress any gaps.

2.3. Ligature - CQC Brief Guide to Inspections

Following the publication of the new 2020 brief guide for inspection teams, the Compliance Team are undertaking a Table top review using the new brief inspectors guide to provide assurance that EPUT are meeting the criteria set.

2.4. PHSO / HSE

The PHSO / HSE action plan was tested by the Compliance Team in September. The group have requested that the Testing plan that was submitted is undertaken on a quarterly basis therefore the Compliance Team will incorporate into their schedule regime.

3.0. Preparing for Annual Inspection

3.1. CQC Update

The CQC confirmed on 16th March 2020 immediate cessation of routine CQC Inspections however it may be necessary to still use some of their inspection powers in a very small number of cases where risks are identified and as such focused inspections at short notice may take place.

On the 16th September 2020, the CQC Chief Inspectors, and Deputy Chief Inspector and lead for mental health services, issued a joint statement setting out how they will regulate during the next phase of the coronavirus (COVID-19) pandemic.

They confirm that from the 6th October 2020, they will begin to roll out their transitional regulatory approach, starting with adult social care and then rolling out to all trusts from the 12th October 2020.

The transitional regulatory approach is flexible and builds on what the CQC learned during the height of the pandemic. The key components are:

- A strengthened approach to monitoring, with clear areas of focus based on existing Key Lines of Enquiry (KLOEs), to enable them to continually monitor risk in a service
- Use of technology and their local relationships to have better direct contact with people who are using services, their families and staff in services
- Inspection activity that is more targeted and focused on where they have concerns, without returning to a routine programme of planned inspections.

The CQC will continue to adapt their transitional regulatory approach, and remain responsive as the situation changes.

3.2. Ligature Inspection Criteria

On the 20th August the CQC issued an update for NHS MH Trusts from Dr Kevin Cleary, Deputy Inspector Mental Health and Community Services and a new 2020 brief guide for inspection teams was published for the CQC inspectors.

Action has started to review the EPUT position against the criteria set however due to the Unannounced CQC inspection, there has been a slight delay. More data needs to be obtained in order to gain a greater understanding Trust wide in order to agree any further actions.

7.0 CQC Guidance / Updates

7.1 CQC draft strategy

The CQC has issued their draft strategy for 2021 and beyond which sets out how the CQC plans to develop its approach in line with a changing health and care landscape taking into account the context and learning from COVID-19, the development of system working and greater use of digital technologies. CQC has identified a need to transform and ensure its regulatory model is relevant and fit for purpose in an evolving system.

- The draft strategy identifies four key areas of focus (People. Smart, Safe and Improve), which set out how CQC plans to change its approach to regulation. A common thread runs throughout of reviewing health and care systems and how they're working together to reduce health inequalities.
- There will be an increased focus on people's experience of care, with a stronger emphasis on gathering the public's feedback in accessible ways, and using that feedback as part of CQC's overall insight into quality of care, and as part of the rating and published information about services that CQC holds.
- CQC will provide a clearer definition of what 'good' and 'outstanding' care looks like, based on what people say matters to them, which is accessible to everybody and underpins CQC's assessments of services. They will also seek to embed a clear and consistent definition of quality across all services to ensure consistency of approach across the organisation.
- It will not be possible to achieve a rating of 'good' or 'outstanding' without evidence of encouraging and enabling people to speak up, and acting upon their feedback. This will apply both to providers and to CQC's view of how systems are listening to their local communities.
- The strategy describes an intention to take a more dynamic approach to regulation, moving away from relying on a set schedule of inspections to a more flexible approach using all regulatory methods, tools and techniques to assess quality continuously. Local teams will have a more regular view of the services they manage and ratings will be updated more regularly.
- CQC will work with providers and other regulators to coordinate data collections, reducing duplication and workload and only asking for information they cannot get elsewhere. They will explore how to improve digital interfaces with services to make it easier for providers to submit data.
- Providers will be expected to work towards an ambition of zero avoidable harm, and CQC will drive providers to develop strong safety cultures, collaborating with others to develop a consistent definition and language for safety. CQC will intervene more rapidly where they identify a risk of poor or closed cultures developing.
- CQC will explore the option of supporting improvement alliances across a broad spectrum of providers, to make direct, tailored, hands-on support available when it is needed. They will seek to maintain collaborative relationships with providers to help them find their own route to improvement, pointing them to sources of guidance and best practice rather than 'telling them what to do', enabling CQC to support services without compromising their core regulatory role.
- As well as assessing individual services, CQC will assess how systems in local areas work, focusing on how they perform against the evidence of what matters to people and the outcomes for people in a community. They will hold local care systems to account for the quality of care in their area, and call out issues in services and

systems as well as highlighting good practice. As part of this CQC will consider it unacceptable for providers not to collaborate as part of the system.

The CQC will be opening a statutory consultation on its plans early next year for roll out from April 2021

The draft CQC strategy is attached as Appendix 1

7.2 Evaluation of healthcare services well-led framework (WLF)

The University of Manchester in partnership with Deloitte were commissioned to evaluate the WLF. The evaluation found that the WLF is clear about what a well-led organisation looks like and covers most aspects for managing healthcare, underpinned by the correct principles and KLOEs. It also found that trust leaders find it useful to have a framework which outlines expectations around governance and leadership, and as a model for self-assessment.

The review suggests that a standardised model is not always appropriate given the diversity of different providers' scale, context and performance, and that some KLOEs are more important than others.

The review found that the framework is strong on technical matters such as governance and process, but recognises a need to refine and strengthen content around culture and leadership considering the increased emphasis on both in national policy, and a general need to keep pace with changing priorities.

The evaluation recommendations:

- Organise the well-led framework (WLF) under two broad headings: 'Governance and processes', and 'Culture and leadership', to prompt a more equitable focus across the two areas.
- Refine the culture and leadership elements of the WLF to include more detail on the measure and prompts for assessing culture, how the focus on quality and other types of improvement work will be assessed, and assessing capacity, capability, empowerment and development of middle managers.
- Expand and consolidate documentation available around the WLF to include further examples of good and outstanding practice for each CQC key line of enquiry (KLOE), with case studies. This should be aimed at encouraging shared learning and providing more stretch for higher performing organisations.
- Use peer reviewers more inclusively and sustainably, ensuring that further training and support is provided to those in these roles.
- Vary the frequency and focus of inspections according to: significant changes to the composition of the board and leadership teams; indicators of changes to staff experience such as through freedom to speak up guardians or the staff survey results; quality metrics like never events and incident reporting.
- Clarify the purpose and interconnectivity between the various applications of the WLF (including self-assessments, developmental reviews and inspections).
- Consolidate, clarify, and expand guidance on system leadership to include as a minimum: • A definition of what is meant by a system, and attributes of effective leadership of a system
- Expectations regarding prevention, population health and working with the wider determinants of health
- Evidence based hallmarks of effective system leadership
- How regulators will encourage system working through inspections processes, including consideration of the local operating context.
- Encourage the use of the WLF for, and by, CCGs and ICSs to promote a single definition of high-quality leadership

- Ensure that the application of the WLF takes into account both the leadership of individual organisations and the extent to which leaders of an organisation effectively operate and input across the broader system. Consider whether it is appropriate to award a rating of 'outstanding' to a provider where there is little evidence of positive and collaborative relationships in the local system.
- Apply reviews of the WLF to system oversight and regulatory bodies, with key findings made publicly available.

8.0 Recommendations and Action Required

The Board of Directors is asked to:

1. Note the contents of this report
2. Identify any further action that is required to be taken.

Report Prepared by:

Amanda Webb
Compliance Officer

On behalf of:

Paul Scott
Chief Executive

The world of health and social care is changing.

So are we.

CQC's DRAFT STRATEGY FOR DISCUSSION

30/9/20

Changing regulation to improve care for all: our new strategy for 2021 and beyond

The Care Quality Commission was established as an independent commission with a clear purpose: to ensure health and care services provide people with safe, effective, compassionate, high-quality care and to encourage those services to improve.

Our purpose is as vital as ever – we'll always be committed to ensuring safe, effective, compassionate, high-quality care, and encouraging improvement. But the world in which we regulate has changed significantly since we were created. The COVID-19 pandemic has accelerated that change: new and innovative types of service started up using new digital channels, and new restrictions have changed how services can deliver care.

In this new world, we must also transform. We need to make changes to offer regulation that's even more relevant and that benefits everyone, while managing risk and uncertainty. The learning from our response to COVID-19 is feeding into new ways of working to put us in a better place for the future to support services to keep people safe.

As an influential regulator, we have a responsibility to use our new strategy to change people's lives for the better.

Even before the pandemic, the organisation of health and social care was evolving rapidly, and we've already seen new ways of working in partnership across different sectors. The crisis has further underlined just how important this is. It's now even more important for health and care services to work together as a system to deliver care – to meet the needs of both the local population and of each individual person. People are living longer, often with multiple, long-term conditions, which means delivering care is increasingly complex.

But the approach of delivering care as a 'system' is very different to the traditional 'single provider service model' that CQC was originally set up to oversee in 2009.

It's now not enough to look just at how one service operates in isolation.

For a system, it's essential that people who use services, those who work in them, and health and care organisations work closely together to design and deliver care. For us as a regulator, we know we need to adapt to this and work in new ways. This means our assessment of people's care must look at every touch point of their journey through the health and care system, looking at both individual services and across different providers and organisations.

But it's **how** health and care services work together that really has an impact on people's outcomes.

As well as changes from local health and care systems, the way people receive care has changed – powered and supported through new technology. The growth of artificial intelligence, the advances in data analytics and the proliferation of mobile communication all point to a future of care that lies in the dynamic working partnership between health and care services, those who work in them and the people who use them. We need to understand where digital services can meet people's needs and improve their outcomes, and change the way we regulate these services.

The pandemic also renewed the focus on inequalities in health and care across different areas of the country and different groups of people.

Reducing inequalities in people's outcomes is a fundamental part of our new strategy. We want everybody to have access to safer and better-quality care and we will champion this in everything we do. We want to understand why there's such variation in people's access to services across the country so we can help drive change.

Our strategy is built on four central and interdependent themes that determine the changes we want to make to our regulation. Running throughout each theme is our ambition to improve people's care by looking at health and care systems and how they're working together to reduce inequalities.

PEOPLE: We want to be an advocate for change, ensuring our regulation is driven by what people expect and need from services, rather than how providers want to deliver them. We want to regulate to improve people's experience so they move easily between different services. The more active people are in their own care, the better the care – and we think the same about regulation. We want people and communities to always feel listened to and understood, and to know how we've acted on what they're telling us. People need to clearly understand how their voice can make a real difference to the safety and quality of the health and social care services they use. We want our information to help people make decisions about care and to enable and empower them to drive change. We have an opportunity to drive care that's built around the person: we want to regulate to make that happen.

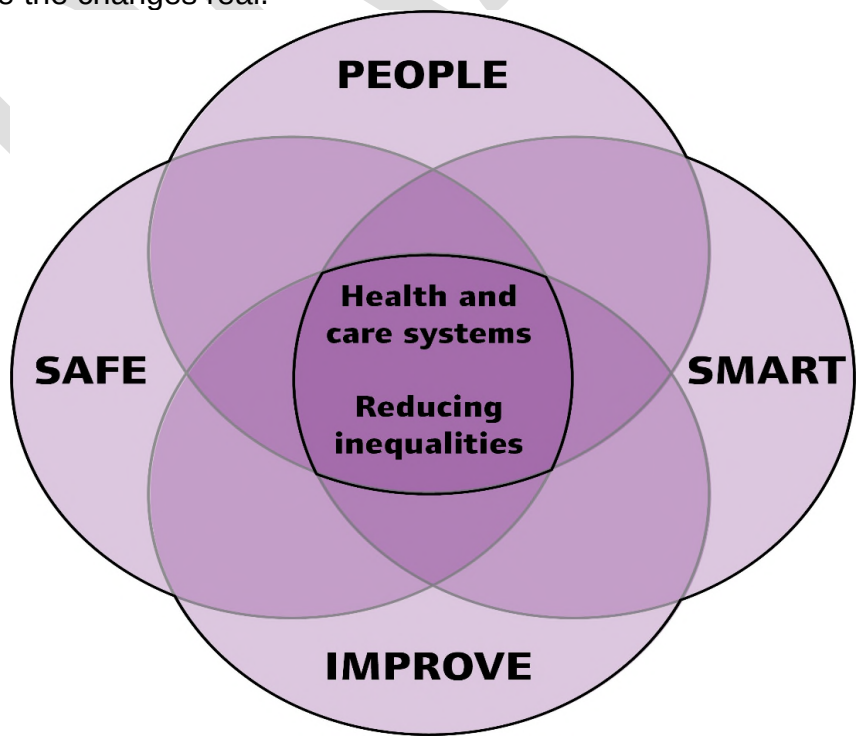
SMART: We want to be smarter in how we regulate, with an ambition to provide an up-to-date, consistent, and accurate picture of the quality of care in a service and in a local area. We want this to help people make choices about care, guide services and commissioners to drive improvement, and enable us to be a more flexible and proportionate regulator.

This means a more dynamic approach to regulating: moving away from relying on periodic inspections of services, and harnessing information from all sources to continually assess quality and update ratings. Data will underpin all our activity, allowing us to understand risk and how people are experiencing care, target our resources for the greatest impact, and be more proactive than reactive.

We want to make it easier for services to work with us through open, ongoing, and constructive relationships, based on trust and our common drive to improve people's care. We want to coordinate the flow of data – both in and out of CQC. Making better use and sharing information with others will reduce the duplication and burden for services: collect it once and use it many times. We want to use what we know to enhance how services target the changes and improvements they need to make.

SAFE: We want all services to promote strong safety cultures. This includes transparency and openness that takes learning seriously – both when things go right and when things go wrong, with an overall vision and philosophy of achieving zero avoidable harm. People's safety simply won't improve unless everyone working across health and care sees this as a top priority, where they are consistently reporting with confidence, learning, and working to improve. We want to have a consistent definition and language to talk about safety across all sectors and settings that's agreed by our national, regional, and local partners. Our approach will reflect this, and we'll commit to enforcing standards of safety much more proactively so that services focus on protecting people, including their human rights. Where quality and safety are compromised, we'll be quicker to intervene to prevent unnecessary harm to people caused by unsafe and toxic cultures.

IMPROVE: We want to play a much more active role to ensure services improve. Improving the quality of care will mean people get easier access to the most appropriate services at the right time, with better experiences and outcomes, and fewer avoidable mistakes. But health and social care services across the country need equal and consistent access to support to improve. So, we want to explore establishing an improvement alliance with key partners from all sectors to support this. By enabling access to shared learning, information, advice, and support, we can empower services to help themselves, while retaining our core regulatory role. We want to provide benchmarking information so they can measure their performance against similar services, and then make sure they have access to the support they need to make the changes real.



1. PEOPLE

We want our regulation to be driven by people's experiences of health and care services. This means focusing on what matters to the public, and to local communities, when they access, use, and move between services.

Listening and acting

We want to transform how we encourage and enable people to share their experiences of care with us in a way that meets their needs, and how we capture, use, and analyse their feedback. We want to build trust with the public and motivate people to share their experiences by being transparent about how we've acted on it.

- We'll enable people to give feedback in different ways that work for them – whether that's by speaking to our national contact centre, our Experts by Experience, our inspectors, Local Healthwatch or our local voluntary and advocacy group partners. By using the power of technology, we'll also make it easier for people to give feedback.

- We'll develop the skills that we need to make sure we enable all people to share their experiences. But we'll have a specific focus on people who are most disadvantaged in our society, who have had distressing or traumatic experiences, and are more likely to experience poor outcomes. This includes people with a learning disability, people with communication needs, those living in poverty, those whose voices are seldom heard, those who experience inequalities, and who are at risk of abuse or other human rights breaches.

- Improving our capacity and capability to get the most out of feedback will be a priority. This means identifying the best additional sources of experiences, and capturing and analysing people's feedback in a way that makes it easier for us to quickly identify changes in the quality of care. It also means building systems that enable us to track and prioritise people's experiences throughout our regulatory processes. We'll be clear about the value and weight we give to quantitative and qualitative information from people when using with other evidence, This includes the stories that people tell us about their experiences of services and pathways of care.

People and communities want us to act on their feedback and know how we've acted on it. We want people to know how valuable their feedback is to us.

- We'll be clearer in our published information about quality about people's experiences of care, and how we and others have acted on it, ensuring our information is relevant to people.

- When people take the time to share their experiences with us we want to close the loop on their feedback. We'll provide a response that clearly tells them how we've acted on what they tell us and how it has informed our view of how a service is performing. We'll provide our response tailored to the way people need it.

- We'll improve the way we assess how services are encouraging and enabling people who use their services to speak up, and how they act on their feedback. It will not be possible to achieve a rating of good or outstanding without evidence of best practice in this area. We'll also focus on this when we look at how local systems are listening to their local communities to improve access to services that meet their needs.

- We know that people are often afraid to speak up. We want to help build a new culture among the public, health and care providers, and our partners, that welcomes, values and acts on feedback to improve care for all.
- We'll always use what we know to speak on behalf of people who use services – calling out poor care, supporting innovation and driving improvement in both individual services and local systems.

People are empowered

To help empower people to drive change, it's important for them to know who we are and understand what we do. We want people to give feedback and to use our services in ways that are relevant to their lives.

- We'll proactively raise public awareness of CQC and be clear about our role as a regulator. We'll invest in the most effective ways of raising public awareness for different population groups, and in 'nudge' campaigns to help people to understand the standards they can expect, encourage them to use our information, and feed back to us.

- We will be clear what standards people can expect from their health and care services, and how their feedback can empower them to drive change.

- Our up-to-date view of the quality of care in a service will help people and their families make informed decisions about where they choose to go for their care, confident in the knowledge that our assessment reflects the care that can expect to receive on the day they experience it.

We want to put people at the centre of all conversations on quality. Having an agreed and shared view of quality will enable a joined-up approach that's applied to individual services, corporate providers, and across system boundaries in both health and social care. It will empower people to have more control in their care and enable services to strive to improve.

- We'll provide a clearer definition of what good and outstanding care looks like, based on what people tell us matters to them, which everybody can easily access, understand, and use to improve people's experiences and outcomes of care. This will underpin our assessments of services and the information that we collect.

Providing independent, trusted, high-quality information about the quality of care is a fundamental part of our work. People need information about the services they recognise to help make the right choices for them and those close to them.

- We'll change what we produce and how we provide information so that it's more relevant, up to date, and meaningful for people who use services and reflects their experiences

- We'll ensure people have access to information in the way they need it, through improved communication channels, and using clear and accessible language.

Prioritising people and communities

We know care is better when it's developed through the eyes of people who use services and delivered in partnership with them: we think the same of regulation. We want to regulate to drive more personalised and coordinated care.

- We'll work closely with people who use services and those that represent them to understand their needs and to co-design and develop how we work, and the services we provide to the public. Any changes we make will start with understanding what people expect and need from care services, pathways, and from CQC. We want to involve people in a meaningful way, so will encourage and enable people to do this in ways that work for them.

Local health and care services need to understand the diverse needs of their populations and work together as a system to meet these needs and improve health and wellbeing. We need to ensure that services in local areas are working with other parts of the local community to enable better outcomes.

- As well as assessing individual services, we'll assess how the systems in local areas work. We'll focus on how they perform against the evidence of what matters to people and communities in their area and the outcomes for people in that community.

- It will be unacceptable for providers not to be working in this way. We'll hold local care systems to account for the quality of care in their area and clearly call out issues in services and systems when we see them – as well as highlighting good practice.

- When we assess services, we'll look at how they work with each other, and in partnership with people and communities, to make improvements. We'll also assess how effectively they involve people in designing and improving services, and how they embed equality,

diversity and inclusion, and corporate social responsibility in everything they do to benefit local health and wellbeing, society, the economy, and the environment.

We will identify and call out unwarranted variation and inequalities in health and care. We know that a person's health and wellbeing is significantly affected by factors outside health and care services.

- We'll support local systems to understand the needs of their local populations, especially those that face the most barriers to accessing good care or those with the poorest outcomes, enabling them to respond positively to inequalities.

- We'll work with other agencies, voluntary and community organisations, system partners and other regulators to develop a shared understanding of the factors that contribute to inequalities and the levers that we and they can use to help tackle them.

2. SMART

Our regulation will keep pace with how health and care is changing, providing up-to-date, high-quality information and ratings for the public, providers and all our partners. We'll regulate in a simpler, more flexible way to reflect the future changes that we can anticipate – as well as those we can't. Being smart means targeting our resources where we can have the greatest impact, focusing on risk and where care is poor, to ensure we're an effective, proportionate, and efficient regulator.

We now have a baseline understanding of quality across health and social care. But we want to provide a more consistent, up-to-date, and accurate picture of quality, and we know that the quality of care can vary from day to day. Using the best information will help us to keep people safe and to protect, respect and fulfil people's human rights.

- We'll have a more dynamic approach to regulation. Inspections are not the only way to assess quality: we want to move away from relying on a set schedule of inspections to a more flexible approach. This means using all our regulatory methods, tools, and techniques to assess quality continuously, rather than relying only on scheduled all-inclusive on-site inspection visits. We want our local teams to have a regular view of the services they manage based on their knowledge – not a calendar date.

- Traditional inspection site visits will become just one of our tools in our toolkit. But we'll still use our powers to inspect when appropriate – in response to risk, when we need specific information, and when sampling to check the reliability of our view of quality.

We want everyone we work with to benefit from our regulation. The way we regulate will become more relevant – using what we know to help services to tackle problems early and providing up-to-date, high-quality information and ratings to give a positive advantage to all.

- We'll use the best information we can about quality in a service to keep ratings and information up-to-date, rather than relying on the outcome of periodic all-inclusive inspections to change them. By making our ratings more dynamic, and updating them more often, they will give everybody an up-to-date view on quality.

- We'll do this through a better understanding of people's feedback and experiences of care, and using a combination of targeted inspections, national and local data from other organisations and partners, insight from our relationships with providers and partners, and providers' own self-assurance, and accreditation.

We now have IT systems that can handle large amounts of data, which will enable us to use artificial intelligence and innovative analysis methods. This replaces more manual handling of data to support intelligence-based activity and will ensure we interpret data in a more consistent way.

- We'll use our regulatory powers in a smarter, more proportionate way so we take the right action at the right time. Based on the best information available, and enabled by technology, we'll be alert and ready to act quickly in a more targeted way, and tailor our regulatory activities to individual services and circumstances.

- We'll be transparent with the data and information we hold on services and use innovative analysis proactively, including data science techniques, to support robust and proportionate decision-making.

Making it easier to work with us

We want to make it easier for providers to work with us and other partners in the system, through digital channels. We want to gather information differently and develop how we work with others by reducing the duplication of requests. This will help staff to focus on providing care safely and finding opportunities to improve.

- From the point of registration, we want to develop ongoing, collaborative relationships with providers, built on openness and trust. We want this to enable effective and proportionate regulation and to focus our regulatory work on those providers and services where quality needs to improve.

- We'll work with providers and other regulators and partners to coordinate data collections. We'll reduce the duplication and workload for providers in collecting and submitting data to us, and to other organisations, by only asking for the information we need and that we can't get elsewhere. We'll use information from other sources and share the information we gather ourselves through data-sharing agreements. We'll collect data once and use it many times.

- We want to explore how we can improve our digital interfaces with services. Where we do need to collect information directly from services, this will make it easier for them to give us the information we need and simpler to update what they've already told us. We'll also make it easier for services to access more of the information we hold about them in one place,

- Our regulatory activity will be more proportionate and consistent. To have a better understanding of quality and performance in each service, we'll have regular contact with them through our ongoing relationships, and spend more time monitoring and analysing data using technology, rather than through inspection activity.

Future proof and focused on what matters most

Like the services we regulate, we're evolving to adapt to all changing models of care, such as integrated systems and digitally-enabled care. The move to looking at how health and care services work together in a local system is a change in our approach. We'll work with providers and other partners to understand how care is changing, ensuring that our regulatory model keeps pace with changes.

- We'll build capability and capacity in our people, our systems, and our processes to adapt to our evolving approach to regulation. We want to learn and improve ourselves to be a flexible and responsive regulator, while staying true to our purpose of keeping more people safe.

- Where services are innovative, we'll look at how they benefit people as well as how they support the sustainability of the local community and how they meet their social and ethical responsibilities. We'll recognise and capture where quality has improved and will share this learning.

- Our assessments will always focus on what matters to people as they access, experience, and move between services. We'll also look more closely at aspects that we know have a positive effect on quality such as the culture of a service, how it works with other local services in a local system, and how it drives improvement.

- We'll focus our assessments on how providers are working together to ensure fair access to health and social care services for everyone.

  The information we gather will enable us to better understand risk relating to inequalities in people's health outcomes and we'll take action where there's a need for improvement.

Relevant for all

We want our ratings and inspection reports to help people to make informed choices about their care and give services an assessment of performance to encourage them to improve.

- We'll evolve our ratings. As well as ensuring they provide an up-to-date view on quality, we want to make ratings reflect how people experience care so they're more meaningful and focus on what matters most to them.

- We'll move away from long reports written after inspections, and instead provide information and data products targeted to an audience. Information for the public will be easier to understand and more accessible. We want people to be able to access information to suit their personal circumstances, either online or through an app.

- We'll also provide a clear definition of quality, which everybody can understand and use as a reference for what good and poor care looks like. We'll be transparent about how we apply this to assess the quality of services. This definition will be at the heart of our regulatory processes to help us improve consistency in our regulatory activity, so people can be confident that good means good wherever they are in the country and whatever service they are using.

3. SAFE

There's a great deal of commitment and work happening to improve the safety of services. But safety is still a key concern as it's consistently the poorest area of performance in our assessments, and avoidable harm remains a factor in services across the country. From our work over the past few years, we know safety starts with a culture of learning and improving, where risks aren't overlooked, ignored or hidden. We want to promote open cultures where the voice of health and care staff and people who use services drives learning and improvement.

We know that we need to work as one system across health and social care to improve safety and protect people's rights consistently, and our strategy provides an opportunity to do this.

Culture

Our assessments show us that in a good safety culture, staff are expected to report concerns openly and honestly, confident that they won't be blamed. There's an acceptance that all incidents – positive, negative, and wholly avoidable – provide an opportunity to learn and improve. We want this type of culture to be universal and it should be developed and supported not only by leaders and staff, but by everyone in health and care settings, including people who use services, carers, and families.

- To help develop strong safety cultures, we'll collaborate with others to develop a definition and language for safety that works across all health and care settings and reflects what is important to people. We want this to create absolute clarity on what we mean when we talk about safety so that providers know what we expect when we regulate.

- In developing this definition and language we'll expect everyone in all services to have people's safety as a top priority. We'll expect honest, open, and blame-free reporting, with learning and improving a fundamental part of everyone's role. We'll also develop opportunities to share learning. This may be by sharing exemplary practices that we've observed or by publishing the changes and improvement that services have made as a direct result of our regulatory action.

- With stronger safety cultures, we'll also expect services to have a vision of achieving zero avoidable harm. This is not a target: it's a change in attitude and approach to drive the right behaviour and the right culture. Any level of avoidable harm to people who use health and care services is an opportunity to learn, to do better, to become safer. So we're challenging everyone to change and drive our systems to be the safest in the world.

Oversight

NHS trusts have access to guidance and support, and alerts on safety from a national patient safety team. But this type of national support and oversight doesn't exist in other sectors. Although there are bodies who might provide support or receive incident data, this oversight or champion role is fragmented, meaning these sectors risk being left behind. It's crucial that all health and care services have access to the right support and insight to help them on their journey to build strong safety cultures, learn from safety incidents and improve their practice.

- We want to understand where there is and isn't support and expertise for safety across all sectors that we regulate. We want to work with others to develop solutions to ensure that all services have support and leadership during difficult times, and that they have the right tools to provide safe care as a standard. We'll need to understand where this oversight is best placed and develop the right frameworks as required.

Regulation

We know that some of the greatest safety risks happen when people struggle to access the right care, when they're transferred between services or after they're discharged. We also know that some services are more at risk of these than others and that sometimes the system works against health and care staff, making it hard to take the right and safest action.

Safety incidents include breaches of human rights, which can lead not only to poor care but to psychological harm. Poor and closed cultures are more likely to develop in services where people are far from their communities, where there is weak leadership and staff don't have the right skills or training, where people are often not able to speak up for themselves, and where there is a lack of external oversight. These are some of the hardest places to regulate safety: where it's difficult to identify where and why an error has happened, and to see where in the system the culture has failed people.

With new ways of delivering care and working as a system, we need to change how we regulate safety in all services, particularly those that present the greatest challenge. We want to be firmer in our approach and be more proactive to protect people from harm before it happens.

- We'll focus on safety from the start – before we make a decision to register a service – and keep safety at the forefront of our relationships with services.
- While supporting services to improve safety, we'll be looking at how they do it, ensuring they focus on the right things. This includes the culture as well as processes. We'll expect learning to be the primary response to all safety concerns – whatever the setting. We'll also look at how they collaborate with others to ensure a safe journey of care for people moving between services.
- We'll use what we know about a service to intervene much earlier than we have before to assure ourselves that services are focusing on protecting people before they experience poor care and avoidable harm.
- We'll use our powers and act quickly where improvement takes too long, or where change isn't sustainable. Services that are not open to learning are not safe. We'll take action where services are unable to identify systemic issues in their own organisational culture or fail to learn lessons from widely publicised failures happening across the wider health and care landscape.
- Where we see systemic safety issues in a sector or local area, we'll use the combined power of what we know and our independent voice to speak out and to encourage meaningful change. We'll also support services to improve by sharing what we know to help reduce system safety issues. We will share the learning from our insight on themes, trends, and best practice.

Expertise

We know that shifts in safety culture won't happen without the right expertise at all levels across health and social care – including at CQC. We all need to understand why safety is important at a practical level, how we can each individually improve it in our area of work, and create an excitement and movement around it that motivates people every day to improve.

- We'll expect all services and parts of the system to use the safety expertise that's available, including training, support, and insight. This includes staff being familiar with the most up-to-date safety concepts, including human factors, and how system design can influence safety practice in any setting or department. Staff at all levels will then feel motivated to drive change and improvement as they'll have the tools and knowledge to make it happen.

- We'll improve and increase our own safety expertise. We need to do this to ensure our own frameworks are in line with the latest safety thinking and that our regulatory approach enables us to properly assess the right safety culture. We'll need to be able to challenge and highlight both provider and system failures, while also having the expertise to properly support services to learn and improve using our unique data and insight.

Involving everybody

People have a right to expect safe care when they use health and care services and making sure they experience the safest care is everyone's job. To provide the safest care, leaders, their staff, and the people using their services all need to be involved. People should influence the planning and prioritisation of safety and be truly involved as equal partners in their care at all levels.

- We'll promote and emphasise the need for those who work in services to be committed to involving people in their own safety at all points in their health and care journey. This collaborative approach has the potential to transform safety and to ensure that people's human rights are upheld.

- We'll expect services to give people the right information they need to help them be equal partners in their care and play a part in their own safety. We will also expect them to listen to people's unique perspectives and their challenges to assumptions about safety and rights. We'll expect to see proper processes and frameworks to show how people are being involved, and evidence to prove this is happening.

4. IMPROVE

We can do more with what we know to drive improvements across individual services and systems of care by emphasising a culture of learning. We want to use our unique position to spotlight the priority areas that need to improve and provide support where it's needed.

We want improvement within individual services, and between services. Services and local areas that want to improve should get the support they need to make this happen.

Where individual services or a local health and care system need to improve, it's essential to get this right for the people who use and rely on them. This is important so that improvement happens in ways that people can recognise: easier movement between services and pathways of care, access to the most appropriate services at the right time, fewer avoidable mistakes, and better experiences and outcomes – all delivered by a diverse workforce that is thriving.

Making improvement happen

The support that's available to help services improve the quality of their care varies between and within health and care sectors and across England. Some services have limited access to the support they need. We want to play a much more active leadership role in driving improvement. We want all sectors to have equal and consistent access to support and take a more proactive role in priority areas.

- We want to explore the option of establishing an improvement alliance across a broad spectrum of health and care partners. The aim would be to make support available throughout the country that's given consistently to services that need it, including those in special measures. We want this to ensure that all providers have access to direct, tailored, hands-on support as and when needed.

- We'll develop collaborative relationships with services, helping them to find their own route to improvement by pointing them to sources of guidance, best practice, and other organisations. We want an approach that supports services to find the best way forward rather than 'telling them what to do'. This will enable us to support and help services who want to improve while retaining our core regulatory role, which means using our powers to act where we see poor care.

- Through our assessments, and across our work, we'll identify and investigate the things that are most important to ensuring good quality of care. We'll use the evidence we collect to support improvement and speak up on priorities where improvement is needed most. To do this, we'll focus our effort and collaborate with partners to achieve change in an agile and responsive way.

Empowering services and local areas

As health and care evolves, what was considered good a few years ago isn't good enough today, and what is good today won't be good enough in the near future. People have higher expectations about safe, high-quality care – and so do we.

We encourage improvement through our unique insight and independent voice, but there's so much more that we can do to really drive this.

- We want to encourage sustained improvement in quality. To achieve this, we'll be clearer on the standards that we, and those who use health and care services, expect. We'll set a higher bar for what we expect of good services that matches public expectations. We'll expect services to continually improve so they remain good and to drive improvement in their local health and care system.
- To support ongoing improvement in services and local systems we'll use our independent voice to share good practice and the conditions that drive improvement. This can be through events, workshops, and by publishing reports, guidance, resources, and frameworks.
- We'll play a role in coordinating improvement activity, and support services to work together to target and accelerate change, including how best to address health inequalities where these arise.
- We'll empower providers and local systems to improve themselves by offering analysis and benchmarking data. This will enable them to self-assess how they're performing against similar services and areas, so they can use this to target improvements themselves.

Encouraging innovation

Innovative practice and technological change present an opportunity for rapid improvement in health and care, but services don't always understand it or implement it well.

- We'll be proactive in understanding changes on the horizon in how care is being delivered. We'll then work with health and care services to develop how we can regulate new innovations and technology effectively and understand how they can improve the quality of people's care. In doing this, we'll consider where the use of new technology might disadvantage some people and what is needed to mitigate this, so that nobody is left behind.
- We encourage and champion innovation and technology-enabled services where they benefit people and where the innovation results in more effective and efficient services. We know the path to innovation is difficult; we want to use what we know as a regulator to create an environment where services can try new ways to deliver safe, high-quality care. We'll support their efforts to improve care through clear advice and guidance and, with our partners, by taking a coordinated approach to regulating innovation in a proportionate way.

An approach based on evidence

We want to use our knowledge and insight about improvement to inform our regulatory approach. Through all our regulatory activity, we want to promote an improvement culture across both health and social care.

We want this activity to be based on evidence about what really works.

- We'll invest in research and make better use of existing evidence to have a better understanding of the conditions that drive quality improvement, including evidence and best practice from other industries. Our benchmarking data will also inform where we focus our efforts to drive improvement.

- We'll use the best available evidence to inform our approach to regulation and embed a culture of learning in our workforce to maximise our impact on the quality of care and people's outcomes.

	Agenda Item No: 12a
SUMMARY REPORT / **BOARD OF DIRECTORS PART 1**	**25 November 2020**

Report Title:	**Use of Corporate Seal**					
Executive/Non-Executive Lead:	Paul Scott Chief Executive					
Report Author(s):	Angela Horley PA to CEO, Chair and NEDs					
Report discussed previously at:	n/a					
Level of Assurance:	**Level 1**	**x**	**Level 2**		**Level 3**	

Purpose of the Report		
This report updates the Board of Directors of when the Trust Corporate Seal has been used.	**Approval**	
	Discussion	
	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 EPUT Corporate Seal has been used on the following occasions this month:

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

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

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

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

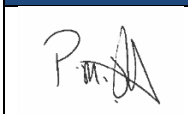
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	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

			Capital £ Revenue £ Non Recurrent £
Governance implications			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

Supporting Documents and/or Further Reading

Lead



Paul Scott
Chief Executive