Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

31 January 2024

10:00 GMT Europe/London

Hamptons Sports & Leisure, Tydemans off Beehive Lane, Great Baddow, Chelmsford, CM2 9FH

AGENDA

AGENDA

- Standing item

REFERENCES

Only PDFs are attached

#0 Part 1 Agenda 31.01.2024.pdf

Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public
Hamptons Sports & Leisure, Tydemans off Beehive Lane, Great Baddow, Chelmsford, CM2 9FH
Wednesday 31 January 2024 at 10:00

Vision: To be the leading health and wellbeing service in the provision of mental health and community care

PART ONE: MEETING HELD IN PUBLIC via Microsoft Teams

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
PRESENTATION **Brighter Days are Here to Stay** **Chloe Cawston, Clinical Service Manager**				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 29 November 2023	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chair's Report (including Governance Update)	SS	Attached	Noting
6	Chief Executive Officer (CEO) Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
7.1	Quality & Performance Scorecard	PS	Attached	Noting
7.2	Committee Chairs Report	Chairs	Attached	Noting
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework 2023/24	PS	Attached	Approval
8.2	Board Safety Oversight Group	SS	Attached	Noting
8.3	Freedom to Speak Up Service	NL	Attached	Noting
8.4	Learning from Deaths Q2 Report	FB	Attached	Noting
9	**STRATEGIC INITIATIVES**			
9.1	People & Education Strategy	MR	Attached	Approval
9.2	Strategic Impact Report	ZT	Attached	Noting
10	**REGULATION AND COMPLIANCE**			

10.1	CQC Compliance Update	DG	Attached	Noting
10.2	Safe Working of Junior Doctors Quarterly Report	MK	Attached	Noting
10.3	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
10.4	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
10.5	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
10.6	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
11	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
12	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
13	**DATE AND TIME OF NEXT MEETING** Wednesday 27 March 2024			

Professor Sheila Salmon
Chair

1. APOLOGIES FOR ABSENCE

Standing item | Professor Sheila Salmon | 1 minute

2. DECLARATIONS OF INTEREST

Standing item | Professor Sheila Salmon | 1 minute

PRESENTATION: BRIGHTER DAYS ARE HERE TO STAY

Other | Chloe Cawston | 15 minutes

3. MINUTES OF THE PREVIOUS MEETING HELD 29 NOVEMBER 2023

Standing item | Professor Sheila Salmon | 2 Minutes

REFERENCES

Only PDFs are attached

BOD Part 1 - Board Minutes 29.11.2023 Final Draft.pdf

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 29 November 2023
Held Virtually via MS Teams Video Conferencing

Attendees:

Prof Sheila Salmon (SS)	Chair
Paul Scott (PS)	Chief Executive
Zephan Trent (ZT)	Executive Director of Digital, Strategy and Transformation
Trevor Smith (TS)	Executive Chief Finance Officer
Denver Greenhalgh (DG)	Senior Director of Corporate Governance
Alex Green (AG)	Executive Chief Operating Officer
Milind Karale (MK)	Executive Medical Director
Nigel Leonard (NL)	Executive Director of Major Projects and Programmes
Frances Bolger (FB)	Interim Chief Nursing Officer
Susan Young (SY)	Interim Chief People Officer
Loy Lobo (LL)	Non-Executive Director
Rufus Helm (RH)	Non-Executive Director
Elena Lokteva (EL)	Non-Executive Director

In Attendance:

Angela Laverick	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings (CJ)	Assistant Trust Secretary
Clare Sumner	Trust Secretary Administrator
John Jones	Lead Governor
Stuart Scrivener	Public Governor
Martine Munby	Director of Communications
Dr Esther Kiehl	Consultant Clinical Psychologist
Dr Liz Millward	Consultant Clinical Psychologist
Kim Russell	Head of Communications
Angela Wade (AW)	Director of Nursing
Matthew Sisto	Director of Patient Experience
Ivor Shanley	Member of the Public
Zoe Tidman	Member of the Public

SS welcomed Board members, Governors, members of the public and staff joining this in public Board meeting

The meeting commenced at 10:02

135/23 APOLOGIES FOR ABSENCE

Apologies were received from Stephen Heppell, Manny Lewis, Mateen Jiwani.

136/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

137/23 PRESENTATION – TRANSITION PSYCHOLOGY SERVICE

Dr Esther Kiehl, Consultant Clinical Psychologist and Dr Liz Millward, Consultant Clinical Psychologist joined the meeting to provide the Board with an overview of the transition psychology service, which had recently been shortlisted for a HSJ award from over 100 services.

The core work of the service was around supporting individuals who experience high levels of stigma within Mental Health system in a context of high complexity and both physical and mental disease burden. The team offer specialist trauma informed attachment focussed therapies such as EMDR and Sensorimotor psychotherapy.

The service was mainly for long term inpatient and community settings, but the team were also about to pilot a five session choose and book face to face consultation model for people who meet the criteria.

Most clients have multiple comorbidities that preclude them from accessing or have made them struggle to use other Personality Disorder services.

Generally the team follow five principles:

- **Assertive**: work hard to engage clients
- **Flexible**: patients can choose to see the team at own frequency that can change over the course of the treatment.
- **Holistic**: lots of 'bottom up' therapies, looking at body, senses, movement, often use play / visualisation and work in many different ways to engage and while look at the individual also look at the whole system including carers, family, GP etc
- **Reliable**: see people both in and out of hospital setting.
- **Intensive**

The team offered trauma informed services, looking at how all aspects are affected by trauma and how patients are affected by what may have happened to them and make sense of it. Understanding this may help to support service users. The main aim of the service was to improve quality of life and help people leave and stay out of hospital. Most clients in the year after they have been with the service have a reduction in inpatient day's year on year. Positive feedback had been received from service users, staff and trainees.

SS thanked EK and LW for this informative presentation, stating board members were very engaged with the direction of trauma informed therapy.

MK was supportive and appreciative of the service and approach, which fills the void some patients experience and it was no surprise this team were recently nominated for a HSJ award. MK noted the service was not available on all wards and would welcome this as a development. EK confirmed that a business case for this was currently in development.

PS queried whether if funding followed, the service could be scaled up or were there qualified people who we could attract. EK advised it was currently difficult to recruit to clinical psychologist roles, but was the size of the cohorts had increased in the last year, so was hopeful going forward. SS commented she was pleased in the increase and felt the Trust needed to be ready to attract the individuals when they qualify.

LL queried whether there was opportunity to introduce AI into this service. EK agreed that there was a place for online automated healthcare but not for those with high complexity and high risk. AG agreed there was a role for AI but as a tool in conjunction with services not a replacement.

AG noted most patients of this service had comorbidities, and queried whether there was more could be done to strengthen partnerships. LW agreed that this was an area that could be strengthened, they team work with physical health psychology services but it would be good to link with other services.

SS noted that there were some challenges, but also opportunities and thanked EK and LW for the informative presentation.

138/23 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 27 September 2023 were agreed as an accurate reflection of discussions held.

139/23 ACTION LOG AND MATTERS ARISING

The action log was reviewed and discussed, noting that there were no items currently due.

Matters Arising:

Workforce Race Equality Standards (WRES) / Workforce Disability Equality Standards (WDES)

It was noted final sign of WRES and WDES data had been delegated to the People, Equality and Culture Committee and was now presented to Board for formal receipt and noting. The data had been published on the Trust website on 30 October 2024 in line with timescales set nationally.

The Board discussed and approved the Action Log. The Board noted the final WDES / WRES action plans.

140/23 CHAIRS REPORT

SS presented the report highlighting the following:

- Two new Non-Executive Directors had been appointed (Diane Leacock and Jenny Raine), commencing in post in December 2023 and January 2024 respectively. SS looked forward to welcoming both in future public board meetings. SS thanked the Council of Governors for their support in the appointment process.
- A new substantive Executive Chief Nurse, Ann Sheridan had been appointed and was due to commence in post in February 2024.

The Board received and noted the Chair's Report.

141/23 CEO REPORT

The CEO report was taken in combination with Quality and Performance Scorecard.

PS highlighted the following:

- PS was delighted Ann Sheridan was joining the Trust as Executive Chief Nurse. This appointment continued to show that EPUT able to attract talent and want to drive change for the better.
- The Lampard Inquiry terms of reference were currently out to consultation. PS reiterated that the Trust would do everything we could to support the Inquiry and ensure families have the answers they need.
- Four services were recently shortlisted for HSJ awards, which demonstrated the changes being put in place are starting to be recognised outside of the local area.
- SS and PS had undertaken a number of service visits over recent weeks, which was a welcome opportunity to see services, changes and progress being made.
- The processes around Standard Operating Procedures (SOP's) and Electronic Patient Records (EPR) were both large transformation projects changing the way clinicians operate and how care is delivered.

EL commented she had recently undertaken a service visit to Rochford Hospital where she had heard first-hand about improved staffing levels, which was very positive and extended a huge congratulations to all. EL had also met staff who had previously left EPUT and then re-joined, who had stated that EPUT were an exceptional organisation and it was positive that ex-staff wished to return.

EL queried what are the main decisions taking place at system level that would help EPUT to provide better care. PS advised the biggest decision would be to support an EPR at system level. Prior to that would be the Southend, Essex and Thurrock (SET) strategy. PS added that there is a lot of work that goes on at system level that was not about decision making, such as discharge and commissioning mental health services. SS added in terms of physical health the community collaborative continued in Mid & South Essex with North East London Foundation Trust (NELFT) and Provide. A board meeting of the collaborative took place last week, with lots of work taking place and building momentum, the success of this work was very reliant on engagement with the system.

The Board received and noted the CEO Report.

141/23 QUALITY AND PERFORMANCE SCORECARD

PS presented the Quality and Performance Scorecard as part of the CEO Report, and asked Executive Directors for any key areas to highlight.

Operations – Alex Green

AG provided assurance that key areas of challenge and focus have oversight through care unit accountability framework meetings, with escalation to the Finance and Performance Committee.

In terms of flow and capacity, occupancy levels were currently reported at 97.9% in adult and 93.4% in older adults, with an improvement in average length of stay. There had been positive system involvement in managing constraint to discharge.

- In terms of flow and capacity, the occupancy rates had risen for adult and older adults services and there had been a small reduction in the average length of stay.
- Out of Area Placements had seen a reduction in terms of the number remaining in an out of area bed at month end, which is in-line with the internal reduction trajectory.
- 93% of Crisis 111 calls were answered within 60-seconds, which whilst below the target of 95% continued to steadily improve over the past six-months.
- Access rates for Therapy for You have improved in Mid & South Essex, but have fallen in North East Essex. The trajectory is expected to remain below target, but the upward trajectory over the past 12-months shows improvements are being made.
- The waiting times for the Lighthouse Children's Centre continued to be ahead of the national target to reduce wait times.
- There were challenges in delivering the 95% target for physical health reviews in Drug & Alcohol Services in North East Essex. There is a 12-week improvement plan in place, which will have oversight through the Accountability Framework.

People and Culture – Susan Young

- The work undertaken in relation to recruitment and retention was having an effect, with vacancy and turnover rates below 10%.
- The Trust had welcomed a number of newly qualified nurses who had now commenced preceptorship and this had increased from the same time in the previous year.

- There was a strong focus on Equality, Diversity & Inclusion at Board-level, which had been taken forward at a recent Board Seminar Session.
- A staff member who was part of the RISE Leadership programme for people from an ethnic minority background, had recently won a rising star in excellence in nursing award at the Zenith Global Health awards.
- The Trust launched work on health care assistant recruitment with an event held at The Lodge, hosted for the Mid & South Essex Integrated Care System. Good feedback had been received from the event.

Finance – Trevor Smith

- At the end of October (M7) the Trust recorded £307m operating costs against an income of £300m. Finance leads were working closely with region and system colleagues to bring back into financial balance.
- Capital investment, recorded £7.4m expenditure, with an aim to spend £19m by the end of the financial year
- Cash balance was positive with £56m invested.

Nursing – Frances Bolger

- There was a continued focus on reducing the number of falls, pressure ulcers and restrictive practice.
- The PSIRP has been launched and published on the Trust website; this is shown as an example to other systems moving to the approach.
- There had been lots of continued work on learning from incidents and visits from the CQC. An evidence assurance group had been established and actions had been tested with service users and ICB colleagues.

The Board of Directors received and noted the report.

142/23 COMMITTEE CHAIR'S REPORT

This report summarised assurance reports from the Board of Directors Standing Committees, which were crucial for governance and for the Board to be able to discharge responsibility appropriately.

It was noted that an escalation was highlighted from the Audit Committee regarding Charitable Funds Annual Accounts. It was noted that this had been fully addressed and was on the agenda today for endorsement by the Board of Directors.

The Board of Directors:

1. **Received and noted the contents of the report and the assurance provided.**

143/23 BOARD SAFETY OVERSIGHT GROUP ASSURANCE REPORT

SS advised that she continued to chair this Group on an interim basis. SS advised work continued at pace and it was important for the Group to have oversight of the work of the Executive element of the group.

The Board of Directors:

1. **Received and noted the contents of the report.**

144/23 CQC UPDATE

FB provided the following update:

- Following an unannounced inspection of Rawreth Court in September 2023, the Trust has received a final inspection report, which is published on the CQC website. The report identified a number of areas of good practice, but areas for improvement have also been identified, with two warning notices issued. An action plan is due to be submitted to the CQC on the 30 November 2023.
- The action plan following the core services inspection completed earlier in the year continues to be implemented with any slippage in timescales having recovery plans with trajectories. The slippages related to sub-actions, with the overarching actions remaining on track. There was a commitment to ensure changes where implemented, embedded and sustained, with work underway with ICB colleagues to ensure this was sustained.
- Two evidence assurance groups have been held, where local service leads take their evidence of changes made, learning and how evidence had been embedded. This was then tested by external colleagues to make sure they were embedded.
- Positive meetings were taking place with teams demonstrating where it had was recognised where systems and process could be improved, where they've made their changes and how they have been sustained.

DG advised the Trust was in the process of registering a new manager for Rawreth Court, with separate managers for Clifton Lodge to allow focussed senior oversight. DG emphasised the importance of local ownership of actions and that the peer support and ICB colleagues had been positively received.

LL asked how completion of action translates to quality and outcomes in practice. FB advised this was a work in progress, with a weekly task and finish group in place, focussing on how evidence is tested with services. The group includes ICB colleagues, ward managers and matrons. There was also work underway to develop Key Performance Indicators to capture improvements and quality control. This is combined with work around the quality assurance framework to look at how the assurance flows through the organisation and how data is analysed to drive quality improvement.

RH noted the disappointing outcomes of the inspection to Rawreth Court nursing home and asked whether it would be appropriate to bring someone into the organisation with knowledge in this area. DG agreed and work was underway to actively pursue links to get support for the nursing homes. The nursing homes were historically mental health wards that were re-purposed, so staff were also on a journey to change.

EL asked whether there was any assurance around the actions, which were not on track, in terms of ensuring these were closed. DG advised there was a weekly meeting to monitor progress and if actions were not on track, there was plan to recover the action. There were some risks in the plan, for example, pharmacy recruitment relies on individuals passing exams and the delivery of the Time to Care programme. DG advised as risks to progress emerge, these are discussed. PS advised overall progress was in track and this was reviewed by the Executive Team. There was also time being spent with teams to ensure changes as a result of the action plans were sustainable and metrics were in place to monitor. PS emphasised the important the Trust sees the delivery and outcome of the action plan.

SS commented she had seen the enthusiasm of staff and peer support leads and workers during a recent service visit. SS felt staff were coming together in delivering the improvements and it was important to ensure the strong leadership continued to ensure momentum was maintained.

The Board of Directors:

Signed: …… Date: ……

In the Chair

1. **Received and noted the contents of the report.**
2. **Noted the progress update on the improvement plan**
3. **Did not request any further information or action**

145/23 BOARD ASSURANCE FRAMEWORK 2023/24

DG presented the BAF which detailed high level strategic risks that the executive team believed were not managed and mitigated, could lead to non-delivery of strategic aims of the Trust. There had been no change in terms of risk score, although risk scores may begin to come down over the next few months as the new risk manager uses the "critical friend" approach.

There was one new strategic risk SR9 Digital and Data Strategy Risk, which had previously been incorporated been managed as part of an infrastructure risk. The Digital and Data Strategy had been presented to a previous public board which set out a programme of modernisation and transformation to support staff in providing the best possible care. It was recognised across the NHS digital and data was essential to health care delivery. This risk had been set out separately to give oversight as to how the Trust managed that risk.

LL commented on the strategic risks becoming implementation risks as the plans were delivered. The overall risk profile would reduce, but the implementation risk would increase, and it was important to monitor the connection as it was only on the completion of the implementation that the risk profile would dissipate.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Noted the addition of the new risk SR9 Digital and Data to the Strategic Risk Register**

146/23 END OF LIFE ANNUAL REPORT

FB presented the End of Live annual report which had been discussed and reviewed at the Quality Committee. The report covered the period July 2022 – September 2023. FB highlighted the following:

- The End of Life sub-committee continued to meet and oversee the implementation of the End of Life Framework, reporting into the Quality Committee.
- There was a new set of questions which captured patient feedback on I Want Great Care (IWGC) relating to End of Life Care.
- The Trust continued to participate in the National Audit of Care at the End of Life (NACEL), which had received positive results.
- The Trust has End of Life Care Champions with Rufus Helm identified as the Board-level NED champion.
- The Gold Standard Framework process has been established on Tower Ward, which has achieved accreditation.
- The report outlined End of Life Care framework for 2023 – 2024, and how this aligned to national ambitions.

EL asked what the most challenging area for the Trust, from all the areas of progress outlined in the report. FB felt do not attempt resuscitation (DNACPR) processes was likely the most challenging, as this was something many organisations struggled with, from a number of factors, including training, documentation etc. There had been attempts to develop a national framework and standard tool. MK commented he was happy to see I Want Great Care (IWGC) integrating into policies, seeing it becoming a core element of our services feedback.

SS highlighted previous CQC inspections had recognised end of life care as an outstanding service. FB agreed and noted there were always areas to improve when looking at end of life care, however there was a real passion to get it right by the people who work in those services. MK agreed with the assurance that leaders in this area are passionate and committed to providing the best possible care. FB agreed that there was a real passion for that service.

AG believed there were opportunities in terms of digitalisation of the end of life register and partnership approaches, with the right opportunities we can succeed on that journey.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Approved the report.**

147/23 LEARNING FROM DEATHS MORTALITY REVIEW - QUARTERLY

FB presented the report which had been discussed in depth at the Quality Committee. The report was part of the mandatory requirement to report mortality data quarterly, the report covers Q1 and provides learning from reviews and information regarding mortality and surveillance of death.

Q1 data was in line with previous quarters. There had been a change in scope of requirements, however when compared like-with-like was comparable to previous data. The report outlined number of areas of good practice as well as areas for improvements.

LL queried how learning was communicated across the organisation to embed in practice and how the impact was measured. FB advised that learning would be in all areas including documentation, training, policies or guidelines. Each ward has a folder, which captured learning and communicated via different means, including ward meetings, trust wide meetings, mandatory training etc. There was a system approach to testing learning and changing what we are doing to ensure learning is embedded and sustained. MK advised he had recently attended Patient Safety Incident Response Programme (PSIRP) training recently, which highlighted the use of technology, improvement in policies and strategies which contributed to sustained learning.

NL added that through potential changes to the Executive Safety Oversight Group, some of the thematic reviews could come back to Board, so it can see empirical evidence that learning is being embedded. ZT advised that a comprehensive report had previously been taken to board on year 2 of the Safety First Safety Always Strategy, with a year 3 report due in March 2024 picking up on themes including culture of learning. ZT noted that this was an important report that reflects work ongoing to ensure a rigorous and comprehensive evidence of progress and honest reflection on where there was further work to do.

EL asked whether the report list of deaths in scope were in line with the Lampard Inquiry. MK advised the scope was different, however discussions had taken place regarding expanding our scope to align with that of the Inquiry. While continuing to follow national guidance, as we move into the Inquiry there was an opportunity to look for alignment.

The Board of Directors:

1. **Received and noted the contents of the report.**

Action:

1. **Consider expanding the Learning from Deaths criteria to align with the Lampard Inquiry Terms of Reference. (FB)**

148/23 QUALITY OF CARE STRATEGY

FB advised that the Safety First, Safety Always Strategy was in its final year, with the Quality of Care strategy the next step in that journey. The strategy had been presented to and endorsed by both the Executive Team and Quality Committee. A short video was played which introduced the strategy, recognising the people approach to the development and the focus on engaging people who receive care from the Trust. The video demonstrated how many people had been listened to, to create the underpinning principles of the strategy. Within the document was an overarching plan for years 1, 2 and 3, as well as assurance of delivery of the quality of care strategy using quality principles.

ZT was happy to receive this strategy at board. ZT reflected when the Board of Directors endorsed the Trust's 5-year strategic plan, it was noted the Trust would involve people and families at the heart of everything we do, this strategy was an excellent example of that. ZT also reflected on the robustness of the strategy development process.

LL agreed that the effort to coproduce this strategy came through clearly. The document came across positively and the video helped reinforce the content. Within the NHS and as a service, there was a huge opportunity to utilise the asset available through the people we serve and this linked with the social impact strategy, as part of the overarching strategic objective of helping communities to thrive. LL congratulated all that had been involved, welcomed this important step and looked forward to receiving updates on how health is coproduced.

MK reflected the strategy brought three arms together: experience, safety and effectiveness, and welcomed this more integrated approach.

PS welcomed the strategy and the work from colleagues and patients. The strategy put people at heart of what we do. PS welcomed the robust governance process outlined in the strategy.

AW commented it had been a positive experience working with people in communities in the development of the strategy. AW felt the quality outcomes identified in the strategy could be delivered as these had been developed across professional groups. AW thanked the Board for the positive comments on the strategy and the recognition of the work undertaken.

SS took the opportunity on a recent visit to speak to staff about their views on the culture shift and overall feedback was very supportive and staff were excited at this new way of working.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Approved the content of the Quality of Care Strategy**

149/23 RESEARCH, INNOVATION AND COMMERCIAL STRATEGIES

MK presented a report providing three linked enabling strategies; Research, Innovation and Commercial. EPUT is a research active organisation and is involved in a range of research activities. This provided a platform for the next three years to launch the strategy and aspire to be a leading research and innovation organisation. There was a desire to co-design research with lived experience partners and in addition to meeting the national requirements, to see how this affects and improves the quality of care and clinical outcomes. There were eight key commitments including working with partners and education institutions to make EPUT a centre of excellence with a focus on research and innovation.

TS advised the commercial strategy worked alongside this, and set-out how commercial opportunities are to be maximised through partnership and collaboration. The strategy had been

considered at the Finance and Performance Committee and the strategy was supported by detailed action plans, results of which would flow through to accountability framework corporate meetings and into the Finance and Performance Committee.

AG reflected the links with the Quality of Care Strategy through the ambition to improve care and drive clinical outcomes through research. AG welcomed the inclusive approach and was pleased to see research activities coming through Care Unit accountability framework meetings.

LL endorsed the strategies noted the link to the Trust vision of being the best mental health and community care provider, with the research and commercial strategies being key enablers.

PS commented that investing in research and innovation created a safer organisation, which also helped attract the best people to the organisation. It also helped to develop solutions to delivering health care in the future, with the changing needs and demography. NL agreed the developments would help attract specialist individuals to the organisation. NL welcomed the ambition within the strategy, particularly the academic links identified.

LL reflected on the importance of ensuring there are mechanisms in place to monitor the implementation process. ZT advised the Director of Strategy was in the process of coordinating a risk summit to fully understand risks to individual enabling and overall strategies, which includes phasing implementation to ensure the strategies are not competing, but reinforcing each strategy. The outcome of this will be provided in the strategic impact report to Board.

TS added that strategies overall set out the Trust's ambitions and the annual operating plan to set out the detailed prioritisation and resource. PS agreed that strategies set the direction for everyone contributing to EPUT.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Approved the Research, Innovation and Commercial Strategies as key enablers to the Trust's five-year strategic plan.**

150/23 WORKING IN PARTNERSHIP WITH PEOPLE AND COMMUNITIES STRATEGY

ZT presented the report recognising the work of the Patient Experience Team, including the co-production conference with over 200 in attendance, which illustrated the approach taken to work in partnership with people and communities. The strategy links with the Quality of Care Strategy, specifically the experience section of the strategy in that the emphasis is on involving people in the design, delivery and influence of services. The strategy had been coproduced with people with lived experience and our staff, and had been presented to and endorsed by the executive team and PECC.

LL supported the strategy overall, but queried the high level of the success measures and wondered if progress and impact could be measured. ZT welcomed the feedback and advised the strategy set out in broad terms, with the detailed key performance indicators developed to ensure adequate assurance is provided.

SS commented it was important to note the collaboration, which came through clearly in the document.

AG reflected there had been a connection through agenda items at today's meeting in terms of trauma informed care, reiterating the Trust's commitment to strengthen our approach of which this will play a vital part.

SS extended thanks to Mark Dale who had been hugely supportive and ambassadorial in terms of driving this forward, and acknowledged that the patient experience team and lived experience ambassadors were finalists in care awards; this was further recognition that the trust was working to coproduce and ensure the voice of the service user was heard.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Approved the strategy to move forward into delivery.**

151/23 MEMBERSHIP STRATEGY

DG presented the Membership Strategy for approval and noted the work undertaken by CJ, in collaboration with the Council of Governors Membership Committee in its development. DG advised the Membership Strategy underpinned the statutory requirement of hearing the views of Trust membership.

There were three priorities within the strategy:

- Build membership base, get more people engaged and ensure is representative of our communities.
- Build ability to put COG in the right environments to hear views of membership and wider public to represent those views to inform future plans going forward.
- Hearing the public voice and recognise membership of the system.

ZT commented he had seen the Membership Strategy presented alongside the Working in Partnership Strategy at a recent Your Voice meeting, which demonstrated the links between the strategies. ZT felt membership was crucial to working with communities and welcomed the first priority regarding establishing membership representative of the population served by the Trust.

SY queried the rationale of staff membership only open to staff members with a permanent contract or fixed-term contract of over 12-months. DG advised this was part of the constitution, however, it should be noted the role of the Staff Governor is to hear the views of all staff, including temporary staff.

SS acknowledged the significant work that had gone in to this strategy and time spent in strategy sessions and socialisation through Your Voice meetings which had been well received.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Approved the membership strategy.**

152/23 CHARTIABLE FUNDS ANNUAL REPORT AND ACCOUNTS 2022/23

TS presented the annual report and accounts which had been considered by the Audit Committee. TS confirmed that two changes requested by the Committee around trustee for charity and investment assets had been made in the final document. On that basis is the annual report and accounts were recommended to Board for approval.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Approved the final Charity Annual Report and Accounts for 2022/23**
3. **Approved the Letter of Representation for signing by the Chair of the Audit Committee and Executive Chief Finance Officer.**

4. **Approved the going concern concept as the basis of accounts preparation to the Board of Directors.**

153/23	EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) NATIONAL CORE STANDARDS RETURN 2023

NL presented the annual self-assessment which had been through a check and challenge process. The Trust were reporting substantially compliant with 96.5% compared to 90% last year.

EL asked, when analysing the EPRR, how this adequately covered the exposure to cyber threats. NL advised there was awareness of cyber threats in the EPRR strategy and a number of exercises had been undertaken by the Trust. The Trust also has a Digital Security Team, which remains up to date with national alerts to ensure patches are implemented with national guidance.

DG advised there were fundamental principles around business continuity in this scenario. ZT advised there were business continuity plans in place and learning from incidents would inform changes to these as required.

The Board of Directors:

1. **Received and noted the contents of the report.**

154/23	SAFE WORKING OF JUNIOR DOCTORS QUARTERLY REPORT

MK presented the quarterly report advising there were four exception reports raised by trainees between July 2023 and September 2023. The gaps in the rota were slightly higher than the last quarter, but the number fo posts had increased. Junior Doctors participated in the industrial action in July, August and September, with hours covered by internal locums.

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

155/23	COUNCIL OF GOVERNORS RELATIONSHIP WITH THE BOARD OF DIRECTORS POLICY AND PROCEDURE

DG advised a review had been undertaken with the Council of Governors. The policy and procedure sets-out how the Board of Directors supports the Council of Governors undertaken its statutory duties and the mechanisms for resolving any disputes between the governing bodies. The policy and procedure had been updated in line with the new code of governance. The policy and procedure had been approved by the Council of Governors on 24 August 2023.

The Board of Directors:

- **Received and noted the contents of the report.**
- **Approved the reviewed Policy and Procedure**

156/23	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.

157/23	REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

SS asked LL to lead on the reflection on equality as a result of decisions and discussions.

Signed: …… Date: ……

LL highlighted the diverse society and the importance of ensuring needs are met, through outreach and engagement. The strategies presented today worked together and demonstrated the engagement and coproduction to help respond to the challenges within EPUT.

LL highlighted the success of the strategies provided an opportunity to utilise the human assets and talent in the organisation to improve services and shape services required by the community.

AG reflected on the content of the Transition Psychology Service presentation, which reflected people facing stigma due to life experience and mental health issues.

AG agreed that much of that was evident in our transition psychology service presentation, with people facing stigma because of life experience and mental health issues.

SS commented that the End of Life report also exemplified that reach out and inclusivity. FB stated inclusivity was present in every report strongly today, with that ambition and desire to include people in everything we do clear and evident.

158/23 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

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

159/23 ANY OTHER BUSINESS

There was no other business.

160/23 DATE AND TIME OF NEXT MEETING

SS thanked all for joining the meeting.

The next meeting of the Board of Directors is to be held on Wednesday 31 January 2024.

161/23 QUESTION THE DIRECTORS SESSION

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

The meeting closed at 13:07

Signed: …… Date: ……

In the Chair

Appendix 1: Governors / Public / Members Query Tracker (Item 161/23)

Governor / Member of the Public	Query	Response
John Jones, Lead Governor	Notice that under audit report there were 12 contracts which were waived from being subject to competitive quotations in September and October. This seems to be fairly high figure. Also note that healthcare service regulations 2023 require relevant authorities which precludes FTs to operate under a procurement regime, are these two facts in conflict with each other?	Waivers were considered and reported each month in the Executive Team, identifying those that are retrospective and those that are not, this was also picked up at Audit Committee. Over a period of time there had been a reduction in waivers and significant work had taken place promoting good procurement practices. There were times in matters of urgency or continuity of service provider where waivers were required, but these were subject to significant scrutiny at Executive and sub-committee level. The Audit Committee had sought additional information to understand what drives the necessity to waive the tenders. There was a national direction to reduce the number of frameworks organisations were using and the Trust were taking this as part of planning.
	The agenda for the meeting today did not contain any reports from the ICB, is there any plans to have these as items in the future.	The ICB Board records are in the public domain and would not be repeated at another public meeting. There are members of the Board who were members of committees beyond the scope of EPUT and any relevant information is fed through the relevant Standing Committee and onto Board within relevant reports. It should also be noted there are a number of other committees, groups, organisations etc. in

Signed: …… Date: ……

In the Chair

Governor / Member of the Public	Query	Response
		which the works and any relevant information is fed through internal systems and through relevant strategies (e.g. the Southend, Essex and Thurrock (SET) Strategy)
	The Commercial Strategy refers to progressing towards more collaborative working, how will the effectiveness of the strategy be measured and adjusted over time?	The Trust would be setting out annual plans and targets which will be reflected in the operational plan which the Board signs off in March. Specific actions associated with performance against those actions would be monitored by commercial and finance teams as part of corporate accountability framework meetings.
Ivor Shanley, Member of the Public	Beneficial to observe and beneficial for colleagues to also see this, effective work going on and more noise should be made about it. there is a clear appetite for change and dynamic approach and should filter down further.	Thank you for reflection.

Signed: …… Date: ……

In the Chair

4. ACTION LOG / MATTERS ARISING

Standing item | Professor Sheila Salmon | 1 minute

REFERENCES

Only PDFs are attached

Part 1 - Action Log 31.01.2024.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting Action Log

Lead	Initials	Lead	Initials	Lead	Initials
Nigel Leonard	NL	Susan Young	SY		
Marcus Riddell	MR	Frances Bolger	FB		

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	Progress	Status	RAG
147/23 November	Consider expanding the Learning from Deaths criteria to align with the Lampard Inquiry Terms of Reference.	FB	~~January 2024~~ March 2024	Initial scope between draft ToR and current scope for Learning from Deaths review undertaken. Differences between two documents are deaths up to 3 months following discharge (current scope is 30 days), those who died while awaiting an assessment under the Mental Health Act or while waiting for a bed in a mental health inpatient unit following a clinical assessment of need and those who died following any mental health assessment provided by a relevant Trust where the decision was not to admit as an inpatient (this includes but is not limited to any death following a review in A&E, or an assessment under section 135 and 136 of the Mental Health Act).	Open	

Minutes Ref	Action	By Who	By When	Progress	Status	RAG
				Data for the period Oct – Dec 2023 is being obtained in order to compare current scope with scope of Inquiry ToR to understand potential impact on Learning from Deaths process. A Meeting with Medical Director and Medical Lead for Learning from Deaths has been organised. It is proposed this action remains open until the final terms of reference for the inquiry is received.		
093/23 July	Provide a further update to the Board regarding relevant recommendations from the Rapid Review into Data on Mental Health Inpatient Settings.	NL	~~January 2024~~ March 2024	This will be presented to the People, Equality & Culture Committee (PECC) in Feb '24 for scrutiny prior to presentation to the Board. Request extension until March 2024 to allow this to happen.	Open	
057/23 May	Referring to the Staff Survey -to consider process for linking with and learning from outstanding organisations.	~~SY~~ MR	~~September 2023~~ January 2024	This has been included as part of the People & Education Strategy which is to be presented to the Board of Directors in January 2024.	Closed	

5. CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

Standing item | Professor Sheila Salmon | 5 minutes

REFERENCES

Only PDFs are attached

Chair's Report 31.01.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31 January 2024

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

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Finance and Resources Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Statutory Public Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital	✓
Does this report mitigate the Strategic risk(s)?	~~Yes/~~ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes/~~ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Board of Directors with a summary of key headlines and shares information on governance developments within the Trust.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

Summary of Key Issues

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Chair's Report

Lead
Professor Sheila Salmon **Chair**

Board of Directors Part 1
31 January 2024

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Changes to the Board of Directors

I am delighted to welcome Diane Leacock and Jenny Raine to the Board of Directors following their recent appointment to Non-Executive Director positions at the Trust. Both Diane and Jenny have been undertaking an induction programme since joining us in December 2023 and January 2024 respectively. They are looking forward to visiting more services across the Trust.

Frances Bolger will be leaving the Board of Directors in February following the appointment of Ann Sheridan to the role of Executive Nurse. On behalf of the Board, I would like to extend our sincerest thanks to Frances for her commitment and leadership during her time at EPUT.

Marcus Riddell has been appointed as Interim Executive Chief People Officer following the conclusion of the fixed term contract held by Susan Young in that position. I warmly express our sincerest thanks to Susan for her contribution and leadership over the past few months, and welcome Marcus to this interim position whilst the recruitment process for the substantive Executive Chief People Officer continues.

2.2 Recruitment Event in Harlow

I was delighted to hear of the successful NHS career showcase and recruitment event that recently took place in Harlow. This was a joint event organised by EPUT, Princess Alexandra Hospital NHS Trust and Harlow College. Staff from both NHS Trusts were available throughout the day to talk about working for the Trusts and give information on roles available in the NHS. The event also included workshops for those attending on how to make job applications stand out and how to prepare for interviews, with staff from Harlow College and Job Centre Plus in attendance. Congratulations to all involved for arranging this successful and worthwhile event.

2.3 MP Engagement

I was pleased to join Paul Scott and members of the Executive Team recently at a 'Drop In' session for our local MPs in Westminster. We are committed to engaging proactively with the MPs whose constituencies are served by EPUT, with plans for further briefing sessions underway as well as the regular newsletter which shares a roundup of news from across the Trust. The Trust has also recently welcomed visits to services from local MPs including the recent visit from the Home Secretary, the Right Honourable James Cleverly MP, to the Gables in Brentwood, where he heard about the range of services we run in Braintree and the local area, with opportunity for discussion with staff.

2.4 By Your Side – Maternal Mental Health Service

The Trust's "By Your Side" maternal mental health service has expanded to support more women who have experienced a perinatal loss. The specialist maternal mental health service, provided in collaboration with midwifery colleagues, is the first of its kind in Essex and supports those who experience mental health difficulties as a result of miscarriage, still birth, neonatal death or planned termination. "By Your Side" launched across south west Essex during Baby Loss Awareness Week in October 2023. On 8 January the service expanded to accept referrals for patients living in south east Essex.

2.5 Quality and Excellence Awards

Nominations for our annual Quality and Excellence Awards have been announced. This year we received more than 270 worthy nominations of colleagues, volunteers and partners who go the extra mile to support the delivery of high quality patient care.

3.0 LEGAL AND POLICY UPDATE

3.1 The Provider Selection Regime – some Governance Implications

The Health Care Services Regulations 2023 ("PSR Regulations") will come into force on 1 January 2024. "Relevant Authorities" (which includes ICBs and NHS Trusts/Foundation Trusts, NHS England, local and combined authorities) need to take steps to prepare for the regime for procuring relevant health care services in England.

For Information: **The Health Care Services Regulations 2023 - Hempsons**

3.2 New procurement threshold

The recent PPN 11/23 on the new thresholds reminds us that while contract values are taken inclusive of VAT for the purposes of assessing whether the thresholds are met, the contract values inputted into Contract Notices and Contract Award Notices should continue to be stated exclusive of VAT from 1 January 2024

For Information: **Procurement change to thresholds - Mills-Reeve**

3.3 Junior doctor strikes could cause significant impact to patients and services

Matthew Taylor warned that the strikes could further jeopardise efforts to recover services and tackle waiting lists.

For Information: **Strike action impact - NHS - Confederation**

3.4 Covid-19 Inquiry: Module 6 (Care Sector) opens

Module 6 opened on 12 December 2023 and will investigate the impact of the pandemic on the publicly and privately funded adult social care sector in England, Scotland, Wales and Northern Ireland.

On opening Module 6, the Inquiry confirmed that it will consider the consequences of government decision-making, including the restrictions that were imposed on those living and working within the care sector. It will also consider decisions concerning capacity in hospitals and residents in adult care and residential homes. The steps taken in adult care and residential homes to prevent the spread of Covid-19 and examine the capacity of the adult care sector to respond to the pandemic with be considered. More details are included in the provisional scope for Module 6, which is published on the Inquiry website.

For Information: **Covid-19 Inquiry, Care Sector opens - Hempsons**

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Standing item | Paul Scott | 15 minutes

REFERENCES

Only PDFs are attached

CEO Report 31.01.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31 January 2024

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

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Finance and Resources Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Statutory Public Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital	✓
Does this report mitigate the Strategic risk(s)?	~~Yes/~~ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes/~~ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

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

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

Summary of Key Issues

The report attached provides information on behalf of the CEO and Executive Team in respect of performance, strategic developments and operational initiatives.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Chief Executive Officer Report

Lead
Paul Scott **Chief Executive Officer**

Board of Directors Part 1
31 January 2024

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 Visit from Home Secretary James Cleverley

I was delighted to welcome Home Secretary and MP for Braintree, James Cleverly on a visit to the Trust recently. Mr Cleverly visited The Gables in Braintree where he heard about the range of services we run in Braintree and the local area. Mr Cleverly's visit also coincided with NHS England's announcement on the 9 January 2024 of further enhancements to Op COURAGE, the NHS's dedicated support service for armed forces veterans, their families and loved ones. EPUT delivers the Op COURAGE service in partnership with other organisations across the east of England.

Mr Cleverly is an Army Reservist, and our Armed Forces Champion David Powell was able to brief him about Op COURAGE, the services offered and how it is helping veterans manage their wellbeing, both when they leave the Forces and in the months and years after. Thank you to everyone who was involved in making the visit a success.

1.2 Engagement with Local MPs

As part of our continuing commitment for more engagement with local MPs, the Chair, myself and members of the Executive Team recently held a 'drop in' session in Westminster. This session gave the opportunity to discuss any concerns or issues that MPs may wish to raise and to showcase some of the outstanding work that is taking place across the Trust. A regular newsletter circulated with a roundup of the latest news from the Trust.

1.3 Sexual Safety

Staff and patient safety, including sexual safety, remains a high priority for the Trust. The Trust will be hosting a sexual safety conference in February; the conference will be an opportunity to hear from renowned guest speakers and learn about what we are doing to enhance safety across the Trust, as well as take part in a series of workshops led by EPUT staff and partners focussing on safety.

1.4 Industrial Action

There have been two recent periods of industrial action by Junior Doctors from 22 – 23 December 2023 and 3 - 9 January 2024. Industrial action is pro-actively managed through the Trust's emergency preparedness, resilience and response process. There have been no matters arising during industrial action, which have required regional or national escalation, after action reviews have been undertaken after each period of industrial action.

The BMA currently has a mandate for strike action with Junior Doctors until 29 February 2024, which the BMA has announced it will may seek to extend. Following ballots (closed on 18 December 2023), Consultants and Speciality (SAS) Doctors have a mandate for strike action until 17 June 2024.

On 14 December 2023 the BMA Consultants Committee formally put forward a pay offer to Consultants made by the Government on 27 November 2023. The pay offer was for 4.59% investment in pay for this financial year, in addition to the 6% pay uplift already awarded. Consultants narrowly rejected the pay offer on 25 January.

1.5 Changes to Executive Team

As reported at the last Board of Directors meeting, Ann Sheridan has been appointed as Executive Chief Nurse and will join the Trust in February; we look forward to Ann joining future Board of Directors meetings. I would also like to take the opportunity to thank Frances Bolger for her leadership and contribution to the Trust and the Executive Team as Interim Nurse over the past few months. On behalf of the Board, I wish her every success in the future.

With regards to the Executive Chief People Officer role, I can advise that Marcus Riddell has been appointed as Interim Chief People Officer following the conclusion of the fixed term contract for this role held by Susan Young. Sincere thanks to Susan for her leadership during that period, with very best wishes for future endeavours. The recruitment for the substantive Executive Chief People Officer continues, with some interesting and exciting candidates. Further updates will be provided in due course.

1.6 HOSC

Alex Green and I attended a meeting of Thurrock Council's Health and Wellbeing Overview and Scrutiny meeting on 11 January, along with our Partnership Director for community services in Thurrock. This was a routine attendance as part of our programme of working with local authority overview and scrutiny functions. We updated the Committee on progress and key issues since our last attendance at Thurrock a year ago. Committee members welcomed the information provided and were pleased to hear of the progress the Trust has made in key areas of patient safety, experience of care and staffing levels.

2. PERFORMANCE AND OPERATIONAL ISSUES

2.1. Operations – Alex Green, Executive Chief Operating Officer

- Crisis 111 service exceeded the 95% performance target answering 96% of calls within timescale. This is the first time the service has achieved target since its implementation, with 4,829 calls received within the month.

- Wheelchair Services urgent access assessment delivered significantly improved performance from 86.5% to 94%, which represented one breach in assessment wait time.

- Small reduction in average length of stay for adult mental health services with an increase in older adult inpatient services, driven largely by delays in accessing supported accommodation or care home placement.

- Increase in the number of people placed inappropriately in out of area beds at the end of January, driven by challenges including system impact of industrial action. Additional controls in place to mitigate the risk of further deterioration against our internal trajectory.

- Challenges meeting the first to second appointment waits for Children's Speech and Language Therapy with 59 of 78 patients seen within timescale. Local mitigations in place to manage vacancies and successful recruitment within the month and further interviews taking place.

- Reduction in Therapy For You access rates, particularly in Castle Point and Rochford and North East Essex. There is evidence to support this being a seasonal drop and in line with previous years. Limbic technology continues to impact positively, with 260 referrals received through the system in month.

2.2. Workforce – Marcus Riddell, Interim Chief People Officer

- Good progress continues on recruitment and retention, with the vacancy rate at 8.7% and turnover at 9.3%.

- Agency usage is trending downwards generally, although expenditure remains higher than we would like. A Temporary Staffing Task And Finish Group has now been established to take forward actions to drive reductions in use and spend, including strengthening the approvals process. Furthermore, we have introduced Establishment Control Panel to ensure that investment in staffing is both supporting the trusts objectives and improving our financial position.

2.3. Finance – Trevor Smith, Chief Finance and Resources Officer

- Year to Date (M9) revenue deficit £12m with capital investment totalling £10.6m slightly ahead of plan.

- Continued focus on internal controls, efficiencies and operational, workforce and financial planning for 24/25. Operational planning groups in place, internal budget setting underway and contractual discussions with Commissioners commenced.

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

Discussion Item | Paul Scott | 5 minutes

REFERENCES

Only PDFs are attached

Quality Performance Scorecard 31.01.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31st January 2024

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

Risk Assessment of Report		
Summary of risks highlighted in this report	All inadequate and requiring improvement indicators.	
State which of the following Strategic risk(s) this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	Continued monitoring of Trust performance through integrated quality and performance reports.	

Full Report
To view the EPUT Quality & Performance Board Report (Power BI dashboard) click **HERE**.

Purpose of the Report		
This report provides the Board of Directors • The Board of Directors report present a high level summary of performance against quality priorities, safer staffing levels, and NHSI key operational performance metrics. • The report is 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

This report to Board provides an interactive and detailed summary of performance across the Trust. It incorporates items from the NHS System Oversight Framework, Safer Staffing, and CQC.
Each Key Performance Indicator (KPI) can be selected and viewed alongside trend analysis and informative narrative.

Within performance for December there were 31 KPIs achieving targets and therefore RAG rated Green, there were 0 KPIs requiring improvement and therefore RAG rated Amber, and there were 16 KPIs unable to achieve targets and therefore RAG rated Red. A further 3 do not currently hold targets, and are RAG rated pink.

Of these KPIs highlighted to Board, the following were escalated through the Trust's Committees most recently:

Mental Health Inpatient Capacity -
Overall, throughout December inpatient capacity is reporting an improved position. Occupancy across all areas has reduced, as well as delays for those clinically ready for discharge, and with the exception of older adults; average length of stay has reduced.
Adult bed occupancy reduced to 95%, the lowest seen since June 2023. PICU bed occupancy remains low whilst the Hadleigh unit takes new admissions following it's reopening in late November. Bed occupancy within older adult services remains high at 93.5%, however this is an improved position from 94.8% in November.

Adult average length of stay both with and without the assessment units reduced in December, following a spike in November. Performance reduced to 57 days excluding the assessment units, and 40 days including the assessment units. These do remain outside the <35 day benchmark however are both reduced from the same period in 2022. PICU average length of stay remains consistent at 21 days, within the target of <50. Older adult length of stay rose to 110 days (<74 target) in December, and this continues the trend of higher lengths of stay seen since March 2023. Of the 33 older adult discharges in the month, 23 of them were long stays (over 60 days).

The proportion of bed days for those patients who are clinically ready for discharge remains very low and all areas are within targets. Adult services witnessed a rate of 0.6% in December, and older adult services reported 2.5%. Both PICU and specialist services report no patients clinically ready for discharge.

Inappropriate Out of Area Placements –
In December the number of patients in a bed at month end increased, as well as the number newly placed in an out of area bed during the month. There were 30 new clients placed OOA (25 Adult and five PICU) in December, and a total of 34 (30 adult and 3 PICU) remained in an ooa bed at month end.
There were 21 repatriations during the month (18 Adult & three PICU).
These placements resulted in 902 occupied bed days in December (excluding Danbury & Cygnet), this is an increase on the number of OOA placement bed days reported in November.
Operational decisions are made to repatriate people early in the day with recognition that further OOA admissions may or may not be needed later in the day. Sit rep calls remain in place to continuously monitor, plan, and mitigate bed capacity shortages.

Therapy for You (IAPT) –
During December access rates across all three areas reduced, however this is consistent with previous years and suggest a seasonal drop in access rates.
Castle Point and Rochford reduced to 294 against a target of >306, the lowest seen since December 2022. Southend reduced to 358 which is almost in line with the <374 target. North East Essex reduced significantly to 492, against a much higher target of >844. This is the lowest access intake seen since reporting began for NEE.
These targets increase every quarter, therefore from January the services will be expected to attain a higher access rate than previously set.

Limbic continues to have a positive impact with 260 referrals received in month via that route. This takes the total to 4,117 referrals received via Limbic since its launch in December 2022.

CQC Action Plans –
The CQC action plan has been developed in line with new trust process which focused on engagement, sustainability and ownership of actions developed.
Work has been undertaken to bring together core CQC and other related plans into one document to ensure consistency of delivery, avoidance of duplication and consistent assurance routes.
Oversight of the improvement plan is through a newly formed CQC Action Leads Meeting, which reports to the Executive Operational Committee on a monthly basis.

The Trust is currently in the 'Action Plan Delivery' phase of the CQC Action Plan Process and this is scheduled to run through until March 2024. As of the 14th December 2023, there were:

- 32 Must do action complete in total (45%) (4 (6%) being agreed for closure through the Evidence Assurance Group)
- 226 sub-actions complete (11 (3%) being agreed for closure through the Evidence Assurance Group)
- 6 sub-actions are off plan

Financial Summary
Income and Expenditure
M9 results are YTD deficit £12m. This includes pay overspends in Inpatient areas associated with acuity, observations, capacity and the impact of industrial action. The Trust continues to apply internal and external mitigations and support to improve this position.
Efficiency programme
The 23/24 financial plan includes £22.9m of efficiencies equivalent to 4.4% of operating spend. The M9 position is delivery of £14m against the plan of £15.8m, £1.9m behind plan. Additional work has identified opportunities with EPUT and joint opportunities with System partners.
Temporary Staffing Costs
Total temporary staffing spend in the month was £7.0m; bank spend £4.5m and agency spend £2.6m. The increased deployment of International Recruitment nurses and increased financial controls will support the reduction in temporary staffing costs. The Trust has introduced a vacancy control panels and enhanced controls on temporary staffing expenditure.
Maximising Capital Resources
The Trust has incurred capital expenditure of £10.6m at M9. The overall forecast of £23.8m is higher than plan reflecting impact of IFRS16 inflationary uplifts. Mitigations for the impact of IFRS16 are being discussed with Regional and System colleagues.
Positive Cash Balance
The cash balance as at end of M9 is £48.4m, behind plan by £7.2m, which includes the impact of the deficit.

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

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

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

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

Acronyms/Terms Used in the Report			
ALOS	Average Length Of Stay	FRT	First Response Team
AWoL	Absent without Leave	FTE	Full Time Equivalent
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies
CHS	Community Health Services	MHSDS	Mental Health Services Data Set
CPA	Care Programme Approach	NHSI	NHS improvement
CQC	Care Quality Commission	OBD	Occupied Bed days
CRHT	Crisis Resolution Home Treatment Team	OT	Outturn

Supporting Documents and/or Further Reading
EPUT Quality & Performance Board Report **HERE**.

Lead
Paul Scott **Chief Executive Officer**

7.2 COMMITTEE CHAIRS REPORT

Decision Item | Chairs of Standing Committees | 5 minutes

REFERENCES

Only PDFs are attached

Committee Chairs Report 31.01.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31 January 2024

Report Title:	**Committee Chairs Report**					
Executive/ Non-Executive Lead:	Chairs of Board of Director Standing Committees					
Report Author(s):	Chairs of Board of Director Standing Committees					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital	✓
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report provides a summary of key assurance and issues identified by the Board of Director Standing Committees.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the report and assurance provided.
2 Provide feedback for any identified issues for escalation.

Summary of Key Issues

The Board of Directors regularly delegates authority to the Standing Committees in line with Trust Governance documents (SoRD, SFI's etc). Standing Committees are expected to provide regular reports to the Board of Directors, providing assurance on the key items discussed and any progress made to resolve identified issues.

Each Board meeting, Chairs of Standing Committees will provide details of meetings held and:

- Any key assurance to be provided to the Board
- Any issues identified for noting where the Standing Committee is taking action (Alerts)
- Any issues / hotspots for escalation to the Board for further action (Escalation)
- Any issues previously identified which have now been resolved, including the identification of lessons learnt.

The attached report provides updates in relation to the following Standing Committees:

- Quality Committee (Dr Rufus Helm)
- Finance & Performance Committee (Loy Lobo)
- Charitable Funds Committee (Dr Mateen Jiwani)

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

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

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

Lead
Dr Rufus Helm, Chair of Quality Committee Loy Lobo, Chair of Finance & Performance Committee Dr Mateen Jiwani, Chair of Charitable Funds Committee

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Committee Chairs Report

Board of Directors Part 1

January 2024

EPUT

1. INTRODUCTION

Purpose of the report

The Board of Directors regularly delegates authority to standing committees of the Board in line with the Trust's governance arrangements (SoRD, SFI's, etc.)

Standing committees provide regular reports to the Board of Directors, providing assurance on the key items discussed and any progress made to resolve any identified issues.

For each Board meeting, the Chairs of standing committees will provide details of meetings held and report:

- **Assurances** - Any key assurances to be provided to the Board
- **Alerts** - Any issues / hotspots for escalation to the Board
- **Action** - Any issues identified for noting where the standing committee is requesting or taking action
- **Information** – Any issues previously identified which have now been resolved, including the identification of lessons learned

2. QUALITY COMMITTEE

Chair of the Committee: Rufus Helm (Non-Executive Director)

Committee meeting held: 14 December 2023 & 11 January 2024

Assurance

Quality Performance Report - Quality & Safety Dashboard data was reviewed by Committee members. The Committee was updated in the progress of aligning key performance indicators to committees and new reporting to be available soon.

Rawreth Court - The Trust had received a final CQC report for the inspection of Rawreth Court in September 2023, and has subsequently submitted an Improvement Plan and also submitted evidence in support of our actions taken in response to the warning notice. There has been a system Quality Visit to the nursing home which had been positive.

Suicide Prevention Strategy & Implementation Plan Annual Report 2023 – received a report detailing key developments, with the developing Suicide Prevention Framework being a priority area within the new Quality of Care Strategy for 2024/25 with an appointed lead. Also report on the enhanced focus on autism spectrum disorders and suicide risk, and links with other public services; with good update of the Oliver McGowan training.

IPC Board Assurance Framework – Received the report detailing areas of compliance and areas where improvement is ongoing. The Director of Infection Prevention and Control provided updates in all key areas.

Patient Safety Incidents Response Framework (PSIRF) - an update on PSIRF activity during July-October 2023 noting learning themes which had been identified and would be taken forward in improvement work.

Board Assurance Framework (BAF) - Good to see the EPUT Lessons Identified Management System now being live (following testing) and when fully embedded to enhance our capabilities in this area. Another key development is the roll out of Safewards following wards receiving training which would be a good focus for conversation when visiting ward areas. And, the recruitment progress within the Pharmacy Team being increasing established and that the business continuity plan was now scaled back.

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QUALITY COMMITTEE

Chair of the Committee: Rufus Helm (Non-Executive Director)

Committee meeting held: 14 December 2023 & 11 January 2024

Information

Complaints Process Evaluation Redesign - An evaluation of the redesign of the new Complaints Process was received, and Committee Members agreed that this demonstrated significant improvements compared to the previous year.

CQC Compliance Update

- Received an update on progress (this is presented to Board as a full agenda item).

Action

- The Committee received a Learning from Deaths Review of Learning and Data report for Quarter 2 which is presented to the Board as a full agenda item.
- The Committee was interested in understanding bed occupancy at the Trust. Noting that patient flow was a key focus for the Finance and Performance Committee it asks that the committee reviews as part of its performance oversight. (Action: Chair of Finance and Performance Committee)
- For the Board to consider holding a Seminar session on ligature risk reduction.

Alert

There are no new Alerts for the Board of Directors.

3. FINANCE & PERFORMANCE COMMITTEE

Chair of the Committee: Loy Lobo (Non-Executive Director)

Committee meeting held: 25 January 2024

Assurance

Quality & Performance - Performance topics were presented by the Executive Chief Operating Officer who noted improved positions for 111 crisis calls answered within 60 seconds and wheelchair assessments. Areas of challenge were noted for Children's Speech and Language therapy, but the Executive Chief Operating Officer provided assurance that the MSE Community Collaborative is focused on this and it will be picked up with partners to further strengthen the service.

A seasonal drop in Therapy for You access rates was discussed as well as an upcoming increase in targets for Q4, but positive results from Limbic Access continue to be seen.
The Director of Operational Performance attended to present the recent challenges and mitigations being worked through for mental health inpatient capacity. This discussion noted the improvements in length of stay and occupancy, and the increase in out of area placements. Contributing factors to the increase in out of area placements were noted with two periods of industrial action, the festive season pressures, and system level delays. To mitigate, ward MDT and discharge processes have been aligned, SOAC groups are taking place, as well as NHS Discharge Executive and MADE events. Teams are focused on length of stay and clinical reviews, identifying patients fit for discharge and setting estimated discharge dates.

Finance Month 9 - The Director of Finance attended to present the Month 9 financial position, noting the Trust's year to date revenue is at a £12m deficit, £10.2m adverse to plan.
The YTD Capital position is £10.6m, £0.6m above YTD plan.

Cyber & Information Governance Assurance Report - The Executive Director of Strategy, Transformation & Digital reported on progress and assurance. The assurances provided highlighted no concerns.

BAF Risk Summaries – Received and reviewed the BAF risks aligned to the committee which provided a good sense of what was happening within each risk, and how some actions impact or contribute to other risks too.

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FINANCE & PERFORMANCE COMMITTEE

Chair of the Committee: Loy Lobo (Non-Executive Director)

Committee meeting held: 25 January 2024

Assurance (cont'd)

Strategic Impact Report
To ensure oversight of strategic progress, the Strategic Impact report is produced three times a year for Board, which each report focusing on three different care units. In addition, the report provided an update on planning progress. Members noted the report and its contents.

Information

No items this month.

Action

Strategic Impact Report - Received the Strategic Impact report which focused on three different care units. In addition, the report provided an update on planning progress. Members noted the report and its contents. The Board will receive this report as a full agenda item at the Board meeting in January.

Alert

No alerts for the Board of Directors this month.

4. CHARITABLE FUNDS COMMITTEE

Chair of the Committee: Dr Mateen Jiwani (Non-Executive Director)

Committee meeting held: 1 November 2023

Assurance

Report of the Financial Trustee - As at the end of October 2023, the overall charitable fund had a value of £1,067,094 which is an increase of £5,845 on the previously reported balance as at the end of June 2023.

Members agreed to recommend to the Board that, following a review of under-utilised and inactive funds, a re-categorisation be undertaken of funds totalling £80k which will help support the general bidding round for both current and future years. This is subject to a separate agenda item.

The Committee received an update on actions being taken to explore possible corporate partnerships and shared learning from colleagues at Mid and South Essex NHS Foundation Trust. In addition, a more local fundraising group has been established to support care units with fundraising. The communications department will also provide further support around raising awareness of the Charity and fundraising

Information

General Bidding Round
The Committee approved 10 bids for funding totalling £27,501. This was out of a total of 20 bids being received totalling £44,117. These bids were approved by the Committee pending Board approval of the re-categorisation of funds detailed above.

Action

Investment Advisor
Following identification of a suitable framework, one provider confirmed that they would be able to provide independent investment advice to the Charity at a cost of £9,000. The Committee agreed that, prior to an approval being made, further work to compare our investment approach with colleagues at MSEFT would be undertaken.

Alert

No alerts for the Board of Directors this month.

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 BOARD ASSURANCE FRAMEWORK 2023/24

Discussion Item | Denver Greenhalgh | 10 minutes

REFERENCES

Only PDFs are attached

Board Assurance Framework Report 31.01.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31 January 2024

Report Title:	**Board Assurance Framework Report**					
Executive/ Non-Executive Lead:	Denver Greenhalgh Senior Director of Governance & Corporate Affairs					
Report Author(s):	Denver Greenhalgh Senior Director of Governance & Corporate Affairs					
Report discussed previously at:	Executive Team					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	All high-level risks included in the Strategic and Corporate Risk Registers.	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Finance and Resources Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Statutory Public Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital and Data	✓
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report provides a high-level summary of the strategic risks and high-level operational risks (corporate risk register) and progress against actions designed to moderate the risk.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board is asked to:

1 Note the contents of the report
2 Note the closure of CRR34 where the remaining actions have been merged with CRR11 Suicide Prevention Strategy.
3 Note the reduction in risk scores for CRR98 Pharmacy Resource and CRR45 Mandatory Training.
4 Request any further information or action

Summary of Key Issues

This report provides a high-level summary of the strategic risks and high-level operational risks (corporate risk register) and progress against actions designed to moderate the risk.

These risks have significant programmes of work underpinning them with longer term actions to both reduce the likelihood and consequence of risks and to have in place mitigations should these risks be realised.

The Board is asked to note:

- Section 1 – Board Assurance Framework dashboard providing an oversight.

  Following our new Head of Risk and Incident Management commencing, we have been undertaking a review of all current risks and profiling for next year. Work today signalling the following risks for early review / reassessment (further information provided within the body of the report.

  SR1 Safety – To assess the impact of our actions from the Safety First, Safety Always Strategy as it ends in March 2024 and we launch the new Quality of Care Strategy.

  SR2 People – To assess the new People and Education Strategy and its implementation plan.

  CRR77 Medical Devices - A reassessment of the risk is underway to assess the impact of the improved asset register function and service records with the potential to reduce the risk.

  SR6 Cyber Security - Review of risk score in Feb '24, following delivery of action to improve controls.

- Section 2 – Risks that have changed in risk score

  CRR98 Pharmacy Resource - Recruitment campaign continues with a good pipeline on track to achieve reduction from initial 17% to an 8% vacancy factor by August '24. The business continuity plan for Pharmacy has been scaled back by two thirds, with further incremental return to business as usual and therefore the risk score being reduced 16. As new starters join the risk will be, continuously review and will take into account the additional short-term risk of supporting newly qualified pharmacists into that assessment. To note: the two new colleagues who joined the department in January 2024 had trained as students with the service and now choosing to come and work for EPUT, which is a great compliment to the team.

  CRR77 Mandatory Training - The recovery programme (set 2022/23) has been successful for substantive staff - with trust wide performance achieving plan at 90% for TASI and 91% for all mandatory training (January '24 figures). Following successful recruitment strategy in 2022/23 there is a cohort of new staff to train and as we transition back to annual TASI update training (from COVID arrangements being 2-yearly) constant oversight will be required through business as usual processes to sustain the position (see new action). Therefore risk score has been reduced (driven by likelihood of staff not having the required training). Likelihood reduced to a 3, in recognition that there remains a risk to sustained compliance as we transition TASI training back to an annual update for staff and we provide training for new staff both substantive and bank (new actions).

- Section 3 – Strategic Risk Register at a glance for each individual risk with updates against each action being taken to increase risk controls provided by each Executive Responsible Officer

- Section 4 – Corporate Risk Register at a glance for each individual risk with updates against each action being taken to increase risk controls provided by each Responsible Officer

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

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

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

Acronyms/Terms Used in the Report			
IG	Information Governance	BSOG	Board Safety Oversight Group
DSPT	Data Security Protection Toolkit	TSG	Transformation Steering Group
DR / BCP	Disaster Recovery / Business Continuity Plan	CQC	Care Quality Committee
ESOG	Executive Safety Oversight Group		

Supporting Reports/ Appendices /or further reading

- Board Assurance Framework Dashboard
- Strategic Risk Register
- Corporate Risk Register

Lead

Denver Greenhalgh
Senior Director of Governance & Corporate Affairs

NHS
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NHS Foundation Trust

Board Assurance Framework

31 January 2024

Denver Greenhalgh
Senior Director of Corporate Governance

EPUT

Risk Dashboard

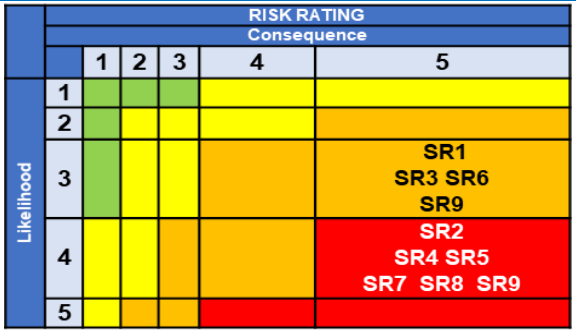
January 2024

EPUT

Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
9	0	0	0

Risk Score Increase	Risk Score Decrease	Risk Score No Change	On Risk Register >12 months
0	0	9	8



% Risks with Controls Identified	% Risks with Assurance Identified	Actions Overdue	Risk Reviewed by Risk Owner
100%	100%	7	9

ID	SO	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
SR2	2	People	MR	Safety Experience Regulatory Service Delivery Reputation	5x4=20	20 > 20 > 20	National challenge for recruitment and retention	The new People and Education Strategy is to be presented for approval at Board meeting Jan '24; following which the risk will be reviewed to both reflect on the analysis that led to the original risk entry (being principally driven by as a reflection of our then vacancy positon, which reached 18% in April 2022).The vacancy rate has since halved across EPUT, with inpatient services beginning to report over-establishment for registered nursing posts in some wards, aiding our efforts to implement Time to Care. Turnover is below 10%, and below 8% in inpatients and specialist care units. However, the risk rating does not reflect this progress as the actions over time have covered a wider set of areas beyond the staffing position. The review will look at ways to break the risk down so staffing stands alone and can be accurately assessed. We will consider whether education and learning, and employee experience and engagement, should become separate strategic risks.
SR5	1	Lampard Inquiry	NL	Regulatory Reputation	5x4=20	15 > 20 > 20	Government led public inquiry in to Mental Health services in Essex	Continue to have a strong focus on information processes and systems to ensure our responsiveness to the Inquiry requests for information. Records Management Accreditation process was achieved in June 2023 for Mobius. SystmOne, EMIS, Theseus, IAPTUS and Excelicare all are all working in line with the required standards. Extra resources are being secured to ensure Paris meets the standards. The revised terms of reference for the Lampard Inquiry are awaited.
SR7	All	Capital	TS	Safety, Experience, Regulatory, Service Delivery, Reputation	5x4=20	20 > 20 > 20	Need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	Continuing to horizon scan to maximise opportunities both regional and national to source capital investment. And now looking forward to planning for financial year 2024/25.
SR8	All	Use of Resources	TS	Safety, Compliance, Service Delivery, Experience, Reputation	5x4=20	20 > 20 > 20	The need to effectively and efficiently manage its use of resources in order to meet its financial control total targets and its statutory financial duty	Continue to focus on financial management and efficiency at AF meetings. Forecast outturn has been reviewed by the Finance and Performance Committee and recommendation made to the Board, agreed with NHS England and restated for M9 national submission. Again looking forward to planning for financial year 2024/25.

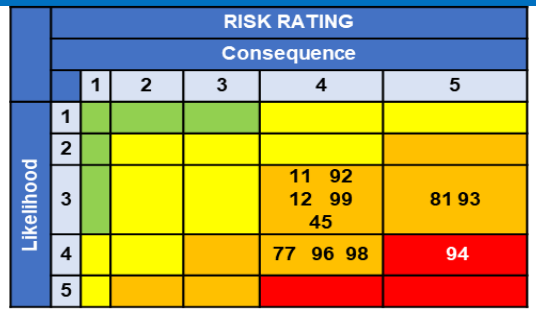
ID	SO	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
SR4	All	Demand and Capacity	AG	Safety, Experience, Regulatory, Service Delivery, Reputation	5x4=20	20 20 20	Long-term plan. White Paper. Transformation and innovation. National increase in demand. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	Time to Care implementation of year 1 priorities progressing. Work underway looking at demand vs capacity analysis Delivery of the overarching UEC / Inpatient MH Flow action plan has been completed and Improving Flow Operational Group established with good progress against year 1 priorities. Implemented governance structure with reporting to MH Urgent Care and Inpatient Care Unit / Accountability Framework. Working to the GIRFT principle of 'get it right first time' by providing: 1. Equitable access to timely and effective core mental health community care and treatment before people reach emergency need level. 2. Deliver the right care, at the right time in the right setting, by carrying out robust gate keeping and clinical prioritisation ensuring a purposeful admission and rapid therapeutic input 3. Maximise bedded capacity by flow improvement and reduction in average length of stay to create 'easy in, easy out' services , stopping people being stranded in the wrong part of the pathway
SR1	1	Safety	FB	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	20 15 15	Rising demand for services; Government MH Recovery Action Plan; Covid-19; Challenges in CAMHS & complexities; Systemic workforce issues in the NHS	Based on incidents, non-compliance with standards and regulatory sanctions Context and approach Over the last three years, the Trust has focused on becoming a more open, responsive and learning organisation with a desire to modernise services in co-production with patients, families, carers and staff. Over this time, we have made significant progress but we know there is more to do. We are committed to continually listening, learning lessons and improving. As we come to the end of our Patient Safety Strategy (Safety First, Safety Always) and move forward with the new Quality of Care Strategy, we are evaluating the impact of our actions by: • Rigorously reviewing evidence and risk assessments • Reassessing what we mean by safety and safe care, in a way that is meaningful for our patients and staff • Continuing to invest in learning and listening We recognise that there will always be more to do. New clinical risks will always emerge and will require a robust response, from both local and national learning, such as the recent increase in methods of self-harm other than the use of fixed point ligature. Findings from inquests and complaints, as well as incidents and issues in other similar organisations, will also highlight improvements we need to consider. Initiatives and improvements made since late 2020 which have contributed to increased safety 1. Staffing • Investing in dedicated resource to drive and embed safety improvements across the Trust, including £xm for the new Patient Safety Incident Management Team and EPUT Lessons Team • Improving and sustaining staffing levels and consistency of staffing, particularly within adult acute and PICU services, helping reduce variation in practice and increase adherence to care delivery standards • Using international and local recruitment initiatives to reduce vacancy rates in inpatient wards from a high of 40% to a current rate of 10%, with a clear trajectory to have no vacancies on inpatient wards by the end of 2024; overall staff turnover has reduced to pre-pandemic levels of under 10% • Developing our inpatient workforce model to maximise the therapeutic impact of every admission • Investing in in local operational focus by establishing the new Care Unit structure and introducing the accountability framework, allowing operational leads to make decisions and improvements at a local level. Each Care Unit has a triumvirate leadership team of a Director of Operations, Deputy Director of Quality and Safety and an Associate Medical Director providing leadership to teams of clinical leaders at service, unit and ward level.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
								2. New ways of working • Piloting the national Patient Safety Incident Response Framework (PSIRF) which is now being rolled out to all trusts, evaluating the learning and quality of learning from the pilot as the framework is embedded • Investing in technology to support care delivery, in particular the roll out of e-observations and the Oxehealth remote monitoring system • Working in partnership with local NHS organisations to procure and develop a new, single EPR to streamline the number of systems we use and share patient records with colleagues in primary and acute care • Committing to ensuring that any inpatient admission has a clearly defined and recorded purpose and increasing the levels and variety of meaningful activity for patients whilst they are on our wards • Changing our approach to responding to regulatory inspections and reports, with significant involvement from front line teams to develop sustainable and effective improvements
								3. Environmental improvements • Refurbishing inpatient wards and garden areas to meet modern standards and create more holistic and therapeutic environments • Programme of fitting door top and side alarms and other improvements to reduce fixed ligature points as far as is reasonably practicable Improvements are also measured through the practical experience of people who use our services and our staff. Examples include reductions in: • Absconsions from inpatient units • Injurious falls • Fixed point ligature incidents – no incidents reported • Grade 3 / 4 pressure ulcers • Use of prone restraint • Use of long term segregation and seclusion
SR3	All	Infrastructure	TS	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15		Capacity and adaptability of support service infrastructure including Estates & Facilities, Finance, Procurement & Business Development/ Contracting to support frontline services.	Commercial strategy approved by Board in November 2023. The Estates Strategy phase 1 development is completed. An internal delivery and steering groups is in place. External support in place. Draft to be socialised via Finance & Performance Committee and Board (via seminar) with final sign off at Public Board Jul '24.
SR6	All	Cyber Attack	ZT	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15		The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	Development of business continuity and disaster recovery plan has been completed and is currently at sign off stage. Upgrade of Mobius is now complete. The final remaining servers (5) can now be upgraded and is expected to be completed by the end of Jan '24. Cycle of penetration tests are back in business as usual and any future identified risks will be escalated if needed via the risk register.
SR9	1	Digital and Data Strategy	ZT	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15		The risk of not being a digitally and data enabled. Resulting in poor and/or limited implementation of systems and technologies, with reduced quality and safety of care and lack of data intelligence to inform change / transformation.	Funding secured for business case to support transformation programme. Data warehouse continues to be delivered, governance and platform built. Funding awarded for cloud migration tender

Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
11	0	2	1

Risk Score Increase	Risk Score Decrease	Risk Score No Change	On Risk Register >12 months
0	2	8	8



% Risks with Controls Identified	% Risks with Assurance Identified	Extended Actions	Risk Reviewed by Risk Owner
100%	100%	6	100%

ID	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR94	Engagement & Supportive Observation	AG	Safety Regulatory	5x4=20	20 > 20 > 20	CQC found observation learning not embedded	Following delivery of training on the Safewards model, we have moved on to the delivery phase of Safewards Interventions. Safewards interventions seek to reduce rates of behaviours that threaten patient safety or the safety of others (violence, suicide, self-harm, absconding etc.) and seeks to minimise harmful outcomes (e.g. PRN medication, special observations, seclusion, etc.)
CRR98	Pharmacy Resource	FB	Safety	4x4=16	20 > 20 > 16	Continuous state of business continuity plan	Recruitment campaign continues with a good pipeline on track to achieve reduction from initial 17% to an 8% vacancy factor by August '24. The business continuity plan for Pharmacy has been scaled back by two thirds, with further incremental return to business as usual and therefore the risk score being reduced 16. As new starters join the risk will be continuously review and will take into account the additional short term risk of supporting newly qualified pharmacists into that assessment. To note: the two new colleagues who joined the department in January 2024 had trained as students with the service and now choosing to come and work for EPUT, which is a great compliment to the team.
CRR11	Suicide Prevention	MK	Safety	4x3=12	12 > 12 > 12	Implementation of suicide prevention strategy	The Draft Suicide Prevention Framework is in final sign off stage following socialisation with system colleagues (Jan '24) and is a priority area within our new Quality of Care Strategy. The work flow has commenced with the introduction of STORM training (Effective self-harm and suicide prevention training). CRR34 which was about having the training capacity to deliver the STORM training has been merged into CRR11 as we now have the resource in place to meet the current training requirements, including licensed cascade trainers. Further work is ongoing to take forward analysis and develop a business case to create sustainable training capacity . As training is an integral component of delivery of the framework the decision was taken to combine the risks and CRR34 has been closed.
CRR34	Suicide Prevention - Training	MK	Safety			Implementation of suicide prevention strategy	See above CRR11 - CRR34 closed on the risk register.
CRR45	Mandatory Training	MR	Safety Regulatory	4x3=12	16 > 16 > 12	Training frequencies extended over Covid-19 pandemic leaving need for recovery	The recovery programme (set 2022/23) has been successful for substantive staff - with trust wide performance achieving plan at 90% for TASI and 91% for all mandatory training (January '24 figures). Following successful recruitment strategy in 2022/23 there is a cohort of new staff to train and as we transition back to annual TASI update training (from COVID arrangements being 2-yearly) constant oversight will be required through business as usual processes to sustain the position (see new action). Therefore risk score has been reduced (driven by likelihood of staff not having the required training). Likelihood reduced to a 3, in recognition that there remains a risk to sustained compliance as we transition TASI training back to an annual update for staff and we provide training for new staff both substantive and bank (new actions).
CRR77	Medical Devices	FB	Safety Financial Service Delivery	4x4=16	16 > 16 > 16	Number of missing medical devices compared to Trust inventory	Making good progress with our systems and process for the safe management and use of medical devices. All equipment is captured on an asset register and all medical devices have an 'end of life' time stamp which will enable improved forward planning as part of the newly approved Medical Devices Replacement Strategy (Jan '24). We continue to work towards putting in an external quality assurance process for our point of care testing equipment and rolling out training to staff in the safe use of equipment. A reassessment of the risk is underway to assess the impact of the improved asset register function and service records with the potential to reduce the risk.

ID	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR81	Ligature	AG/TS	Safety Regulatory Reputation	5x3=15	15 15 15	Patient safety incidents	New environmental standards with new ways of recording have agreed, with these now being updated into policy documents and statements of work. We have commenced rolling out new ligature training (TIDAL) and continue to delivery on planned environmental improvements overseen by the Board Safety Oversight Committee. There has been a marked reduction in fixed point ligature incidents and therefore the risk is being reassessed to review the risk score based on latest patient safety incident data (to include no harm incidents) and will take in consideration new emerging risks associated with other methods of self-harm.
CRR92	Addressing Inequalities	MR	Experience	4x3=12	12 12 12	Staff Experience	From Feb'24 we will launch new mandatory module for EDI within the leadership development, with the impact of learning to be monitored through EDI KPIs within the Accountability Framework for all Care Units and Directorates. On track to meet the March '24 objectives within the NHS England EDI plan to have in place Executive and Board objectives in place. EDI is one of the priorities within the new People and Education Strategy which is to be presented to Board for approval in January '24.
CRR93	Continuous Learning	FB	Safety Regulatory	5x315	15 15 15	HSE and CQC findings highlighting learning not fully embedded across all Trust services	Standard Operating Procedure being drafted to incorporate Human Engine process maps ESLMS in place in the live environment from December 2023 The future model for QI and associated resources has had first review by the Executive Team and will be represented in Jan '24 for approval and consideration in the 2024/25 business planning cycle.
CRR96	Loggists	NL	Regulatory	4x4=16	16 16 16	Major incident management	Our first in house training session has been complete, with further sessions for EA's up to end of March 2024. Once we have a cohort of trained loggists to ensure appropriate recording keeping were a major incident be declared, the risk will be closed.
CRR99	Safeguarding Referrals	FB	Safety	4x3=12	12 12 12	Escalation from operations and high increase in referrals	We continue the work of embedding safeguarding forms into patient record systems, with a planned go live in 4-5 weeks. We are also in conversation with Essex County Council in regards to the potential for the development of an online portal for this purpose. Good progress continues with recruitment being complete into all clinical posts within the Safeguarding Team; and the business support team structure review having been reviewed and being costed to support reorganisation of roles. The S75 handover with Southend UA has been completed.

Strategic Risk Register

January 2024

EPUT

SR1- Safety (At a Glance)

Risk Description: If EPUT does not invest in safety or effectively learn lessons from the past, then we may not meet our safety ambitions, resulting in a possibility of experiencing avoidable harm, loss of confidence and not meeting regulatory requirements.

Likelihood based on: Incidence of incidents, non-compliance with standards (clinical audit outcomes) and regulatory sanctions imposed historically.

Consequence based on: Avoidable harm incident impact and extent of regulatory actions.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L3 =15*	*C5 x L2 = 10*	**Note:** Action 5 previously removed as integral part of action 1**.**

Executive Responsible Office: Interim Chief Nurse
Board Committee: BSOG and Quality Committee

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Patient Safety Incident Management Team	Team Established (note vacancies and some team members undertaking skills development).	Patient Safety First Safety Always - Leadership Pillar Report end of Yr. 2	PSIRF Yr1 early adopter review
EPUT Lessons Team	Team Established	Patient Safety First Safety Always - Leadership Pillar Report end of Yr. 2	
Learning Collaborative Partnership	Forum - live		
Quality and Safety Champions Network	Network - live		
Information sharing communication strategy (lessons learned)	Lessons identified Newsletter Induction Videos Mandatory Training (name)		
Capital Investment	Delivery of essential safety improvements		CQC CAMHS inspection report (safety improvements)
Patient Incident Response Plan	Incident Response Plan - live and being used	Refreshed Incident Response Plan (2023-25)- approved and published on the Website	Refreshed Incident Response Plan (2023-25)- approved by ICB
Culture of Learning Programme		BSOG reviews on progress	
Patient Safety Dashboard	Safety Dashboard - live (Note: additional development see actions)		

	Actions (to modify risks)	By When	By Who	Gap	Update 17/01/24
1	Deliver the Patient Safety Incident Response Plan	Mar '25	MA	Control	The Patient Safety Incident Response Plan (PSIRP) 2023-25 has been approved and is live on EPUT website. First step is to undertake thematic analysis of the key areas to inform Safety Improvement Plans to date 3 are complete covering: Falls, Ligature and MDT Communication and 2 are in progress: Clinical Handover and Medication
2	Deliver Yr3 - Patient Safety Strategy (Safety First Safety Always	Mar '24	FB	Control (Road Map)	See BSOG report.
3	Complete automation of two dashboard elements	May '24	MS	Control	The financial funding required has been agreed and is available in year for the programme work to integrated IWGC data into the Patient Safety Dashboard. A contract with the supplier is being finalised for work to commence. As signalled at Board in Nov '23 workflow now set and timeline for achievement stated End May '24.
4	Implement Quality Improvement Programme	Mar '24	SY	Control	Contract renewed for use of LifeQI Platform, with circa 100 staff registered and 50 projects live. The future model for QI and associated resources has first review by the Executive Team and will be represented in Jan '24 for approval and consideration in the 2024/25 business planning cycle.
6	Implement EPUT Lessons Identified Management System (ESLMS)	Complete	MA	Control	ESLMS has been successfully reviewed within the test environment and is now functional in the live environment and action is complete. Next steps (see action 7 below) is to put in place governance controls within care units for its use.

7	Ensure good governance controls for monitoring to progress towards action closures and achievement of additional controls	Extended April '24	SY	Assurance	This is integral to the new patient safety response plan and includes establishing the PSIRF Oversight Group.

SR2- People (At a Glance)

Risk Description: If EPUT does not effectively address and manage staff supply and demand, then we may not have the right staff, with the right competencies, in the right place at the right time to deliver services, resulting in potential failure to provide optimal patient care / treatment and the resultant impact on quality of care (safety, effectiveness and experience).

Likelihood based on: Establishment of existing and new roles verses the vacancy factor and shift fill rate.

Consequence based on: Impact of staffing levels on service objectives; length of unsafe staffing (days) through the Sit Rep Return; staff morale; availability of key staff; attendance at key training.

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previous reported completed actions 1 and 3 have been removed from the report.
C5x 4L = 20	*C5 x L4 =20*	*C5 x L3 = 15*	

Executive Responsible Office: Interim Chief People Officer Board Committee: PECC	Controls Assurance		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
People & Culture Team / Hr Policies	Leadership Team Established Interim Chief People Office - awaiting appt. of substantive CPO		
Care Unit Staffing Plans	Workforce plans in place Safer staffing reports	Quality and Performance Scorecard	CQC Inspection - regularity of temporary staffing on inpatient wards (negative assurance)
Recruitment and Retention Programme	Vacancy rate 9%, with mental health nursing in Inpatient and Specialist Services approaching full establishment	PECC reports	
Workforce Plans and Strategies	Establishment reviews Framework for health and wellbeing	PECC reports	NHSE & System Workforce returns / benchmarks
Training and Development	Training Tracker in place RISE Programme (completed)	Training and Development report to PECC	Staff Survey / OoAPT successful June '23 / Ofsted Inspection July '22 - Good
Staff Wellbeing Offer	Engagement Champions Employee Experience Managers	Employee Experience reports to PECCC	Staff Survey / Quarterly Pulse
Just Learning Culture	Behaviour Framework FTSU Guardian	Employee Experience reports to PECCC	Staff Survey
Equality and Inclusion Framework	Executive led sponsors for networks ED&I objectives in appraisal Racial abuse guidance for staff and debriefs		WRES / WDES Data

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update (Date)**
2	Develop People and Culture Strategy (incorporating previous action to implement an Education Strategy)	Extended Jan '24	MR	Road Map	The People and Culture Strategy is prepared to go for approval at Trust Board meeting at the end of January 2024.
4	Review long-term strategy for smart working	Mar '24	FW	Control	Meeting planned with Estates in January 2023 to discuss next steps of Smart working and implement anything missed from NHE recommendations. Timeline to align with the Estates Strategy (planned Jul '24 Board meeting).
5	Recovery plan for delayed HR policies	Extended April '24	DP	Control	Action remains overdue its stated timeline - A number of documents are beyond the stated review timelines, with industrial action having impacted on HR capacity to achieve the reviews. A revised recovery plan continues to be taken through the Policy Oversight and Ratification Group with a staggered approach to be delivered by end of March '24 (to safeguard against further industrial action). There is a co-dependency on any changes being agreed with Staff Side. Current documents have been assessed as fit to continue in use by subject matter experts.

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update (Date)**
6	Produce new programme on improving inclusion, particularly for those with worst experiences, and brief Board, as the next phase of EDI plan	Extended Mar '24	LH	Control	A series of meetings is scheduled with the Executive Team/Chair to draft their objectives. In addition, there have been changes on the Gender Pay Gap report which now includes a breakdown in data for race. These are as part of the NHS England EDI Improvement Plan and both need to be in place by March 2024.
7	Deliver agreed objectives with MSE ICB to reduce vacancies and temporary staffing	Mar '24	PT	Control	A series of meeting with the ICB's are planned to discuss the next steps to reduce temporary workforce
8	Review of Operating Model and Structure of P&C Directorate to support organisation to meet its strategic objectives	Mar '24	MR	Control	Some delay due to recruitment of substantive CPO, Process planned to now start in February 2024.
9	Deliver against EDI plan and complete in depth work into experiences and progression of minority staff	Extended Feb '24	LH	Control	NHS EDI improvement plan is being reviewed with our current strategy. With a plan to align existing strategy with EDI improvement plan. Work in progress. Feb 2024
10	Ensure robust plans are in place to mitigate the impact of strike action	Ongoing	DP	Control	Update: Successfully managed the last strike and are awaiting details of the next round of industrial action

SR3- Finance and Resources Infrastructure (At a Glance)

Risk Description: If EPUT does not adapt its infrastructure to support service delivery then it may not have the right estate and facilities to deliver safe, high quality care resulting in not attaining our safety, quality and compliance ambitions.

Likelihood based on: The possibility of not having the right estate and facilities to deliver safe high quality care

Consequence based on: The potential failure to meet our safety, quality and compliance ambitions

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previous reported completed actions 1 and 3 have beeen removed from the report.
C5x L3 = 15	*C5 x L3 =15*	*C5 x L2 = 10*	

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: F&P and Audit Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
EPUT Strategy	EPUT Strategy (approved Jan '23)	Bi-annual Board Report	
Operational Target Operating Model	Care Unit Leadership in place Procurement Team restructured to align with TOM	Accountability Framework	
Estates and Facilities, Contracting and Business Development, Finance Teams	Established Support services	PMO support in place reporting to ESOG Restructure fully recruited to	IA Estates & Facilities Performance (Moderate/Moderate Opinion)
Range of corporate, finance policies	Policy Register and procedures in place	Accountability Framework	
PMO, Capital Programme, E-expenses system,	Capital Steering Group	Capital Planning Group	
Audit Programme and ISO		Audit Committee	
Premises Assurance		Premises Assurance Model in place with assessment	
6-Facet Survey			6-Facet Survey
Business Continuity Plans	Business continuity plan in place		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update 17.01.24**
1	Develop Commercial Strategy	Complete	MM	Roadmap	Commercial strategy was approved by Board in November 2023. Therefore action is closed.
2	Develop Estates Strategy & Development Plan (as informed by the 6-facet survey)	Extended Jul '24	MM	Roadmap	Phase 1 - current status complete. Internal delivery and steering groups in place. External support in place. Draft to be socialised via Finance & Performance Committee and Board with final sign off at Public Board Jul 2024.
4	Review tenancy responsibilities / leased property risks, staff vs property owner accountability, PFI contract deficiencies	Completed	JD	Control	Weekly operational meetings now in place for PFIs. Brockfield House settlement deed in place. P2G extensively engaged. Improved the governance controls on all other leased properties. Estate Strategy baseline has acheived improved visibility of all leased properties across the estate. Action closed.
5	Business case related to additional estates resource to be prepared prior to budget setting round 2024/25	Mar '24	MM	Control	In progress.
6	To extend the Accountability Framework to corporate directorates	April '24	TS/AG	Control	In progress, initial round of meetings being held and performance indicators being developed.

SR4- Demand and Capacity (At a Glance)

Risk Description: If we do not effectively address demands, then our resources may be over stretched, resulting in an inability to deliver high quality safe care, transform, innovate and meet our partnership ambitions.

Likelihood based on: Mismanagement of patient care and length of the effects (both inpatient and community)

Consequence based on: Length of stay, occupancy, our of area placements etc.

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previous reported completed actions 2 and 5 have been removed from the report.
C5x 4L = 20	*C5 x L4 =20*	*C5 x L3 = 15*	

Executive Responsible Office: Executive Chief Operating Officer Board Committee: BSOG and F&P	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Operational staff (including skilled flexible workforce via Trust Bank) Discharge Co-ordinator Teams	Establishment and Fill Rate Director of Operational Performance Agency Framework in place New roles: Activity Coordinators Clinical Flow Lead (TTC) and CD Flow	Performance Reporting Accountability Framework Meetings	
Care Unit Leadership	Establishment Integrated Director posts		
Target Operating Model / Accountability Framework / Flow and Capacity Policy. MAST roll out / Safety First Safety Always Strategy	Dedicated discharge coordinators CPA Review performance UEC in place	Accountability Framework Meetings Safety First Safety Always Yr2 Report to Board (Mar '23)	
MH UEC Project, MSE Connect Programme. Partnerships, Mutual Aid	Flow and Capacity Project MH Urgent Care Emergency Department opened 20 March 23	Purposeful admission steering group Monthly inpatient quality and safety group	Provider Collaborative(s) MH Collaborative Whole Essex system flow and capacity group
Service Dashboards / Daily SitReps/ Performance Reporting	Updated OPEL framework Essex wide daily sit reps Joint inpatient and community review meets EDD and CRFD reporting in ward review template on EPR, with daily reports providing status	Performance and Quality Report to Accountability Meetings and F&PC Safety KPI dashboard live and accessible	System oversight and assurance groups
Business Continuity Plans	EPRR planning Business Continuity Plan in place		
Care Unit Strategies / Operational Plan 2023/24	Developed including out of area plan	Performance Reporting Published alongside EPUT Strategy One year touch points and monitoring through accountability	
Pan Essex System Flow and Capacity Group	Established Review of bed modelling (supported by KPMG)		System Escalation in place
Bed Stock	157 North Adult beds; 44 North Older Adult beds; 89 South Adult beds; 66 South Older Adult beds; 24 Contracted appropriate OoAP beds		

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update 17.01.24**
1	Time to Care Programme	Complete	AG	Control	Submission of TTC staffing model initiative prioritisation form for integrated flow team roles completed.

Actions (to modify risks)		By When	By Who	Gap	Update 17.01.24
3	Analysis piece on demand vs capacity	Phase 1 May '23 further phases to be added	JL	Control	Work ongoing on data flow. Planning to set timeline for further phases by next reporting
4	Delivery of the overarching UEC / Inpatient NH Flow Action Plan	Completed	Detailed actions have individual leads	Control	Action has been Completed. Improving Flow Operational Group established with good progress against Yr1 priorities. Improving Flow Operational Group is now ongoing BAU.
4.1	Implement Governance	Completed	Project Group	Assurance	Action Completed Governance structure in place with reporting to Mental Health Urgent Care and Inpatient Care Unit / Accountability Framework
4.2	Reclassification of OoAP contracted beds	Mar '24	LB	Control	Once contracts agreed, resubmission for ongoing reclassification to 'appropriate OoAP' can be made
4.3	Robust oversight on patient flow and OoAP with ownership	Mar '24	SG	Control	Regular Inpatient and HTT consultant flow meetings established however these have been paused following step down of CD Flow. Impacting on all flow metrics.
4.4	Improving Sit Reps	Mar '24	SB	Control	Third phase PDSA to include SMART Capacity / Ward Level Data (paused awaiting outcome of TTC admin staffing)
4.5	Discharge Co-ordination	Mar '24	SB	Control	2 Essex County Council Move On Facilitators are working as core members of the Adult Discharge Team
4.6	Reducing variations across wards	Mar '24	LW	Control	Plan for draft chapters to be in place for end Dec '23 (Completed) with collation and review to follow
4.7	GIRFT Ambition	Mar '24	LW	Control	Good progress against Inpatient / Urgent Care tasks. Working to the GIRFT principle of 'get it right first time' by providing equitable access to timely and effective core mental health community care and treatment before people reach emergency need level. 2. Deliver the right care, at the right time in the right setting, by carrying out robust gate keeping and clinical prioritisation ensuring a purposeful admission and rapid therapeutic input. 3. Maximise bedded capacity by flow improvement and reduction in average length of stay to create 'easy in, easy out' services , stopping people being stranded in the wrong part of the pathway.
4.8	System transformation supporting alternatives to admission	Mar '24	AG/MK	Control	MSE MH UCD Operational; Ambulance cars in place in MSE & NE; Crisis House/Café in place. MH accommodation pathway review and recommissioning completed NE & WE – MSE commenced. MADE events held and incorporated into BAU

SR5 - Lampard Inquiry (At a Glance)

Risk Description: If EPUT is not open and transparent, with the correct governance arrangements in place then it will not serve the Inquiry effectively or embed learning from past failings resulting in undermining our Safety First, Safety Always Strategy

Likelihood based on: the possibility that the Trust cannot effectively meet the requests of the Inquiry nor embed earning, resulting in damage to its reputation and potentially poor CQC ratings

Consequence based on: National media coverage, parliamentary coverage and a total loss of public confidence

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previous reported complete actions 1, 2 and 4 have been removed from the Board report.
C5x 4L = 20	*C5 x L4 =20*	*C5 x L2 = 10*	

Executive Responsible Office: Executive Director Major Projects
Board Committee: Audit Committee

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Project Team Support from external consultants with experience of inquires.	Establishment Expanded to meet increased ask	EOC and Board oversight	
Internal methodology for working with inquiry	In place	In place and used for reporting Project Group Oversight	As above
Inquiry Terms of Reference MOU and Information Sharing Protocol	In draft		
Learning Log	Log in place	Reporting ET / Audit Committee and Auditors	
Exchange portal in place to safely transfer information to the inquiry	Data protection impact assessment	Reporting in place	
Learning from Deep Dives	Deep dive into sample of deaths in scope over 20 year period Deep dive in 13 prevention of future death notices		
Audit on Learning from Independent Inquiry		Assurance checks completed and presented to ET - approved ongoing assurance through Care Unit Accountability Frameworks	IA - opinion moderate for design and effectiveness

	Actions (to modify risks)	By When	By Who	Gap	Update 17/01/24
3	EPUT should assure itself that its information processes and systems are fit for purpose, and controls around data input and records management to be reviewed across the Trust to minimise risks associated with information recording and management going forward.	Mar '24	GB	Control / Assurance	Update: Forms part of the Records Management Accreditation process which was achieved in June 2023 for Mobius. SystmOne, EMIS, Theseus, IAPTUS and Excelicare all are all working in line with the required standards. Extra resources are being secured to ensure Paris meets the standards. Records management for the areas identified is part of the Care Units Accountability Frameworks. Transfer of historic records to Restore completed and cataloguing of records being finalise
5	New Action: Track the use of historical learning themes through the Quality Senate and the outcomes.	Mar '25	AW	Assurance	Quality Senate is due to operational from April '24 in line with the launch of the Quality of Care Strategy.

SR6- Cyber Security (At a Glance)

Risk Description: If we experience a cyber-attack, then we may encounter system failures and downtime, resulting in a failure to achieve our safety ambitions, compliance, and consequential financial and reputational damage.

Likelihood based on: Prevalence of cyber alerts that are relevant to EPUT systems.

Consequence based on: assessed impact and length of downtime of our systems

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L3 =15*	*C4 x L3= 12*	**Note:** Previous actions 1 and 3 are complete and will be removed from the Board report. **Note:** Review of risk score will be undertaken in Feb '24, following delivery of action to improve controls.

Executive Responsible Office: Executive Director Strategy Transformation and Digital
Board Committee: F&P (noting move from AC)

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place	***New Control*** **:** Substantive post holder (Aug '23)	IGSSC	NHS Digital Data Security Protection Toolkit (DSPT) Cyber Essentials Accreditation
Range of policies and frameworks in place	Virtual and site audits Compliance with mandatory training – Cyber Assurance Framework	IGSSC; BDO internal audit May 22 – overall Moderate Confidence level Medium	As above MSE ICS IG & Cyber Levelling Up Project (annual) BDO Audit actions completed
Investment in prioritisation of projects to ensure support for operating systems and licenses	Prioritisation of digital capital allocation	CPPG – with priority decisions made at DSG	
IG & Cyber risk log	Risk working group reporting into IGSSC – owing and tracking actions from audits and assessments	IGSSC and Digital Strategy Group	DSPT Areas identified for upcoming BDO Audit
Business Continuity Plans and National Cyber Team processes	BCP development plans in progress – due date Dec 23	Successfully managed Cyber incident	Annual Testing as part of DSPT NHS Digital Data Security Centre, Penetration Testing, Cyber Essentials+
CareCert notifications from NHS Digital	Monitored and acted upon within 24 hours of their announcement	Reported to IGSSC	NHS Digital
Cyber Essentials Accreditation	Certification achieved	Monitor controls through IGSSC	Accreditation certified
MSE ICS DSPT & Cyber Maturity Baseline	Completed	Audit Committee	DPST BDO audit completed, recommendations accepted and in plan

	Actions (to modify risks)	By When	By Who	Gap	Update 17/01/24
2	Develop business continuity plan and disaster recovery for each system (using third party)	Initial by Dec '23	AW	Control / Assurance	BCP policy developed and approved by Information Governance Committee. Moving forward for approval through governance forums for sign off. (PORG meeting Feb '24).
3	Complete actions from IT Security Health Check and Penetration Testing	Extended Jan '24	AW	Control	Upgrade of Mobious is now complete. The final remaining servers (5) can now be upgraded and is expected to be completed by the end of Jan '24. Cycle of penetration tests are back in business as usual and any future identified risks will be escalated if needed via the risk register.

SR7- Capital (At a Glance)

Risk Description: If EPUT does not have sufficient capital resource, e.g. digital and EPR, then we will be unable to undertake essential works or capital dependent transformation programmes, resulting in non achievement of some of our strategic and safety ambitions.

Likelihood based on: Percentage of capital programme unable to deliver / deferred

Consequence based on: What not delivered and the impact on the strategic plans.

Initial Risk Score	*Current Risk Score*	*Target Score*
C5x 4L = 20	*C5 x L4 = 20*	*C5 x L3 = 15*

Executive Responsible Office: Executive Chief Finance & Resources Director
Board Committee: F&P

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team in place	Decision making group in place and making recommendations to ET, FPC and BOD	
Purchasing / tendering policies	Policy Register		Internal Audit
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2023/24	Capital Project Group forecasting	Capital Resource reporting to Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£new resources secured	Capital Resource reporting to Finance & Performance Committee	
ICS representation re: financial allocations and MH/Community Services	EPR convergence business case developed with additional capital resources identified	ECFO or Deputy Attendance at ICS Meetings; CEO or Deputy membership of ICB;	
Prioritised capital plan to maximise the use of available capital resources	Capital Plan 2023/24 in place		
EPR Programme	Progress published June 23 outlining programme structure and governance principles and timelines	EPR Oversight Committee Convergence and Delivery Board	OBC Agreed

	Actions (to modify risks)	By When	By Who	Gap	Update (17/01/24)
1	Horizon scan to maximize opportunities both regional and national to source capital investment	Ongoing	JD	Control	Currently over committed the programme by circa £1.2m which is planned to be covered by sys
2	Capital Plan for financial year 2024/25	End Mar '24	JD	Control	New action: Planning underway for 2024/25
3	Track key strategic investments i.e EPR to be monitored for impact on Capital Programme	Mar '25	JD	Control	New Action: EPR FBC to be finalised in Mar '24

SR8- Use of Resources (At a Glance)

Risk Description: If EPUT (as part of MSE ICS) does not effectively and efficiently manage its use of resources, then it may not meet its financial controls total, Resulting in potential failure to sustain and improve services

Likelihood based on: Likelihood based on: EPUT financial risk and opportunities profile

Consequence based on: Consequence based on: assessed impact on long financial model for EPUT and the System

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previous reported completed action 1 has been removed from the report.
C5x 4L = 20	*C5 x L4 =20*	*C5 x L3 =15*	

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: F&P	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team Establishment	Use of Resources Assessment	Use of Resources NHSE Assessment
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place Scheme of Delegation in place Accountability Framework in place	Financial Management KPIs Audit Committee F&PC Accountability Framework	IA Key Financial Systems – Budget Management (Sep '22) Substantial opinion and Costing (March 2023).
Estates & Digital Team (Response to new resource bids)	Team in place		
Deliver efficiency savings and targets 23/24		Finance Report	
Finance reporting	Finance Reports AF Reports	EA of Accounts	NOF Rating
Budget setting	Completed mid year financial review. Key risk and opportunities assessments performed	Accountability framework reporting; Finance reporting to F&PC; National HFMA Checklist Audit	Annual VFM through external auditors identified no significant weaknesses
Operational Plan 2023/24			
Forecast Outturn and risk/ opportunities assessments 23/24			

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update 17.01.24**
2	Deliver Financial Efficiency Target	31 Mar '24	TS	Control	Continued focus on financial management and efficiency at AF meetings.
3	In year forecast outturn (FOT) and associated risk and opportunities assessment	Monthly Touch Points to end Mar '24	SC	Assurance	FOT scrutinised by F&P recommended to Trust Board. Agreed with NHS England and restated for M9 national submission.
5	Deliver Operational Plan 2023/24	Mar '24	AG/TS	Control	Provisional Target 24/25 set at 3% and planning underway; paper on National planning guidance and Internal budget setting principles being delivered to and agreed by Exec.

SR9- Digital and Data Strategy (At a Glance)

Risk Description: If we do not have the required capability and expert knowledge to deliver the digital and data strategy, then the trust may fail to achieve strategic ambitions, specifically: embedding a digital mindset and culture, which may result in limitations in our ability to procure and implement the appropriate technology to support the integration of care closer to where our service users live, and support staff to carry out their duties effectively; Threaten the development of our patient facing technologies to support our service users, families and carers; and stall our capability and agility to use data to inform both direct care and insight driven decision making.

Likelihood based on: The likelihood of conditions that place constraints on the ambitions of both the digital and data strategy, e.g. capability, resource availability and transformation programme prioritisation

Consequence based on: The inability to realise the wider organisations strategic ambitions as well as the inability to maintain regulatory and compliance data security and cyber assurance.

Initial Risk Score	*Current Risk Score*	*Target Score*
C5x 3L = 15	*C5 x L3 =15*	*C5 x L2 =10*

Executive Responsible Office: Executive Director of Strategy, Transformation and Digital Board Committee: F&P	Controls Assurance		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Resources			
IT/Digital team Resource and skill set is appropriate and sustainable	Education and training in specific technology Target operating model - modernise digital services	Digital strategy resource management (RAID Log)	
Clinical Digital leadership are engaged with dedicated leads responsibilities defined.	CCIO/CNIO oversight		
Strategies & Policies			
Information Governance policies and controls are in place to provide secure and appropriately governed processes and procedures	Information governance controls processes	Information Governance Steering Sub-Committee reporting and assurance	Data Security and Protection toolkit assesment (Standards Met)
Data quality is of a standard that assures national standards.	Data quality group reporting and assurance	Internal Audit	National data quality framework
DSPT “standards met” can be achieved		Internal Audit	DSPT submission and Cyber assurance framework
Investment			
Capital allocation to digital and data initiatives secured	Approved Digital capital plan		CDEL allocation from system for 23/24 schemes
External funding is obtained for schemes that are supported by national envelopes	Cost modelling of the digital strategy programme	Digital, data and technology group assurance report	
Innovation			
The space and governance exists to support innovation	CIO discover opportunities from national forums and partners (inl. Academic)	Innovation strategy governance - Strategy Steering Group	
Academic partnerships promote innovation	CIO engagement with academic partners on digital innovation opportunities		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update 17.01.24**
1	Digital Transformation programme Plan	Feb '24	JL	Road Map	Digital Transformation Plan is underway.
2	Business case to support transformation programme plan (Secure funding)	Complete	JL	Control	Funding secured - action closed.
3	Data warehouse and governance implementation	Complete	AW	Control	Data warehouse continues to be delivered, governance and platform has been built - action closed.
4	Digital target operating model implementation	July '24	AW	Control	Digital target on plan for Jul '24

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update 17.01.24**
5	Cloud migration tender	Complete	AW	Control	Progressed by contracting team under framework - action closed.
6	Service desk transformation plan development	Mar '24	AW	Road Map	In progress and on plan.
7	Clinical safety Officer framework development	Mar '24	RP	Control	In progress and on plan for first proposal.
8	New Action: Development of Full Business Case for Unified Electronic Patient Record.	Mar '24	ZT	Control	In progress and on track.

Corporate Risk Register

January 2024

EPUT

CRR94 - Observation and Engagement

Risk Description: If EPUT does not manage supportive observation and engagement then patients may not receive the prescribed levels resulting in undermining our Safety First Safety Always Strategy.

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previous reported completed actions 1-9 have been removed from the report.
C5x 4L = 20	*C5 x L4 = 20*	*C5 x L2= 12*	

Executive Responsible Office: Executive Nurse Director Lead: Director of Nursing and IPC Leads: Deputy Directors of Quality & Safety (Inpatients and Specialist Services) Board Committee: Quality Committee	**Controls Assurance**

Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Observation and Engagement Policy	Policy in place Personalised Engagement Boards		
Weekly Ward Huddles	AD's undertaking 15 leadership steps Local oversight of roster quality checks		
Electronic observations recording tool	e-observations in wards (with exception of 7 wards)		
Tendable Audits (quality control)	Audit results reviewed at weekly huddles		
Observation and Engagement e-learning and training videos			
Engagement resources	Purchased equipment e.g. games / newspapers etc. Garden Protocol (with spots checks)		
Deep dive into unexpected deaths in inpatient services or within 3 months of inpatient admission between 2000 - 2022		Analysis of 1500 unique recommendations with identification of 31 themes. Validation with stakeholders. Mapping exercise and assurance report to ET Apr '23	
Ward Improvements	Planning supported by patients Grab Therapy Resources available		

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update 17.01.24**
10	Implement Safe Wards Interventions	Mar '25	LJ	Control	Following completion of Safe Wards training now moved into implementation phase.

CRR11 - Suicide Prevention

Risk Description: 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.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4x 4L = 16	*C4 x L3 = 12*	*C4 x L2= 8*	**Note:** CRR34 Suicide Prevention Training has been amalgamated into this risk as part of delivery of overall Suicide Prevention Framework, with CRR34 being closed on the risk register. **Note:** Previous reported completed actions 2, 3 and 4 have removed from the report for CRR11. **Note:** Previous reported completed actions 2 and 3 have been removed from the report for CRR34.

Executive Responsible Office: Executive Medical Director Director Lead: Dr Nuruz Zaman Deputy Medical Director Leads: Glenn Westrop, Deputy Director of Quality and Safety Board Committee: Quality Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Observation and Engagement Policy	Policy in place Personalised Engagement Boards		
Electronic observations recording tool	In trial phase		
Wad level oversight	Tendale Audit results reviewed at weekly huddles	Patient led safety huddles (Basildon)	
Observation and Engagement e-learning and training videos	STORM training		
Engagement resources	Purchased equipment e.g. games / newspapers etc. Garden Protocol (with spots checks)		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update 17/01/24**
1	Development of revised framework in line with national guidance	Extended timeline Jan '24	NZ	Roadmap	Draft Framework is in sign off phase. This is now a priority within the Quality of Care Strategy approved by Trust Board in Nov '23. The Framework has also been socialised with system colleagues. Plan to present for approval at Executive Team in January '24.
5	Review approach to ligature risk management training (through the introduction of effective self-harm and suicide prevention training).	July '24	GW	Control	STORM (Effective self-harm and suicide prevention) training rolling out which will have a greater focus on neuro diverse services users and be an extended training package. Training is available and being tracked, with continued promotion. Further work being taken forward to update safety plans and fit to leave plans.
6	Implementation of the Suicide Prevention Framework (as aligned to the Quality of Care Strategy	Dec '26	GW	Control	Next steps following approval of the framework (action 1) is to work with our Lived Experience Ambassadors and our communities to take forward actions.
CRR34 1	Expand the capacity of trainers to deliver Skills STORM (skills based training on risk management - suicide prevention) training	Complete	PT	Control	*Note: action transferred from CRR34* Resources meet current training requirements, including licensed cascade trainers.
CRR34 2	Business case to be developed to create sustainable training cacpacity (trainers).	April '24	PT	Control	*Note: action transferred from CRR34* In progress.

CRR45: Mandatory Training

Risk Description: If EPUT does not achieve mandatory training policy requirements then patient and staff safety may be compromised resulting in additional scrutiny by regulators and not meeting the IG Toolkit requirements

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L3 = 12	*C4 x L3 = 12*	*C4 x L2 = 8*	**Note:** Previous reported completed action 2 has been emoved from the report. **Note:** Compliance with mandatory training trust-wide has met its recovery plan and therefore risk score reduced (driven by likelihood of staff to having the required training. Likelihood reduced to a 3, in recognition that there remains a risk to sustained compliance as we transition TASI training back to an annual update for staff and we provide training for new staff both substantive and bank (new actions).

Executive Responsible Office: Executive Director People and Culture Director Lead: Paul Taylor Board Committee: PECC	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Training Team	Established – current resource 8.5WTE TASI trainers increased		12 month TASI accreditation from BILD
Induction and Training Policy	Policy and Procedure in Place		
Training Tracker	Management Check	Accountability. F&PC and PECC, SMT and TB	
Training Recovery Plan	Team switching staff incrementally to an amber rating giving 3 months to complete training Recovery plan on TASI	Training venues Executive team approval to incremental approach to annual updates Task and Finish Group Communications strategy Executive team oversight on STORM training update and compliance	BILD
Flexible workers	Equal priority on mandatory training		
Training Venues	Training room identified at The Lodge		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update 17/01/24**
1	Implement recovery plan	Complete	Training Team	Assurance	The recovery programme (set 2022/23) has been successful for substantive staff - with trust wide performance achieving plan at 90% for TASI and 91% for all mandatory training (January '24 figures). Following successsful recruitment strategy in 2022/23 there is a cohort of new staff to train and as we transition back to annual TASI update training (from COVID arrangements being 2-yearly) constant oversight will be required through business as usual processes to sustain the position (see new action).
3	Ensure staff do not expire on their training all at the same time by spreading compliance across the year	Complete	PT	Control	Staff bookings made in priority order in 3 month phases to ensure annual updates will be staggered throughout the year and we make best use of face to face training capacity.
4	New Action: Monitor transition of TASI training back to yearly update arrangements and that all new starters have successfully completed the full suite of mandatory training.	Mar '25	PT	Assurance	Monitoring through Accountability Framework meetings.

Actions (to modify risks)		By When	By Who	Gap	Update 17/01/24
5	New Action: Provide TASI training to bank who have joined EPUT temproary workforce.	Sept '24	PT	Control	

CRR71: Medical Devices

Risk Description: If EPUT does not fund resources and the deep dive to address the clinical rationale/ pathway for medical devices, then unsafe, non-serviced, non-calibrated and inappropriate devices remain in use, resulting in a failure to achieve our safety first, safety always strategy, and reputational damage

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L3 = 12	*C4 x L4 = 16*	*C4 x L2 = 8*	**Note:** Previous reported completed actions 1, 6-8 have been removed from the report. **Note:** A reassessment of the risk is underway to assess the impact of the improved asset register function and service records with potential to reduce the risk score.

Executive Responsible Office: Executive Nurse
Director Lead: Angela Wade
Board Committee: Quality Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Corporate Nursing Team and Datix Team including Head of Deteriorating Patient and Clinical Governance.	Established Nominated Central Alert System person MDSO in post with dedication administrative support		
Medical Devices Group	Established	Overseen by Physical Health Sub-Committee	
Ergea contract for device maintenance	Medical Devices Group oversight of Monthly KPI Report		
Procurement process in place Medical Devices Policy	eQUIP Asset Register	Tendable audits – medical device safety / management	Internal Audit Report 2021/22 (Moderate / Limited Assurance)
Incident Reporting	In place		
Business Continuity Plans	Ergea BCP		

	Actions (to modify risks)	By When	By Who	Gap	Update 17/01/24
1a	Implement the solutions from the outcomes of the deep dive	Extended Aug '24	NA	Control	Management actions concluding. Remaining action associated with actions detailed below.
2	Options appraisal for Capital replacement programme and Medical device replacement strategy	Complete	NA	Control	Medical device replacement strategy paper has been reviewed by all stakeholders, and Paper approved by Exec team 15 Jan '24. All medical devices now have an 'end of life' time stamp and for each annual planning cycle will feed into Capital programme for prioritisation. Medical Devices equipment that is marked 'end of life' on the asset register is subject to risk assessment for approval of its continued use or removal for the clinical areas.
4	Medical Device Management training ensuring staff know that they have a responsibility to ensure pieces of kit are calibrated	Extended Sept '24	NA	Control	Ongoing and part of the training
5	Introduce point of care testing quality assurance process to avoid use of equipment that is not calibrated or serviced	Extended Aug '24	NA	Control	Exploring working in partnership with MSEFT for the provision for quality assurance programme. In process of procuring new devices to support the programme.
9	**New Action:** Tender contract for medical devices programme.	Sept '24	NA	Control	Tender for contract will commence April '24, with timeline for completion Sep '24. The current contract runs to the 31 Dec '24.

Actions (to modify risks)		By When	By Who	Gap	Update 17/01/24
10	**New Action**: To enhance the Medical Devices Policy with detail of risk assessment for equipment marked as 'end of life' to support continued use in a clinical area.	Jun '24	AB	Control	In progress with the Medical Devices Safety Officer.

CRR81: Ligature

Risk Description: If EPUT does not continue to implement a reducing ligature risk programme of works (environmental and therapeutic) that is responsive to ever changing learning, then there is a likelihood that serious incidents may occur, resulting in failure to deliver our safety first, safety always ambitions

Initial Risk Score C4 x L3 = 12	*Current Risk Score* C4 x L4 = 16	*Target Score* C4 x L2 = 8	**Note:** Previous reported completed actions 2, 3, 5 and 6 have been removed for the report. **Note:** Risk assessment is being reviewed to assess the current risk exposure score.

Executive Responsible Office: Executive Director Operations
Director Lead: Nicola Jones / Moriam Adekunle
Board Committee: Quality Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Estates Ligature/ Patient Safety Co-ordinator H&S Team and Compliance Team LRRG / EERG Ligature Project Group	Teams established LRRG in place	LRRG reports Escalations via Accountability framework	BDO Audit November 2022 (Patient Safety) Design: Substantial; Effectiveness: Moderate
Ligature Policy and Procedure including environmental Standards	Ligature wallet audits / ligature inspections. Policy review and approval March 2023	Annual Report	BDO Audit November 2022 (Patient Safety) Design: Substantial; Effectiveness: Moderate
Ligature Training (target 85%) and Tidal training	TIDAL training. OLM prevention of suicide by ligature training – August 2023 – 88% compliance	Reporting to LRRG	
Trend Analysis	Benchmark 42 per 1000 bed days. EPUT Trend analysis April 21 – March 23 remain on average slightly above benchmark. Ligature analysis 2022-23 Report	Reporting to LRRG and BSOG	
Reduced ligature environment	Range of innovations in place including DTAs and Oxevision. Estates safety/ligature annual	Annual ligature inspection for all MH wards	
Learning from incidents and safety alerts via Lessons Team/ ECOL/ 5 key messages	Enhanced learning within annual reporting utilising deep dive data		Actions completed from the CQC Brief Guide
Local Area Ligature Network and Awareness and ownership of ligature reduction work	Network Established		
Support for staff	Support package developed – debriefing facilitated by Nursing in Charge/ Ward Manager/ Matron/ Service Manager/ Clinical Lead/ Consultant (or other member of Senior Medical Team)	Here for You – signposting for individual follow up Input from Psychological Services Patient Safety Team facilitates 'cold' debrief in the form of after action review for staff support	

Actions (to modify risks)		By When	By Who	Gap	Update 17/01/24
1	Identify new system for recording ligature actions (overseen by Project Group)	Complete	SP	Control	LRRG agreed to new Environmental standards with new ways of recording. Proposal agreed and action complete. New action to review policy and put new system in place.
4	Further roll out of environmental improvements	Mar '24	MM	Control	Action continues to be on track for delivery with regular ligature/patient safety environment improvements reported to ESOG and BSOG.
6	Pilot the project for a year followed by evaluation (in house training)	Complete	Project Group	Control	Action complete with new training proposal approved by Executive Team. New action to roll out training (see action 8).
7	Implement new environmental standards with new way of recording maintenance breaches only on 3i	Jul-24	SP	Control	New action

Actions (to modify risks)		By When	By Who	Gap	Update 17/01/24
8	Roll out new ligature training	Jul-24	Project Group	Control	New action

CRR92: Addressing Inequalities

Risk Description: If EPUT does not address inequalities then it will not embed, recognise and celebrate equality and diversity resulting in a failure to meet our People Plan ambitions

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previous reported completed actions 2 and 3 have been removed from the Board report.
C5 x L4 = 20	*C4 x L3 = 12*	*C3 x L2 = 6*	

Executive Responsible Office: Executive Director People and Culture
Director Lead: Lorraine Hammond
Board Committee: PECC

Key Controls	Controls Assurance Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Employee Experience Team including Director	Established and 6 Employee Experience Managers in post. Working with VAPR and safety teams		
Equality and Inclusion Policies	Policy and Procedures in place	Governance - Equality & Inclusion Sub-Committee and reporting to PECC	
Range of equality networks and staff engagement methods	Networks Established Executive Sponsors		
Training (inc. RISE Programme)	Workshops on micro-incivilities completed RISE Programme in place	RISE (3 cohorts completed with positive staff feedback)	
WRES and WDES	WRES and WDES plans in place Executive Sponsorship of plans		
EDI Culture	Ongoing programme in place to Nov 24 Supporting staff affected by discriminatory behaviour, abuse and bullying		
Behaviours Framework	Behaviour Framework in place		
EDI Framework RAG system	Framework developed		

	Actions (to modify risks)	By When	By Who	Gap	Update 17.01.24
1	Improve EDI learning offer for EPUT	Complete	LH	Control	EDI programme approval with launch Feb '24. EDI has been designated a mandatory module in the leadership development programmes. Impact of learning will be monitored through EDI key performance indicators within the Accountability Framework, for all Care Units and Directorates.
4	Improve the environment of psychological and physical safety for staff. Address racial abuse and sexual safety at EPUT.	Mar '25	LH	Control	Working with key stakeholders to introduce visual charter which includes behaviours that patients and staff commit to improving their working/living environment. Meetings underway to co-design and strengthen behaviour protocols in wards. Developing a targeted plan which aims to reduce abuse, bullying and harassment of staff by focussing on hotspot areas for a specfic period of time (Feb 24). Working to update appraisals and 121 templates to include EDI discussions where areas of concerns can be captured and discussed.
5	Implement the EDI framework as part of NHS England EDI plan (including new Leadership Behaviour Toolkit)	Extended Dec '25 To align with NHS England EDI Improvement Plan	LH	Control	On target to meet March 2024 deadlines which includes implementation of Executive and Board Objectives and including the breakdown of race data for the Gender Pay Gap. To drive awareness of the activity within the plan, EDI is a core pillar in the People and Education Strategy.

Actions (to modify risks)		By When	By Who	Gap	Update 17.01.24
6	***New Action*** : Update the Equality Inclusion and Human Rights Policy (Reference CP24)	May '24	LH	Control	Updates are to reflect any new legistlative changes or recommendations.

CRR93: Continuous Learning

Risk Description: If EPUT does not continuously learn, improve and deliver service changes, then patient safety incidents will occur and vital learning lost resulting in failure to achieve our safety strategy ambitions and maintain or improve CQC rating.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L3 = 15	*C5 x L3 = 15*	*C5 x L2 = 10*	**Note:** Previous reported completed actions 3-5 have been removed from the report.

Executive Responsible Office: Executive Nurse
Director Lead: Moriam Adekunle
Board Committee: Quality Committee

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Patient Safety Incident Management Team (PSIM)	Established (some vacancies) Deputy Director in post	Governance Structure in place Training in place	
Quality and Safety Champions Network	84 People registered (June '23)		
Learning Collaborative Partnership and Learning Oversight Committee	Forums in place	ESOG and QC Reporting	Pan Essex CQRG
Adverse Incident Policy incl. PSIRF SOP and People and Culture Policies	Policy and Procedures in place		
Culture of Learning Project	Culture of Learning Programme live	ESOG and QC reporting	IA - Learning from the Independent Inquiry (Mar '23) Design Moderate and Effectiveness Moderate
Themes allocation to clinical / assurance / transformation groups			
Learning information sharing	Communications Plan Lesson Newsletter Internal Safety Alerts Champions Network		HSE (2021) CQC (2021, 2022) findings
Patient Safety Dashboard	Dashboard Live (Feb '23) Triage and early warning tool Power BI		

	Actions (to modify risks)	By When	By Who	Gap	Update (Date)
1	Review Human Engine process maps to incorporate into patient safety incident team standard operating procedure	Complete	MA	Control	Standard Operating Procedurein place.
2	Develop and implement EPUT Safety and Lessons Management System (ESLMS)	Extended April '24	MA	Control	ESLMS in place in the live environment from December 2023. Next steps (Timeline extended to align with action 7 in SR1) is to put in place governance controls within care units for its use.
6	Develop QI methodology	Mar '24	MA	Control	The future model for QI and associated resources has had first review by the Executive Team and will be represented in Jan '24 for approval and consideration in the 2024/25 business planning cycle.
7	Ongoing awareness campaign to continue to increase the number of Quality and Safety Champions and embed the network	Mar '24	MA	Control	Requirement of Quality and Safety Champions remains an ongoing activity and the numbers are steadily increasing (recruitment and awareness supported through induction and other communication channels). 87 champions in place, with aim of achieving 100 by end March '24.

CRR96: Loggists

Risk Description: If EPUT is unable to increase the number of trained loggists and increase hours available for 24/7 then there may not be sufficient loggists available to log a major incident resulting in poor decision / action audit trail in the event of a major incident.

Initial Risk Score C4 x L4 = 16	*Current Risk Score* C4 x L4 = 16	*Target Score* C4 x L1 = 4	**Note:** Previous reported completed actions 1-2 have been removed from the report.

Executive Responsible Office: Executive Director Major Projects Director Lead: Nicola Jones , Director of Risk and Compliance Leads: Amanda Webb Board Committee: Quality Committee	**Controls Assurance**

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Pool of trained loggists, including EPRR Team and Executive Directors PAs	All EPRR incidents have been logged to date	Command structure	EPRR Core Standards Return and EPRR Annual Report 2022/23 notes number of EPRR events in 2022/23 and that appropriate response was stood up successfully.
Loggist Training	Available from NHS EoE and from in-house provision		
Major Incident Policy	Major Incident Policy in place		

	Actions (to modify risks)	By When	By Who	Gap	Update 17/01/24
3	Deliver Loggist training as per training needs analysis for new entrants on the Loggist register	Mar '24	NJ	Control	First in house training session complete. Programme of sessions in place for EA's up to end of March 2024

CRR98: Pharmacy Resource

Risk Description: If EPUT is unable to fill new and pre-existing positions within Pharmacy Services, then it may not be able to deliver a comprehensive Pharmacy Service to Trust patients, resulting in delayed treatment, poor clinical outcomes and possible patient harm.

Initial Risk Score C4 x L4 = 16	*Current Risk Score* C4 x L4 = 16	*Target Score* C4 x L2 = 8	**Decision Point:** Proposed re-score to 16 (with a potention to 12 in Feb'24) as a consequence of further incremental reduction iof the 'STOP LIST' within the business continuity plan (version 6). The likelihood score driving the change from a 5 (almost certain) to a 4 (likely). A further review of the risk score will be undertaken in Feb '24 following review of the plan as a consequence of new starters in Jan '24.

Executive Responsible Office: Executive Nurse Director Lead: Tendayi Musundire Leads: Tendayi Musundire Board Committee: Quality Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Pharmacy Team	Vacancy Factor high New posts to support new registrants	Executive Team - provided additional funding for pharmacy resources.	Collaboration with HEE and HEIs to develop a sustainable pipeline of staff CQC (July 2023) Must Do Action
Use of band and agency staff	Support from ICB secondment of pharmacist part-time		
Support from Patient Experience Team			
Rolling recruitment programme	£300k additional substantive staffing agreed - implementation in progress to fill posts	Performance reporting	
Business Continuity Plan	Using Datix Dashboard for pharmacy related incidents and monitored by pharmacy		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update 17/01/24**
1	Continue with recruitment campaign	Ongoing	HS	Control	Recruitment campaign remains ongoing and continuing to see recruitment with clear pipeline running throughout 2024 (with offers made, noting some dependent on exam success / GPhC registration, on track to achieve reduction from 17% to an 8% vacancy by Aug '24. Current vacancies 13.2 wte. Business continuity plan for Pharmacy has been scaled back with a review of the risk score. A further review of the business continuity plan will be undertaken in Feb '24 following new straters in Jan '24.

CRR99 Safeguarding Referrals

Risk Description: If EPUT is unable to manage the increase in safeguarding referrals then it may not adequately assess patient needs resulting in compromised patient safety, wellbeing and compliance with safeguarding best practice and regulation.

Initial Risk Score C4 x L4 = 16	*Current Risk Score* C4 x L3 = 12	*Target Score* C4 x L2 = 8	**Note:** Previous reported completed actions 1-2 have been been removed from the report.

Executive Responsible Office: Executive Nurse
Director Lead: Tendayi Musundire
Leads: Tendayi Musundire
Board Committee: Quality Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Trust Safeguarding Team	Gap: Vacancies within Safeguarding Team	Local system to monitor child safeguarding case involvement	
Safeguarding Policies and Procedures	Policy and Procedure in place		CQC Inspection
Prioritisation for oversight of S17, S47, MAPPA and MARAC attendance at appointments and involvement in reports, as well as attendance at statutory meetings on behalf of doctors.	Prioritisation and monitoring in place		
Safeguarding Training	Training in place ad monitored	Accountability Framework Metric Performance Reporting	
Caseload Management	Team Managers monitor caseloads and circulate monthly caseload reports to Operational Teams	Safeguarding Reports	
Datix Reporting	Datix amendments for sign off and categories		
Southend Unitary Reporting Authority Open Referrals Closed	Completed 19 May '23		

	Actions (to modify risks)	By When	By Who	Gap	Update 17/01/24
3	Incorporate safeguarding forms into patient records	Sept '23 Extend to April '24	TM	Control	We continue with the work of embedding the Safeguarding Forms into patient record systems, Paris and Mobius, with a planned go live in 4-5 weeks. For information: Essex County Council have indicated a potential change in process from the use of physical forms to an online portal. Our Safeguarding Lead has a meeting scheduled with ECC on the 02 Feb '24 to discuss and agree the process (as well as being engaged in any test environment trailing prior to go live. Following the meeting the Trust will scope how the portal will link with patient records.
4	Explore options to establish Associate Safeguarding Practitioners to assist Care Co-Ordinators to facilitate safeguarding (adult patients)	Mar '24	TM	Control	Recruitment into all clinical posts is complete to establishment within the Safeguarding Team. Business support team structure review has been completed and being costed, with any additional resource requirements being factored into business planning 2024/25.
5	Develop action plan to share with Southend UA to ensure all future open referrals are signed off	Complete	TM/ DP	Assurance	Action complete with handover of S75 being achieved and new agreed safeguarding processes in place.

8.2 BOARD SAFETY OVERSIGHT GROUP

Information Item | Professor Sheila Salmon | 5 minutes

REFERENCES

Only PDFs are attached

BSOG Report 31.01.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31 January 2024

Report Title:	**Board Safety Oversight Group Report**					
Executive/ Non-Executive Lead:	Professor Sheila Salmon, Chair					
Report Author(s):	Alison Ives, Deputy Director of Transformation					
Report discussed previously at:	Executive Safety Oversight Group Board Safety Oversight Group					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	~~Yes~~/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes~~/ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Board of Directors with an update on the progress of projects, programmes and activities linked to the safety priorities within the safety strategy.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The report provides details of the following areas:

- Ligature Risk Reduction
- EPUT Culture of Learning
- Embedding Gold Standard SOPs
- ePMA

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓

SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

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

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

Acronyms/Terms Used in the Report			
ESOG	Executive Safety Oversight Group	BSOG	Board Safety Oversight Group
SOP	Standard Operating Procedure	ePMA	Electronic Prescribing and Medicines Administration
ESLMS	EPUT Safety and Lessons Management System		

Supporting Reports/ Appendices /or further reading
Main Report

Lead
Professor Sheila Salmon **Chair** **Chair of the Board Safety Oversight Group**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

BOARD SAFETY OVERSIGHT GROUP REPORT

This report provides the Board of Directors with an update on the progress of projects, programmes and activities linked to the safety priorities within the safety strategy.

In this period the key areas of focus for the Executive Safety Oversight Group (ESOG) and Board Safety Oversight Group (BSOG) remain with Ligature Risk Reduction, EPUT Culture of Learning, Embedding Gold Standard SOPs and Electronic Prescribing and Medicines Administration (ePMA) projects and programmes.

Ligature Risk Reduction

The focus of the ligature risk reduction programme remains on the environment of our in-patient estate and the ligature related training project.

Training
The Executive team fully supported and approved the training proposal post its pilot and recruitment is now underway to on-board the necessary team to deliver this training across the Trust from April 2024.

Embedding of Gold Standard Operating Procedures (SOPs)

The SOPHIA App (digital platform for viewing and reviewing SOPs) has been running as a pilot since the beginning of December 2023 with Carradale carrying out both virtual and face to face training for all participants.

All remaining SOPs which do not form part of the above pilot remain on track for development as per the plan with a target completion date of the end of May 2024.

EPUT Culture of Learning (ECOL)

Version 1 of EPUTs Safety and Lessons Management System (ESLMS) went live in mid-December 2023. Following this internal workshops have been taking place to understand how the new system will best fit with business as usual work.

The Patient Safety Incident Response Plan (PSIRP) is now available on the Intranet, with an advertising banner on the EPUT home page.

Electronic Prescribing and Medicines Administration (ePMA)

The Electronic Prescribing project is progressing through the key gateways from implementation planning into the system configuration and testing phase. The project remains on track to commence rollout of pilot wards from May 2024.

Report prepared by

Alison Ives,
Deputy Director of Transformation

On behalf of
Professor Sheila Salmon
Chair

8.3 FREEDOM TO SPEAK-UP SERVICE

Information Item | Nigel Leonard | 10 minutes

REFERENCES

Only PDFs are attached

Freedom to Speak-Up Guardian Report 31.01.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31 January 2024

Report Title:	**Freedom to Speak Up Guardian Service**					
Executive/ Non-Executive Lead:	Nigel Leonard, Executive Director Major Projects & Programmes					
Report Author(s):	Bernie Rochford, Principal Freedom to Speak Up Guardian					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Finance and Resources Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Statutory Public Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	No but FTSU provides insight into	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Board of Directors with an overview of EPUT's Freedom to Speak Up Guardian Service for Q3 2023.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors are asked to:

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

Summary of Key Issues

EPUT's Freedom to Speak Up Principal Guardian (contractual requirement) complements other arrangements already in place in the Trust for colleagues to raise concerns such as via line managers, Employee Resources, Safeguarding, Engagement Team and Student Liaison Facilitators. The Trust's Freedom to Speak up Policy / Whistleblowing Policy and Procedure support this arrangement.

Colleagues are raising concerns through the Freedom to Speak Up (FTSU) service, which is encouraging. Steps are being taken to put in place to review how, when, why and where the service is being used and for what purpose in order to ensure it is able to meet demand and expectations.

There is great potential for Freedom to Speak Up to develop further as well as link in and support wider work streams across EPUT.

Currently, the greatest challenge is trying to run a service whilst waiting to recruit additional resources. I am working closely with Executive Directors and Enable East to mitigate this issue.

In line with CQC *Guide to trusts in establishing FTSU Guardians*, Freedom to Speak Up has moved from the People Directorate to Nigel Leonard, Executive Director of Major Projects and Programmes

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			-
Involvement of Service Users/Healthwatch			-
Communication and consultation with stakeholders required			✓
Service impact/health improvement gains			✓
Financial implications:		**Capital £** **Revenue £** **Non Recurrent £**	Potential cost pressure to stabilise the FTSU Guardian team
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			
FTSU	Freedom to Speak Up	NGO	National Guardians Office
BAU	Business As Usual	EMREN	Ethnic Minority & Race Equality Network
SU, LU, FU	Speak Up, Listen Up, Follow Up		

Supporting Reports/ Appendices /or further reading
Freedom to Speak-Up Guardian Service Report

Lead
Bernie Rochford MBE, **Principal Freedom to Speak Up Guardian**

Board of Directors Part 1
31 January 2024

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Freedom to Speak Up Guardian Service

1 Purpose of Report

This report provides the Board of Directors with an overview of EPUT's Freedom to Speak Up Guardian Service for Q3 2023.

2 Executive Summary

This short report covers Q3 2023 as immediate and interim feedback on the Freedom to Speak Up (FTSU) service before a full year report is submitted to the Board in future.

Following an open, external recruitment process for a Principal Freedom to Speak Up Guardian, I joined EPUT in July 2023. Coming in as an 'external' creates an ideal opportunity to review the service, need and direction. I am heartened by the support and enthusiasm from seniors and colleagues across the trust. I recognise elements of the service are at different stages of maturity but overall the appetite for Freedom to Speak Up and developing it further is clear and not a hard sell. By capitalising on this, enlisting, and utilising the support of colleagues I believe, there are some real opportunities for developing not only the FTSU service but also the trust to become a Freedom to Speak Up organisation.

As can be expected in any handover adjustment period, managing casework, both legacy cases and incoming new ones requires sensitive handling. Exploring this further has proved insightful in better understanding the trust culture and how / where 'cases' are entering the service and for what reason. This in turn informed a long-term action to empower and upskill colleagues to have more open, supportive conversations between them earlier on.

During this time (Q3), I have worked as part of the Letby Response Group and agreed to move any remaining actions under the umbrella of the FTSU plan of action, rather than separately report twice. This will enable a clear development path for implementing actions associated with the Trust's response to Letby so they remain sustainable within the Trust going forward.

Further work has been undertaken towards the Board Reflection and Planning Tool (NHS England / National Guardians Office requirement). Building on a Board Development Session I delivered to the Board late September 2023 - *Freedom to Speak Up development over time* – I delivered a further Board Development Session early December 2023 on *Detriment.* In this session, I outlined some key learnings around fear of detriment after speaking up and shared some ideas on potential roll out training to HR (Employee Relations) and Managers in 2024. These Board sessions form part of the Board reflection process to assess, prioritise and build on improvement work for the Freedom to Speak Up service. Updates to the Freedom to Speak Up policy were also made during this period to reflect the changes in Executive Lead oversight.

In addition, over the Q3 period, we ran an extended three-month campaign raising awareness around Speak Up, Listen Up, and Follow Up. This included running a series of Listen Up sessions for managers for them to share their feedback, frustrations or any learnings about Freedom to Speak Up and what it means to them. There were some very rich insights, and feedback that will be collated into a forthcoming report. The managers' support and feedback has been instrumental in informing the future direction and shaping of Freedom to Speak Up across the trust to create greater openness and transparency.

My vision for the service is to foster and empower colleagues to own their part in developing EPUT as a Freedom to Speak Up organisation where all become 'co-guardians' of the trust.

And align Speaking Up to the trust values –*Speak Up* / We Care – *Listen Up* / We Learn - Follow Up / We empower.

In line with CQC *Guide to trusts in establishing FTSU Guardians*, the FTSU service moved from the People Directorate to Nigel Leonard, Executive Directive Major Projects in September 2023.

3 Freedom to Speak Up Guardian Service

3.1 History of the FTSU service

The Freedom to Speak Up service has developed over time from an initial arrangement in late 2016 of staff voting and electing the Principal Freedom to Speak Up Guardian, to internal appointments in 2022; to then in 2023 an open national recruitment process in line with national best practice.

During this time, the scope of Freedom to Speak Up has also developed and moved from its initial emphasis on patient safety to later expanding to patient and worker safety. As time went on and intelligence grew, so too did the remit to include 'inappropriate behaviours' and now largely *'anything that gets in the way of colleagues coming to work and performing their role'* can be raised with FTSU Guardians. Nationally by far the greater number of cases reported to FTSU Guardians is around Inappropriate Behaviours, Bullying & Harassment, then worker safety and finally patient safety. EPUT is in line with this picture.

The Freedom to Speak Up service operates both a proactive and reactive service; promoting Freedom to Speak Up and positive culture change whilst at the same time responding to casework and issues as they surface.

October is nationally adopted as Speak Up month with an expectation that over the course of the month there will be an increase in activities around raising awareness of Speaking Up. The national theme this year was to look at 'Barriers to Speaking Up'. Following discussion with EPUT Executive Team about the numbers, types of cases, emerging themes etc. coming through EPUT Freedom to Speak Up service, it was agreed that instead of doing a raising awareness campaign solely in October, we would extend it over a three month period. I thank the Executive team for their support and commitment and novel approach. Over Q3, with the support of the Communications and Engagement teams in particular we ran a three-month raising awareness campaign around Barriers to Speaking Up in October, to Listening Up in November and to Following Up in December. I thank colleagues across the trust for their support and invaluable contributions over the three-month period. Feedback from these sessions in Q3 will be written up and shared in due course.

My role (whilst we look to recruit and appoint additional resource) is backed by an Executive Lead and NED (Non-Executive Director) for additional support and escalation if needed. Historically, EPUT had a local Guardian network which acted as a Champion network but this was largely dormant in recent times. This is earmarked alongside a number of other initiatives for future development. I will be looking to reignite a Freedom to Speak Up Champion network as more resources become available and thank former Local Guardians / Champions for their service to the Speak Up agenda.

3.2 Overview of activity / progress in Q3 2023

Some of the activity / progress gained through Q3 include:

- Three month raising awareness campaign exploring barriers to Speak Up, Listen Up, Follow Up
- Roll out of Freedom to Speak Up e-learning modules across the trust
- A series of focused 'Listen up' sessions for managers to better understand what Speak Up, Listen Up, Follow Up means for them

- Board development sessions around Freedom to Speak Up and detriment (27 September and 6 December 2023)
- Updates to the Freedom to Speak Up policy and Board Reflection and Planning tool
- Letby Response group collated their series of actions and moved into Freedom to Speak Up as business as usual
- A suite of Freedom to Speak Up screen grabs and banners were introduced as communication tools to support the agenda
- Blogs and Freedom to Speak Up communications went out across a number of avenues tying Freedom to Speak Up into other awareness campaigns i.e. Black History month, Disability month, Diversity week, Bullying & Harassment etc.
- Greater emphasis on awareness raising of barriers to Speak Up for those with protected characteristics
- Presenting a session at the Black History Month Celebration event by EMREN Network (Ethnic Minority & Racial Equality Network) on Speak Up (November)
- Improvements made to the online Freedom to Speak Up form for raising concerns
- Review of the local Guardian / Champion network and foundations laid to reignite
- Connections made with regional and national Guardian networks including Herts & West Essex ICS
- Utilise the support and expertise of a NHS Graduate Trainee (psychology background) for a short period of time to look at the psychological research underpinning Speaking Up / Bystander effect; and develop ideas on how to ground the research into practical solutions in the workplace (theory into practice).
- Invite to do a podcast with the National Guardian Dr Jayne Chidgey-Clark https://www.youtube.com/watch?v=fZdF3DFRVts
- Invite to present at Westminster meeting on reform of PIDA legislation (Public Interest Disclosure Act, more often referred to as whistleblowing)

3.3 Issues raised through the Freedom to Speak Up service

Cases brought to the FTSU Guardian in Q3 (October, November, December) **2023**

Total	Open	In Confidence	Anon	Patient Safety	Worker Safety	Bullying Harassment Inappropriate Behaviours	(Fear of) Detriment	Sign-posting
86	59	12	15	14	26	40	5	27

Note –
i) These figures are for Q3 only and should be viewed in context of other factors before interpreting i.e. national as well as local awareness raising campaigns are traditionally held within Q3 which is known to effect raising concerns reporting. The Q3 figures shown are isolated figures for Q3, have not been reconciled and will be resubmitted in a future Board report with more narrative looking at context and trends over time
ii) once reconciled, these figures may change from later submission to the NGO, as data review is still in progress
iii) some concerns raised contain multiple elements or don't quite match the above criteria

EPUT Freedom to Speak Up figures appears to be in line with the national picture provided by the National Guardians Office (NGO) in that the majority of concerns raised via Freedom to

Speak Up are more around inappropriate behaviours and Bullying and Harassment than they are about worker safety & wellbeing and patient safety. The latter being the least reported.

4 Immediate Challenges and Priorities

Challenges

- Recruitment process to support an active uptake service
- As the role of the Freedom to Speak Up service has broadened since introduction in late 2016, so too has the funnel of cases coming through. Initial thinking (nationally) was the main concerns raised via Freedom to Speak Up would be around patient safety; overtime this broadened to worker and patient safety; currently it stands as anything that gets in the way of colleagues coming to work and carrying out their duties. This is a very broad remit which attracts and adds more cases and complexity
- Demand exceeds capacity due to good uptake of the Freedom to Speak Up service. This impacts on response times and managing case work, proactive and reactive work and areas for development or response other than immediate
- Documentation and inconsistent use of case reference numbers which overtime can come adrift from correspondence / email subject headers, cases, requiring more time to manage, keep a track off and file
- Spreadsheets used for housing documentation need reviewing and updating for more refined metrics and fields to be used
- Elements of the current Freedom to Speak Up service appear to be at different stages of maturity, which is challenging given some elements, need to be set up, others scaled up and some wound down. More clarity and definition is needed for the most part.
- Limited capacity (until resources appointed) to support both colleagues speaking up and the Responsible Owners in providing updates and feedback
- The lure of Freedom to Speak Up could pull every day Speaking Up away from BAU within teams, impacting on response times which impacts on confidence levels. The Freedom to Speak Up service has the potential to move from being an additional safeguard / safety valve for colleagues to raise concerns through to a whole entity in itself. This could encourage the development of bypass channels from day to day management within teams at source. This could displace and disempower legitimate management structures but also overload the Guardian service as a safety valve route. More urgent or serious cases may get lost within the sea of wider issues raised. However within that, not all patient or worker safety issues are immediately apparent and could be masked by greater focus on side issues.

Priorities

- Expedite request for an interim additional Freedom to Speak Up Guardian through the Establishment Control Panel (new measures in place to assist with efficiency measures)
- Work with Auditors who will review and benchmark the FTSU service / assess demand and capacity, need, effectiveness and inform budget arrangements for 2024 / 2025
- Utilise where possible existing services, forums and colleagues support to channel key messages through i.e. Communications, Training, Engagement, etc.
- Increase current capacity by enlisting the previous Principal FTSU Guardian to support legacy cases; and Enable East / the bank to support any pieces of non-confidential Guardian work
- Set up systems of work to enable professional caseload management, such as use of reference numbers, filing, feedback, lessons learnt etc.

- Redefine and clarify expectations of the Freedom to Speak Up service and progress through individual and service objectives for the coming year

5 Recommendations

The Board of Directors is asked to:

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

Report prepared by:

Bernie Rochford MBE
Principal Freedom to Speak Up Guardian

25 January 2024

8.4 LEARNING FROM DEATHS QUARTER 2 REPORT

Information Item | Frances Bolger | 5 minutes

REFERENCES

Only PDFs are attached

Learning From Deaths Quarter 2 Report 31.01.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31 January 2024

Report Title:	**Learning from Deaths – Quarterly Overview of Learning and Data (Quarter 2 2023/24)**					
Executive/ Non-Executive Lead:	Frances Bolger, Interim Executive Nurse					
Report Author(s):	Michelle Bourne, Project Lead					
Report discussed previously at:	Learning and data included in report considered by: • Learning from Deaths Oversight Group • Learning Oversight Sub-Committee • Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	
	SR3 Finance and Resources Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report presents the Q2 2023/24 Learning from Deaths Quarterly Overview of Learning and Data report, which includes the following: • An overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and actions being taken as a result. • Information relating to the context of mortality data and surveillance under the Trust's Learning from Deaths arrangements (Appendix 1). • Data relating to deaths recorded on Datix for Q2 2023/24 (1st July – 30 September 2023) and updated data for Q1 2023/24 (Appendix 2). • Updated data for deaths relating to previous years (Appendix 3).	**Approval**	
	Discussion	
	Information	✓

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

Summary of Key Issues
1. The Trust implemented a new Learning from Deaths Policy and Procedural Guidelines from 1 April 2022. 2. The attached quarterly report provides an overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and examples of actions being taken as a result. This learning is presented on a monthly basis to the Trust's Learning Collaborative Partnership, Learning from Deaths Oversight Group and Learning Oversight Sub-Committee. There are immediate actions taken as a result of learning identified, as well as longer term actions that will form part of the Trust's Safety Improvement Plans. 3. The attached report also presents data that the Trust is nationally mandated to report to public Board meetings on a quarterly basis – i.e. the number of deaths in scope; the number reviewed and level of those reviews; and the assessment of problems in care. There are no issues of concern to note from the Q2 data, which is in line with that of previous quarters. 4. The new scope for deaths included within the Trust's Learning from Deaths arrangements has brought a larger number of deaths into scope, enhancing the Trust's ability to learn from deaths. At the point of extracting the data, a total of 73 Stage 1 reviews had been undertaken by local service managers in relation to deaths occurring between 01/07/23 – 30/09/23 to ascertain learning and identify those for further detailed review. This is a review stage that did not form part of the previous Mortality Review arrangements and has thus increased reflective practice and the Trust's ability to identify learning locally. 5. As part of the Trust's mortality surveillance arrangements, a comparison to the categories under the previous Mortality Review arrangements is also undertaken whilst a longer period of comparative data under the new arrangements is built up. This enables identification of any increases in death numbers against the previous scope categories which are outside of Statistical Process Control limits and should thus be investigated further. Again, there are no issues of concern to note. 6. It should be noted that the data for this report was extracted as at 10/11/23. Any updates to information after this date will be included in future reports.

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	✓
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	✓
Financial implications:	
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			
LDOG	Learning from Deaths Oversight Group	MRSC	Mortality Review Sub-Committee
EPUT	Essex Partnership University NHS Foundation Trust	LOSC	Learning Oversight Sub-Committee
LeDeR	National Mortality Review Programme for Learning Disability Deaths	SMI	Severe Mental Illness
PSIRF	Patient Safety Incident Response Framework	EDAP	Essex Drug and Alcohol Partnership

Supporting Reports, Appendices or further reading

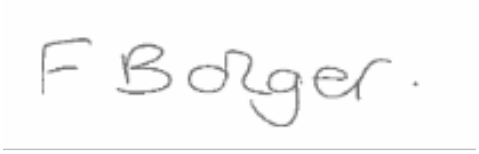
Attached:

- Report: Learning from Deaths – Quarterly Overview of Learning and Data (Q2 2023/24).
- Appendix 1: Context of mortality data and surveillance under the Trust's Learning from Deaths Policy.
- Appendix 2: Summary of Quarter 1 and Quarter 2 2023/24 mortality data.
- Appendix 3: Summary of previous years mortality data

"National Guidance on Learning from Deaths" Quality Board March 2017:
https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

"Implementing the Learning from Deaths framework: Key requirements for Trust Boards" NHS Improvement July 2017:
https://improvement.nhs.uk/uploads/documents/170720_Implementing_LfD_-_information_for_boards_proofed_v2.pdf

Lead



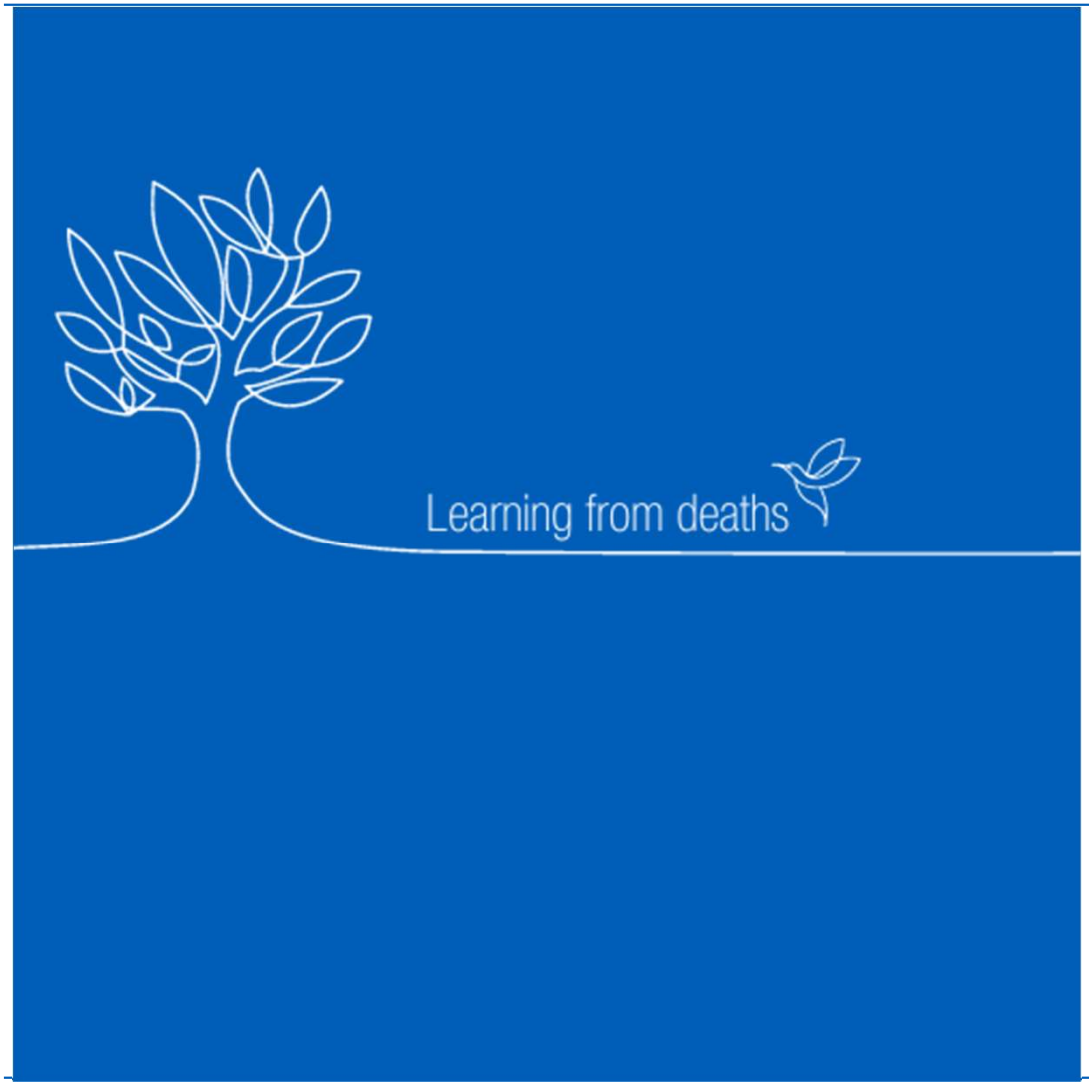
Frances Bolger
Interim Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

QUARTERLY OVERVIEW OF LEARNING AND DATA

Learning from deaths

QUARTER 2 - 2023/24

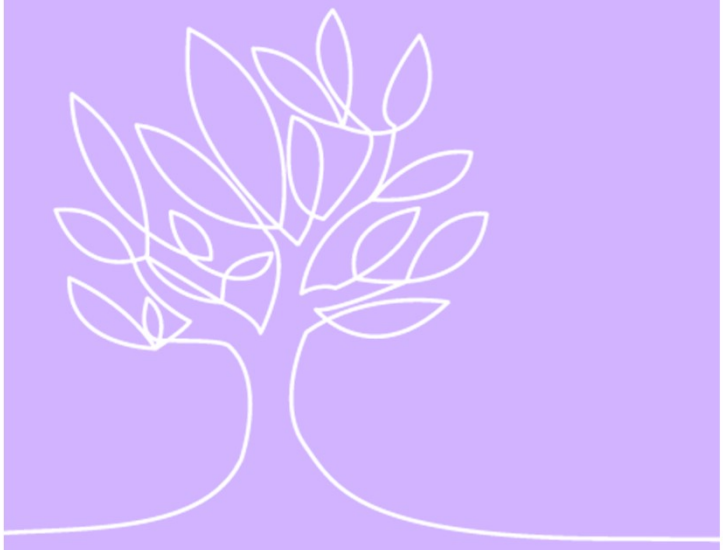


PURPOSE OF REPORT

This report sets out:

- An overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements since the last report to the Board of Directors (November 2023) – ie learning identified between September – November 2023;
- Information relating to the context of mortality data and surveillance under the Trust's Learning from Deaths arrangements in place since 1st April 2022 (Appendix 1);
- Data relating to deaths recorded on Datix for Q2 2023/24 (1st July – 30th September 2023) and updated data for Q1 (Appendix 2); and
- Updated data for deaths relating to 2022/23 and previous years (Appendix 3).

THE TRUST'S APPROACH TO LEARNING FROM DEATHS - CONTEXT



The aims of the Trust's Learning from Deaths Policy are to provide a robust governance framework for undertaking mortality review in order to:

- improve the safety of the care we provide to our patients, and improve our patients', their families' and carers' experience of it;
- further develop systems of care to continually improve their quality and efficiency;
- improve the experience for patients, their families and carers wherever a learning issue from the review of deaths is identified;
- improve the use of valuable healthcare resources; and
- improve the working environment for staff in relation to their experiences of reviewing deaths and associated reviews / investigations.

The Trust sets out to achieve these aims by:

- ensuring that deaths that occur within the Trust are subjected to appropriate review based on the circumstances of the death which enables any good practice, or conversely problems in care, to be identified on an individual basis;
- ensuring that any problems in care for individual cases are addressed appropriately and appropriate actions taken in relation to that death;
- ensuring that any good practice and lessons learnt are shared across the Trust where appropriate and local actions taken to ensure that good practice is increased and improvements in care are implemented across the Trust where necessary; and
- ensuring that the Trust has a corporate oversight of deaths of patients in its care and identifies any trends or themes of concern or good practice emerging which may require further investigation and action.

LEARNING FROM DEATH REVIEWS September – November 2023

This section on learning details:

- Sources of learning
- Examples of good practice identified
- Learning emerging from Stage 1 reviews
- Learning emerging from Stage 2 reviews
- Learning emerging from PSIRF reviews
- Examples of actions being taken to address and action learning from learning from deaths reviews

Sources of learning:

- Completed Stage 1 local service reviews
- Approved Stage 2 clinical case note reviews
- Approved Stage 3 (Patient Safety Incident Response Framework - PSIRF) reviews
- Completed Essex Drug and Alcohol Partnership (EDAP) multi-agency collaborative reviews
- Completed National Learning Disability and Autism Mortality Review Programme (LeDeR) reviews

Examples of good practice identified in reviews September – November 2023 (1)

- Patient accessed timely care from the Crisis Response Team and subsequently from Home First when in crisis. Patient was referred to the community team who carried out a joint review to establish their needs post-crisis. Patient was identified as needing specific treatment that was facilitated and carried out in a relatively brief timeframe. Community team communicated with psychology team to ascertain what other support could be offered before closing down the referral. Patient was actively engaging in therapy at the time of his death. Cause of death physical health related.
- Patient had a Patient Initiated Care Plan (PICP). At the time of their death the Social Care Review Team were actively involved, had assessed the patient, and made a number of arrangements in order to get the funded care package in place.
- Patient was being nursed under End of Life care with a Do Not Attempt Resuscitation in place with the son's involvement.
- Patient had good input from their previous care co-ordinator who was engaging with them every couple of weeks, more when they felt the patient's mood was low. Current care co-ordinator had seen patient twice since April but had been in contact with care home for updates and appears to have had a good relationship with the patient.

Examples of good practice identified in reviews September – November 2023 (2)

- Patient had a poor history of engagement – however staff involved had attempted to manage this despite high caseload numbers. There was evidence that staff had been concordant with the positive engagement policy.
- Team responded well and in a timely manner when calls came in with concerns and when Hospital Liaison asked them to review the patient in hospital.
- There is clear evidence that the Care Co-ordinator engaged or attempted to engage with the patient frequently and consistently. There are several such contacts recorded each month. The fact that the Care Co-ordinator discussed the care in caseload supervision and there was a clear plan around how to manage the poor engagement was documented.

Learning themes emerging from Stage 1 reviews September – November 2023 [1]

CONTINUING THEMES:

- Often **cause of death is not available** at the point of completing Stage 1 review – limits conclusions (and causes issues re timing of PSIRF / Stage 2 reviews)
- Opportunities to **strengthen communication** to improve care of service user and following death:
  - With individuals (eg proactively encouraging face to face contact when telephone appointments undertaken)
  - With partner agencies (eg potential for closer contact with GP; communication with acute Trust to facilitate effective discharge; sharing feedback with hospital liaison teams; obtaining detailed information relating to deaths from some care homes)
- Majority of the deaths reviewed are from **physical health causes** (both rapid deteriorations and long term conditions) - opportunities to strengthen management of physical health issues:
  - Monitoring of physical health of patients in community and supporting access to physical health care (eg appropriate action in terms of patient refusals to eat and drink; supporting compliance with physical health medication regimes; having knowledge of DNACPR status)

Learning themes emerging from Stage 1 reviews September – November 2023 (2)

- Need to ensure **proactive follow up of disengagement** – eg importance of face to face contacts with clients, more robust monitoring for Do Not Attends / GP referrals, active re-organising of appointments when patients cancel appointments
- **Clients not open to services at time of death –** eg Coroner Do You Know? enquiries
- **Record keeping** – eg clearly documenting the care plan, clearly and regularly documenting actions that are being taken, documenting follow up plans eg to GP
- Strengthening **care planning arrangements** – eg examples as above
- Ensuring an appropriate **discharge plan** is put in place which is adequate to the patient's needs
- Challenges of maintaining knowledge of **patients who are in prison** / when they are to be released and return to case load etc *(this is the subject of a Quality Improvement Initiative in the Trust)*

EXAMPLES OF NEW LEARNING:

- Ensuring all staff working in the identified service have undertaken validation of death training

Learning themes emerging from Stage 2 Clinical Case Note Reviews September – November 2023

STAGE 2 CLINICAL CASE NOTE REVIEWS:

- Three Stage 2 Clinical Case Note reviews have been approved in the three month period to end November 2023. Key learning emerging from those reviews was as follows:
  - **Physical health:** Venous thromboembolism (VTE) assessments should be undertaken routinely on admission to inpatient units and, where there is the slightest suspicion of DVT, it is advisable to undertaken a D-Dimer to exclude any DVT.
  - **Record keeping:** Information regarding patient wishes relating to transfers to acute settings especially in end of life scenarios should be clearly documented on SystmOne (Electronic Patient Record system) as high priority reminders.
  - **Integrated working with partner agencies:** A more integrated approach, especially between EPUT, GP and Haven services may have encouraged a more holistic approach to the patient's end of life care.

Learning themes emerging from End of Life care reviews September – November 2023

END OF LIFE CARE REVIEWS:

- Importance of prescribing of anticipatory medications by primary care in a timely manner.
- Lack of clear information for patients / families / carers in terms of the start and finish times of Community Integrated Team working could result in delay in symptom management.
- Importance of timely discussion and agreement with patients and families in terms of Do Not Attempt Resuscitation (DNACPR) orders, including by primary care.
- Importance of appropriate management of Implantable Cardioverter Defibrillators (ICD) at End of Life.

Learning themes emerging from EDAP multi-agency collaborative reviews September – November 2023

ESSEX DRUG AND ALCOHOL PARTNERSHIP (EDAP) MULTI-AGENCY COLLABORATIVE REVIEWS:

- **Good practice** examples included:
  - Good liaison and communication between services
  - Good multi-agency working, regular joint appointments
  - Client engaging well and harm minimisation discussed

- **Learning** examples included:
  - **Record keeping** – importance of recording all discussions (formal and informal), importance of recording everything accurately and in a timely manner (including Do Not Attends), if there is a delay in documenting notes the reason for the delay should be documented
  - **Importance of timeliness of interventions –** utilisation of examples of importance of timely intervention within public health information for service users.
  - Good practice to **breathalyse clients** if known to be using alcohol due to risks of mixing alcohol and illicit drug misuse
  - No evidence of **follow up** when clients are advised to go to A&E / GP.

Learning emerging from a thematic review of non-patient safety incident related deaths of patients with Severe Mental Illness

A thematic review of n.15 non-Patient Safety Incident related deaths of patients with Severe Mental Illness (2020-22) has been undertaken by the Trust's Nurse Consultant in Physical Health and the key learning was identified as follows:

- Physical health monitoring and cardio-metabolic screening remains crucial
- Integration with primary care should enable seamless care
- Communication with acute care partners, especially relating to antipsychotic use, can help identify concerns
- The Electronic Patient Record should reflect intensity of interventions to physical health promotion
- Assurance regarding primary care involvement is needed in the Electronic Patient Record
- Involvement of agencies that support healthy lifestyles should be facilitated – eg Equally Well
- Facilitate access to lifestyle services.

Learning themes emerging from PSIRF reviews approved September – November 2023

Similar themes continue to emerge from the review of deaths under the Patient Safety Incident Response Framework (PSIRF) as follows:

- Communication with / involvement of others - particularly other EPUT teams or partner agencies
- Record keeping
- Clinical care
- Referrals
- Staffing
- Training
- Environment
- Disengagement
- Medications
- Policy and Process

Examples of actions being taken in response to learning from deaths (1) – Stage 1 and 2 reviews

- Local immediate actions by services – eg liaison with out of hours services to provide information about contact points and hours of availability of core integrated services to ensure timely response to symptom management for end of life patients, creation of a log of anticipatory medications issues by the Trust's EOL Care Lead to inform system wide discussions to improve, improved transfer processes put in place between Essex Young Peoples Drug and Alcohol Service (EYDAS) and Child and Adolescent Mental Health Services (CAMHS), training to be provided for ambulance services on deactivation of ICDs.
- Learning presented to and considered monthly by Learning Collaborative Partnership – included in Trust communications such as Lessons Learned Bulletin and 5 Key Messages as appropriate.
- Learning used to inform topic areas for "Learning Matters" MST development sessions – eg lessons learned from specific deaths, learning from incidents (sharing learning from PSIRF reviews and examples of where learning has been successfully embedded into practice), engaging disengaging patients (providing an overview of methods and techniques that can be used to positively engage with patients).
- Thematic learning being used to inform the Trust's Safety Improvement Plans.
- Sharing of local learning from Stage 2 reviews is being co-ordinated by Deputy Directors of Quality and Safety (DDQSs), working with local clinical / service leaders to identify and implement change. The learning is also being used to inform subject matter for quarterly learning events being designed and delivered for each Care Unit by DDQSs.

Examples of actions being taken in response to learning from deaths (2) – Stage 1 and 2 reviews

- Examples of specific actions arising from reviews that are being pursued include:
  - Work has commenced to strengthen data flows to the Trust for receipt of information on confirmed causes of death – including liaison with the Regional Medical Examiners Office and systems leads for shared care records.
  - The Integrated Care Boards have been involved in considering the learning emerging from the thematic review of non-patient safety incident deaths of patients with Severe Mental Illness (SMI) and have facilitated attendance at their system wide meetings to enable feedback of learning to other system partners including the acute Trusts, GPs etc. The Trust's Nurse Consultant in Physical Health will be attending the system Physical Healthcare Conference in January 2024 to present their findings and actions that would strengthen holistic services.

Examples of actions being taken in response to learning from deaths (3) – Stage 1 and 2 reviews

- Multi-disciplinary work being facilitated to address Trust wide issues - eg :
  - Physical health – learning from deaths lead continues to link with Trust leads for physical health and the care of the deteriorating patient to ensure learning continually informs work in these areas
  - Terms of reference are now in place for the Quality Improvement Initiative to review and strengthen the pathways between prison healthcare and EPUT services and the multi-agency group to take this forward is being established
  - A Dual Diagnosis Learning Implementation Group is now operational to consider specific learning emerging from the review of deaths of dual diagnosis clients and to jointly agree actions to be taken across EPUT and Essex Drug and Alcohol Partnership services. Actions taken to address learning identified from deaths include increased partnership working between mental health and EDAP services including Dual Diagnosis workers across localities, the introduction of a Transition Clinician to assess and manage clients initially following transfer from another service, joint assessment and care planning by the Home Treatment Team (HTT) and First Response Team (FRT) prior to discharge from the HTT to FRT, development on-going of a system care plan template whereby all aspects of care (eg physical health, mental health etc) will be recorded on one care plan.

Examples of actions being taken in response to learning from deaths (4) - PSIRF

The process for taking forward learning from deaths reviewed under PSIRF is as follows:

- Action responses to Patient Safety Incident Investigations are managed locally within Care Units and are in direct response to the individual circumstances and services involved.
- The learning response methods used as part of the PSIRF review processes ensure that actions are localised and meaningful to the teams involved and are in context to the specific circumstances.
- Horizon scanning and thematic reviews have been carried out to identify broader organisational learning. These have identified certain conditions for safety and are currently listed in the Trust's Patient Safety Incident Response Plan (PSIRP) as core elements to consider within the organisations Safety Improvement Plans.
- This developmental evaluation adopts PSIRF's system thinking approach to safety, whereby any tangible action plans remain localised within Care Unit governance processes and are reported through the Trust's operational Assurance Framework.
- Immediate learning through the on-going work under the PSIRF framework is communicated regularly through the 5 key messages bulletin agreed with the Patient Safety Partnership Group.
- The Trust is also developing a Safety Learning Management System – this is a database that can be used to undertake horizon scanning and thematic reviews using a digital platform rather than the manual approach that has been used in the past to carry out these specific learning response methods.
- Examples of actions taken in response to specific reviews of deaths via the PSIRF process include carer link worker now attending MDT meetings to allow for discussions between clinicians and the link worker; establishment of an "allocations inbox" monitored by the Team Manager and reviewed at the Senior Allocations Meeting to ensure all patients referred for allocation are identified and followed up as clinically appropriate; implementation of a new digital dashboard called Management and Supervision Tool (MaST) which further assists in monitoring caseloads, actions and risks; and development of a "Transfer of Care - Care Coordinator to Care Coordinator" template.

MORTALITY DATA - Context

- The context for the collection and reporting of mortality data under the Trust's Learning from Deaths arrangements (2022/23 and 2023/24) is outlined in **Appendix 1**. This includes details of the deaths which are mandated for report on the Trust's incident management system (Datix) and review.
- Regardless of the mandatory requirements for a formal review detailed in Appendix 1, services are also being encouraged to report on Datix all deaths that are brought to their attention. This increases the Trust's ability to identify potential learning opportunities. These additional reported deaths are also included in the data for Q1 – Q4 2022/23 and Q1 – Q2 2023/24.
- It should be noted that data in this report was extracted as at 10/11/23. Any updates to information after this date will be included in future reports.
- Detailed mortality data is presented to the Learning from Deaths Oversight Group and Learning Oversight Sub-Committee for review and approval.
- A summary of mortality data for Q1 – Q2 2023/24 is attached at **Appendix 2**; and for previous years at **Appendix 3**.

- To comply with the National Guidance on Learning from Deaths, this details:
  - the number of deaths in scope;
  - the number of these deaths subjected to review;
  - the level of review to which the deaths are being subjected; and
  - the determination of whether or not the deaths were more likely than not to have been due to problems in care.
- A review of mortality data processes and reporting has been undertaken within the Trust and refinements put in place to streamline and automate some previously manual processes, utilising more advanced technologies available to the Trust.
- This has included the building of an additional section on Datix which is now completed for every death reported. This enables corporate oversight of progression of the death through the learning from deaths review processes and of the outcome of reviews, previously undertaken manually.
- The refinements made are intended to strengthen efficiency, accuracy and resilience in the production of meaningful data.
- The new processes have been utilised for the production of Q1 2023/24 data onwards.

Summary of Quarter 2 2023/24 mortality data (1) *Refer Appendix 2*

- **Total number of deaths reported:** There were a total of 126 deaths reported on Datix for Q2 2023/24 (including those not falling within the scope for mandatory reporting). This is significantly lower than Q1 2023/24 which was 171. However this differential has been identified to be related to the stand down in agreement with the Integrated Care Boards in July 2023 of a retrospective reporting exercise for Therapy for You deaths which informed a thematic review of those deaths. For Q2, there were 53 less Therapy for You deaths reported than in Q1, which accounts for the differential. Some of the deceased clients had been in receipt of services from more than one service from EPUT and there were a total of 133 Datix reports made in respect of the 126 deaths.

- **Total number of deaths in scope for mandated reporting:** To date, a total of 48 deaths in Q2 2023/24 have been deemed in scope for mandated reporting (Stage 1 reviews are still awaited for 30 deaths which is required to determine whether they are in scope for mandated reporting). This total is broadly in line with the number of deaths confirmed as within the scope for mandated reporting in 2022/23 (Q1 – 62 Q2 – 61 Q3 – 55 Q4 – 58) and in Q1 2023/24 which is 56. The deaths reported on Datix over and above these mandated deaths provide opportunities for the Trust to learn from deaths and staff will be encouraged to continue reporting.

- **Inpatient / Nursing Homes deaths:** Of the 126 deaths reported in Q2, 3 were inpatient deaths and 5 were nursing home deaths. All of the 3 inpatient deaths and 5 nursing homes deaths have been confirmed as due to natural causes. An additional 3 deaths have been identified as occurring shortly after transfer from an EPUT inpatient unit to an acute Trust ward due to deteriorating physical health. Again, all deaths have been confirmed as due to natural causes.

- **LeDeR reporting validation:** All reported Learning Disability deaths (n.5) in Q2 2023/24 have been reported to the national LeDeR programme.

- **Level of review:** Thus far, 48% of deaths in Q2 2023/24 have been closed at Stage 1; 7% have been referred for Stage 2 Clinical Case Note Review or Stage 2 Thematic Review; and 12% have been referred for Stage 3 full PSIRF review. Table 2 in Appendix 2 details how these proportions compare with previous years.

Summary of Quarter 2 2023/24 mortality data (2) *Refer Appendix 2*

- **Stage 1 reviews:** A total of 73 Stage 1 learning from deaths reviews have been conducted by a local service manager in respect of the 126 deaths in Q2. This enables learning to be identified as well as identifying those deaths which should be subjected to a further detailed review. This is a review stage that did not form part of the previous Mortality Review arrangements and has thus increased reflective practice and the Trust's ability to identify learning locally. The timeliness of completion of Stage 1 reviews is monitored on a monthly basis by the Learning from Deaths Oversight Group and any concerns addressed. At the point of preparing data, there were a total of 30 outstanding Stage 1 reviews for Q2 deaths.
- **Stage 2 (clinical case note) reviews:** A total of 9 deaths in Q2 have been identified for Stage 2 mortality clinical case note review / thematic review thus far, and will be commissioned as capacity allows. None have yet been completed.
- **Stage 3 (PSIRF) reviews:** A total of 16 deaths in Q2 have been identified for PSIRF review.
- **Completion of Stage 2 and Stage 3 (PSIRF) reviews:** Continued progress was made over the quarter with completion of Stage 2 and Stage 3 reviews relating to 2022/23 deaths, with 100 now completed set against a total of 80 completed in the Q1 report to the Board of Directors. The completion of PSIRF reviews, due to their nature, is prioritised over completion of Stage 2 reviews and there is some slowing of progress of completion of Stage 2 reviews due to capacity. This is monitored by the Learning from Deaths Oversight Group and mitigating actions to ensure timeliness of review and learning identification are being pursued.
- **Problems in care assessment –** There are 0 deaths for Q2 thus far that have been assessed as being more likely than not due to problems in care by EPUT. The assessment is still to be determined for 77 deaths in Q2. For 2022/23, 3 deaths thus far have been assessed as being more likely than not due to problems in care by EPUT with the assessment still be to determined for 125 out of the total of 520 deaths for the full year. This includes deaths closed following PSIRF review as the assessment of problems in care has been paused whilst further research is undertaken with relevant national / regional / ICB and neighbouring Trust colleagues in terms of an appropriate approach to making this determination given that the PSIRF methodology has not been designed for this purpose. This data will continue to be updated in future reports as reviews are completed and the likelihood is determined.

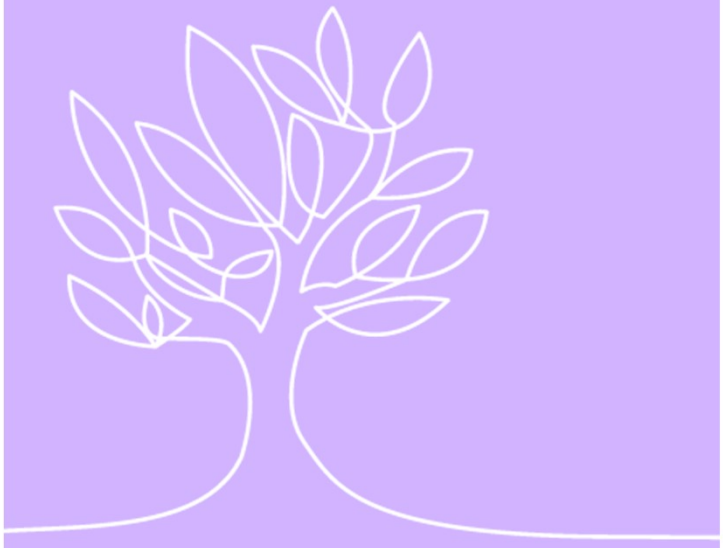
Assessment of Q2 2023/24 data against historic scope (for mortality surveillance) *Refer Appendix 2*

- An analysis has been undertaken of the Q2 2023/24 data using the previous "scope" categories and reporting groupings, in order to identify any trends of potential concern in relation to death numbers in established categories (as substantial historic data under the new groupings does not yet exist). This indicates that reported numbers of deaths are in line with numbers reported under the previous arrangements for periods not impacted by COVID-19 and that the service breakdown also remains consistent with previous months.
- Currently the number of deaths in Q2 2023/24 falling within the previous scope (n. 33) is lower than for previous quarters. However this is again potentially related to the fact that there are a number of Stage 1 reviews requiring completion and thus these deaths awaiting Stage 1 review have not been assigned to a confirmed category. However, even if all those awaiting completion indicated a death that would fall within the previous scope categories, this would result in figures significantly within the upper control limit thus figures do not indicate a cause for concern. Figure 1 in Appendix 2 indicates that the number of deaths in scope in Q2, using the previous scope, fall within control limits.

Summary of previous years' mortality data (2017/18 – 2022/23) *Refer Appendix 3*

- Mortality data for previous years (2017/18 – 2022/23) is attached at **Appendix 3** detailing the mandated requirements of the National Learning from Deaths Guidance.
- In summary:
  - 2022/23 data is presented in the new format and indicates that, since the last report to the Board of Directors:
    - 1 death has been closed at Stage 1 review
    - 1 death has been closed at Stage 2 (clinical case note) review
    - 19 deaths have had a Stage 3 (PSIRF) review approved
    - 1 death has been referred for Stage 2 thematic review
  - 5 reviews for deaths in 2021/22 remain open (4 x PSIRF reviews and 1 x under determination). These all continue to be actively progressed.
  - The significant majority of deaths have been assessed as definitely less likely than not to have had problems in care which may have contributed to the death.

CONCLUSIONS AND ACTIONS REQUIRED



- This report provides information in relation to the learning emerging from reviews of deaths being undertaken under the learning from deaths arrangements; as well as mortality data mandated for report and data to support mortality surveillance.
- It also provides assurance that the learning emerging is being acted upon, with examples provided of actions taken in response to the learning identified.
- The analysis of the data indicates that there are no matters of concern in terms of mortality data surveillance for Q2.
- Given the outcomes outlined, it provides the Trust Board of Directors with assurance that there are robust processes in place in line with national guidance to review deaths appropriately, forming part of the Trust's processes for continually reviewing and ensuring that patients are receiving safe, high quality care. It also highlights the work that has been undertaken, and continues, to strengthen mortality data reporting processes and implement refined processes.
- The Board of Directors is asked to note the information presented; and request any further information or action.

NHS
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APPENDICES

APPENDIX 1 Mortality Data – Context (1)

From 1st April 2022, new arrangements for learning from deaths were implemented across the Trust. This included a new definition for deaths which would be in scope for consideration for **mandatory** individual mortality review in the Trust. This is as follows:

- All deaths that have occurred within Trust inpatient services (this includes mental health, community health and learning disability inpatient facilities).
- All deaths in a community setting of patients with recorded learning disabilities or autism. *All deaths of patients with recorded learning disabilities or autism, whether in an inpatient or community setting, will be referred into the national LeDeR programme and are thus subject to different review processes than other Trust deaths.*
- All deaths meeting the criteria for mandatory review under the Trust's Patient Safety Incident Response Framework (PSIRF) – both the nationally and locally determined categories. The review undertaken under the PSIRF constitutes the review of the death for the purposes of the Learning from Deaths Policy and Procedural Guidance.
- Any other deaths of patients in receipt of EPUT services not covered by the above that meet the national guidance criteria for a Stage 2 Clinical Case Note Review. These deaths will be any deaths where:
  - Family, carers or staff have raised concern about the care provided; or
  - The death was unexpected and the individual:
    - had a diagnosis of psychosis (including schizophrenia, bi-polar, episode of non-organic psychosis, personality disorder, complex and severe depression) or eating disorder during the last episode of care;
    - was an inpatient at the time of death or had been discharged from EPUT inpatient care within the last 30 days;
    - was under the care of a Crisis Resolution Home Treatment Team at the time of death.

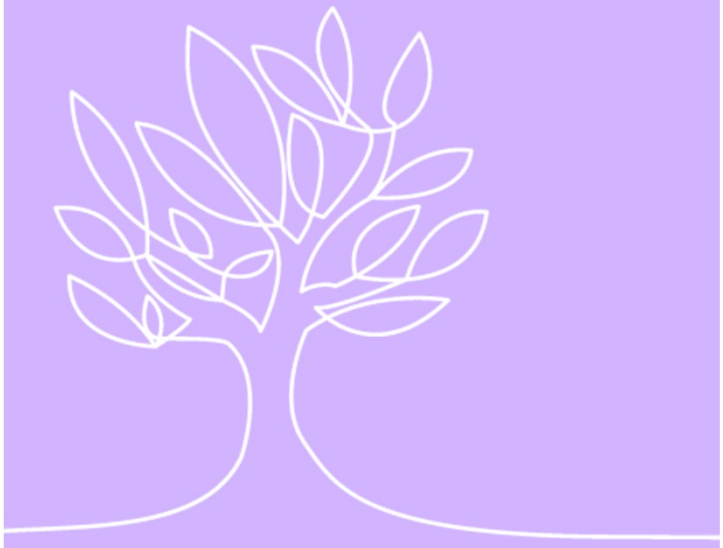
APPENDIX 1 Mortality Data – Context (2)

- In addition, deaths of clients under the care of services provided by EPUT as part of the drug and alcohol services care pathway (EDAP) are subject to specific reporting and mortality review processes including a collaborative multi-agency review. These deaths are therefore also included within mortality surveillance data.
- Regardless of the above mandatory requirements for a formal review, services are being encouraged to report on Datix all deaths that are brought to their attention. This increases the Trust's ability to identify potential learning opportunities. These additional reported deaths are also included in the data for 2022/23 and for Q1 – Q2 2023/24. It should be noted that this will not reflect negatively on the Trust in terms of potential to appear as an "outlier" set against other Trusts mortality figures. The national guidance was clear that, given there is no standard national definition for deaths that should be included in Trust mortality data, no comparison or benchmarking should take place between Trusts – the data should be used solely internally to the organisation to support mortality surveillance and quality development. We are however starting to explore with other local mental health trusts their approach to reporting deaths and data provision to establish whether it is possible to locally determine a defined scope for reporting and benchmarks etc.
- As the scope of deaths included has changed from the previous mortality review arrangements, there is no historic data prior to Q1 2022/23 against which to make comparisons. As a result, as well as analysing the data under the new arrangements, the data for 2022/23 and for Q1 – Q2 2023/24 has also been analysed using previous scope arrangements in order to provide assurances that the Trust is not experiencing increases in death numbers across key services against historic data. A decision will need to be taken in due course in terms of the period of time such analysis will be undertaken under both methodologies (ie at what point the Trust is satisfied that there is sufficient historic data under the new arrangements to provide assurances).

APPENDIX 1 Mortality Data – Context (3)

- Under the new Learning from Deaths arrangements, the previous 6 point scale for assessing problems in care has been replaced with the Royal College of Psychiatrists structured judgement review tool version which requires determination of whether a death was "more likely than not to have resulted from problems in care delivery or service provision" by EPUT. All deaths closed at Stage 1 are automatically deemed to be less likely than not to have resulted from problems in care. Deaths reviewed under the Patient Safety Incident Response Framework (PSIRF) from 01/05/21 were not subject to this determination as the methodology encourages focus on quality learning outcomes. A local methodology was initially put in place to make this determination for deaths reviews under PSIRF from 01/04/22; however this has now been paused whilst further research is undertaken with relevant national / regional / ICB and neighbouring Trust colleagues in terms of an appropriate approach to making this determination for deaths reviewed under PSIRF given that the PSIRF methodology has not been designed for this purpose. This approach to PSIRF deaths is reflected in the data in Appendix 2 & 3.
- The Trust's established mortality data dashboard was amended from 1st April 2022 to enable recording of data in line with the new arrangements, whilst still retaining the ability to use the process as a validation exercise to ensure deaths are reported on both Datix and clinical information systems and that learning disability deaths have been reported to the national LeDeR mortality review programme. A validation exercise between Datix and Clinical Information Systems is undertaken each quarter and actions taken to ensure deaths are reported appropriately on both systems. Work has been undertaken with the Trust Datix, systems and information teams to review the mortality data reporting processes to streamline and automate previously manual processes based on developments over the past year and new technologies available to the Trust since original establishment of the dashboard arrangements. This has resulted in a further refined dashboard process for data from 1st April 2023 which continues to enable the above validation.
- It should be noted that data in this report was extracted as at 10/11/23. Any updates to information after this date will be included in future reports.

APPENDIX 2 Q2 2023/24 mortality data



The table on the following page provides a summary of mortality data for Q2 2023/24 (and updated Q1 data). The following "Notes" are referenced in the left hand column of the table.

Notes:

1) There were a total of 126 deaths reported on Datix for Q2 2023/24 (including those not falling within the scope for mandatory reporting). Some of the deceased clients had been in receipt of services from more than one service from EPUT and there were a total of 133 Datix reports made in respect of the 126 deaths.

2) 1 in Q1 and 3 in Q2 of these deaths occurred after transfer from EPUT inpatient unit to acute Trust.

3) These figures denote the total number of Stage 1 reviews completed in full and the number that are actively awaited. When it is identified immediately that the death did not fall within the scope of the Trust's Learning from Deaths review arrangements as the patient had not been under the care of the Trust services within the 6 months leading up to the death or the death had immediately been identified for PSIRF review, it is not necessary to complete a full Stage 1 review.

4) 1 EDAP death included in the Q1 report has been deemed as out of scope as the client had only had historic contact with the service.

5) All LD deaths in Q1 and Q2 2023/24 have been reported to the national LeDeR review programme.

Table 1: SUMMARY OF 2023/24 MORTALITY DATA (UPDATED AS AT 10/11/2023)	Q1 2023/24 (stated in Q1 report)	Q1 2023/24	Q2 2023/24 (stated in Q2 report)	Q2 2023/24	Q3 2023/24 (stated in Q3 report)	Q3 2023/24	Q4 2023/24 (stated in Q4 report)	Q4 2023/24	YTD (stated in Q1 report)	YTD
DATA ON NUMBER OF DEATHS										
Total death reports on Datix ***Note 1***	*172	*181	N/A	*133					*172	*314
Relating to x deaths ***Note 1***	*163	*171	N/A	*126					*163	*297
Total deaths reported on Datix confirmed in scope of learning from deaths policy to date	51	56	N/A	48					51	104
Total inpatient deaths ***Note 2***	**5	**5	N/A	**6					**5	**11
Total nursing homes deaths	6	6	N/A	5					6	11
DATA ON LEVELS OF REVIEW										
Total deaths subjected to Stage 1 learning from deaths review on Datix (or equivalent under EDAP or LeDeR processes) ***Note 3***	***123	***131	N/A	72					***123	***203
Total deaths awaiting completion of Stage 1 review	21	13	N/A	30					21	43
Total deaths closed at Stage 1 and learning ascertained	105	110	N/A	40					105	150
Total deaths referred on for Stage 2 clinical case note review	2	2	N/A	4					2	6
Total deaths referred on for Stage 2 thematic review (diagnosis of psychosis)	10	11	N/A	5					10	16
Total deaths referred on for Patient Safety Incident Response Framework (PSRIF) review (Stage 3)	20	23	N/A	16					20	39
Total deaths for which Stage 2 review complete and learning ascertained	0	0	N/A	0					0	0
Total deaths for which PSIRF review complete and learning ascertained	1	4	N/A	0					1	4
Total deaths undergoing Essex Drug and Alcohol Partnership (EDAP) multi-agency collaborative review processes ***Note 4***	7	****6	N/A	11					7	****17
Total deaths undergoing LeDeR (national learning disability mortality review) processes ***Note 5***	4	*****5	N/A	*****5					4	*****10
Total deaths for which level of review under determination	6	7	N/A	5					6	12
DATA ON PROBLEMS IN CARE (PIC) DETERMINATION										
Assessed as more likely than not due to PIC	0	0	N/A	0					0	0
Assessed as not more likely than not due to PIC	105	110	N/A	40					105	150
Assessment of likelihood of death being due to PIC still underway	56	60	N/A	77					56	137
Not applicable (EDAP and LeDeR reviews utilising different methodology)	11	11	N/A	16					11	27

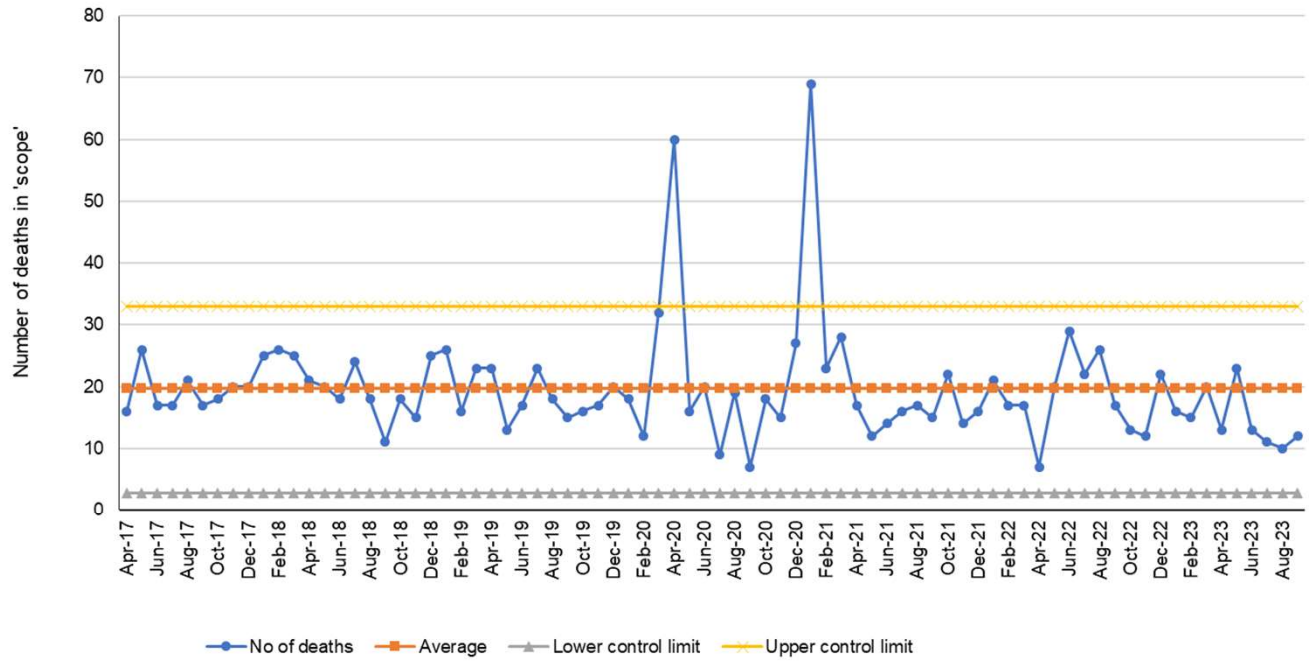
APPENDIX 2 Q2 2023/24 mortality data (2)

Table 2: Confirmed levels of reviews under new Learning from Deaths arrangements compared to previous years

Level of review	Number of deaths 2022/23	As a % of total deaths 2022/23	Number of deaths 2023/24 YTD	As a % of total deaths 2023/24 YTD	Average % under previous arrangements
Total deaths	520	N/A	314	N/A	N/A
Closed at Stage 1	289	56%	150	48%	65%
Being reviewed at Stage 2 Clinical Case Note Review (to date)	82	16%	22	7%	6%
Being reviewed at Stage 3 PSIRF (to date)	80	15%	39	12%	29%

APPENDIX 2 Q2 2023/24 mortality data (3) – comparison against historic scope

Figure 1 below shows the total number of deaths that fell within the scope of the previous Mortality Review Policy each month in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2017 – November 2018). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. The two months where the number of deaths fell above the upper control limit were peaks of COVID-19. Figure 1 below indicates that the number of deaths in scope in 2022/23 and in Q1 – Q2 2023/24 using the previous scope, fall within control limits.



APPENDIX 3 – Previous years' mortality data

The following two pages detail data (updated as at 17/11/23) for deaths as follows:

- **Table 3:** Deaths occurring in 2022/23 (reported and reviewed under the Trust's updated Learning from Deaths arrangements)
- **Table 4:** Deaths occurring in 2017/18 – 2021/22 (reported and reviewed under the Trust's previous Mortality Review arrangements)

Table 1: SUMMARY OF 2022/23 MORTALITY DATA (UPDATED AS AT 17/11/2023)	Q1 (stated in Q1 report)	Q1 current	Q2 (stated in Q1 report)	Q2 current	Q3 (stated in Q1 report)	Q3 current	Q4 (stated in Q1 report)	Q4 current	YTD (stated in Q1 report)	YTD Current
DATA ON NUMBER OF DEATHS										
Total deaths reported on Datix	114	114	115	115	130	130	161	161	520	520
Total deaths reported on Datix confirmed in scope of learning from deaths policy to date	62	62	61	61	55	55	58	58	236	236
Total inpatient deaths ***Note 1***	4	4	6	6	9	9	4	4	23	23
Total nursing homes deaths ***Note 1***	6	6	6	6	3	3	4	4	19	19
DATA ON LEVELS OF REVIEW										
Total deaths subjected to Stage 1 learning from deaths review on Datix (or equivalent under EDAP or LeDeR processes)	111	111	112	113	123	123	153	153	499	500
Total deaths awaiting completion of Stage 1 review	3	2	3	2	7	7	8	8	21	19
Total deaths closed at Stage 1 and learning ascertained	55	55	57	58	76	76	100	100	288	289
Total deaths referred on for Stage 2 clinical case note review ***Note 2***	20	20	14	14	6	6	4	4	44	44
Total deaths referred on for Stage 2 thematic review (diagnosis of psychosis) ***Note 2***	6	7	5	5	15	15	11	11	37	38
Total deaths referred on for Patient Safety Incident Response Framework (PSRIF) review (Stage 3)	18	18	28	28	12	12	22	22	80	80
Total deaths for which Stage 2 review complete and learning ascertained ***Note 3***	14	14	6	7	2	2	0	0	22	23
Total deaths for which PSIRF review complete and learning ascertained ***Note 3***	17	19	24	27	8	12	9	19	58	77
Total deaths undergoing Essex Drug and Alcohol Partnership (EDAP) multi-agency collaborative review processes	11	11	4	4	9	9	11	11	35	35
Total deaths undergoing LeDeR (national learning disability mortality review) processes	3	3	4	4	5	5	5	5	17	17
Total deaths for which level of review under determination	3	2	3	2	7	7	10	10	23	21
DATA ON PROBLEMS IN CARE (PIC) DETERMINATION										
Assessed as more likely than not due to PIC	3	3	0	0	0	0	0	0	3	3
Assessed as not more likely than not due to PIC	82	82	76	77	81	81	101	101	340	341
Assessment of likelihood of death being due to PIC still underway	15	15	31	30	35	35	45	45	126	125
Not applicable (EDAP and LeDeR reviews utilising different methodology)	14	14	8	8	14	14	16	16	52	52

APPENDIX 3 – Previous years' mortality data 2017/18 – 2021/22

Table 4: Summary of deaths closed

Year	Number of deaths in scope *	Number closed	% closed at Grade 1 desktop review	% closed at Grade 2 clinical case note review	% closed at Grade 3 critical incident review	% closed at Grade 4 serious incident review	% deemed more likely than not due to PIC
2017/18	248	248	60%	5%	0.5%	35%	1%
2018/19	235	235	63%	8%	0%	29%	4%
2019/20	228	228	64%	7%	0.5%	29%	2.5%
2020/21	311	311	73%	4%	0%	23%	**0.3%
2021/22	195	190	67%	4%	0%	26.5%	**0%

* ***Note:*** Scope in place 2017/18 – 2021/22 under Mortality Review Policy was different to scope from 2022/23 onwards under Learning from Deaths Policy

** ***Note:*** From 01/05/21 on introduction of the Patient Safety Incident Response Framework (PSIRF) arrangements until 01/04/22 (introduction of Learning from Deaths arrangements), the Trust did not undertake this determination for deaths reviewed via PSIRF arrangements as the focus of this methodology was on quality learning outcomes. The determination was made for all other deaths in scope.

The five death reviews open for 2021/22 deaths remain as follows:

- 1 death for which further information is awaited from operational services to determine the level of review to which the death should be subjected
- 4 deaths still undergoing PSIRF review – 2 of these reviews have been completed and are awaiting consideration and sign off via the Trust's governance process; and the remaining 2 reviews are on-going Patient Safety Incident Investigations

9. STRATEGIC INITIATIVES

9.1 PEOPLE & EDUCATION STRATEGY

Decision Item | Marcus Riddell | 10 minutes

REFERENCES

Only PDFs are attached

People & Education Strategy 31.01.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31 January 2024

Report Title:	**People and Education Strategy**					
Executive/ Non-Executive Lead:	Marcus Riddell, Interim Chief People Officer					
Report Author(s):	Paul Taylor, Interim Director for Education and OD					
Report discussed previously at:	Previous draft discussed at People Equality and Culture Committee on 23/11/23. Draft discussed at Executive Team meeting on 4/12/23, Board Seminar 6th December 2023, Executive Team 22nd January 2024, Education Committee 24th January 2024.					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Finance and Resources Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report provides the Board of Directors the final draft of the People and Education Strategy.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required
The Board of Directors are asked to: 1 Note the contents of the report 2 Approve the People & Education Strategy

Summary of Key Issues
The People and Education Strategy is at the final approval stage and includes: • **Foreword** and **strategic context**, recognising the key challenges to the organisation with the Lampard Inquiry, financial challenges and the development of a new Electronic Patient Record. • **Diagnostic areas** across five key domains: Culture, Leadership, Workforce, Equality, Diversity & Inclusion and Education. • **Priority statements** against the national NHS Long Term Workforce Plan to 'Train, Retain and Reform' • **Leadership Compact** highlighting the expected standards of leadership, practice and delivery for senior leaders and all staff. • **Key metrics** as measures of success against the priority statements. The Deputy Chief People Officer and Interim Director for Education held positive discussions on the strategy at People Equality and Culture Committee on 23rd November and Board Seminar 6th December 2023 and the Executive Oversight Committee on 22nd January 2024. Colleagues were content that the right areas are covered, and welcomed the inclusion of improving the service offered by the People Directorate itself. Subsequently follow up conversations were held with staff, including Lived Experience Ambassadors. Feedback mainly covered the following, which have been addressed in the final strategy: • The diagnostic section was tailored to ensure there is a balance between positive areas and areas for development for the organisation. • A draft framing/foreword for the strategy is included • Clear metrics that are tailored to the national and local context • Further work to be done on recognising the strong foundations the Trust already has progressed with regard to the people agenda • Recognise the good start which has been made on cultural change. • Include more on Care Groups, building on the EPUT ethos that it is 'clinically led and corporately enabled' • Strengthen the links with other strategies, especially the 'Working in Partnership with People and Communities' and 'Quality of Care' strategies which were discussed at Board on 29 November 2023 • Develop clear statements/objectives on the 'Train', 'Retain' and 'Reform' elements. Following approval from the Executive Team on 22nd January 2024 and final comments from the Education Committee on the 24 January 2024, final amendments were made and approval is now sought from the Board of Directors.

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

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

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

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

Acronyms/Terms Used in the Report			
EDI	Equality, Diversity and Inclusion		

Supporting Reports/ Appendices /or further reading
People & Education Strategy

Leads

Marcus Riddell
Interim Chief People Officer

EPUT

NHS
Essex Partnership University
NHS Foundation Trust

PEOPLE & EDUCATION STRATEGY 2024-2028

Helping our people be the best they can be.

CONTENTS

Foreword from EPUT's Chief Executive

I'm delighted to introduce our new People and Education Strategy.

People are at the heart of all that we do at EPUT – our staff, partners and volunteers all play a part in providing high quality care to the people who need us, our patients.

We know that having the right staff in the right place is key to providing the best patient care. Our staff care for some of the most vulnerable people in our community in often complex situations, so it's vital that we continue to build a safe, compassionate and fair environment in which they are supported to deliver exceptional care and empowered to develop their careers.

Our staff are our greatest asset. Like all NHS organisations, we face challenges but I'm continually struck by their dedication, commitment and innovation, and I'm delighted this has been recognised at a national level with award nominations across a range of our community, inpatient and corporate services.

Creating conditions for success is pivotal to us attracting, retaining and developing the very best talent. We know there is more to do – our staff tell us there are improvements to be made across our culture and leadership – and work is taking place at pace across the Trust and with our system partners to address that.

We have made great progress in putting more staff into patient-facing roles. This year we have recruited twice as many newly qualified nurses than last, temporary staffing has reduced across our inpatient settings and we are seeing staff return to EPUT to continue their careers.

We are absolutely committed to helping our people be the best they can be, ensuring they have the tools in place to thrive. This five-year People and Education Strategy provides the foundations from which we will deliver on that commitment.

Paul Scott - Chief Executive

Welcome to our 5 year People and education strategy. The People and Education strategy has been developed at one of the most challenging, and exciting, points in the history of the NHS workforce. The publication of the NHS Long Term Workforce plan in June 2023 has been described as 'once in a generation opportunity to put staffing on a sustainable footing and to improve patient care.' EPUT plans to be at the forefront of this opportunity as it trains, retains and reforms its workforce in accordance with that plan to enable EPUT's own strategy. Our people strategy mirrors the priorities in the national plan to ensure that we have the workforce we need for the future. An important part of this is to ensure that we have the right culture in which our people can thrive and we therefore commit to the seven themes of the NHS People Promise:

We have already achieved a lot in key areas of the People & Culture directorate – vacancy rates for registered nursing is now at an all-time low at 15% from 26% in July 2022. Our workforce plan is above plan for 2023/24 and we have successfully recruited over 260 international nurses and Allied Health Professionals in the last two years. We know that since the pandemic, demand for Mental Health and community services have been significantly increased whilst there has been a national decline in productivity. We have more to do to ensure that our Trust has a workforce that is skilled, resilient and capable to deliver in the most challenging of times. In particular, our fourth organisational strategic objective (supporting our communities to thrive) will be met through inclusive recruitment practices and a specific success measure to enhance the numbers of marginalised groups into employment.

This strategy is part of EPUT's enabling strategies to support the achievement of our strategic objectives, vision and purpose. This strategy enables our people to be the best they can be and builds upon the strategic and operational foundations set out in our operating model – enabling operational colleagues to support and care for our patients and families.

Delivered through our target operating model

STRATEGIC OBJECTIVES

We have four strategic objectives to achieve our vision:

- **We will deliver safe, high quality integrated care services.**
- **We will work with our partners to make our services better.**
- **We will enable each other to be the best we can be.**
- **We will help our communities to thrive.**

OUR VISION

To be the leading health and wellbeing service in the provision of mental health and community care.

OUR VALUES

Operating model

Our **Operating Model** is based around **six clinical operational delivery units** which are led by multi-disciplinary and multi professional leadership teams. They are supported and corporately enabled from corporate business units including People & Culture. Below highlights our People & Culture business unit functions to enable optimal operational delivery:

Our six care units are responsible for place-based and Trust wide services:

- Community Mid and South Essex
- Community North East Essex
- Community West Essex
- Psychological services
- Specialist services
- Inpatient and Urgent and Emergency Care Mental Health.

In 2022/23, we received **512,065** referrals into our services and delivered **1,746,120** face to face contacts. We carried out **49,807** digital face to face contacts, held **317,942** telephone contacts and cared for **236,594** patients.

Our staff are our biggest asset. EPUT cares for patients, carers and families across an Essex, Bedfordshire and Luton geography and provide services including: inpatient mental health services, community health care, urgent care, community mental health and social care. The table below highlights the substantive staffing breakdown and by professional group (Q3, 2023/24):

Staffing group	Sum of FTE budgeted	Sum of FTE actual
Nursing and Midwifery Registered	2079.31	1779.83
Additional Clinical Services	1623.84	1531.67
Administrative and Clerical	1253.62	1291.62
Allied Health Professionals	424.31	372.65
Estates and Ancillary	327.5	268.09
Medical and Dental	364.71	288.05
Add Prof Scientific and Technical	489.33	459.18
Grand Total	**6564.62**	**5991.1**

Our strategy has five core pillars which is our framework for Trust-wide People and Educational delivery. These pillars are: a) Equality, Diversity & Inclusion, b) Leadership, c) Culture, d) Education and e) Workforce.

Workforce

Our staff are our number one asset and their experience from beginning to end tells a story of how successful we are at welcoming, developing and supporting their working lives & career in EPUT and beyond.

Equality, Diversity & Inclusion

Having a diverse and inclusive workforce not only helps tackle health inequalities but also helps in creating a culture where everyone is valued and respected. Greater diversity brings benefits such as efficient services, quality of care, meeting statutory and contractual requirements as well as workforce supply.

Culture

Compassionate and high performing cultures directly relate to safe care for our patients. Civility & respect will be fully explored within the scope of this strategy development.

Leadership & Management

From 'ward to board' leadership development – leaders who can deal with complexity, risk and uncertainty and create psychologically safe environments for effective clinical practice.

Education & learning

To deliver high quality care, our staff must possess a high level of knowledge combined with excellence in practical skills, but they must also show kindness and compassion and respect for patients and their families.

Engagement

- Engagement has taken place at Board level internally and with Chief People Officers in Mid and South Essex, Herts and West Essex and Suffolk and North East Essex.
- We have also spoken extensively to staff at all levels internally, including across the People & Culture directorate and lived experience ambassadors.
- The views of our main higher education partners, Anglia Ruskin University and Essex University, are also incorporated into the findings
- We have spoken to Chief People Officers at East London and Central and North West London Trusts, and colleagues at NHS England, to ensure that sector, regional and national best practice is reflected
- Consideration of private sector people strategies have shown strong similarities with the approaches taken in the NHS. However, in the private sector there is a larger focus on investing in digital transformation
- The diagnostic summarises the feedback from all of the above.

Diagnostic: Where are we now?

Workforce

"Workforce planning should be part of what every unit does on an ongoing basis. It should not just be done for them by a separate team"

"Each unit should be thinking about what they need today and tomorrow - not just in terms of numbers but also in terms of diversity and inclusivity, skill mix, development, sharing of expertise, and working across professional disciplines"

- **Recruitment** has been very successful as EPUT has attracted high numbers of new staff, including international recruits and more newly qualified nurses than before, taking our vacancies to below 10% at the end of 2023. We will now focus on key community roles e.g. social work, allied health professionals and community nursing.
- **Retention** across the Trust has improved with turnover at less than 10% at the end of 2023. Our focus is on listening to and responding to staff feedback, such as from staff surveys, and to support enhanced career development and high performing team cultures.
- **Temporary staffing** has reduced across inpatient settings by over 60% in 23/24 but agency staffing remains higher than we would want it to be in some areas.
- **Medical** vacancies are safely covered with agency locum doctors but we will continue to aim to recruit more substantive medical consultants.
- **Digitisation** could give us great opportunities to improve our people processes, colleagues' experiences and reduce costs.
- **Workforce data analytics** can help give us greater insight and support our decision-making and governance.
- **Workforce planning** can be developed into a continuous approach to improving service delivery.
- **Induction** and efficient on-boarding already supports the arrival of many hundreds of new colleagues each year and we want to work to improve everyone's arrival and welcome to EPUT even further.
- **Embed lived experience** within the mental health **workforce** (e.g. peer support workers and lived experience advisors).

Culture

"We want a consistent culture across EPUT where staff are willing to solve problems creatively with their teams and other directorates and where permission and guidelines are not used as absolute rules. We want our culture to move towards greater empowerment across the organisation so we can all find patient centric solutions"

- Since North Essex Partnership and South Essex Partnership Trusts merged over six years ago, we have continued to develop our culture across EPUT with a **single set of values and behaviours.** Where there are differences, and we can learn from each other, we will share best practices to enable us all to be the best that we can be.
- Similarly across the different systems and **three Integrated Care Boards** we work within we have opportunities for further learning, partnership approaches and sharing across the different geographical parts of our organisation.
- Our staff survey results show that our colleagues' **experiences at work** are significantly improving in many areas.
- Where people do not behave in line with our values and behaviours we will challenge this and will ensure that where **performance** and **behaviour** are not consistent with our vision for a high performing organisation, this is addressed
- Our Speak Up, Listen Up, Follow Up campaign has been very well received and people are feeling more confident about **speaking up.**
- We have signed up to the **NHS Sexual Safety Charter** which will help us to ensure the sexual safety of our staff and patients across all our sites.
- **Quality Improvement** is developing steadily across the Trust and our new quality of care strategy will enable everyone to feel part of improving processes, patient safety and overall performance and delivery.
- **Well-being** is at the centre of our culture and our staff are our number one asset – we need to build on our current offer with staff and build psychological safety as our priority.

Equality, Diversity, Inclusion

"The creation of a compassionate, respectful, kind and psychologically safe culture that inspires staff to high performance require some fundamentals to be in place"

- NHS England rated **EPUT's WRES action plan as outstanding**, which shows the Trust is on the right path. We now need to ensure that the actions taken positively shift the experience of BME staff.
- We have committed to the **NHS EDI Improvement Plan** and the high impact action therein.
- We recognise the importance of **leadership at Board level.** All our Board members will have **EDI objectives.**
- Executives sponsor and support our **staff networks**
- We will develop our leaders to ensure that they are equipped to take an **appropriate and consistent** approach to tackling abuse of staff, leading to staff feeling supported and engaged.
- **Bullying** and **harassment are not acceptable** and we know how this can particularly affect BME and disabled staff, impacting on their morale, sickness and performance.
- We actively seek out BME talent through our **RISE development programme** to help us address that BME staff make up over a quarter of the workforce but are mainly represented in the lower pay bands.
- We actively use our **WRES and WDES data** at Trust level to monitor disproportionate promotions for white staff and formal disciplinary/capability processes and will monitor this more closely at care group level through our Accountability Framework.

Leadership

"Culture ties inextricably with leadership and management. Our leadership capability and capacity needs to keep in step with the vision for our organisational culture – one where learning, empowerment and care is at the heart of what everyone from board to ward does everyday"

- **Devolved** leadership to the Care Units has been established through our Accountability Framework. This distributed leadership has been welcomed, and we can use this to develop more consistent practices across the Trust.
- There are a number of **nationally recognised and award winning teams** across the organisation, demonstrating outstanding leadership that we must continue to champion
- Our staff survey results show that people are experiencing their **immediate managers** as being more supportive and we need to ensure that we continue to ensure that the Board, our **senior management teams** and the **frontline workforce are well connected.**
- There has been a strong focus on **Board and Executive development** in the last year.
- **A new leadership programme** is being designed for a wider group of leaders at different levels of the organisation to support them in **empowering their teams** and in creating conditions of **high performance**, with a **compassionate and inclusive** approach.
- There are **multiple training opportunities** for managers and leaders at all levels of the organisation and we need to make sure these are more widely advertised and targeted to ensure maximum impact.
- A new leadership model that looks not only inwards but **outwards to our system colleagues** so there is greater collaborative action and trust between partners.

Education and Learning

“There is an opportunity for education and learning to refocus staff on cultural transformation by ensuring that learning has at its core an understanding of the patient experience.”

- The trust has made **positive progress on recovering the mandatory training** position following the pandemic.
- The **Leadership Development Programmes** are very accessible and the RISE programme is particularly successful .
- We aim to create more opportunities for staff to **learn in the environments where they provide frontline care.**
- We have an opportunity to develop a **leadership role with our system working and can support** partner organisations with education and learning.
- As a **regulated provider of apprenticeships** we have an opportunity to be more innovative in how apprentices are utilised across the organisation to ensure we maximise our impact and the apprenticeship levy.
- We will engage more proactively with our HEI partners to provide the **best environment for students.**
- We want to have **strong partnerships** with our two local HEIs and Further Education colleges so we can jointly realise the benefits of growing and developing our prospective students, learners, staff and future leaders.
- The **National Staff Survey and National Quarterly Pulse Surveys** are better utilised across the organisation so it becomes more than a one-off activity and instead, intertwined into our decision-making, organisational learning and governance processes.

Train – Growing the Workforce

Continue efforts to reduce vacancies, and reduce the use of temporary staff, through improved, targeted domestic recruitment and student conversion

Meet establishment targets in Time to Care, particularly the additional clinical registered posts

Widen apprenticeship offer, both in terms of apprenticeship courses and uptake

Work in partnership with Mid and South Essex Integrated Care Board and Mid and South Essex Foundation Trust to deliver Health Care Support Worker (HCSW) Academy and retain more HCSWs for the longer term

Increase number of people with learning disabilities and mental health conditions entering into paid employment with EPUT and our partners, positively impacting employment as one of the social determinants of health in the region

Establish programme with schools and colleges in Essex to encourage pupils to join EPUT and enter into clinical undergraduate degrees

Increase the numbers of staff moving from agency to bank, and from bank to permanent contracts

Ensure the learning environment for students, including routes to raising concerns, is improved in partnership with HEIs

Retain – Embedding the right culture and improving retention

In line with NHSE guidance, hold regular organisation wide cultural reviews and ensure actions are met

Develop and implement new Equality, Diversity and Inclusion action plan, delivering against NHSE's 6 High Impact Actions, focusing on executive accountability, tackling racism on our wards and upholding the behaviours framework

Development and implementation of employee value proposition for EPUT

Ensure staff support offer is enhanced to include practicalities of involvement in and impact of the Statutory Inquiry

Embed new Freedom to Speak Up approach, including proactive interventions that allow staff to come forward sooner

Establish regular in-person Executive engagement in the community and on wards, and include in objectives

Remodel staff recognition to ensure there is consistent, in-person, and senior acknowledgement of achievements, and recognition that counts towards appraisal and progression

Establish regular drumbeat of staff feedback via procurement of staff engagement platform, that also supports the annual staff survey

Continue to deliver Here for You internally and consider scaling up to support partners

Embed NHS Flexible Working Principles across the trust and optimise use of office space

Focus on creating a culture of accountability across the organisations, supporting staff to meet standards, and communicating the consequences of not doing so

Reform – Working and training differently

Introduce more new roles into the organisation, increasing targets for Trainee Nurse Associates, Physician Associates and Advanced Care Practitioners, and family and carer focused roles identified in Time to Care programme

Exploration of Artificial Intelligence (AI) Human Resources (HR) helpdesk system, in collaboration with system partners

Full optimisation of existing people systems including Electronic Staff Record (ESR)

Continue to pilot Virtual Reality Training at scale with system partners, and embed use of e-learning platforms that provide extra-curricular development opportunities for all staff

Establish workforce data function and effective database to house all workforce related data

Develop leadership programme for Senior Leadership Group at scale, providing opportunities to develop at system and regional level

Roll out restorative supervision across all services, building on work of North Essex Care Unit

Provide more training and development in community and ward settings where staff are close to patients and service users

Support development of Electronic Patient Records (EPR) and electronic Prescribing Management Administration (ePMA)

Ensure that medical and non-medical education oversight and delivery is aligned, and regularly reported to the Executive Team and Board.

Embed succession planning and talent pathways at all levels in the organisations, starting at Very Senior Managers (VSM)

People and Education Metrics

We have assigned key driver metrics for each pillar of the strategy, as we believe they provide the best measures of success for the People and Education Strategy:

Train

- Meet nursing establishment targets for the Time to Care programme
- Trust-wide vacancy rates improves to 8%
- Registered nursing vacancy rates fall below 12%
- Temporary staffing spending reduces by TBC%
- Apprenticeships grow as a main provider and the levy spend increases to 80%
- Compliance with all mandatory and essential to role training improves to 95%
- Recruitment time to hire improves by 10%
- Increase number of people with LD/MH entering employment year on year
- Strengthen our HEI partnerships and university hospital status further through membership with the University Hospital Association (UHA)

Retain

- Improve on how staff treat each other with greater respect and are polite to one another 74.25% - (78% target)
- Achieve above 12-month rolling average FTSU Guardian cases against peer organisations
- Staff have regular appraisals and 1-1s with their line manager (Trust target: 95%)
- Senior Leadership Team engage with the frontline teams consistently across the year (minimum of 8 practice-based days to frontline teams per year)
- Improve career progression for staff (ethnic background, gender, disability) WRES 60% (currently 52.7%) WDES 62% (currently 54.7%)
- To improve discrimination at work from patients / service users, their relatives or other members of the public. WRES 30% (currently 33%) WDES 28% (currently 32.9%)
- To improve discrimination at work from manager / team leader or other colleagues. WRES 20% (currently 26%) WDES 10% (currently 15%)
- To improve bullying and harassment for employees. WRES 10% (currently 14.8%) WDES 20% (currently 24.4%)

Reform

- Improved aggregate score for NHS survey questions that measure perceptions of leadership culture 75.6% - (80% target)
- 80% of senior leaders (Band 8d and above) are on leadership development programmes.
- 80% of senior leaders (Band 8d and above) have a succession plan in place.
- Workforce planning is triangulated with financial and performance activity, using predictive modelling where required
- The Digital Training team will have a minimum of 10 immersive 360o scenarios available for staff and patients on a variety of training and support topics.
- The Digital Training team will have a minimum of 15 Virtual Human simulations available for staff and patients to access
- Year on year improvements in engagement – staff survey response to 50% (currently 45%).
- Restorative supervision is part of supervisory practice across all care units.
- Year on year improvement on staff wellbeing (61.2% 2022) – 65%

Leadership Compact

We want our senior leaders and staff to create cultures of success and environments which are psychologically safe. All staff need to have a voice and be able to speak up which is actively listened to and acted upon. Staff well-being is of paramount importance to the Trust and it will be through our consistent, respectful and inclusive behaviours that will achieve high quality care for all.

The following leadership compact describes the expected standards required by leaders and all staff across the Trust:

Senior Leaders

Care - Leaders demonstrate compassion consistently with their staff, take a genuine interest in their lives and well-being. They actively role model what high standards of care look and feel like, both in clinical or non-clinical roles and create. Leaders care for themselves and others so they are psychologically able to manage the challenges of leadership - they create a just culture of fairness, openness and learning.

Learn - Leaders are role models for personal and professional development. They equally encourage all of those in their teams to develop the values, skills and knowledge to be their best for patients and their families. Reflective learning is part of the appraisal and 1-1 process so that shared learning and action becomes 'how we do things around here'. Feedback is regularly provided and time for critical reflection promotes individual and organisational learning.

Empower - Leaders give their teams the ability to make decisions and act in the best interests of the patients and their families. Power and responsibility is proactively shared amongst the wider leadership teams and frontline staff. Leaders hold their teams to account for delivery against clear expectations. Leaders will encourage individuals and teams to look outwards, towards greater partnership and support joint endeavour (e.g. across ICS footprints)

All Staff

Care - All staff are civil, polite and friendly to each other and respectful of their team members. Staff operate with a 'one team' approach (e.g. across teams and systems) and a philosophy that has compassion at the centre of their values. Patients, their families and colleagues can expect excellence in care and contribute actively towards having psychologically safe cultures. Staff from our partnerships can expect the same approach to compassion, inclusion and collaboration.

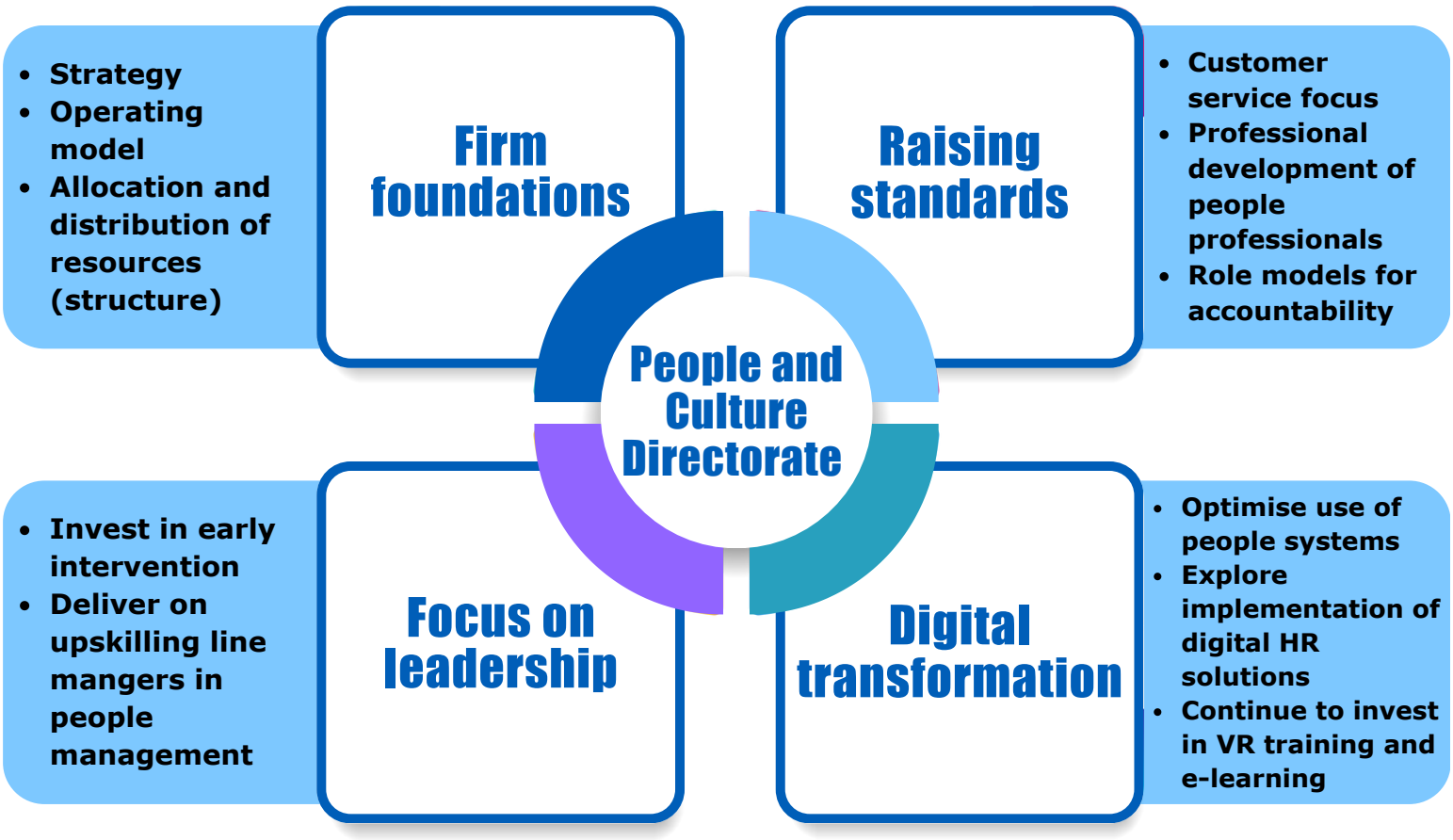
Learn - All staff proactively review their learning needs regularly with their line managers, recognising that their knowledge and skills are at the core of safe and effective delivery. Time is taken to complete training, education and learning which meets and exceeds requirements in order for patients and their families to receive standards of care which are at the very highest level. Learning is shared across organisations and systems and there is a curiosity to look outwards from our own organisation.

Empower - All staff take decisions to positively impact the lives of patients and their families. With decision-making comes accountability and responsibility to deliver expected outcomes and follow through on expectations. Whether they are in clinical or non-clinical roles, all staff are expected to deliver against the very highest standard of care: our patients and their families will receive and expect the very best level of care and support.

Improving the People and Culture Directorate

The People and Culture Directorate must become a high-performing corporate service, consistently putting staff in position to provide the best care to patients and services users, and enabling their colleagues to be the best they can be.

In order to do so, there are 4 high impact domains that we will focus on:



9.2 STRATEGIC IMPACT REPORT

Decision Item | Zephan Trent | 10 minutes

REFERENCES

Only PDFs are attached

Strategic Impact Report 31.01.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31 January 2024

Report Title:	**Strategic Impact Report**					
Executive/ Non-Executive Lead:	Zephan Trent, Executive Director of Strategy, Transformation & Digital					
Report Author(s):	Anna Bokobza, Director of Strategy Richard James, Director of Transformation					
Report discussed previously at:	Executive Committee 9 January 2024 Finance & Performance Committee 25 January 2024					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	~~Yes/~~ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes/~~ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Board with a summary of progress against the delivery of the Trust's strategic objectives as at Month 8 2023/24. This report has been approved by the Finance & Performance Committee on 25 January.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: 1 Note the content of the report.

Summary of Key Issues

A strategic impact report is prepared and presented to the Board three times per year. Its purpose is to monitor and assess delivery of the Trust's Strategic Plan and identify further action where required. The report includes updates on the Trust's major Transformation programmes. The update on the annual operational planning cycle will be included in the version that goes to the Board, but for the purposes of the Finance & Performance Committee, this is presented as a separate item.

A balanced scorecard has been developed to support reporting of progress against delivery of the Trust's strategic plan:

- For each of the four Trust strategic objectives, a small number of metrics have been selected
- Metrics have been selected on the basis that they are indicators of progress with the relevant strategic objective and that, if there is an adverse trend reported for that metric, delivery of the relevant strategic objective could be at risk and corrective action should be considered
- The dashboard provides visual representation of in-year trends
- Supporting narrative has been triangulated with other reporting flows to the Board and sub-committees
- This approach compliments established Board assurance reporting with focus on the delivery of the Trust's strategic plan. This report is not exhaustive and does not replace or summarise other reporting to the Board.

At M8 (Month 8), EPUT is making steady progress against each of its strategic objectives within each care unit. The factors limiting progress against some in-year commitments are varied and therefore require targeted action

- **We will deliver safe, high-quality integrated care:** Across all care units, place-based integration is progressing through a range of delivery models. Safe, high quality and integrated care will progressively be underpinned by a modern and unified Electronic Patient Record, for which procurement has progressed significantly since M4. Harm rates in community health services remain below target. The implementation of the new Quality of Care strategy (approved at Board in November 2023) will drive further improvements in safety, effectiveness and experience of care. There is evidence of a positive trend in Patient Reported Experience measures in the last four months.
- **We will enable each other to be the best we can be:** Major transformation programmes like Time to Care have progressed since the beginning of the financial year with strong multi-professional leadership and buy-in. Work is progressing to refresh our People & Education strategy which is on track for completion and approval in January 2024. Numbers of Lived Experience Ambassadors and Volunteers have grown steadily month on month as part of our new Partnering with People & Communities strategy.
- **We will work together with our partners to make our services better:** Relationships across our four Integrated Care Systems continue to strengthen and there is evidence across the Trust of increasingly integrated and joined up planning and delivery. Implementation of the Southend, Essex and Thurrock All Age Mental Health Strategy has started. Similarly, EPUT continues to play an important role in the East of England Specialist Mental Health Collaborative as we constantly look to improve provision of secure mental health services, specialist mental health services to children and young people and those living with learning disabilities, autism or disordered eating.
- **We will help our communities thrive:** EPUT's Social Impact strategy was approved by the Board in September 2023. In the last four months, the Social Impact Leadership Group has grown to include front line staff representatives and Lived Experience Ambassadors. A small number of ambitious community interventions have been co-designed and Enable East is leading the development of a number of parallel bids to secure grant funding to launch at least one in 2024 and is working with two third sector partners on options for amplifying their impact. Care Unit teams have been heavily engaged with place based inclusive recruitment events and continue to explore ways to collaborate with local partners on existing initiatives. The development of the new EPUT Estates strategy provides an opportunity to consolidate thinking about how we use our buildings to best effect for local communities and maximise environmental sustainability.

The report then provides an update on the positive progress we have made since September to ensure we are successfully delivering our transformation portfolio and that we are seeing meaningful and sustainable change. In the last three months, we have:

- Completed categorisation of Transformation projects and programmes in line with the Trust scheme of delegation and agreed governance for projects identified as small
- Continued to work in partnership with the Digital PMO to mature our portfolio, programme and project processes in line with recognised maturity models and identify opportunities to eliminate duplication of work
- Worked closely with project managers across the organisation to ensure gold standard reports for projects and programmes along with the introduction of dedicated resource to support the turnaround of projects reporting red or amber
- Incorporated efficiency schemes and enabling strategies into the overall portfolio to recognise the resources required to support them
- Completed procurement of Aspyre, a Project, Portfolio Management (PPM) solution to support improved management of the Trust's portfolio of change. Implementation is now underway

Finally, the report presents an update on the development of the suite of enable strategies which are progressing according to plan.

The report was discussed at the Finance & Performance Committee on the 25 January 2024 and agreed for the report to be presented to the Board of Directors.

A Trust-wide full-year update on progress during 2023/24 will be prepared for the Board of Directors meeting in May. Board committees will have the opportunity to scrutinise relevant content during the course of the report's development.

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

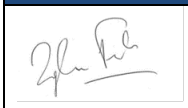
Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
M8 Strategic Impact Report

Lead



Zephan Trent
Executive Director of Strategy, Transformation & Digital

NHS
Essex Partnership University
NHS Foundation Trust

STRATEGIC IMPACT REPORT

M8 2023/24

EPUT

CONTENTS.

NHS
Essex Partnership University
NHS Foundation Trust

INTRODUCTION

EPUT

EPUT'S STRATEGIC PLAN 2023/24-2027/28

OUR VISION

To be the leading health and wellbeing service in the provision of mental health and community care.

OUR VALUES

Strategic objectives

We have four strategic objectives to achieve our vision:

- We will deliver safe, high quality integrated care services
- We will work with our partners to make our services better
- We will enable each other to be the best we can be
- We will help our communities to thrive

Delivered through our target operating model

A balanced scorecard approach has been developed to support reporting of progress against delivery of the Trust's strategic plan

- In the Strategic Plan we committed to a series of outcomes, sub-outcomes and measures for each of our four Strategic Objectives
- For each of the four Trust strategic objectives, a small number of metrics have been selected
- Metrics have been selected on the basis that they are indicators of progress with the relevant strategic objective and that, if there is an adverse trend reported for that metric, delivery of the relevant strategic objective could be at risk and corrective action should be considered
- The dashboard provides a visual representation of in-year trends
- Supporting narrative has been triangulated with other reporting flows to the Board and sub-committees
- This approach compliments established Board assurance reporting with focus on the delivery of the Trust's strategic plan. This report is not exhaustive and does not replace or summarise other reporting to the Board.

Ongoing reporting development process

- This report is the second in a three times yearly reporting cycle and will continue to iterate and evolve based on new data workflows as well as constructive feedback from the Board
- This report has been developed through a combination of:
    - Analysis of available performance data by the Business Information team aligned with the measures agreed for each of the Trust's four strategic objectives
    - Thematic review and distillation of Accountability Framework papers for M5-8 2023/24
    - Supplementing Accountability Framework discussions, informal quarterly meetings with care unit leadership teams to review progress against operational plans for 2023/24 and five-year care unit strategies as well as any risks to operational delivery. This report focuses on three out of six care units (Urgent Care & Inpatients, North East Essex and Specialist Services). The next report in May 2024 will provide a global Trust-wide position at the end of Year 1 of the Strategic Plan
    - Moving forward, we are working towards further alignment of this report with established reporting to Board via the Accountability and the Integrated Performance Report.

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DELIVERY AGAINST STRATEGIC OBJECTIVES

M8 2023/24

EPUT

SUMMARY OF EPUT'S COMMITMENTS FOR Y1 DELIVERY OF ITS STRATEGIC PLAN

We will deliver safe, high quality, integrated care services

- Finish implementation of current safety strategy and develop continuation plan
- Phased implementation of Time to Care models
- Continue to actively engage with the Lampard Inquiry and respond to recommendations once concluded
- Develop clinical quality strategy

We will enable each other to be the best we can be

- Develop people and culture strategy including development of behavioural framework
- Continue to collaborate with local and regional partners on long term workforce development plan
- Improve our staff development offer and extend this to lived experience and volunteer roles

We will work together with our partners to make our services better

- Build on recent successes in the way we partner with lived experience experts, families, carers and communities to drive cultural change within EPUT
- Deepen approach to partnerships with ICSs and Local Authorities to maximize influence
- Better define EPUT's role in Population Health Management across three ICSs

We will support our communities to thrive

- Develop social impact strategy with focus on parity for people with serious mental illness, learning disability or autism
- Form local commercial and innovation partnerships
- Consolidate local recruitment plans

Finalise digital strategy and progress towards streamlined EPR
Develop estates strategy
Develop research & innovation strategy
Become a Trauma-Informed and psychologically-informed organisation

At M8, EPUT is making steady progress against each of its strategic objectives within each care unit. The factors limiting progress against some in-year commitments are varied and therefore require targeted corrective action

- **We will deliver safe, high-quality integrated care:** Across all care units, place-based integration is progressing through a range of delivery models. Safe, high quality and integrated care will progressively be underpinned by a modern and unified Electronic Patient Record (EPR), for which procurement has progressed significantly since M4. The shared care record programme will support the ongoing integration of a single care record across EPUT and our system partners for existing EPRs. Harm rates in community health services remain below target. The implementation of the new Quality of Care strategy (approved at Board in November 2023) will drive further improvements in safety, effectiveness and experience of care. There is evidence of a positive trend in Patient Reported Experience measures in the last four months.
- **We will enable each other to be the best we can be:** Major transformation programmes like Time to Care have progressed since the beginning of the financial year with strong multi-professional leadership and buy-in. There has been particular progress in the co-design of the new therapeutic inpatient care model and roll out of the ward development programme to inpatient matrons. Work is progressing to refresh our People & Education strategy which is on track for completion and approval in January 2024. Numbers of Lived Experience Ambassadors and Volunteers have grown steadily month on month as part of our new Partnering with People & Communities strategy.
- **We will work together with our partners to make our services better:** Relationships across our four Integrated Care Systems continue to strengthen and there is evidence across the Trust of increasingly integrated and joined up planning and delivery. Implementation of the Southend, Essex and Thurrock All Age Mental Health Strategy has started. Similarly, EPUT continues to play an important role in the East of England Specialist Mental Health Collaborative as we constantly look to improve provision of secure mental health services, specialist mental health services to children and young people and those living with learning disabilities, autism or disordered eating.
- **We will help our communities thrive:** EPUT's Social Impact strategy was approved by the Board in September 2023. In the last four months, the Social Impact Leadership Group has grown to include front line staff representatives and Lived Experience Ambassadors. A small number of ambitious community interventions have been co-designed and Enable East is leading the development of a number of parallel bids to secure grant funding to launch at least one in 2024 and is working with two third sector partners on options for amplifying their impact. Care Unit teams have been heavily engaged with place based inclusive recruitment events and continue to explore ways to collaborate with local partners on existing initiatives. The development of the new EPUT Estates strategy provides an opportunity to consolidate thinking about how we use our buildings to best effect for local communities and maximise environmental sustainability.

STRATEGIC OBJECTIVE 1: WE WILL DELIVER SAFE, HIGH-QUALITY INTEGRATED CARE

Trust level highlights M5-8 by exception

- Patient reported experience measures give a good indication of the quality of care EPUT provides. In M5-8 2023/4, 91.2% reported a positive experience (no material change from the previous period) and 4.4% negative (1.4% increase from the previous period), maintaining a significant improvement from 79.8% positive and 14.3% negative experience in the same period in 2022/23
- Patient Safety Incident Reporting rates have followed a positive, upward trend M1-8 with the implementation of PSIRF and the adoption of a learning culture
- The proportion of incidents reported in Mental Health services with low/no harm has increased from 86.7% in M5 to 94.6% in M8 and two successive months ago the 93.9% target. The reverse trend has continued in Community Health Services where some moderate harm relates to pressure ulcers and staffing pressures are impacting on time to sign off incidents. This is forecast to improve in the coming months as all managers dedicate time weekly to review and sign off of incidents.
- Community teams continue to iterate models of network integration with Primary Care across Greater Essex bringing together physical and mental health services. Residents of Thurrock with SMI are receiving physical health checks and performing in the top ten nationally. Chelmsford West now has a similar model in place for holistic 360 review which has been warmly received.

Metric		Target (if applicable)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	Narrative
Patient Safety incident rates (PSIM)	Incident Reporting Rates	>44.33	64.0	75.3	77.1	63.8	68.2	69.6	68.6	66.2	
	Reduction in PSIs	<3	0	3	1	0	2.4	0	2	2	
No harm/low harm incident rates	MH	93.90%	91.50%	92.7%	94.40%	95.90%	90.60%	84.20%	95.90%	94.40%	
	CHS	94.60%	82.00%	83.30%	82.90%	79.90%	83.60%	77.70%	72.20%	77.50%	
Live Integrated Network Teams	West Essex	6							6		
	MSE (SEE)	6							4		
	NEE	10							4		
PREMS	No. reviews		196	314	514	310	345	303	369	367	
	5 star score		4.77	4.76	4.76	4.6	4.73	4.69	4.71	4.72	
	% Positive experience		92.90%	91.10%	92.00%	89.00%	90.10%	91.70%	90.40%	92.60%	
	% Negative experience		2.60%	3.50%	1.80%	4.80%	4.60%	5.30%	4.50%	3.00%	

Note: Any data variance from the Integrated Performance Report is driven by live updates from Datix on incidents reported retrospectively

STRATEGIC OBJECTIVE 1:

WE WILL DELIVER SAFE, HIGH-QUALITY INTEGRATED CARE

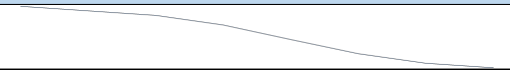
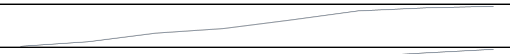
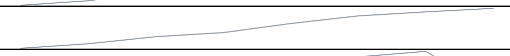
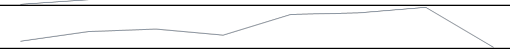
Care unit progress at month 8

Care Unit	Successes at M8
Urgent Care & Inpatients	• Deputy Director of Quality & Safety Safewards roll out • Development of new operational model underpinned by NHSE Inpatient July 2018 • Mental Health Urgent Care Department launched • Royal Collect of Psychiatrists' review completed → co-locating MSE Crisis teams with Home treatment teams • Out of Area Placement reduction trajectory on target (35 in M1 to 15 in M8) • Reduction in average length of stay
North East Essex	• Four system wide integrated neighbourhood teams up and running • EPUT hosting neighbourhood communications post and neighbourhood team managers • Registered Integrated Primary Care Teams' work force fully recruited • Trauma-informed operating model progressing: two workshops completed, B7+ training in place, new care plan format in development, guidance issued to managers; restorative supervision programme launched • Scoping a review of Dementia and Frailty pathway with ESNEFT
Specialist Services	• Secure Services - estates investment in patient safety improvements - CCTV, door top alarms, OxeVision • Established new escalation partners to social care and regional provider collaborative based on early escalation between clinicians → improved flow, fewer reported discharge delays • Risk assessment tools in place in Learning Disability Services facilitating risk stratification and early increase in enhanced support, community Care, Education & Treatment Reviews to find alternatives to admission, increased support by SCFT

STRATEGIC OBJECTIVE 2: WE WILL ENABLE EACH OTHER TO BE THE BEST WE CAN BE

Trust level highlights M5-8 by exception

- Trust-wide vacancy rates have reduced steadily since M4 to a low of 8.7% in M8 against a target of 12%
- Retention rates have been consistently below the 12% target all year and reached a low of 9.1% in M8
- More than 175 new preceptors have joined the Trust so far this year which is key to the development of a strong and competent workforce
- In July, we reported a 92.5% increase in quarterly Pulse Survey responses compared with the prior year. Results were positive overall with improvements in 3/9 questions and worsening scores in 3/9. The window for the next national quarterly survey will open in January.
- The number of and hours invested by Lived Experience Ambassadors and volunteers has grown steadily all year.

Metric		Target (if applicable)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	Narrative
Retention rate	Staff Turnover	12%	10.40%	10.30%	10.20%	10.00%	9.70%	9.40%	9.20%	9.10%	
Range and update of learning & development opportunities (inc. volunteers and lives exp. roles)s			APRIL-NOV 2023 inclusive: Leadership Programme: 45 Management Development Programme: 48 Edward Jenner Programme: 3 STORM Training: 12 PSIRF (Systems Approach to Learning from Patient Incidents): 40 Time Management: 1 Minute Taking: 7 VDT MOCA Training: 2 ACT Training: 13 RISE: 45								Excludes data for ECG Venepuncture etc, delivered by Health Care Training and Developmentand Pension/retirement workshops
Number of PSE and Lived Experience role	Total No. LEAs		106	112	123	129	140	152	156	158	
	Total No. Volunteers inc LEA		251	258	270	277	292	304	311	317	
	Hours LEA (per month)		136.5	278	314.5	225.8	539	557	645	47	
Staff survey - Pulse results	Reported quarterly		**Reporting window July 2023** There has been a 92.5% increase in response rate when compared with Q1 2023/24, with 605 responses • Results from the survey are overall positive, with: • EPUT performing above national averages on engagement scores • Improvements in 3 of 9 questions • Worsening scores in 3 questions • 3 question scores remaining in line with Q1 2023/24				There is no update for NQPS as it is currently live as of 1st January.				In July 2023 we changed provider to People Pulse. Their results platform is more comprehensive and therefore the questions supplied are different to last quarter

STRATEGIC OBJECTIVE 2:

WE WILL ENABLE EACH OTHER TO BE THE BEST WE CAN BE

Care unit progress at month 8

Care Unit	Successes at M8
Urgent Care & Inpatients	• A number of wards close to full establishment • Recruitment plan, including from abroad, on track • Roll out of dialectical behaviour therapy (DBT) informed coping skills groups to five wards • Autistic Spectrum Disorder (ASD) and neurodiversity pilot training at Linden Centre • New reflexive spaces for all ward managers and Mental Health Urgent Care Department matrons • Ward manager development days and matrons forums conducted
North East Essex	• Successful Community Apprenticeship recruitment, 6 WTE recruited from local area • Place based recruitment plan underway looking at immediate recruitment needs and longer term planning through employment fairs in local educational establishment for next three to five year pipeline • Successful recruitment of Band 3 Care Navigators in Community 360 and Tendring CVS • Developing Band 7 Advanced Community Practitioner to develop career pathways and retention • Mentorship and restorative supervision of leadership team
Specialist Services	• A number of wards close to full establishment • Development of new roles, experts by experience in Child Adolescent Mental Health Services (CAMHS), carer rep in rainbow, forensic/ others. East of England Family Ambassador within CAMHS • Recruitment ahead of trajectory for Time to Care implementation • 49% (high) level of national staff survey responses • Uptake of the Oliver McGowan training to improve knowledge, skills and understanding (100% compliance in LD) • Increase in substantive staff with IR nurses and newly qualified staff training

STRATEGIC OBJECTIVE 3: WE WILL WORK TOGETHER WITH OUR PARTNERS TO MAKE OUR SERVICES BETTER

Trust level highlights M5-8 by exception

- EPUT is able to evidence numerous examples of how it is working with its system partners to improve the quality of care available to local people. The new Quality Together governance structures put in place with Essex Integrated Care Board leaders is fundamental to this new way of working
- EPUT is a key partner in delivering the Southend, Essex and Thurrock all age mental health strategy, the implementation of which has started during 2023
- EPUT is a key partner in the County of Essex Crisis Care Concordat alongside local statutory NHS and social care providers and Essex Police who work together to improve urgent care pathways
- Across all the places EPUT serves, the Trust is an active player in place-based integration of health and social care, working with Local Authority partners on a range of innovations like virtual wards, integrated network teams, hybrid workforce development and collaborative research projects.

The data dashboard to provide assurance of progress against strategic objective three remains in development.
In particular, The Patient Experience Team plan to survey LEAs for their experience supporting EPUT, the results of which will feature in the M12 Strategic Impact Report.

STRATEGIC OBJECTIVE 3:

WE WILL WORK TOGETHER WITH OUR PARTNERS TO MAKE OUR SERVICES BETTER

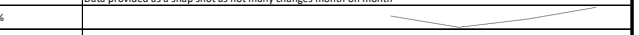
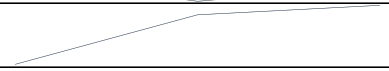
Care unit progress at month 8

Care Unit	Successes at M8
Urgent Care & Inpatients	• Mental Health Urgent Care Department launched • North East Essex & Mid & South Essex Ambulance cars operational – through partnership with Integrated Care Boards • Revised Pan-Essex system recovery plan on trajectory including Multi-Agency Discharge Events (MADE) • Urgent Care pathway involvement group set up to co-produce with patients/careers at all level • Stakeholder engagement in the Therapeutic acute inpatient operating model workshops
North East Essex	• Phase One – neighbourhood alignment completed 2021 • Phase Two review of neighbourhood model now under development • Joint review of Dementia and Frailty Model with ESNEFT underway. • Additional Roles Reimbursement Scheme (ARRS) roles key partners in local neighbourhood team
Specialist Services	• High performing service working alongside Essex Police, magistrate and crown courts and voluntary sector organisations. 25% reduction in section 136 activity in M6 and patients being diverted into mental health and social care services and away from custody and our health based paces of safety • Working with ICB developing neuro-diversity pathway • Delivering specialist training across ICBs and teeing up for region e.g. eating disorders

STRATEGIC OBJECTIVE 4: WE WILL HELP OUR COMMUNITIES TO THRIVE

Trust level highlights M5-8 by exception

- We are now able to profile staff locality to the services in which they work as an indicator of EPUT's economic and environmental impact as a local employer. In M8, 81% of EPUT staff live and work in the same county.
- The proportion of B7+ posts held by BAME staff have reduced from by 5% in since the last reporting period. The Executive team will agree objectives in January 2024 to increase diversity
- Based on value of Purchase Orders, EPUT has spent 10% up to M8 of its procurement spend with suppliers based in Essex, Bedfordshire or Suffolk. Work is required with system partners to benchmark this analysis and assess options which may enable us to increase this year on year with awarding contracts where EPUT has a choice of supplier. Purchase Orders do not account for 100% of EPUT's spend as they do not cover large, national supplier arrangements e.g. HMRC and other statutory suppliers where there is no alternative option.
- Contracts tendered include 10% evaluation weighting for social value at the point of procurement, however the Trust has not yet mapped the capacity required to monitor the social value delivered through the life of contracts. Social value requirements will be mapped during Q4 to determine how best to monitor delivery.
- Since M1, 31 sessions of suicide prevention training have been held with 192 delegated in total and 79% of delegate places filled. This is an increase from 65% of places filled in the previous period.

Metric		Target (if applicable)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	Narrative
% of workforce employed from local communities			Snapshot as at Nov-23: 5484 out of 6750 (81%) employed and live in same county								Data provided as a snap shot as not many changes month on month
% BAME staff in roles >B7							20.65%	20.56%	20.63%	20.72%	
% procurement spend with local suppliers			8.20%	5.95%	3.73%	45.32%	14.35%	15.22%	13.59%	48.00%	
Uptake and evaluation of suicide awareness training	Preventing Suicide by Ligature	85%	Training data between Apr-Aug 2023 not available					89.9%	89.8%	87.8%	
	Clinical Risk for Registered Staff	85%	Training data between Apr-Aug 2023 not available					87.7%	86.6%	87.3%	
	Clinical Risk for Non-Registered Staff.	85%	Training data between Apr-Aug 2023 not available					88.5%	90.0%	90.3%	
	Suicide Prevention & Self-harm Mitigation (Storm):		From 1st January -1st December 2023:- 31 courses offered, 248 delegates could have been trained. 4 courses were cancelled due to facilitator unavailability, 3 were not released on the mandatory training calendar due to an error/oversight, therefore out of the potential 248 available places, only 192 were offered for training. 151 delegates were trained (79%)								

STRATEGIC OBJECTIVE 4:

WE WILL HELP OUR COMMUNITIES TO THRIVE

Care unit progress at month 8

Care Unit	Successes at M8
Urgent Care & Inpatients	• Local Community garden parties and summer fêtes • Local place based recruitment fairs
North East Essex	• Harwich Hub – open day for opportunities for joint working. • Perinatal training "Saving Mothers Lives" provided across Essex stakeholders. • Successful Community Apprenticeship recruitment, 6 WTE recruited from local area • Over 900 responses from community engagement event. • Development of multi provider bereavement service
Specialist Services	• Op Courage becoming regional service, success of inpatient detox (Topaz), additional bid for Drug & alcohol services in Suffolk and potentially Thurrock • Positive response to Asylum seekers, new service opportunities in Suffolk and Thurrock, increase in Op Courage offer

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TRANSFORMATION DELIVERY FRAMEWORK

JANUARY 2023

EPUT

INTRODUCTION

EPUT remains focused on its agenda to improve services, change our culture and learn lessons from the past and is committed to concentrating on the programmes and projects which will deliver meaningful and sustainable benefits to our patients, service users and colleagues.

The Transformation Team support this extensive agenda by maintaining, managing and assuring a portfolio which consists of transformational programmes & projects, incremental and quality improvement projects. In October we also added the approved financial efficiency schemes and the remaining enabling strategies.

There are three distinct functions of the Transformation team which are summarised below with target time spent on each activity:

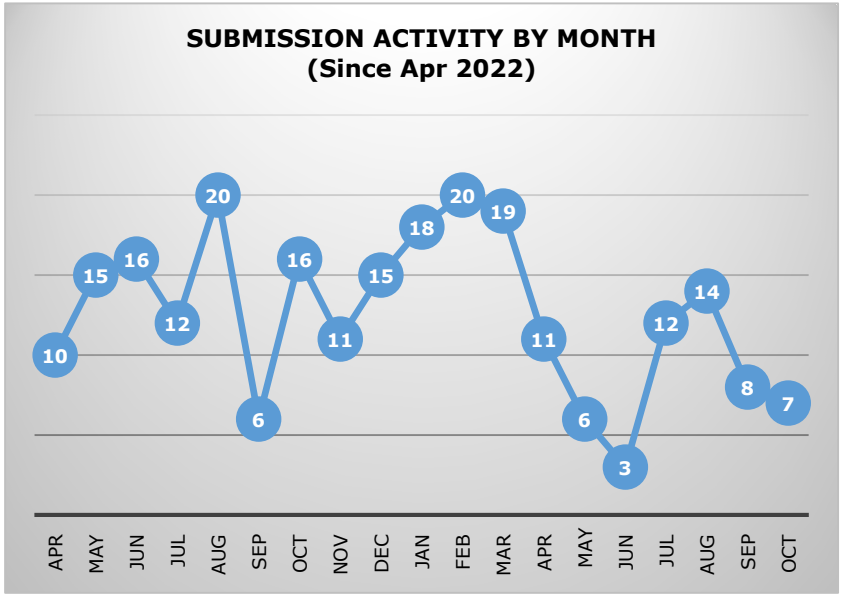
Assurance **Oversight & assurance of our overall change portfolio**	**Delivery** **Project & programme management and delivery**	**Coaching & Support** **Supporting colleagues to deliver change**
Target: 15%	Target: 70%	Target: 15%
• Reporting on the overall Trust portfolio • Project/programme assurance reviews • Project/programme management standards, governance processes and controls • Project stage gate reviews, reporting & health checks • Assurance of efficiency schemes	• Defined project and programme management resource to deliver high priority and transformational projects and programmes • Business partnering and project portfolio management for Care Units, Corporate Services and Community Care Units • Translation of strategies into prioritised portfolios of projects/programmes • Portfolio Management Office providing oversight, prioritisation and management of the overall portfolio	• Assisting care units and their teams to understand their change portfolios • QI projects and QI centre of excellence • Coaching and support of individuals/teams to support small/medium sized projects • Tools, templates and best practice to support project initiation, planning, execution and closure • Support 'Single Front Door' (SFD) submissions

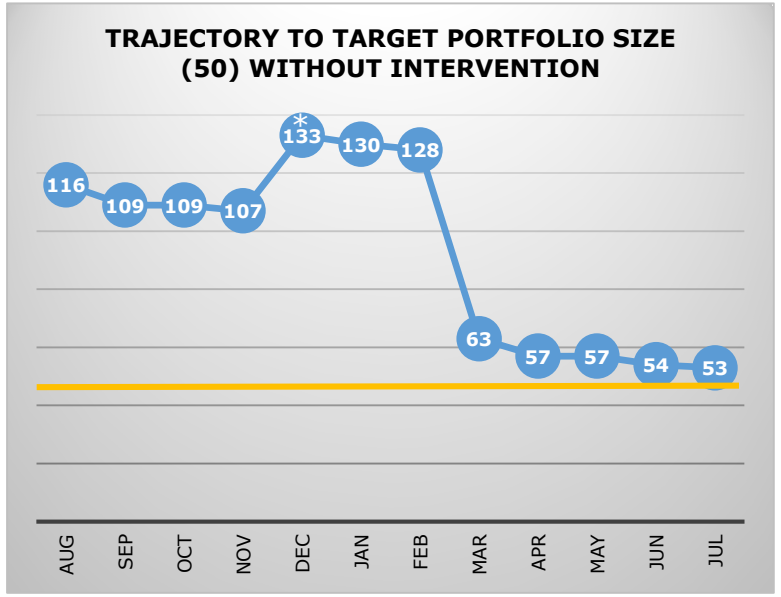
PROGRESS SINCE SEPTEMBER 2023

- Continued review of transformation team resource commitments and forecast to ensure the team are deployed on the highest priority projects/programmes. This includes leading and supporting the projects/programmes and other activity highlighted in the "Key Projects and Programmes" section.
- Continuation of work to reduce our overall portfolio to c50 projects and programmes by financial year end in order to focus on a smaller number of projects and transformational programmes that will deliver the maximum benefits.
- Completed categorisation of projects and programmes in line with the Trusts scheme of delegation
  - Board Approved 'Large' (above £1m)
  - Executive Approved 'Medium' (£101k > £1m)
  - Executive Delegated 'Small' (up to £100k)
- Continued working in partnership with the Digital PMO in order to mature our portfolio, project and programme processes in line with recognised maturity models e.g P3MO
- Worked with project managers from across the organisation to ensure we move towards gold standard reporting for projects and programmes with dedicated resource to support the turnaround of programmes and projects reporting red or amber status
- Incorporated efficiency schemes and enabling strategies into the overall portfolio in order to recognise the resources required to support these
- Completed procurement of portfolio management software Aspyre and commenced implementation

PORTFOLIO STATUS

	March 2023	June 2023	Sept 2023	Dec 2023
Active Projects *(initiate, plan, execute)*	**136**	**141**	**116**	***121**
Committed Projects	*(not reported)*	**85**	**75**	**51**
Non committed projects	*(not reported)*	**56**	**41**	***70**
Projects supported or led by Transformation Team	**70**	**69**	**59**	***74**
Planned projects due to close in the next 3 months	**32** *(Mar, Apr, May)*	**30** *(Jun, Jul, Aug)*	**9** *(Sep, Oct, Nov)*	**5** *(Dec, Jan, Feb)*
Actual projects closed in past three months	**9** *(Dec, Jan, Feb)*	**32** *(Mar, Apr, May)*	**20** *(Jun, Jul, Aug)*	**31** *(Sep, Oct, Nov)*





* The 23/24 efficiency schemes and enabling strategies were added in October 2023 to the overall portfolio in order to recognise the resource required to support these

TRANSFORMATION DASHBOARD – JANUARY 2023

Time To Care	Workforce & Culture	Safety, Learning & Q.I.	Clinical Model	People & Community	Digital & Data	Estates and Commercial
Executive Sponsor Alex Green	**Executive Sponsor** Marcus Riddell	**Executive Sponsor** Francis Bolger	**Executive Sponsor** Milind Karale	**Executive Sponsor** Nigel Leonard	**Executive Sponsor** Zephan Trent	**Executive Sponsor** Trevor Smith
Overview - Staffing model; process improvement	**Overview -** Changing culture; staff development & leadership	**Overview -** Safety; learning; independent inquiry; QI	**Overview -** Clinical strategy; clinical pathways	**Overview -** Community engagement; lived exp. & participation	**Overview -** Modernisation of digital and data systems and processes	**Overview -** Modernisation and optimisation of estates
Projects 3 projects in Execute, of which • 1 Green • 2 Amber • 0 Red 16 Pipeline projects	**Projects** 1 projects in Execute, of which • 1 Green • 0 Amber • 0 Red 2 Pipeline projects	**Projects** 8 projects in Execute, of which • 5 Green • 2 Amber • 1 Red 6 Strategies 10 Pipeline projects	**Projects** 17 projects in Execute, of which • 11 Green • 6 Amber • 0 Red 16 Pipeline projects	**Projects** 3 projects in Execute, of which • 1 Green • 0 Amber • 2 Red 1 Pipeline project	**Projects** 14 projects in Execute, of which • 4 Green • 1 Amber • 9 Red 18 Pipeline projects	**Projects** 19 projects in Execute, of which • 16 Green • 3 Amber • 0 Red 1 Strategy 8 Pipeline projects
Transformation team Resource Committed • 1.8 WTE	**Transformation team Resource Committed** • 0.6 WTE	**Transformation team Resource Committed** • 1.8 WTE	**Transformation team Resource Committed** • 4.2 WTE	**Transformation team Resource Committed** • 1.5 WTE	**Transformation team Resource Committed** • 1.4 WTE	**Transformation team Resource Committed** • 0.3 WTE
Key programmes/ projects Time to Care • Handover Quality Improvement • Peer Support Worker Pilot • International Recruitment of Nurses and AHPs	**Key programmes/ projects** • Rebuild of EPUT intranet • HCA Academy • Trust Wide Vacancy Review and Reduction	**Key programmes/ projects** • Lampard Inquiry • Safety Dashboard • Embedding Gold Standard SOPs • Ligature Risk Reduction – Training • Switch from Xeplion to Generic Paliperidone	**Key programmes/ projects** • Integrated Mental Health Primary Care Transformation Programme • Outcomes Measures • Approved/ Responsible Clinician • Complex Care Programme • Specialist Perinatal Mental Health Transformation • Eating Disorders Transformation	**Key programmes/ projects** • Coordination CareCentre Programme • West Essex Feasibility of an Integrated Older Adult Inpatient Ward	**Key programmes/ projects** • EPR • ESLMS • ePMA	**Key programmes/ projects** • CAFM • Woodlea Clinic Refurb • Brockfield House Safety Improvement Works • Ligature Risk Reduction – Ward Environment Improvement
Projects moved to BAU or Closed • Ward Manager Development Programme	**Projects moved to BAU or Closed** • AHP Review	**Projects moved to BAU or Closed** • Quality of Care Strategy • CQUIN	**Projects moved to BAU or Closed** • System Partnership and Engagement	**Projects moved to BAU or Closed** • Rough Sleepers Programme	**Projects moved to BAU or Closed** • Digital Strategy • Data Strategy	**Projects moved to BAU or Closed** • Hadleigh Unit Refurbishment

KEY PROJECTS/PROGRAMMES - TIME TO CARE, WORKFORCE AND CULTURE, SAFETY LEARNING & QI

In Execute:

PROJECT/PROGRAMME NAME	STATUS UPDATE
Time To Care	**To release significant & quantifiable time to care on inpatient mental health wards through changes focused on four key areas Staffing Model Redesign; Process Improvement; Data / Technology Improvement; and Engagement, Inclusivity and Wellbeing.** Work continues responding to key questions on the Staffing models business case ahead of stakeholder meetings in January. The staffing models work will be supported by an embedding change workstream to focus on the implementation of the proposed Staffing model and associated Operating Models for Inpatient care and on coordinating efforts across the organisation to help staff adapt to change to ensure the realisation of the benefits of the programme. Following the successful pilot of the Ward Manager Development Programme throughout 2023, this will now be rolled out to the remaining Ward Managers Trust wide. The Handover Quality Improvement project has progressed with a pilot to standardise the process rolling out in early 2024. Work continues to develop the Inpatient Dashboard in Power BI which will further improve the quality of ward handovers by making relevant data more easily accessible.
Lampard Inquiry	**To support the Lampard Inquiry to investigate matters surrounding the deaths of mental health inpatients across NHS trusts in Essex between 2000 and 2020** Since being in post, Baroness Kate Lampard CBE launched a public consultation on the proposed Terms of Reference for the Lampard Inquiry. Consultation commenced on 1 November 2023 and ended on 28 November 2023. The final Terms of Reference will be published on the Inquiry's website in due course. The Trust's dedicated Project Team are continuing to review information taking into consideration the proposed changes to the Terms of Reference, in particular the extension of the inquiry to investigate the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trust(s) in Essex between 1 January 2000 and 31 December 2023. The Trust remains committed to supporting the Inquiry now and in the future so that families, carers and service users receive the answers they rightly deserve.
Safety Dashboard	**To visualise data from different sources in a digital dashboard view to enable timelier, data driven decision making to further improve patient and staff safety** The initial EPUT roll out took place in Autumn 2023 and the dashboard is now fully live. Continued development to add additional capability to the dashboard will start in January 2024.
Embedding Gold Standard SOPs (Standard Operating Procedures)	**To develop 'Gold Standard' digitised Standard Operating Procedures (SOPs) to support staff to deliver the Mental Health and Community Services in a way that is safe, effective and consistent.** In partnership with Carradale Futures, 11 SOPs for three of the priority areas are being piloted until 31st January 2024, having been developed, approved and digitalised. Approximately 200 members of staff will participate in the pilot and then provide feedback to assess usability, efficiency and effectiveness to inform the plan to implement SOPs for the remaining priority areas. 10 priority areas have been identified for SOP development; (1) Local induction, (2) Transfers, (3) Risk assessment, (4) Admissions, (5) Post-discharge follow-up, (6) Record keeping, (7) Disengagement, (8) Identification and Management of deterioration, (9) Management of Falls (10) RAG rating for Care Coordinators.
Ligature Risk Reduction – Training	**To develop a bespoke in-house Ligature Risk Awareness and Management Training course for all clinical and non-clinical EPUT staff that allows for practical mandatory training drills, therapeutic engagement, identifying and managing environmental risks and after incident care for staff.** The Executive Team and Ligature Risk Reduction Group approved the training proposal for a half day face to face session complimented by an online learning module. Training will commence in April 2024.

Transferred to Business As Usual:

PROJECT/PROGRAMME NAME	STATUS UPDATE
International Recruitment	**Across 2021/22, EPUT had significant registered nursing vacancies. This increased temporary staffing expenditure and over-reliance on agency staffing. A programme of international recruitment was established.** Since Oct 2021, we have recruited a total of 240 nurses of which 92% (220) remain working at the Trust. 70 of these nurse are registered Mental Health nurses and 150 are registered General Nurses. As part of Business As Usual the team will complete a benefits realisation review that explores not only any efficiency benefits, but the impact therapeutically and on quality, workforce and our learning.
AHP (Allied Healthcare Professional) review	**To embed a clear AHP operational and leadership structure to align with each care group to more effectively deliver change at pace, with improved alignment between operational and strategic agendas.** By increasing AHP visibility and empowerment, in addition to increasing effectiveness and impact this change will lead to more AHPs wanting to join EPUT inpatient services and ensure improved staff satisfaction in their role. The Deputy Directors of Quality and Safety reviewed the proposed AHP leadership new staffing model options and suggested that a realignment of existing resources be explored. The work on realignment is being taken forward within Business As Usual as project management support is no longer required.
CQUINS(Commissioning for Quality and Innovation)	**To achieve the annual performance aims set out in 9 national Commissioning for Quality and Innovation (CQUIN) improvement goals as part of our culture of continuous improvement to support better patient and staff outcomes.** The CQUIN goals are focused on patient outcome measures, reduction of restrictive practices, flu vaccination campaign and improvement of community services. We remain on track to meet our performance targets for seven of these. The two remaining CQUINs that we continue to work on relate to staff vaccinations and pressure ulcer risks. EPUT will continue to support and encourage staff to have the annual flu vaccination, however this is voluntary and so will impact achieving the CQUIN goal. Work has begun to change the templates on Electronic Patient Records in line with national guidance for roll out by Q1 24/25.

KEY PROJECTS/PROGRAMMES - DIGITAL AND DATA, ESTATES AND COMMERCIAL

In Execute:

PROJECT/PROGRAMME NAME	STATUS UPDATE
EPR (Electronic Patient Record)	**To provide a unified Integrated Care System enterprise-wide digital Electronic Patient Records solution for community, mental health and acute services** Procurement activities taking place currently with the programme remaining on track to select the preferred supplier. A Full Business Case (FBC) will then be presented to Trust Boards and once approved this will go to NHSE Regional and National teams for review ahead of Ministerial approval.
ESLMS (EPUT Safety and Lessons Management System)	**To deliver a digital solution to drive a culture of continuous learning and safety improvement, through the analysis and interpretation of data relating to incidents.** Development and implementation of a digital lessons management system in partnership with MASS Cohort PLC which can gather information from Datix (our incident reporting system) and perform thematic analysis. The Lessons team will use information from this system to further enhance and prioritise learning to be shared and embedded within the organisation. Version 1 of the system is live and we are providing training to familiarise clinical colleagues.
ePMA (Electronic Prescribing Medicines Management Administration)	**To remove paper-based processes for prescribing and medicines administration by implementing a dedicated bespoke digital system** Delivery is planned over three phases: (1) Pre-implementation, which includes development and configuration of the system, training materials, processes and policy; (2) Preparation of the inpatient wards including training of staff in system use and then go live of the system at each ward; (3) Training and go live of our community mental health teams. Phase 1 to configure the system and develop training materials, process and policy is now underway. Recruitment has taken place of the core project team, with the remaining roles being progressed through the required processes.
CAFM Solution	**To replace our digital Computer Aided Facilities Management (CAFM) system to improve the facilities services we offer to staff and service users** The Estates and Facilities team alongside EPUT procurement leads completed the procurement process for a new system and submitted a final business case to the Executive team for approval in December 2023 with a view for implementation starting in January 2024.
Woodlea Clinic Refurbishment	**To improve the therapeutic environment for our patients and to ensure that patient safety improvement works take place to meet with the Trust standards** A suitable contractor was appointed in October 2023 following a successful tender process. Construction work started in November and is due for completion mid 2024. The ward remains operational during these works although capacity has been reduced. Estates teams are working closely with the Clinical teams to ensure minimal disruption for patients.
Brockfield House Safety Improvement Works	**To enhance our patient environments and to increase patient safety, a significant programme of improvement works is currently in progress for Brockfield House** Work includes the replacement of patient bedroom doors with alarmed reduced ligature doors, installation of Oxevision to all bedrooms, removal of drawer units and installation of CCTV to all common areas on the wards. In addition, work has taken place to replace fire doors, installation of new flooring, new lighting and decoration of the wards at the same time. The programme of works will run until March 2024.

Closed:

PROJECT/PROGRAMME NAME	STATUS UPDATE
Hadleigh Unit Refurbishment	**Upgrade the existing environment to improve patient experience and to meet the Trust Risk Stratification standards to reduce potential ligature issues.** Phase 1 works commenced in June 2023 and the unit opened at the end of November 2023. Final snagging will take place in order to resolve any defects, which have occurred since the opening of the unit.

In Execute:

PROJECT/ PROGRAMME NAME	STATUS UPDATE
Integrated Mental Health Primary Care Transformation Programme	**Delivering Integrated Mental Health Primary Care Network (PCN) Teams across Essex is part of the national drive to provide a GP wrap around provision of physical, mental health, social care and Voluntary, Community and Social Enterprises (VCSE)**. Across Essex Primary Care Networks (PCNs), organised around GP surgeries, now have a Mental Health practitioner (Nurse, Social worker or Occupational Therapist) for rapid access to mental health triaging, assessments and where required treatments. A new additional tier of psychological services bridging the gap between NHS primary care talking therapies and secondary care psychology and psychotherapy has been established. Most PCNs already have MH pharmacy embedded and some consultant psychiatrist sessions providing advice and support, and in some areas treatment. Further work is taking place to enable all PCNs to have access to psychiatry sessions. A plan to enable all Essex GPs to direct book MH appointments in in progress. Development work with the voluntary sector is taking place across Essex to deliver more integrated care pathways.
Outcomes Measures Programme	**Implementing a Clinical Outcomes Framework (1) New Care Plan (2) Outcome Measures Tools** Routine use of outcome measures by clinicians and independently by patients gives ongoing feedback on how effective care delivery is as part of the new Care Plan. This will launch mid 2024 and has an in-built outcome measure that captures statistically significant clinical change. This will give clinicians, supervisors, managers, the Trust, commissioners, and most importantly patients and carers feedback on care delivery effectiveness. It also contains another outcome measure providing the opportunity for staff delivering care and people receiving care to check progress along the way. The care plan is built for use with all local providers in health, social care and the voluntary services and will be available over time as developments in technology allows over the next few years. EPUT is working with the NHS patient digital app to build a set of outcome measure tools integrated with our Electronic Patient Record systems. These outcome measures will allow patients to access the app independently and complete the outcome measures to demonstrate progress. The data from patients will feedback into the Trust clinical record and we are planning for system launch mid 2024.
Approved/Responsible Clinician	**To train mental health professionals, other than psychiatrists, to carry out Approved Clinician (AC) duties to deliver an enhanced quality of care while ensuring the best use of our skilled and professional diverse workforce.** The cohort of Multi Professional Approved Clinicians (MPAC) continue to progress through training and their work-based portfolios.
Complex Care Programme	**To review and redesign the community Mental Health Team model as a complex care pathway. An Essex wide review and redesign project which includes the changes required to move away from the Care Programme Approach (CPA)** This is a whole systems pathway redesign involving Community Mental Health Teams, Social Care, voluntary organisations, substance misuse and gambling services, employment support, Probation, Housing, Police, Ambulance and physical health care providers. Pilots are currently taking place in Essex to understand how we can achieve full local system integration from a single point of access to treatment for both physical and mental health and social care needs. West Essex, as an early implementer has an advanced whole systems model for comprehensive care delivery and management and will continue to develop fully integrated local system infrastructure over the next year. North East Essex is piloting the joining up of its Community Mental Health Teams and integrated MH PCN Teams with full implementation progressing throughout 2024/25 in line with the required delivery of the NHS Long Term Plan.
West Essex out of Hospital programme incorporating the Care Coordination Centre (CCC)	**To improve people's outcomes and experience by navigating them to services at the right time, in the right place.** The CCC is an established integrated multi-disciplinary service to manage referrals and care approach to adults across all health and social care systems in West Essex. A streamlined telephony system in place and in 2024 the implementation of the Transfer of Care Hub (ToCH) will be implemented to support a system wide approach to discharges from hospital. The Virtual Hospital (VH) service in West Essex celebrated its first year of service in December 2023 and has supported 961 adults in receiving face to face, remote monitoring or a combination of both within their usual place of residence. Both the CCC and VH services priorities are to support prevention of admission and early discharge from hospitals.
Specialist Perinatal Mental Health Transformation 2019 – 2024	**To ensure that 10.6% of all pregnant people in Essex have access to perinatal mental health care through an expansion of specialised perinatal mental health care services** We are in the final year of a four-year transformation programme, with access figures target of 10.6% being surpassed (now at 12.38% across Essex) the service is utilising the final year to focus on quality and health inequalities. We are currently extending our contract with Parents 1st to include a screening and peer support offer for the partners of those accessing our specialised perinatal mental health care service, to expand upon the current peer support offer. The first phase of a digital dashboard is being utilised to enhance the services data insights to support better monitoring of safe and good quality practice. Further in line with the Long-Term plan EPUT launched Essex's Maternal Mental Health Service 'By your Side' in South West Essex for those who have had a severe to moderate mental health response following a perinatal loss, EPUT has plans to expand this therapeutic offer to all of Essex by April 2024.
Eating Disorders Transformation	**To transform adult community eating disorders services to provide a safe staffing level, roll out early intervention services for 18-25 and merge the two teams (north and south) into one Essex-wide service.** Collaboration continues with Acute colleagues (Gastroenterology Consultants, Service Manager and Dietitians) to embed the MEED (Managing Emergencies in Eating Disorders) pathway. We will be working with Acute colleagues, Primary Care Network and GPs, on a structured approach to develop shared care protocols Q1 2024. The newly appointed Service User Network Co-ordinator joined EPUT in November to lead the coproduction element of the transformation. We are looking at our recruitment and operating model resource options in response to recruitment challenges.

NEXT SIX MONTH PLAN

NEXT MONTH	1-3 MONTHS	4-6 MONTHS
Complete a deep dive assurance on 'live' projects to ensure they are 'set up for success' to deliver the desired outcomes / outputs	**Plan for 2024/25 portfolio of change** Business Partner planning with care units and corporate service leads to establish a portfolio of change that considers projects carried forward from 23/24 FY and new initiatives for 24/25. Ensuring we incorporate organisation capacity to deliver to inform a realistic view for achievability and options	**Start to on board approved, planned 2024/25 change** to the EPUT Portfolio to gain an early view of the 'ask' and assess benefits
Commence migration of the overall Trust Portfolio of programmes and projects onto the procured digital solution (Aspyre) to provide better insights for decision makers and improve processes	**Engage programme and project managers on the new procured digital solution (Aspyre)** to ensure adoption across Transformation and Digital PMOs	**Embed the overall Trust Portfolio of programmes and projects onto the procured digital solution (Aspyre)** where this starts to be used as the main repository for management and project status reporting
Implement a new governance process for QIAs, EIAs and HIAs (Quality and Equality Impact and Health Inequalities Assessments)	**Embed the QIA, EIA and HIA** governance process and implementation throughout the organisation	
Complete benefits realisation assurance on closed projects to assess and inform future project and programme continuous improvement and learning lessons	**Expand benefits realisation assurance to nominated Transformation projects and programmes in delivery** to assess and inform future project and programme continuous improvement and learning lessons	
	Expand work on our intranet presence and consider other ways we can share learnings and best practise to support colleagues	**Relaunch our intranet presence** as a means of sharing best practise, lessons learnt and coaching for continuous improvement
	Finalise the approach for embedding QI methodologies throughout the organisation and commence implementation plan following approval	**Continuous improvement of the QI implementation** Undertake training and development of key teams in order to further disseminate the learning and build the capability throughout the organisation
	Translate Digital Strategy into an implementation plan which includes, projects, costs, resources and prioritisation of delivery activity. This will become the blueprint for other strategies	**Support other agreed Trust strategies** and their implementation planning process and activity

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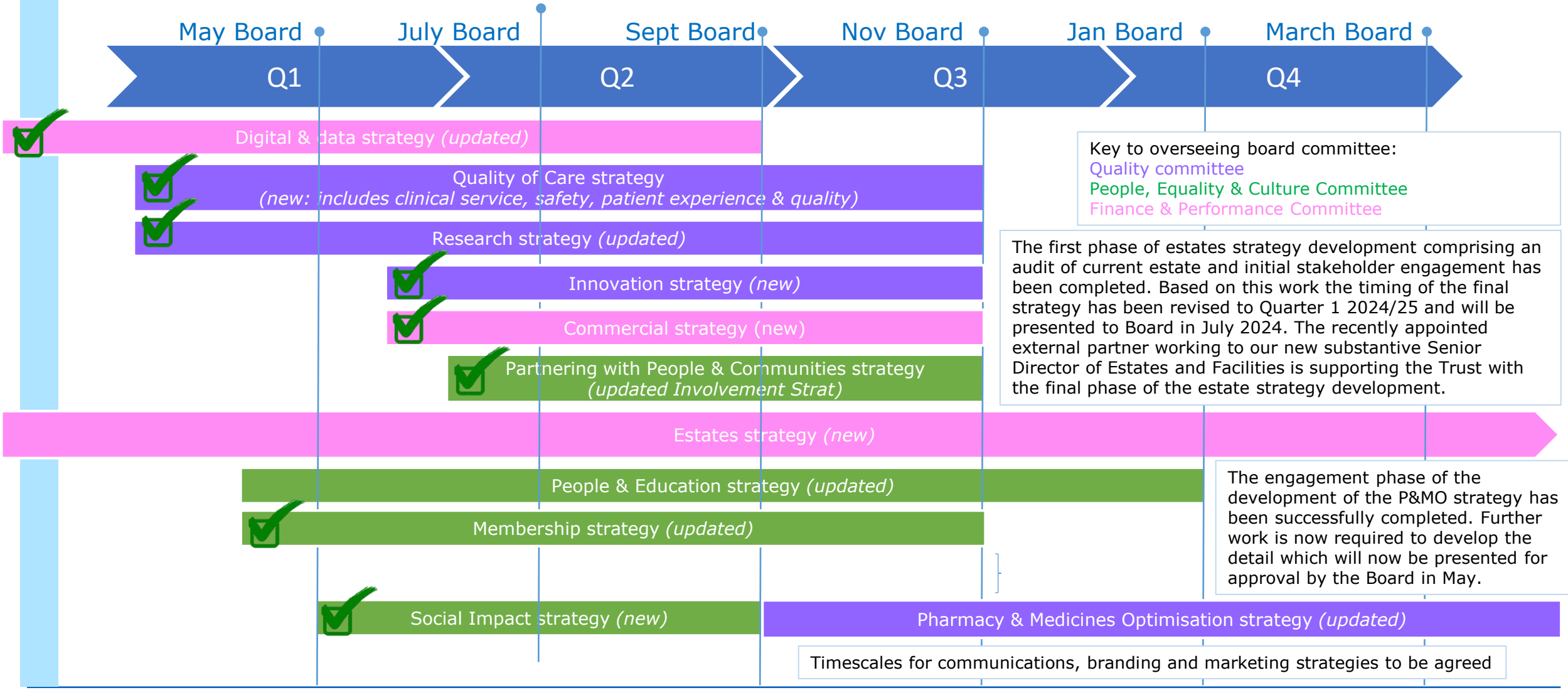
DEVELOPMENT OF CORPORATE STRATEGIES

EPUT

Since September, EPUT has completed development of a further six enabling strategies that support the delivery of its Strategic Plan. The remaining three are on track to be completed by the end of the financial year



Key to overseeing board committee:
Quality committee
People, Equality & Culture Committee
Finance & Performance Committee

The first phase of estates strategy development comprising an audit of current estate and initial stakeholder engagement has been completed. Based on this work the timing of the final strategy has been revised to Quarter 1 2024/25 and will be presented to Board in July 2024. The recently appointed external partner working to our new substantive Senior Director of Estates and Facilities is supporting the Trust with the final phase of the estate strategy development.

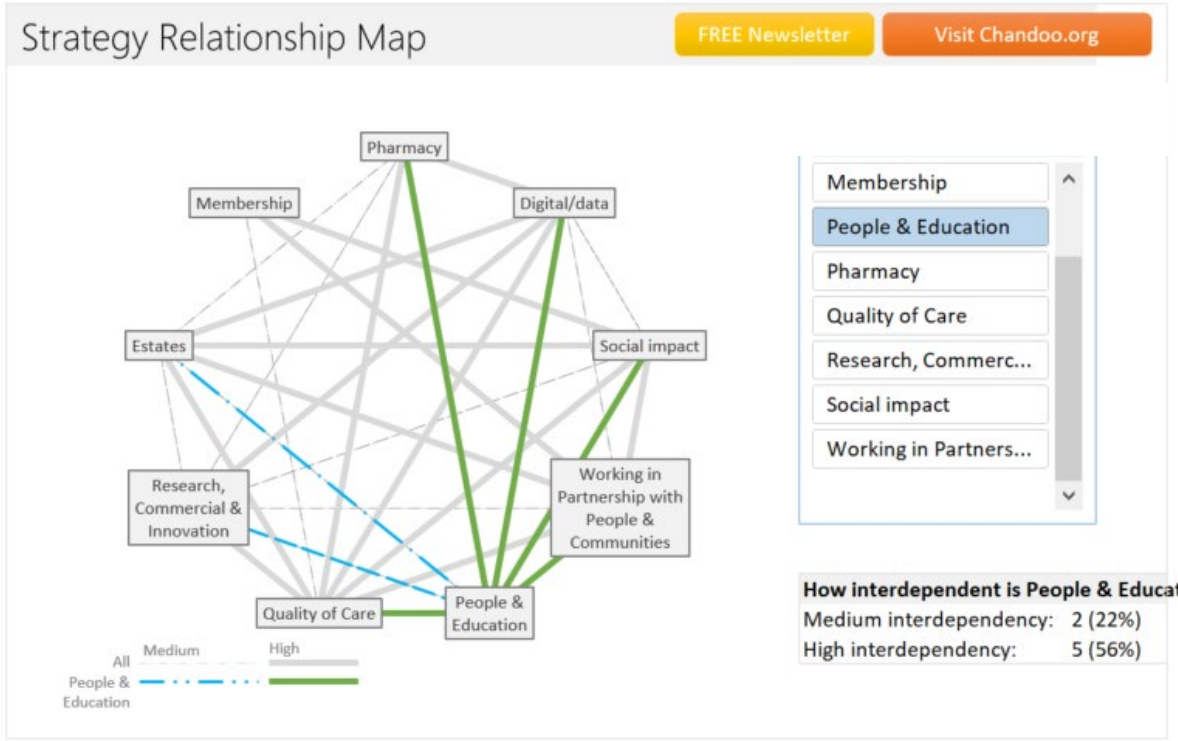
The engagement phase of the development of the P&MO strategy has been successfully completed. Further work is now required to develop the detail which will now be presented for approval by the Board in May.

The Strategy Steering Group is leading a process of profiling the risks related to each corporate strategy and the interdependencies between them

This exercise serves three purposes:

1) Improves strategic grip on delivery
2) Informs strategic prioritisation decisions around use of organisational capacity and investment of resources
3) Provides the opportunity to test and refine a blueprint for risk assessment and management as part of EPUT's strategic development framework, with potential for application to other corporate portfolios.

An initial mapping of risks and interdependencies was conducted by the Strategy Steering Group (including Lived Experience Ambassadors) on 7 December. A further session will be scheduled for February followed by further engagement with the Senior Leadership Team of the Trust. The output will be shared in the M12 Strategic Impact Report.



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APPENDICES

EPUT

In January 2023, the Board approved the new EPUT Strategic Plan 2023/4-2027/8. EPUT's new approach to progressively monitoring and assessing delivery of its Strategic Plan was agreed by the Board at its development session in June

- In the Strategic Plan we committed to a series of outcomes, sub-outcomes and measures for each of our four Strategic Objectives
- The majority of the measures already feature in standard reports, whereas some have required the development of new data flows
- Due to the varying stages of development of our strategic commitments, some measures represent outcomes whereas some, appropriately, represent inputs. As interventions and projects mature, so will associated reporting practice
- A **strategic impact report** is prepared and presented to the Board three times per year and is structured based on the Risk and Viability reporting guidance from the Financial Reporting Council. This includes updates on the Trust's major Transformation programmes and the annual operational planning cycle.

Figure 1.1 The business model as narrative. Source: Financial Reporting Lab (October 2018) *Business Model Reporting; Risk and viability reporting*. Reproduced with permission.

1. **September** report: Strategic impact metrics (M4 YTD) + proposed plan for 2024/25 Operational Plan development
2. **January** report: Strategic impact metrics (M8 YTD) + update on progress with 2024/25 Operational Planning
3. **May** Report: Strategic impact metrics (end of Y1) + reflections on 2024/25 Operational Planning process

We will work together with our partners to make our services better: Mid & South Essex mental health joint response vehicle launched April 2023

- Joint initiative between EPUT and the East of England Ambulance Service (EEAST), supported by Mid and South Essex Integrated Care Board
- Vehicle is ready for call outs from **1pm to 1am, seven days a week**
- Staffed by an EEAST ambulance clinician and an EPUT mental health specialist

- **By mid December 2023, the service had supported 1,160 patients -** average of five a day:
  - 636 face to face interactions
  - 524 telephone advice calls
- **Of the 636 people seen face to face, over 83% were cared for at home or in the community** and did not need to be taken to an acute hospital A&E or the Mental Health Urgent Care Department

We will help our communities thrive: Arts and mental health programme saved my life

An artist who credits a community arts and mental health programme with saving her life is now **helping other people boost their wellbeing through creativity**. Allie Watson worked in retail management for 27 years and had a fast paced job training 100 managers. But she had to give up the job she loved after she became ill and needed brain surgery, which affected her memory. She then suffered severe nerve damage in her dominate arm after undergoing other surgery. She also faced bereavement following the sudden death of a loved one.

Allie was hit hard by facing all of these combined within a short space of time. "I went from an outgoing, self-confident manager to someone who couldn't leave the house," she said. Allie had a breakdown and was diagnosed with post-traumatic stress disorder and borderline personality disorder. She spent ten months at an inpatient ward in London, then began receiving support from our Southend Community Mental Health Team, where she found out about **Open Arts**.

Open Arts is a community arts and mental health programme, which helps to manage mental health and wellbeing through creativity. It is **managed within EPUT's Trust Charity Fund** and runs courses, workshops and events. These are led by professional artists and supported by volunteers. Open Arts supports people with their recovery and develops their confidence, self-esteem and self-identity. It also helps them feel part of their wider community.

Allie said: "I can't say enough about Open Arts. I would go as far as saying it saved my life. "Because I went to it at a time when I was feeling really low and I didn't see a point in living and having a place in society. "Being there, I felt perhaps maybe I have a place in society and maybe there was a point in being there and there were other people I could talk to who understood. "It's made such a difference to my life. It's absolutely saved my life and that's not an overstatement. "We need to get art on prescription."

10. REGULATION & COMPLIANCE

10.1 CQC COMPLIANCE UPDATE

Information Item | Frances Bolger | 5 minutes

REFERENCES

Only PDFs are attached

CQC Compliance Update 31.01.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31 January 2024

Report Title:	**CQC Compliance Update**					
Executive/Non-Executive Lead:	Frances Bolger, Interim Executive Chief Nurse					
Report Author(s):	Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Executive Operational Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	Maintaining ongoing compliance with CQC registration requirements	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
The purpose of this report is to: 1. Provide an update on the key Care Quality Commission (CQC) registration requirements. 2. Provide an update on related CQC activities within the Trust. 3. Provide details of guidance/updates that have been received since the previous report up and to the end November 2023	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Receive and note the content of the report

2 Note the progress update on the Improvement Plan

Summary of Key Issues

- EPUT continues to be fully registered with the CQC.
- The Trust received a CQC request for an Adult Social Care Provider Information Return (PIR) in respect of Rawreth Court on 08 Nov '23 and responded to this within the required timescale (06 Dec '23). The PIR request for Clifton Lodge nursing home was received on 10/01/24 which requires completing and returning no later than the 07 Feb '24.

- During December 2023, the CQC raised one enquiry in relation to one mental health ward. The Safeguarding team facilitated an investigation into the concern and met with the CQC to provide assurance on the Trust's response to the concern raised.

- The Trust continues to focus on the implementation of the CQC improvement plan. Good progress continues to be made with implementation of actions. The overall plan remains on track albeit with some mitigation plans for sub action slippage being in place.

- The CQC has undertaken 3 MHA inspection during December 2023.

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

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

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	EPUT	Essex Partnership University Trust
CAMHS	Child and Adolescent Mental Health Service	EOT	Executive Operational Team
PICU	Psychiatric Intensive Care Unit	CCG	Clinical Commissioning Groups
MHA	Mental Health Act	PIR	Provider Information Return
MHOST	Mental Health Optimal Staffing Tool	CHS	Community Health Services
NED	Non-Executive Director		

Supporting Documents and/or Further Reading
CQC Compliance Report Appendix 1 - CQC Improvement Plan Update January 24

Lead
Frances Bolger **Interim Executive Chief Nurse**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Compliance Update

1 Introduction

The purpose of this report is to:

1. Provide an update on the key Care Quality Commission (CQC) registration requirements.
2. Provide an update on related CQC activities within the Trust.
3. Provide details of guidance/updates that have been received since the previous report up and to the end November 2023

2 CQC Registration Requirements

2.1 Registration

EPUT continues to be fully registered with the Care Quality Commission. There have been no ratings changes in the period.

2.2 Non-Executive Director (NED) CQC Registration

Regulations require all Board members (both voting and non-voting) to be registered with the CQC, therefore both Diane Leacock (NED) and Jennifer Raine (NED), have both been registered.

2.3 CQC Provider Information Request (PIR)

Provider Information Requests (PIRs) are part of how the CQC continually monitor nursing home services. Within the PIR the CQC collect information on changes the homes have implemented and how we ensure the nursing homes are safe, effective, caring, responsive and well-led. The purpose of the PIR is to help the CQC to identify areas to explore in more detail as part of their continuous monitoring of a service and ahead of any site inspection.

As previously reported the Trust received a CQC request for an Adult Social Care Provider Information Return (PIR) in respect of Rawreth Court on 08 November 2023 and we submitted our return within the required timeline of 06 December 2023. The return was reviewed and approved by the Executive Management Team.

Further to this, the Trust received a CQC request for Clifton Lodge nursing home on 10 January 24, with a timeline of the 07 February 24 to submit. The Registered Manager (with support from the Compliance Team) is preparing the response.

3 CQC Inspections

3.1 CQC Action plan Implementation

The Trust has continued to focus on implementation of the overarching CQC improvement plan which is being overseen by the CQC Action Leads meeting. It is noted that the plan no includes the actions associated with Rawreth Court inspection.

As of the 18 January 2024, there were:

- (6%) Must Do/ Should do Actions have been closed following review at the Trust CQC Leads Meeting and Joint Evidence Assurance Group with ICBs

- 46 (64%) Must do/ Should do actions are complete next step is for the evidence to be presented to CQC Leads Meeting and Evidence Assurance Group

- 249 (78%) sub-actions have been completed/closed

- 15 sub-actions past timescale of 18 January 2024, with potential impact on 10 overall actions status. Recovery plans have been established to minimise any delays beyond stated timelines. Please refer to appendix 1.

- 44 internal inquiry actions have been completed

The Evidence Assurance Group has not met since the last report. The next scheduled meeting is in February 2024.

Assurance metrics continue to be developed to demonstrate sustainable change.

A full update on action progress is provided in appendix 1.

3.2 CQC Enquiries

All CQC enquires received are reviewed in full and a formal response is returned following approval by the Chief Operating Officer / Executive Chief Nurse.

During December 2023, the CQC raised one enquiry in relation to a MH Adult Ward. The Safeguarding team facilitated an investigation into the concern and met with the CQC to provide assurance on the Trust's response to the concern raised.

3.3 CQC Mental Health Act (MHA)

The CQC have continued with programme of MHA visits to Trust Wards. Following each inspection, a monitoring report (Provider Action Statement) is received by the ward with recommendations for improvement. All wards develop action plans to address these recommendations supported by the MHA Office and report to the Safeguarding and MHA Committee who monitor MHA compliance.

During December 2023 there have been three MHA inspections and three provider action statements received following previous inspections. Key learning themes are:

- Reviewing blanket restrictions and recording of patient rights

- Utilising IMHA

- Detail recording of patient involvement in care planning

- T2 forms not always attached to medical chart

- Recording of LTS reviews

The Safeguarding Team have been asked to provide a full thematic analysis and tracking of actions arising from the MHA reviews to the next Quality Committee for review and assurance.

4 CQC Guidance / Updates

4.1 CQC Mental Health Insight Report

CQC has reviewed its approach to sharing NHS CQC Insight Reports with NHS Trusts and regulatory partners. The decision has now been made not to resume external sharing of the NHS CQC Insight Reports.

4.2 New Fundamental Standard: Visiting and Accompanying in care homes, hospitals and hospices

The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2023 introduce a new fundamental standard of care with effect from 6 April 2024 – Regulation 9A is entitled "***Visiting and accompanying in care homes, hospitals and hospices***".

It applies to all providers delivering a CQC regulated activity in a care home, hospital or hospice, and provides that unless there are exceptional circumstances, service users whose care or treatment involves an overnight stay or the provision of accommodation, must be facilitated to receive visits; must not be discouraged from taking visits away from the care home, and if their care and treatment doesn't involve an overnight stay, must be enabled to be accompanied by a family member, friend or person providing support.

Specifically, a provider needs to ensure that visits are appropriate, meet service user's needs and so far as practicable reflect their preferences; that in relation to being supported to go out, action or precautions are put in place in a proportionate way to facilitate visits and trips out; that when making arrangements or taking decisions due regard is had to care and treatment plans and that relevant people are involved in any decision making.

Nothing requires someone to be taken out or a visit to take place without the person's consent or where it would not be in their best interests or would be contrary to a Court or Tribunal order.

By making the requirement to support visiting, and support trips out, a regulatory requirement, CQC will now be in a position to take action if a provider is failing in this area.

5 Action required

The Board of Directors is asked to:

1 Receive and note the content of the report
2 Note the progress update on the Improvement Plan

Report Prepared by:
Nicola Jones
Director of Risk and Compliance

On behalf of:
Frances Bolger
Interim Executive Chief Nurse

22 January 2024

Appendix 1:

CQC Improvement Plan Update – 17 January 24

Trust Board Report: January 2024

CONTENTS

Introduction

The purpose of this report is to provide an update on implementation and assurance status against the trust CQC action plan.

The CQC action plan has been developed in line with new trust process which focused on engagement, sustainability and ownership of actions developed.

Work has been undertaken to bring together core CQC and other related plans into one document to ensure consistency of delivery, avoidance of duplication and consistent assurance routes. This includes:

- Initial s29 plan (Willow and Galleywood Wards – Oct '22)
- Intra-inspection feedback of acute wards for adults and PICU (Nov '22)
- Internal report for 2 Adult Acute Wards (Jan '23)
- CQC report Acute Wards for Adults and PICU (published Apr '23)
- CQC report Core Services and Well Led (published July 23)
- CQC report Rawreth Court (published Nov '23)

Level of Assurance: Level 1

Key Messages

There are currently 72 'must do' / 'should do' actions being taken forward (Note: combination of some actions into one), with 319 sub-actions (as at 18 Jan '24) associated with CQC activity.

There are 54 actions associated with EPUT internal inquiry following the Dispatches Programme.

Overview:

- 4 (6%) Must do/Should do actions have been closed following evidence review by EPUT CQC Leads Meeting and the Evidence Assurance Group with ICBs
- 46 (64%) Must do/Should do actions have been completed (next steps is for the evidence to be presented to CQC Leads Meeting and the Evidence Assurance Group)
- 249 sub-actions have been completed
- 44 internal inquiry sub actions have been completed

15 sub-actions are past timescale (18 January 2024), with potential impact on 10 overall full action status. Recovery plans have been established to minimise any delays beyond stated timelines.

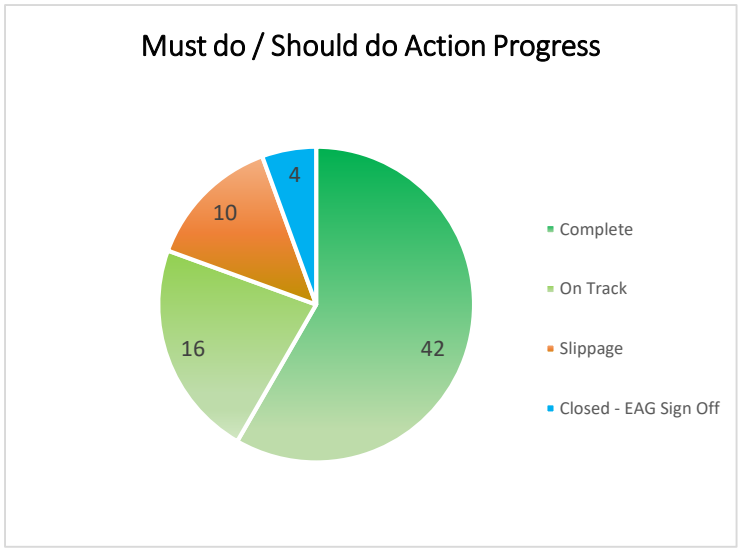
The CQC Action Leads meeting continues to hold action owners to account for delivery. The meeting is chaired by the Senior Director of Corporate Governance (who is independent) and attended by Executive Chief Nurse and Executive Chief Operating Officer.

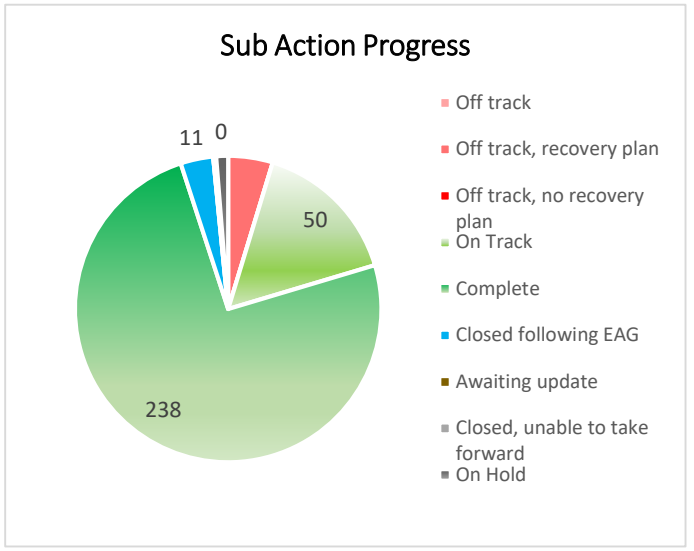
Action Progress Update

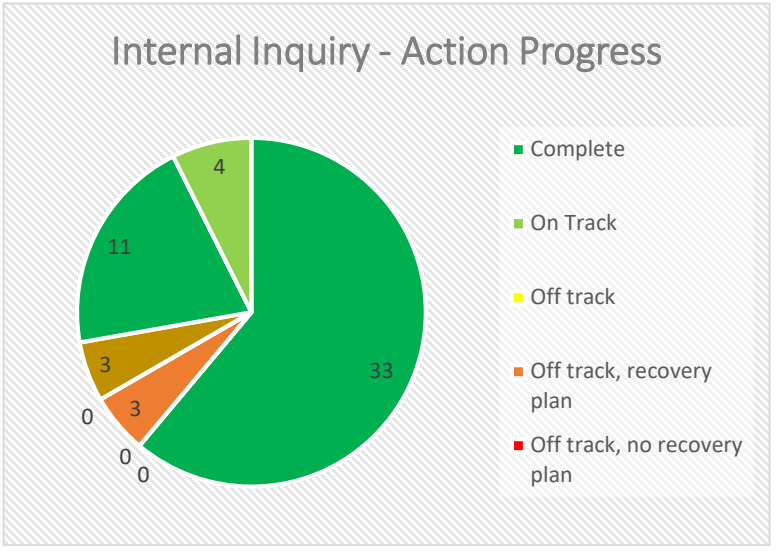
NHS Essex Partnership University NHS Foundation Trust

Summary of implementation status

- 72 Must do / Should do actions as at 18.01.24
- 319 Sub-Actions identified as at 18.01.24
- 4 (6%) Must do/Should do actions closed following review at CQC Leads Meeting and Evidence Assurance Group
- 46 (64%) Must do / Should do actions complete (next step is for the evidence to be presented to the CQC Leads Meeting and Evidence Assurance Group)
- 249 (78%) sub-actions complete/closed
- 15 sub-actions past timescale as at 18.01.24 (Nb. This impacts 10 overall actions status however recovery plans are in place
- 1 Must Do (M32) (containing 4 Sub Actions) reported as 'On Hold' due to a re-frame paper being submitted (please see next page)
- 54 Internal Inquiry sub-actions with 33 complete and a further 11 complete as part of CQC actions. 3 sub-actions are off track with recovery plans in place.







Summary of activities and highlights

NHS Essex Partnership University NHS Foundation Trust

Summary of key activities completed in the last month:

- A re-frame paper has been submitted for 1 Must Do (M32) (containing 4 Sub Actions) to review and change the action to align better with the Community Mental Health Framework, which is 'replacing the care programme approach (CPA) for community mental health services. The new framework care plans will not have 'discharge plans' rather goals with outcome measures aligned to the persons individual needs. The CQC leads meeting were generally supportive of the change, with communication of the change to CQC relationship managers at the next meeting with the Trust
- M1 (Trustwide Action) Quality Assurance Framework in pre-launch phase following approval of the Quality of Care Strategy approved in November 2023
- M3 (Trustwide Action) The MSE ICB Shared Care Record programme continues to progress
- M6 (Adult acute inpatient) Phase 2 of the in-ward CCTV installations across the Trust has been completed. Also change to on call structured for Estates to ensure 1 on call manager is available out of hours to access CCTV if needed.
- M9, M12, M17 (Adult acute inpatient) Inpatient Welcome Pack approved, and in local use. A professional printed is being made available within the coming months.
- M22 (Adult acute inpatient) Hadleigh refurbishment is complete and unit re-opened.
- M35 (Older adults) Pilot of electronic emergency equipment checks completed. Data being collated to review outcome and make recommendations.
- M45 (LD) EPUT staff member has undertaken train the trainer in order to deliver Tier 2 training. Makaton training is scheduled for delivery January.
- S4 (Crisis and HBPoS) Barriers to completing care certificates undertaken and the subsequent implementation of completing care certificate recovery plan in place
- S7 (Crisis and HBPoS) Royal College of Psychiatrists - Standards for Crisis Resolution and Home Treatment team Review completed and new My Care, My Recovery Plan printed and rolled out.
- S10 (Crisis and HBPoS) Assurance received for prioritisation of clinical supervision one to ones.
- S13 (Community MH) Care Plan Training complete within Community MH
- S16 (Older Adults) reviewed available activities for older adults to ensure meaningful for patients on each ward
- S16 (Older Adults) Pilot of activities on Older Adult Ward complete with a new form introduced clearly identifying what activities a service user has undertaken, now rolling out to other Older Adult Wards
- S21 (Older Adults) Appraisal recovery plans in place.
- RC01 (Rawreth Court) Audit of all care records undertaken. Care Plan reviews being included in 1-1 support meetings. Pilot of Freda in progress. EOL training booked for January.
- RC02 (Rawreth Court) All Personal Emergency Evacuation Plans (PEEPS) have been reviewed
- RC03 (Rawreth Court) Deputy Directors of Quality & Safety meeting undertaken to review restrictive practice within Adult Social Care. Safeguarding attended to review the Deprivation of Liberty Safeguards (DoLS) monitoring process

Actions Closed

No new actions closed in the period

42 must do/should do actions complete and ready for closure and are currently being prepared to be taken through evidence assurance processes

Summary of activities and highlights

NHS Essex Partnership University NHS Foundation Trust

Key Slippages (15 Sub-actions are past timescale)

Action	Current Position	Recovery Plan	CQC Lead
M1.2 Development and Implementation of EPUT Quality Assurance Framework (QAF)	Quality of Care Strategy signed off. Launch prep meetings commenced.	QAF and Quality of Care Strategy will formally launch through Feb '24 and March '24	Nicola Jones
M3.4.1 Complete Paris upgrade which will include waiting list management	Worked with Civica to finalise the implementation / delivery for upgrade.	Agreed and funded in place at end of December '23 and end of March '24 for upgrade completion.	Jan Leonard
M4.1 Review of Quality Improvement (QI) including development and implementation of new processes	QI structure has been reviewed and in process of working up business case.	Business Case planned for Executive Team first week Feb '24.	Steven Yarnold
M21.1 Undertake scoping exercise to review content, frequency and delivery of medicines management training for nurses and preceptorship	Scoping report undertaken.	Report being presented at Clinical Governance on 6th Feb '24 for agreement.	Dr Gbola Otun
M38.1 Review options for change of trolley assessors from ward manager/matron to peer assessor (preventing failure to fail)	Included within Medicine Management proposal above at M21.1.	Report being presented at Clinical Governance on 6th Feb '24 for agreement.	Dr Gbola Otun
M39.1 Deliver recruitment programme within older adult inpatient wards: Recruitment plan to minimise vacancies within Psychological Services'	Meadowview & Gloucester vacancy filled. Beech ward establishment is co-dependent on TTC funding.	Review to be undertaken to assess current position against position at time of CQC inspection.	Greg Wood
M45.3 Offer tier 2 (focused on Learning Disabilities population) training (one day face to face) to all clinical staff on the ward delivered externally (experts by experience).	1 Byron Court Staff member identified to support the roll out of the training and has undertaken train the trainer.	EPUT trainer fully trained to commence delivery of training Byron Court and LD Community Staff will be prioritised in training roll out. Timescale aim March 24	Janet Childs
M45.5 Learning Disability (LD) & Autism, training from psychological services (a couple hours)	28% (7/25) staff still require Autism training. Date for further training being arranged for the remaining staff.	Sessions being held to capture remainder of staff. Timescale aim March 24	Janet Childs

Summary of activities and highlights

NHS Essex Partnership University NHS Foundation Trust

Key Slippages (15 Sub-actions are past timescale)			
Action	**Current Position**	**Recovery Plan**	**CQC Lead**
S1 Completion of internal inquiry action plan	Progressing however impacting by slippage of co-dependent CQC actions	Continuing to progress with end of March aim.	Moriam Adekunle
S12.1 - Annual clinical audit plan for Home First Teams	Included as part of the Trust wide Clinical Audit Programme.	Meeting agreed to design plan based on the royal colleague guidance benchmark and relevant NICE guidelines. Clinical Audit Team are developing the audit plan with the service by end Feb '24.	Cindy Weaver
S16.4 Pilot activities on a ward and scale up	Pilot complete with new form being introduced.	Being rolled out to all Older Adult Wards during January '24.	Mobolaji Lewis
S18.2.2 Embedded escalation process to be monitored via the MHA audit	Assurance Provided PMAC audits being completed.	MHA have requested to have sight of audits prior to confirming closure	Dr Gbola Otun
S19.2 New smart care plan to be launched later this year late Q3 (key principles of SMART, Simple and uncluttered, short and to the point, includes primary outcome measure and secondary outcome measure)	Care Plan signed off by project Board. Training started in January '24.	On track for launch in April '24	Tendai Ruwona
S19.3 To roll out bite-size training to clinical staff	New Care Plan launch April '24 with training underway. Current 'care plan' refresher training available as an interim mitigation.	Refresher Sessions being held as interim until new Care Plan is launched.	Tendai Ruwona
S22.3 Tendable data to be made available on safety dashboards to ease accessibility of data.	The funding required has been agreed and is available in year for the programme work to integrated data into the Patient Safety Dashboard. A contract with the supplier is being finalised for work to commence.	As signalled at Board in Nov '23 workflow now set and timeline for achievement stated End May '24.	Moriam Adekunle

Risk Management

The table below highlights potential risks to achieving actions

Ref	CQC finding	Sub-Action	Potential Risks / Challenge	Cause	Countermeasure	Owner
M42.5 (existing risk)	The provider must ensure that all care and treatment records are complete and accessible (Regulation 17(2)(c)).	Positive Behaviour Support (PBS) training for staff facilitated by Hertfordshire Partnership Foundation trust (HPFT) and EPUT (3, ½ day sessions) Timescale 30 March '24	Slippage against timescale	Dependency on external training being available	Train the trainer identified from the trust. 2 training dates confirmed for early December, expert by experience being in the process of being identified with aim that training will be completed to Byron Staff by January 24.	Janet Childs

Next steps

NHS
Essex Partnership University
NHS Foundation Trust

Areas of focus for the next month

- Continued focus on delivery of improvement plan
- CQC Leads with support from Compliance Team to build evidence assurance presentations for completed actions to undertake internal check and challenge and submission to the Evidence Assurance Group with ICBs
- Further development and reporting of Metrics report to ensure monitoring the impact changes are making
- Ongoing implementation of the practice assurance toolkit for wards/services to provide assurance of delivery and change at local level

10.2 SAFE WORKING OF JUNIOR DOCTORS QUARTERLY REPORT

Information Item | Dr Milind Karale | 5 minutes

REFERENCES

Only PDFs are attached

Safe Working of Junior Doctors Quarterly Report 31.01.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	31 January 2024

Report Title:	**Safe working Hours of Junior Doctors, Quarterly Report**					
Executive/ Non-Executive Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr P Sethi MRCPsych, Consultant Psychiatrist and Guardian of Safe Working Hours					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	✓
	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	Yes/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	Yes/ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk	Trainees escalate any issues to their Clinical Supervisor and Clinical Tutor. If unresolved they escalate at Junior Doctors Forum, any unresolved issues is further escalated to Dr Karale.	

Purpose of the Report		
This report provides the Board of Directors with assurance that doctors in training are safely rostered and that their working hours are compliant with the Terms and Conditions of the Junior Doctors Contract	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 There are 5 Exception reports raised by trainees.
3 No fines were issued in this quarter.
4 Gaps in the on-call rota filled by MTI and LAS doctors. No agency locums were used.
5 Trainees felt supported by Trust on the Junior Doctors industrial Action.

Summary of Key Issues
➢ Gaps in the rota are less compared to previous years. ➢ A total of £39.891 was spent on shadow rota to cover the gaps during industrial action, for safe running of service

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

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

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

Acronyms/Terms Used in the Report			
MTI	Medical Training Initiative	FY	Foundation Year
LAS	Locum Appointment for service		

Supporting Reports/ Appendices /or further reading
Main Report

Lead

Dr Milind Karale
Executive Medical Director

Board of Directors Part 1
31 January 2024

QUARTERLY REPORT ON SAFE WORKING OF JUNIOR DOCTORS

1 Purpose of Report

This report provides the Board of Directors with assurance that doctors in training are safely rostered and that their working hours are compliant with the Terms and Conditions of the Junior Doctors Contract.

2 Executive Summary

This is the 26th quarterly report submitted to the Board on Safe Working of Junior Doctors for the period 1 October 2023 to the 31 December 2023. The Trust has established robust processes to monitor safe working of junior doctors and report any exceptions to their terms and conditions.

Exception Reports:

A total of 5 exception reports were raised in this quarter.

1. 4 October 2023: Trainee raised an exception report on immediate safety concern, highlighting areas on increased workload, time taken to travel between sites, lack of rest period and lack of support during on-call. Clinical tutor was made aware and time off in lieu was given.

2. 23, 24, 25, 27 October 2023: Trainee raised 4 exception reports for working a total of 7 extra hours (Liaison Psychiatry) on the above dates, as being the only doctor on site. Time off in lieu given.

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on 6 December 2023

Doctors in Training Data

Total number of posts	**158**
Number of doctors in training posts (total inclusive of GP and Foundation)	**156**
Number of doctors in psychiatry training on 2016 Terms and Conditions	**92**
Total number of vacancies	**11**
Total vacancies covered LAS/ MTI/Agency	**6**
Total gaps	**5**

Agency

The Trust did not use any agency locums during this reporting period but relies on the medical workforce to cover at internal locum rates as follows

Locum bookings (internal bank) by reason*					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy/Maternity/ sick/COVID	143	143	0	1702.5	1702.5

Total	143	143	0	1702.5	1702.5

Junior Doctor Industrial Action

There have been two episodes of industrial action taken by junior doctors (2 to 4 October and 20 to 22 December 2023) The Trust ensured that patient safety was not compromised and a shadow rota was set up for December 2023 so that there was both day and night cover across all five areas of the Trust. In October both junior doctors and consultants took joint industrial action and the doctors scheduled to be on call were required to work as there was a Christmas Day service provision so no shadow rota was required.

In total 329 hours were covered by internal locums and a total of £39,891 was spent on the shadow rota and daytime cover where authorised for the December period of industrial action.

Actions taken to resolve issues:

The Trust has taken the following steps to resolve the gaps in the rota:

1. Rolling adverts on the NHS jobs website. Few International doctors who were appointed have started their posts.
2. Emails are sent to former GP and FY trainees if they would like to join the bank to do on-calls, this is now part of the termination process for GP's and FY's so they can express an interest in covering extra shifts when they leave EPUT.
3. 11 Fellows under the EPUT Advanced Fellowship programme have been appointed last year

Fines: None issued in this quarter.

Issues Arising:

1. Junior doctors felt supported by the Trust on the recent Industrial Actions
2. Senior trainees lack opportunity to conduct Mental Health Act assessments. Medical Director was made aware of this matter.

3 Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 There are 5 Exception reports raised by trainees.
3 No fines were issued in this quarter.
4 Gaps in the on-call rota filled by MTI and LAS doctors. No agency locums were used.
5 Trainees felt supported by Trust on the Junior Doctors industrial Action.

Report prepared by

Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours

10.3 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

Information Item | Professor Sheila Salmon | 1 minute

10.4 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

Discussion Item | ALL | 1 minute

10.5 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

Discussion Item | All | 5 minutes

10.6 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (S.O REQUIREMENT)

Information Item | All | 1 minute

11. ANY OTHER BUSINESS

Discussion Item | All | 5 minutes

12. QUESTION THE DIRECTORS SESSION

Discussion Item | All | 10 minutes

13. DATE AND TIME OF NEXT MEETING

Information Item | Professor Sheila Salmon | 1 minute

Wednesday 27 March 2024 (Virtual)