NHS
Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors

Wednesday 29 March 2023

EPUT

Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public
Wednesday 29 March 2023 at 10am

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

PART ONE: MEETING HELD IN PUBLIC AT ANGLIA RUSKIN UNIVERSITY, BISHOP HALL LANE, CHELMSFORD, CM1 1SQ, MICHAEL ASHCROFT BUILDING (MAB) ROOM 404a/b

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting	10:00
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting	10:02
	West Essex Virtual Ward Vanessa Wakefield, Deputy Director, Care Coordination, West Essex				10:05
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 25 January 2023	SS	Attached	Approval	10:20
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting	10:22
5	Chairs Report	SS	Attached	Noting	10:25
6	Chief Executive Officer (CEO) Report	PS	Attached	Noting	10:30
7	**QUALITY AND OPERATIONAL PERFORMANCE**				
(a)	Quality & Performance Scorecard	PS	Attached	Noting	10:50
(b)	Committee Chairs Report	Chairs	Attached	Noting	10:55
(c)	Safety First, Safety Always Strategy (Video)	NH	Video	Noting	11:15
(d)	Safety First, Safety Always Strategy Annual Report	NH	Attached	Approval	11:20
(e)	Learning from Deaths Quarterly Overview of Learning and Data (Quarter 3 2022/23)	NH	Attached	Noting	11:40
COMFORT BREAK					11:45
(f)	Equality, Diversity & Inclusion (EDI) Annual Board Report 2023	MR	Attached	Discussion	11:55
(g)	Public Sector Equality Duty Report 2022-23	MR	Attached	Approval	12:00
(h)	Equality Delivery System (EDS) Reporting Template 2023	MR	Attached	Approval	12:05

8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**				
(a)	Board Assurance Framework 2022/23	DG	Attached	Approval	12:10
(b)	Approval for policies under matters reserved for the Board of Directors: • Health & Safety Policy and Procedure • Being Open Policy & Procedure • Major Incident Plan Policy & Procedure • EPRR Policy	DG	Attached	Approval	12:15
9	**REGULATION AND COMPLIANCE**				
(a)	Code of Conduct for the Council of Governors	DG	Attached	Approval	12:17
10	**OTHER**				
(a)	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval	12:20
(b)	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting	12:22
(c)	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting	12:27
11	**ANY OTHER BUSINESS**	ALL	Verbal	Noting	12:30
12	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors				**12:35**
13	**DATE AND TIME OF NEXT MEETING** Wednesday 31 May 2023				**12:50**
14	**DATE AND TIME OF FUTURE MEETINGS** Wednesday 26 July 2023 Wednesday 27 September 2023 Wednesday 29 November 2023				**12:50**

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 25 January 2023
Held Virtually via MS Teams Video Conferencing

Attendees:

Prof Sheila Salmon (SS)	Chair
Paul Scott (PS)	Chief Executive
Alex Green (AG)	Executive Chief Operating Officer
Nigel Leonard (NL)	Executive Director of Major Projects and Programmes
Natalie Hammond (NH)	Executive Nurse
Zephan Trent (ZT)	Executive Director of Digital, Strategy and Transformation
Trevor Smith (TS)	Executive Director of Finance and Resources
Denver Greenhalgh (DG)	Senior Director of Corporate Governance
Marcus Riddell (MR)	Acting Executive Director of People and Culture
Janet Wood (JW)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director
Loy Lobo (LL)	Non-Executive Director
Rufus Helm (RH)	Non-Executive Director
Mateen Jiwani (MJ)	Non-Executive Director
Stephen Heppell	Non-Executive Director
Jill Ainscough	Non-Executive Director

In Attendance:

Angela Horley	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	Assistant Trust Secretary
Jared Davis	Governor
Paul Walker	Governor
Paula Grayson	Governor
Elena Lokteva	Associate Non-Executive Director
Dianne Collins	Governor
John Jones	Lead Governor
Jason Gunn	Governor
Mark Dale	Governor
Pippa Ecclestone	Governor
Jessica Seed	EPUT staff member
Cort Williamson	Governor
Ricinda Mills	Care Quality Commission
Johnny Townson	Senior Business Manager
Zoe Tidman	Health Service Journal
Pam Madison	Deputy Lead Governor
Clare Sumner	Trust Secretary Coordinator

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

SS noted that the Board meeting would not have a presentation as normal to allow time to discuss the EPUT Trust Strategy for approval, including a video presentation including patient perspectives.

The meeting commenced at 09:31am

001/23 APOLOGIES FOR ABSENCE

Apologies were received from Sean Leahy.

002/23 DECLARATIONS OF INTEREST

There were no Declarations of Interest.

003/23 MINUTES OF PREVIOUS MEETINGS

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

Minutes to be amended to reflect that LL was present at the meeting.

004/23 ACTION LOG AND MATTERS ARISING

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

The Board discussed and approved the Action Log.

005/23 CHAIRS REPORT INCLUDING GOVERNANCE UPDATE

SS presented the report which was taken as read. There were no issues to highlight for further discussion.

The Board received and noted the Chair's Report.

006/23 CEO REPORT

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

PS advised that the Trust had received an open letter from the Chair of the Essex Mental Health Independent Inquiry regarding low levels of staff engagement. PS advised that an additional national piece around MH inpatients had been commissioned by the Secretary of State, with Dr Strathdee, Chair of Inquiry also taking the role as Chair on this national piece. It is apparent that there was growing interest in mental health services nationally, and with our focus of change and improvement he was confident the Trust was serving the Inquiry and had made suggestions to improve engagement.

As a Trust we continue to try and make change and improvements across the organisation. A number of services have recently been nominated for or received awards including Basildon Mental Health Unit who won the Best Patient Safety Initiative, and were also shortlisted in the Best Interior Design and Best External Environment categories, at the national Building Better Healthcare Awards. Service users and staff were instrumental in contributing to the design of the new unit and this award is recognition for the hard work and dedication they have all shown. PS extended thanks and congratulations on behalf of the Board.

ML was encouraged by the report on Time To Care, particularly around the number of major projects going into pilot phase, this was exciting in terms of trialling new phases of delivery for effectiveness. ML asked whether additional resources required to deliver transformational change had been

anticipated and whether pilots were able to go ahead without additional investment. PS responded that there were two significant investments made or needed – investment into change management, this was taking place by appointing a partner to work with us. He advised that pilots can go on without material resource requirements, the biggest ask would be around staffing models. He commented that there were potentially a range of outcomes, all of which require investment and this will be considered with our commissioners.

Regarding the Essex Mental Health Independent Inquiry, NL provided assurance that the Trust have continued to provide information to the Inquiry team, as well as working with NHS England and colleagues in each system.

JA thanked PS for the update and noted the excellent response to inquiry letter. JA was surprised at the tone of the open letter and requested PS comment on that. PS responded that issues around staff engagement had not been escalated to the Trust previously and so could not comment, but agreed that a meeting with the Inquiry Chair was paramount and would request this takes place as soon as possible to keep communication channels open. PS assured the Board the Trust were actively encouraging staff to engage with the inquiry, for the inquiry to be able to meet it's terms of reference and to ensure families get the answers they deserve.

MJ noted the positive updates within the report, suggesting it was beneficial to vocalise that across the organisation and that this would be good for morale. In terms of IAPT, it is acknowledged that there is a national problem and we are part of the journey to reduce waiting times, MJ queried whether we were confident we have learned from others to improve access to IAPT and were using digital solutions. PS thanked MJ for feedback regarding amplifying good work in the trust and advised that AG would comment on IAPT during the operational update.

Operational Update – Alex Green
AG confirmed that the Trust have been responding to the system wide pressures across NHS and Social Care, with teams have worked tirelessly to support those pressures. A 'virtual hospital' had been implemented in West Essex, and the UCRT service continued to achieve against the national key performance indicator of seeing people within two hours and continued to see improvements. Additional resource for discharge had been recruited and concentrating on safe transfers of care. The average length of stay and occupancy had remained stable during this period and now have in place ward and patient level data on a twice daily basis so can see in real time length of stay. PICU indicators remained stable. IAPT has been particularly challenged on treatment times and in South Essex had seen numbers continue to fall below target. Comparably, the service was performing better than the national average, but recognised there remained room for improvement. AG was pleased to report improvement against CPA reviews for second month, this had been due to a combination of good housekeeping in the service but also on the approach on risk management using the MAST tool and clinical supervision. AG advised there is a move away from the CPA framework, and as such management of risk becomes important to manage universally across the service.

TS stated that there was now very clear and detailed information on Psychology Services as part of the Accountability Framework meetings, and we are engaging further psychological support and outsourcing capacity with a digital approach to support waiting times.

RH was pleased to see the improvement against CPA reviews. The Quality Committee had received a presentation of the MAST tool which looked impressive, and RH had seen this being used first hand during a service visit with a District Nurse in Canvey. In terms of IAPT, RH noted that 78% of access targets had been achieved, however there were 3 services with ranges between 56 – 66% in terms of access. AG clarified that this was due to services being provided in three different areas, with different performance each of those areas, including North Essex which had inherited a large waiting list for that service.

MK reflected that the two significant issues in relation to bed pressures are length of stay and delayed discharge. A weekly consultant meeting had been established and reduction in delayed discharges has been seen, MK was confident with collaborative working from medical staff, bed management and operations further reductions could be achieved. AG agreed that there had been real improvement with a continued emphasis on clinically led decision making. The Trust were also working with Essex police and social care regarding crisis work and escalation with Lizzy Wells (Director of Mental Health Urgent Care & Inpatient Services) chairing the Crisis Concordat.

Safety and Quality – Natalie Hammond
NH reported that the Culture of Learning team continued to work on learning lessons regarding safety with strong governance. Different modes of learning being utilised with a variety of lessons identified and shared throughout the organisation through videos, animations, learning safety newsletter and five key lessons infographic. The review of the Safety First Safety Always strategy was underway, looking at work undertaken over the past year. This would be presented to a future public board session with progress, outcomes and measures. Recent staff engagement indicated that 91% of staff agreed that safety had improved. There has been over 30% reduction in the number of fixed point ligatures. A review of standard operating procedures is underway to bring more efficiency, safety and brevity as we integrate into our electronic systems, working in partnership with Carradale. A business case for a refresh to the electronic prescribing systems was being developed and would be presented to the Board. Once approved full implementation is expected to take 18 months with medicines optimisation, safety and learning expected as a result.

JW looked forward to the presentation on the progress on the Safety First Safety Always metrics at a face to face event. JW stated that it is important to emphasise to the public and patients why EPUT can be relied on and why we are safe and it was essential that evidence to that effect is highlighted through the presentation in March 2023. NH agreed, the main ambition of the safety strategy was for patients and carers / family to feel safe and stakeholders to be confident in the safety of care we provide. Lots of engagement had taken place including patient safety partners engaging with patient groups and being the voice of patients. I Want Great Care has also been modified to focus on questions around safety and emphasised the need to maximise and focus that in year 3.

Medical – Milind Karale
Mk reported that the Mental Health Emergency Department was in line to launch on 13 March 2023. Work was being undertaken to ensure policies and procedures were in place and staff appointed prior to launch. MK was confident this new innovative service would make a real difference and reduce pressures on acute partners, but would also provide a better experience for our patients. MK was proud to announce the launch of a new one of its kind Neuromodulation service and the first in the East of England to provide treatments for treatment resistant patients. Dr Gupta had been invited to speak at national conference in Malta, which was very well received.

SS noted the good examples of innovation and improvement taking place across the Trust. SS reflected being hugely impressed upon seeing the perinatal service first hand and was pleased that Dr Gupta had been able to share experience of this service to an international audience.

AG reflected that system partners are anticipating the impact of the new MH ED. While this service will concentrate on the MSE geography at the moment, system partners in HWE and SNEE will also have an eye on the impact of the MH ED on patient experience, staff experience and what it means for system partners, so this was a really important strategy piece for the organisation.

Digital, Strategy an Innovation – Zephan Trent
ZT report that the Strategic Plan for 2023-28 is to be presented to Board for approval. ZT advised for context that Integrated Care Board were partners leading on plans so the combination of our own strategic and operational planning sets us up to be active contributor for system plans over the coming 5 years. The use of digital tools was very important. Lots of improvements being made are digitally

enabled, i.e. MAST, digital enablement of standard operating procedures, and how clinicians on the front line are prioritising patients with longer length of stay using digital data to support that. This supported the Trust ambition to achieve clinically and operationally led services enabled by corporate services. In order to support the transformation agenda, the Transformation Team has been restructured to allow care units to have a dedicated business partner to support on transformation objectives, working together with colleagues across the Trust and with members of staff and colleagues with lived experience on Time to Care. A draft outline business case for a new Electronic Patient Record (EPR) system was progressing and was anticipated to be presented to the March 2023 board for discussion. A recent board seminar had focussed on how to use data better to enable change. This is being looked at from the point of getting fundamentals right in terms of infrastructure to ensure data quality is high, and using data to transform services. Progress continued to be made on the Safety Dashboard. The Patient Experience team continued to work on people participation across services, and seeing the strength and depth of commitment around lived experience and people participation. There has been a real shift and further focus from the Trust in this important area. A new complaints process was now in place, reporting that the new process was redesigned with service users and is an example of co-designed work.

LL was concerned that there was not the ability to visualise a whole portfolio of projects across the Trust, how they are progressing and outcomes in terms of benefits realisation. ZT confirmed that a single front door had been put in place to provide clear oversight regarding the number of transformation projects which were being tracked through the Transformation Steering Group. A 9 month progress report and overall review had been presented and discussed at the Executive Team to provide assurance on the overall position and an annual progress report will be presented to that Board in the next few months to report on the overall status and progress made. LL was pleased that progress was reviewed quarterly rather than annually to give greater assurance to the Board of implementation against the strategic plan. ZT confirmed that the annual report would include recommendations for regular reporting going forward. PS amplified the commitment to patient involvement, emphasising that in everything we do we start to include thinking about patient involvement and the family engagement.

People and Culture – Marcus Riddell
MR reported on potential for industrial action confirming that ballots received from RCN, Unison, CSP had all not reach the threshold for strike action. The BMA Junior Doctor ballot was expected in February, with the impact of any strike action being discussed at the industrial planning group. MSE FT did reach the threshold for CSP strike and had requested system support.

International recruitment: 184 nurses were in post by end December, with the 185th arriving today, achieving the programme target number of international recruits. 50% had a NMC PIN and 122 allocated to wards across the Trust. MR acknowledged the issues experienced in the summer, and reassured the Board that these had been overcome and the project was back on track.

Referring to equality diversity and inclusion advised that new guidance had been introduced focusing on dealing with and responding to incidents of racism. With monitoring being put in place to ensure staff feel supported.

Major Projects – Nigel Leonard
NL reported that the autumn vaccination programme came to a close in December 2022. The Trust had achieved in excess of 161 million vaccines during that programme. EPUT was the only provider in the region that has exceeded the vaccination target. The autumn programme was the first time in the vaccination programme that we had to deliver in the financial envelope of price per vaccine and NL was delighted to report that EPUT had delivered within budget. The programme itself is not over, but had moved to a more mobile model to maximise the evergreen offer to our populations. The Trust had held some recognition events for staff acknowledging that this had been a unique programme. A

commemorative book had also been designed and produced which records the project. NL confirmed that information is anticipated from the JCVI to update on plans for a spring programme.

Finance – Trevor Smith
TS advised that in terms of revenue position, operating income and expenditure, the Trust remains on target to deliver a planned forecast position of breakeven at year end. Capital investment the Trust continues to forecast maximum use of its capital resource.

PS summarised that the CEO update had shared contextual information regarding the Independent Inquiry, acknowledged the operational pressure (in common with other providers) and flagged work regarding the rethink around mental health inpatients. The Board had heard about the focus on performance management and best use of resources, about the real transformational work regarding the mental health emergency department, flow and capacity, recruitment etc. that will have an impact in the near term. The Board had also heard about systemic work going on nationally, with the ICB, involvement of patients and digital agenda that will have longer term impact. It is clear that all is leaning in to address today's challenges as well as make longer term improvements. PS continued that there are wonderful developing services and overall a comprehensive update of the breadth of work taking place led by the executive team.

MJ reflected that there is a strong focus on being clinically led which had been strongly worded in the report and reiterated that this was paramount to everything we do and that decisions are about keeping patients safe.

SS was encouraged to hear that the international recruitment programme was back on track and had achieved the target of recruiting 185 nurses from overseas and welcomed all international recruits to EPUT.

The Board received and noted the CEO's Report.

007/23	**QUALITY AND PERFORMANCE SCORECARD**

Discussed as above.

The Board of Directors received and noted the report.

008/23	**LEARNING FROM DEATHS – SUMMARY OF QUARTER 2 3022/23 DATA AND LEARNING**

NH presented the report which provides an update on the continued progress since the implementation of the Learning from Deaths Policy and Procedural Guidelines from 01 April 2022. NH reminded colleagues that the report presents information that the Trust is nationally mandated to report to public Board meetings on a quarterly basis. Additional information is also included to provide additional assurance on inpatient / nursing home deaths and the timeliness of learning from deaths processes within the Trust.

NH highlighted that:

- The Quality and Safety forum analyse, review and identify learning.
- There is an increased pace and progression of reviews.
- All learning is taken through LOSC, Learning Collaborative and Quality Committee
- The reports indicates no statistical variations and progress is on track with reviews.
- The majority of deaths were expected and therefore physical health is a key area to focus on to ensure care provided is exemplary.

- The Trust has invited ICB colleague to join LOSC to work through at pace where systems or other care providers need to join in the learning.

In response to a query from JW, NH advised that terminology regarding how we determine and report deaths was mandated. Unexplained / unexpected means the patient was not receiving end of life care. Deaths require a cause of death to be ascertained which may require inquest. This would then go under a different investigation.

In terms of learning lessons, MK advised that in addition to monthly reflective learning sessions, the Trust had also launched a learning lessons podcast discussion which will contribute to learning and bring salient points to staff.

AG continued that in the spirit of leaning, there is a real opportunity for us to learn in the enhancing physical health area, and there is an opportunity to look further down line at positive impact.

The Board of Directors:

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

009/23 OPERATING PLAN UPDATE

TS introduced the report advising that this was a collective team effort which sets out our draft plan. It has been clinically led and corporately enabled, including our work with system partners to meet national deadlines. The draft plan has been reviewed by the Finance and Performance Committee, the final draft is to be agreed in March, with clear connections to the first year of our strategic plan.

The update is presented for noting to update on the status of the development of the plan. PS reemphasised the earlier point about patient involvement and ensuring patients and families are engaged as part of the planning process. ZT added that the Director of Patient Experience would be a key part of the team working on the planning approach and will build on work done through the strategic plan using lived experience ambassadors to input, feedback and be fully engaged.

LL commended the three year rolling plan approach, and queried whether thought had been given to scenario based planning approach as this was not mentioned within the document. LL continued that while there are assumptions about the plan from an EPUT perspective, this would need to dovetail with partners and the ICB and would need to allow some tolerance for slippage. LL welcomed outcome based measures planning and expected to see a wider range of measures around flow and capacity etc. to get a whole system view of performance.

TS thanked LL for his helpful comments raised both at the Board meeting and also the Finance & Performance Committee, advising that these were being followed through. TS continued that what is key is our integration in the organisation of patient numbers, performance and people plan, but equally integration across the three systems, confirming that EPUT were very much engaged with them as part of planning arrangements.

ML noted that the 2022/23 operational plan was quite extensive and was commended for being service led and had a bottom up approach. ML queried whether that will be reviewed in terms of performance and outcomes and things to improve on before sign off of a new plan for 2023/24.

TS confirmed that this had been through the accountability framework meetings in terms of progress care units have made, and the continued drafting of the plan will come through both the accountability framework meetings and Finance and Performance Committee. TS continued that we look to further

develop what was a good set of foundations from the last planning round, as well as further developing planning around capital planning and expand into future planning projections.

The Board of Directors:

1. **Noted the contents of the report.**

010/23 BOARD ASSURANCE FRAMEWORK 2022/23

DG presented the Board Assurance Framework reminding colleagues that it is a summary of high level risks that may impact our strategic plans. She referenced that through reports so far, the Board have heard updates associated with key risks, and continue to see safety, people and demand and capacity as key areas of risk for the organisation. In terms of presentation of this report, the team continue to work on how to present and provide oversight and clear information effectively. The next stage as we move to strategy and planning for 2023/24 is to confirm the organisational risk appetite going forward.

TS made reference to a good set of discussions held at the Finance & Performance Committee regarding making sure the organisation had confirmed target risk score dates and the need to reassess use of resources and capacity linked to a new round of budgets and systems projections.

JW added that the reflection of the Finance & Performance Committee was the importance of defining what the risk is, particularly around capital as a system risk, also the importance of understanding what is and what isn't in our control.

In terms of risk movement (section 7), there was only one risk that had seen movement this month - cyber-attack, however this did not seem to be reflected on the risk on a page. DG confirmed that there had been a proposal to move this risk which was not supported and advised this had been corrected on the recirculated paper. ZT reassured RH around the cyber risk to give confidence in rating advising that a programme to replace older phones which had vulnerability had taken place, an internal audit report on cyber had been signed off and there are action plans in place on each point raised through that. A new cyber assurance manager role has been appointed to with the successful applicant commencing in post in February. This is a dedicated role with a sole focus on assurance around cyber security. Given the prominence of this risk, this will further strengthen day to day assurance.

ML noted the new risk regarding pharmacy resource and the level of urgency around this. ML queried the rationale behind the urgency and suggested resourcing challenges were picked up within the PECC meeting. NH responded that there was sudden movement within the team through promotion that had resulted in a number of vacancies. The Executive Team had been sighted but this had reached the point of business continuity and mitigations. There has been significant activity around a recruitment plan and system support. MR added that there had been lot of recruitment activity and there was a full action plan to address the risk. Usual steps that would be taken had been exhausted and a full update would be presented to PECC. SS agreed the importance of understanding the issue and having a mitigating strategy in place.

MK provided assurance that in terms of pharmacy resource issues, despite pressures the dispensary is functioning and medicine is being provided to wards and teams.

The Board of Directors:

1. **Received and noted the BAF and CRR.**

011/23 STANDING COMMITTEES

(i) **Audit Committee**

JW advised that as part of the internal audit programme, a cyber-security audit was included to support the strategic risk. The report concludes the risk as moderate for design and effectiveness. This dovetails into the new appointment of a cyber-manager and the changing environment in the area of cyber security and the continuing evolvement of SOP. The rating is understandable and shows the dynamic area of cyber security. Business continuity was identified as moderate, and all recommendations were accepted. JW noted that it is clear to see how work around internal audit is giving further assurance and recommendations for improvement.

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

(ii) Charitable Funds

JW advised that overall £30k charitable fund spend had been approved. JW also noted MJ would be taking over the role of substantive chair of this committee going forward.

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

(iii) Finance and Performance Committee

Performance metrics show the Trust continues to be under pressure. The Committee continue to keep a close eye on metrics and how they could shift as investments begin getting through benefits realisation, such as Time to Care, International Recruitment etc.

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

(iv) Quality Committee

RH advised that the Committee had reflected on commendable services and tools including the MAST tool which identified risk and helped to make the make most of resources available, the perinatal MH service was a well-managed service and the only perinatal MH service in the area exceeding its objectives. The Committee had seen videos of patient stories, lessons learned etc. and this was very useful to get a feel of the patient experience and can be hard hitting.

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

(v) Board Safety Oversight Group

SS advised that the Group continued to stay close to ligature risk reduction and work therein, with investment and monitoring to drive the risk down further. A full report regarding progress of the EPUT Culture of Learning had been received and SS was encouraged by what was happening in the systematic approach to learning across the organisation. The Transformation Team are generating evidence which will be included as part of the update around the Safety Strategy that will be presented fully to the March board as a critical review of what had been achieved in first two years of the strategy, as well as an approval and endorsement of the priorities that will be pursued in year three of the strategy. There has been significant work with SS encouraged by the amount of detail and process.

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

012/23 EPUT STRATEGY 2023 – 2028 VIDEO

ZT introduced the video which sets the scene for the EPUT Strategy 2023 – 2028.

Following the video, ML commented that this reflects the breadth of what we do, with a good cross section of our teams included. As part of a new start for us, it is important to ensure we build on a communications and PR perspective. ML applauded the focus on where we are innovating and would like to see in the context at a future board seminar how we continue to promote the 'new' EPUT.

SH appreciated the genuine unscripted feel with real people speaking from the heart. PS agreed that this was a good production that was content rich and was a genuine piece that had come from our teams. AG agreed that there was a real authenticity which reflected what AG saw when visiting services. There are some really proud staff and patients that want to talk about their recovery journey and there was an opportunity to utilise this in recruitment campaigns and inductions about the breadth of EPUT services.

JW agreed that this was a powerful video and there was potential to utilise shorter clips and wider promotion, stating the importance of celebrating the fantastic work that goes on every day.

ZT acknowledged and welcomed comments, stating that the passion and commitment of our staff and positive experiences of service users really come through in the video. ZT thanked the Communications Team for their involvement in producing this video.

013/23 EPUT STRATEGIC PLAN 2023-2028

ZT presented the Strategic Plan which describes our vision, values, purpose and strategic objectives and will guide how we develop our services over the next five years by ensuring service users and their families and carers are at the heart of everything we do.

The Strategy was drafted in line with a clear view agreed by the Board in September 2021 when the Board agreed new vision, values and strategic objectives for the organisation. To support the vision a new operating model with six care units for West Essex, Mid and South Essex, North East Essex, Urgent Care and Inpatient Services, Specialist Services and Psychological Services was created, each with their own multi-disciplinary leadership teams. The strategy has been built from the bottom up, starting with feedback from service users, staff, families and carers, developing a plan through care units with fantastic engagement with care units.

Some feedback from service users, carers and families has been reflected in the strategic plan, including the desire for more choice, better information and signposting, coproducing in development of services, focus on continuity of care, support in transition of services, the opportunity to raise awareness and address stigma on their behalf. ZT confirmed that we will be an advocate for our service users as well as focus on services we provide.

The plans have been developed iteratively and will be implemented iteratively. TS highlighted the link between operational planning and strategic planning, stating that there was a focus on where we will be in 1 year and 5 years so we can tie clearly 1 year commitments into operational plans and see through to delivery.

The plan itself is organised around the strategic objectives we are committed to as a Trust, for each objective set, the KPIs are driven by outcomes we want to see achieved for those that use our services. Indicators go wider than some traditional indicators, looking at indicators of engagement, experience, staff engagement etc.

Previous discussions have highlighted the robust communications plan going forward and highlighted governance process in terms of reporting to board. There is also a strategy steering group that will manage oversight on a day to day basis.

SS noted the impressive document as well as the journey of development, acknowledging the bottom up approach. The board were cognisant of the huge amount of work that has taken us to this point.

AG stated that an unintended consequence of the process for care units, was the development of drive, leadership and maturity of care units. AG continued that this has provided context and ambition for improvement plans and we can clearly see that with the inpatient and UEC plan with the ambition driven by the ambition to drive down length of stay. AG was pleased to see alignment with the All Age Mental Health Strategy and noted that local plans were also reflected.

PS thanked ZT for leading this work and the team involved, including patients families and staff across the trust. As a whole the Trust is committed to delivering and serving our population and can hold each other to account from a positive way.

ML suggested that as the strategy continues to be refreshed, there may be opportunity to consolidate, with a lot of integrated work in care units that could potentially be pulled into one care unit plan. When reading the strategy as a whole, ML felt there were examples of re-coverage of content and felt that strategic objective 4 supporting the community to thrive, was a significant agenda and work was needed to identify exactly what we wished to achieve, acknowledging the scale of this objective.

JW commented that in terms of enabling strategies and in the context we operate within the NHS with financial pressures, staffing pressures and demand and capacity pressures, ultimately we are still under pressure for efficiencies and so these enabling strategies are imperative to deliver our services and we need to weave these enabling strategies in at pace.

LL referred to the bottom up approach to metrics, stating the need to build a narrative on how the loop is closed and how we track progress against the strategy in a meaningful way. This is an ambitious plan and we need to do many of these things, but LL was conscious that by undertaking too much at the same time will stretch resources and be more likely to fail. There is a need to spend time thinking carefully about prioritisation, and identifying key enabling projects to focus on initially.

RH commented that this was a very clear document, it was positive to see themes emerging over the past year reflected in this document. The process to achieve the bottom up approach is commendable, and it is positive that there are clear outcome measures to define progress.

ZT stated that the strategy fits with and supports local strategies, as well as consideration to ICP strategies which cover all services as well as the All Age MH strategy being developed. EPUT's strength is the ability to integrate and work with partners. By recognising the scale and complexity of the organisation and by empowering care units and the leadership team to think about key areas that are important to their services and patients, we are able to devolve some prioritisation and resources across the organisation. Care unit plans set out local commitments against strategic objectives of the trust and it is important how we bring this into practice. In response to ML's comment around strengthening strategic objective 4, helping communities to thrive; ZT agreed this is an area to continue to focus on and strengthen. ZT recognised the importance of enabling strategies and their contribution to enabling the vision and purpose of the service.

ZT reflected that the focus of the communications plan, as well as progress reporting, will be sharing with our communities what we are doing and how.

The Board indicated full endorsement and thanked all involved.

Signed: …… Date: ……

The Board of Directors:

1. **Reviewed and approved the Trust's strategic plan for 2023 – 2028.**

014/23	CQC COMPLIANCE UPDATE

DG presented the update for information, confirming that this had thorough review at the Quality Committee. This report captured key recent activity:

- The adult social care provider information return for Rawreth Court and Clifton Lodge had been completed and submitted to the Care Quality Commission.
- De-registration of Mountnessing Court as an inpatient location for EPUT; noting that there continued to be some community services delivered from that office location however these are registered with Trust Headquarters address.
- The Care Quality Commission continued with their inspection of core services and are now significantly progressed through the well led component of the inspection.
- Continue to progress actions responding to intra inspection escalations, with a weekly inpatient support meeting taking place. This reiterates local ownership with oversight from the Executive Team and Quality Committee.
- The CAMHS action plan from the inspection that took place last year was closed by the Executive Team following thorough review.
- NH also recognised the recent national award given to the EPUT CAMHS service. Adding that we are also due to expect a visit from the national team undertaking a Quality Review on Mental Health services.
- A recruitment and retention piece is underway in terms of the pharmacy service and system support has been sought to support our pharmacy teams. There are also some vaccination centre staff who are now available to work in the organisation who are receiving training around medication management and further support to the team to optimise medications safety in clinical areas. Mitigations are in place as we seek recruitment or redeployment from the system.

The Board of Directors:

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

015/23	SAFE WORKING OF JUNIOR DOCTORS QUARTERLY REPORT (OCTOBER - DECEMBER 2022)

MK presented the report quarterly report for October – December 2022 advising that the guardian of safe working continues to work with junior doctors. The Trust has recently recruited 11 international doctors which will help to increase capacity.

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

016/23	CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

There were no items circulated to the Board since the last meeting.

017/23	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.

018/23 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

SS reflected that the strategy and approach to strategic development emphasised our collective aspirations. ZT agreed that what was powerful from the feedback received was that different people who use our services have different experiences, this came through in their expectations of us and where we need to put our emphasis going forward – to support people from different circumstances and backgrounds to access our services in a different way. The Trust's commitment to supporting communities to thrive by being a partner and an advocate not just a provider is important.

LL reflected on the disparity between where we are on benchmarks and aspirations set out in the strategic plan. LL was confident we have the right team in place but we have a steep hill to climb. LL relished the challenge ahead for us collectively, and the need to mentally prepare for that.

PS, ZT and AG agreed that equality for patients has to manifest in everything that we do, reflecting on learning from deaths, discussions around physical care in MH, and the ambition to integrate and bring together services to look at whole person wellbeing.

019/23 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 with the following exceptions:

10:15 – 10:20 – ML intermittent access re IT issues
11:00 – 11:06 – JA temporarily left and returned.

020/23 ANY OTHER BUSINESS

There was no other business.

021/23 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 29 March 2023. Planning is currently underway for a face to face session in a central location with details published in due course.

022/23 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 12:28.

Signed: …… Date: ……

Appendix 1: Governors / Public / Members Query Tracker (Item 022/23)

Governor / Member / Public	Query	Response provided by the Trust
John Jones	Page 96 appendix from NHS objectives for 2023-24, included is target for LD to receive annual health check of at least 75%. How likely is this to be achieved?	AG to get exact figure. This is an area we have done relatively well in and provide the services sitting alongside primary care along with transforming care partners and Hertfordshire Partnership Trust. We are proposing to increase our resource to do better, and have recently approved a business case to enhance the level of support we are providing in the service.
John Jones	Capital Plan – pleased to hear on target to reach capital spend for the year. Seemed to be on the risk register and showed red. Didn't understand the explanation please can this be clarified?	TS advised that the risk is around the sufficiency of the capital allocation of what we want to do, and was broader than non-delivery on this year. TS will look at refining the wording, but the risk is around is there sufficient capital to do all the things we want to.
David Bamber	Five Year Plan – how far we move beyond service users in the community and how far we move in to the areas of employers. Been keen in years as a governor in this area, but is difficult economic times, and how we use the positive media sources to enhance our message and our communications, not just in this area but to extend our message wider and spread the learning.	ZT advised that in regards to employment opportunities, the strategic plan recognises our role as an anchor organisation, we have some great work offering apprenticeships and will go further in terms of actively recruiting people to work in the trust. Another aspect is working with partners supporting service users and using wider public service to support better opportunities in employment. In terms of positive sources of information, there was discussion earlier about awards we are winning as a trust, ZT hoped the video today can also be used to promote work we are doing. Communications are working on sharing learning and positive stories wider as part of our communications plan.
Pippa Ecclestone	Assurance has been received in Quality Committee Report on progress of implementing safety strategy with reference made to 10 key factors. Disappointing to see metrics received in the report the seven day follow up of MH discharges, only data available is back in September.	AG agreed with the importance of up to date data. AG was aware of the issues and will ensure the right updates are in place. AG thanked PE for raising this.

Signed: …… Date: ……

	On pg 35 of the Q&P scorecard the narrative under shifts unfilled lists Poplar (CAMHS) as one of the wards with more than 10 days of shifts filled in Dec. How does this relate to the fill rate table on pg 36 where Poplar (CAMHS) is blue and green for Dec 2022	**Natalie Hammond, Executive Nurse** spoke with Pippa Ecclestone regarding her question and Pippa was satisfied with Natalie's response.
	In the Quality Committee Assurance report it is mentioned, that assurance had been received on the progress of implementing the Safety Strategy, reference was made specifically to one of the 10 key factors "contact with discharged MH patients within 48 hours". It is therefore disappointing to see that in today's board papers the last data available on "*7 day follow up after MH discharge*" is from September. (Pg 21, 2.8.1) graph final – bottom axis, date ends Sept 2022. Can we expect more up to date data for this metric at the next board meeting?	**Alex Green, Executive Chief Operating Officer:** I have spoken to the team and as a result of resource challenges within the team, the data was not refreshed as it should have been. The team express their apologies to you and the report circulated this month now includes updated data.
	How many patients are on the CAMHS wards Poplar, Longview and Larkwood at present? Do we have any expectation of being able to admit and safely treat, more patients within the foreseeable future or is the level of acuity of young people on the waiting list too high?	**Louise Summers, CAMHS Service Manager** Larkwood 7, Longview 8, Poplar 9 Current activity level is consistently high across the service due to complex cases in service. St Aubyn Centre will not be in a position to increase patient numbers until AC approval is confirmed for the consultant position. We remain in communication with the Provider Collaborative regarding bed numbers.

Paula Grayson	On SO4 specifically, this form of output measure does not match our learning ambitions, being only numerical and input not outcomes "Number of community meetings attended by EPUT staff. Feedback from local community groups. It will be very helpful to see some numbers in the SO4 measures about trainees and apprenticeships please.	**Anna Bokoza, Director of Strategy** is meeting with Paula Grayson on 24th March 2023 to discuss the question.
John Jones	In the CEO report (pg 11) it states the capital plan is on target, to reach capital spend of the year. However, in the BAF (SR7) the capital risk is red, but John did not understand the rationale given?	**Trevor Smith, Executive Chief Finance and Resources Officer**: The Risk in the BAF is the overall sufficiency and availability of capital resources to enable the Trust to maintain, modernise and transform rather than the in-year delivery of the capital plan.
	On Page 97, Appendix A, NHS Objectives, target for LD's for annual health checks at least 75%. What is the current rate? How likely will this be achieved?	**Alex Green, Executive Chief Operating Officer**: The team will be completing these new forms for new referrals only from April, over time they will however be gradually completing them for existing referrals through the use of overtime. As these forms are not being rolled out for use until April there are only a couple in the system currently and these have been used for testing with the service.

Signed: …… Date: ……

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting (25 January 2023)

Lead	Initials	Lead	Initials	Lead	Initials

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

Minutes Red	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
No Open Actions						

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 March 2023**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

Summary of Key Issues

The report attached provides information in respect of:

- Essex Mental Health Independent Inquiry Staff Engagement
- Welcome Elena Lokteva, Associate NED
- LGBT+ History Month / Southend Winter Pride
- Visits to EPUT Services from Local MPs and Chair of Hertfordshire and West Essex ICB
- International Women's Day
- Service User Participation
- Patient Safety Partners

- Service Visits
- View of Members and Governors

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

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

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

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

Supporting Reports/ Appendices /or further reading
Main report.

Lead
 **Professor Sheila Salmon** **Chair**

Agenda Item: 5
Board of Directors Part 1
29 March 2023

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

1.1 Independent Inquiry Staff Engagement

The Senior Leadership Team continue to encourage staff to volunteer to give evidence as part of the Essex Mental Health Independent Inquiry. Only by engaging with the Inquiry Team to share experiences and views can the Inquiry fulfil its aims and help to give patients and families the answers they deserve. Alex Green, Executive Chief Operating Officer recorded a short video explaining how to take part. A dedicated Independent Inquiry intranet page is also available for staff which has questions, answers and information on the support available to staff, patients and families. The Trust has no visibility of who is giving evidence or the nature of that evidence and there is a clear message to staff that no one will suffer any negative consequences at work because of the evidence given. Support mechanisms are also in place and have been re-emphasised to staff. The common aim is to give our patients, service users, families and carers the answers they deserve and to look forward and deliver on our plans to improve the care and services we provide. All members of the Board of Directors have also committed to provide evidence to the Inquiry Team.

2.2. Welcome Elena Lokteva, Associate NED

I am delighted to formally welcome Elena Lokteva to EPUT in the role of Associate NED. Whilst the role of Associate NED is not a voting member of the Board of Directors, Elena will be working closely with our current NEDs, in particular our current Audit Chair, Janet Wood, in readiness to transition into that role from 30th September when Janet completes her term of office. Elena brings a wealth of public and private sector top level leadership and audit experience, having served on multiple Boards.

2.3 LGBT+ History Month / Southend Winter Pride

EPUT proactively supports members of the LGBT+ Community, with colleagues volunteering at the Southend Winter Pride event to celebrate LGBT+ History Month, explaining to visitors how EPUT provides person centred care to members of the LGBT+ community accessing our services. Goody bags were available and information was shared on some of the job opportunities we have available at the Trust. Our LGBT+ Network Chair also joined the Executive Team at a recent All Staff Live Event to talk about LGBT+ History Month.

2.4 Visits to EPUT Services from Local MPs and Chair of Herts and West Essex ICB

The Trust has recently hosted visits from Local MPs Priti Patel, Anna Firth and Sir James Duddridge as well as Paul Burstow, Independent Chair of the Hertfordshire and West Essex ICB. As a Board we are extremely proud of our services and welcome the opportunity to host visits such as these to allow stakeholders to meet and engage with our amazing staff and service users and to share the real improvements being made across the Trust.

2.5 International Women's Day

Wednesday 08 March saw the Trust celebrate International Women's Day, celebrating the achievements of women all over the world, and of course our colleagues here at EPUT, including a special International Women's Day themed staff update led by our Executive Chief Operating Officer Alex Green. With around 80% of our workforce being women, EPUT are committed to ensuring everyone has equal opportunities to career development, support and recognition of their achievements, regardless of their gender. Significant work on this agenda is taking place across the

Trust, and I am delighted that a new Gender Equality Network has been launched, that is open to everyone and will meet regularly to help guide and inform Trust decisions around policies, priorities and colleague wellbeing. Our Organisational Development Team also held two Career Lounge Sessions at which colleagues shared their inspirational career stories, as well as a speaker from the NHS Leadership Academy who spoke about the development programmes and pathways available to all across the NHS and at EPUT.

2.6 Service User Participation

The recent "Your Voice" meeting led by our Governors on 9th March was well attended and evaluated. Zephan Trent (Executive Director Strategy & Digital) attended with two of his leadership team and set out the central dimension of service user and carer participation in the development and delivery of the EPUT strategy 2023-28. It was encouraging to hear that the Trust now has circa 100 people with lived/living experience purposefully involved in multiple ways with an aspiration to reach the figure of 500 by the end of year 1. Patient safety partners are a specific live example of the importance of this purposeful involvement (please see below).

2.7 Patient Safety Partners

As part of the Trust's ongoing commitment and focus on safety across the organisation, I am delighted that five Patient Safety Partners have now been recruited. The Patient Safety Partners will bring lived experience and will act as a voice for patients, their families and carers. They will act as a critical friend to the Trust to ensure service user and carer views are fully represented thus supporting the development of services from the perspective of someone who knows what it feels like to receive care. The Partners have a vital role to play in helping us ensure we deliver the best possible care, and will be visible on our wards talking to patients and carers.

2.8 Service Visits

The NEDs and I are pleased to be able to continue our schedule of visits to services across the Trust. Since the last Board meeting, visits have taken place to the Derwent Centre, Basildon MHU, Ardleigh Ward, Willow Ward, Beech Ward, Tower Ward, Peter Bruff, Meadowview, North Essex STaRS and Wood Lea Clinic. The value of these visits cannot be underestimated and provide a real insight into challenges faced by our staff at the coal face, but also are an opportunity for the Board members to see first-hand the excellent care provided by our dedicated staff.

3.0 VIEWS OF MEMBERS AND GOVERNORS

The information below sets-out the mechanisms in place during 2021/22 to ensure the views of Governors and Members are shared with the Board of Directors.

3.1 Council of Governors

One of the general duties of the Council of Governors is to represent the interests of the members of the Trust and interests of the public. The Council of Governors meeting is held on a quarterly basis and has been held met on five occasions during 2022/23:

- 6 June 2022
- 27 September 2022 (Annual Members Meeting)
- 7 November 2022
- 14 December 2022 (Extra-Ordinary)
- 15 February 2023

All members of the Council of Governors are expected to attend these meetings and in the case of Public and Staff Governors are elected by members of their constituencies to represent their views.

Appointed Governors are nominated to represent the views of their organisations. The table below provides the composition of the Council of Governors as at 22 March 2022:

Constituency	No. of Governors	Vacancies
Public Governors		
Essex Mid and South	8	1
North East Essex and Suffolk	3	0
Milton Keynes, Bedfordshire, Luton and the Rest of England	2	0
West Essex and Hertfordshire	4	1
Staff Governors		
Clinical	4	0
Non-Clinical	2	0
Appointed Governors		
• Essex County Council • Southend-on-Sea Council • Thurrock Council • Anglia Ruskin / Essex Universities • Council for Voluntary Services (CVS) Essex	4	1
Total	**30**	

The next elections for Public and Staff Governors will be held in September 2023 and will incorporate all vacancies.

The Council of Governors have further opportunities to meet with members of the Board of Directors through the following meetings:

Meeting	Frequency	Detail
Chair and Lead / Deputy Lead Governor Meeting	Quarterly	The Chair and Lead / Deputy Lead Governor meet to discuss the upcoming business for the Council of Governors and raise any items directly with the Chair of the Trust.
Chief Executive Officer Briefing	Quarterly	The Chief Executive Officer (CEO) briefs the Council on any operational matters and provides an opportunity for any items queries or clarifications prior to the Council of Governors meeting.
Chair of Sub-Committee Meetings	Quarterly	The Vice Chair and Chairs of the Council of Governors Sub-Committee meetings discuss items arising from these meetings and share learning.
Non-Executive Director / Governor Informal Meetings	Quarterly	Informal sessions providing an opportunity for relationship building between the Non-Executive Directors and Council of Governors and provides an opportunity for broader discussion on any topics.
Constituency Meetings	Quarterly	Non-Executive Directors and Governors meet by constituency to discuss any topics specific to their own constituency. Operational Service Managers / Directors also attend where possible to provide information about local services.
Joint Board Seminar Sessions	Twice-yearly	The Board of Directors and Council of Governors meet together to discuss strategic items and provide views for consideration as part of the strategic development.

The Governors are able to contact the Trust Secretary's Office to raise any concerns or queries which are then directed to the relevant member of the Board of Directors for response.

3.2 Membership

The Trust maintains a Membership Database which contains a list of all members currently registered with the Trust. The database is used to ensure communication with members is maintained and can provide certain metrics, based on information available.

The following metrics provide details of the current membership composition as at January 2023 when the Council of Governors last met. The information is updated for each report to the Council and any changes advised:

	Current Membership as at January 2023
Total Membership	14,460
Public Members (34%)	4,919
Staff Members (66%)	9,537
By Constituency (Public)	
Essex Mid & South	1,933
Milton Keynes, Bedfordshire & Rest of England	1,691
West Essex & Hertfordshire	701
North East Essex & Suffolk	594
By Gender (Public)	
Male (38%)	1,872
Female (59%)	2,919
Not Stated (3%)	128

3.3 Your Voice Meetings

The Trust holds public members meetings (Your Voice) which is an opportunity for the Trust to share information on certain topics and Governors to liaise directly with the membership. There have been two Your Voice Meetings held in the 2022/23 reporting period (March 2022, June 2022 and December 2022). Both meetings were held virtually for all members to attend.

The topics for the meeting were as follows:

- Crisis Line – NHS 111, Option 2 (March 2022)
- Celebration of EPUT Volunteers / Volunteering for the Buddy Scheme (June 2022)
- Focus on Safety: What does safety mean to you and your community? (December 2022)

The meetings were attended by 137 individuals and the table below provides a breakdown of the attendee group:

Attendee Group	No. of Attendees
Public Member	60
Staff Member	34
Governor	33
Non-Executive Director	7
Executive Director	3
Total	**137**

Feedback from the meetings were both informal and via a feedback form and were positive in terms of content and discussion provided. The Membership Committee considered the feedback for each session2 and highlighted the positive comments and considered improvements for future sessions.

A Your Voice meeting was held in March 2023 and will be included in next year's report.

3.4 Annual Members Meeting

The Trust held its Annual Members Meeting (AMM) on the 1 November 2021 via Microsoft Teams and included:

- A reflection on the last 12-months, including the Safety First, Safety Always Strategy, senior leadership and infrastructure.
- The Trust Annual Report and Accounts, including the outcome of external audit.
- Details of progress with Strategic Objectives 2020-2022
- The Quality Account 2022, including future Quality Priorities, including safety which linked into a detailed presentation on progress with the Safety First, Safety Always Strategy.
- A video showing collaborative working in the Thurrock constituency.
- A report from the Council of Governors, including details of what the Council does and key achievements over the last 12-months.

The meeting ended with a Question and Answers session, with members and Governors invited to ask any questions of the Board of Directors present at the meeting.

4.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

4.1 **Government Consultation Outcome: Appropriate Clinical Negligence Cover:** Please see the link below for a copy of the report published on 7 February 2023 outlining that all healthcare professionals owe a duty of care to act in the best interest of their patients and to have adequate cover to enable paying compensation costs and legal fees to patients in cases proven clinical negligence. **For Information: Link**

4.2 **Update On Medical Device Regulation:** Please see the link below for a copy of the proposed amended act approved by the Council of the European Union on 26 January 2023 **For Information: Link**

4.3 **Integrated Care Strategy, Health and Wellbeing Board And Joint Forward Plan Guidance: What You Need to Know:** Please see the first link below for a copy of the guidance published on 17 January 2023 that outlines that the ICP will be required to produce an integrated care strategy to set the strategic direction for health and care services across the whole geographic area of the ICS, including how commissioners in the NHS and local authorities can deliver more joined-up, preventative, and person-centred care for their local population. The ICB and its partner trusts have a duty to prepare a joint forward plan (JFP), to set out how they will arrange and/or provide NHS services to meet their populations' physical and mental health needs. The second link is a copy of Annex A: People and organisations to consider involving and the third link is Annex B: Glossary containing definitions of terms found in the Guidance. **For Information: Link; Link; Link**

4.4 **Health And Care Sector Latest Developments:** Please see the link below for a copy of the latest Covid19 data for England. **For Information: Link**

5.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by

Angela Horley
PA to Chair, Chief Executive and NEDs

On behalf of
Professor Sheila Salmon, Chair

		Agenda Item No: 6
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 March 2023**

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

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
Does this report mitigate the Strategic risk(s)?	~~Yes/~~ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes/~~ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
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, specifically: 1. EPUT's Operational Plan for 2023/24 2. EPUT's Patient Safety Strategy 3. Mental Health Urgent Care Department 4. Industrial Action 5. Electronic Patient Record 6. Electronic Prescribing and Medicines Administration (ePMA) 7. International Women's Day 8. Eating Disorder Awareness Week

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report

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

Agenda Item: 6
Board of Directors Part 1
29 March 2023

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1. Operational Plan

The priorities and commitments for year one of EPUT's strategic plan for 2023/24 - 2027/28, approved at last month's Board meeting, will be set out in EPUT's Operational Plan for 2023/24. The Operational Plan is designed to ensure early progress against each of the Trust's four strategic objectives and will support us in fulfilling our ambition of becoming the leading health and wellbeing service in the provision of mental health and community care. All six care units have formulated their own specific plans with specified local commitments under each of the four strategic objectives. The Plan has been designed to focus on ambitious but deliverable priorities, based on careful triangulation of activity, finance and workforce information in collaboration with our three local Integrated Care Systems.

1.2. Safety Strategy

This month marks the two-year review of our patient safety strategy, Safety First, Safety Always, which we launched in 2021 to support our ambition of providing the safest possible care for our patients. It is important that we reflect on the achievements and improvements we have collectively made against a backdrop of unprecedented demand and challenge. Since its launch, our staff have embraced the Safety First, Safety Always message, showing extraordinary commitment to our service users and each other and I am delighted that we are able to see the tangible benefits this continued focus is having on our patients, service users and colleagues. Despite COVID pressures, we have moved the dial on key safety indicators including a significant reduction in serious incidents, a 95% reduction in use of prone restraints and a 40% reduction in seclusion incidents. I am hugely encouraged to see the positive impact our focus on leadership development and building an open, just and fair culture is having on our workforce, supported by our new operating model. We are continuing to embrace new ways of working and digital innovations to ensure data driven decision making at a local level and embedding the highest safety standards. However, as the report highlights, we know we have lots more to do as we enter the final year of the strategy to continue to improve in collaboration with patients, carers, families and system partners and deliver the safest possible patient care.

1.3. Mental Health Urgent Care Department

Last week saw the official opening of our new Mental Health Urgent Care Department at Basildon Hospital. The first of its kind in Essex, this innovative facility offers a calm and therapeutic space for people with urgent mental health needs and an alternative to hospital emergency departments which are often not the right environment for them. Open 24 hours a day, seven days a week, the facility will offer services to people aged 18 and over through a team of specialists who will work with people to understand how they are feeling, what has triggered their crisis and provide support to return home or facilitate a referral to an appropriate service.

With more than £5m investment from the MSE Integrated Care System, EPUT has worked in collaboration with health and social care partners from across mid and south Essex alongside local people with lived experience to develop this new innovative facility. I want to extend a huge thank you and congratulations to everyone involved. We should all be incredibly proud of this initiative, which will transform people's experience of urgent mental health care, whilst relieving pressure on local emergency departments.

1.4. Industrial Action

The Junior Doctors Industrial Action took place between 13 and 16 March 2023. Strike action will inevitably mean some disruption, but considerable effort was made to manage business continuity with plans put in place to ensure inpatient wards and on-calls were covered as priority. Detailed preparations were put in place to preserve planned appointments where possible, with patients being reviewed by the consultants to ensure patients were risk assessed, although some outpatient clinic appointments required rescheduling. All patients affected by these changes were contacted directly with changes to their appointment. I'd like to extend my sincere thanks to all those involved in these preparations who helped mitigate the impact on our service users and staff as much as possible. Throughout the strike around 30% of the Junior Doctor workforce participated in the industrial action, who were fully supported throughout this period and their decision to take part in any industrial action was actively supported by Senior Leadership.

1.5 Electronic Patient Record

Following several pre-market engagements with potential suppliers for the new electronic patient record system we are encouraged by their confidence and enthusiasm in supporting our vision of a unified patient record. We are now readying ourselves for procurement alongside our system partners ahead of the business case being considered by the Board this month, and then onward for national approval. Our aspiration to be a data-driven organisation is taking shape with the new data strategy also being considered by the Board. This will mark a new chapter for our Trust and start an existing programme of work to put data insights at the heart of our decision making.

1.6 Electronic Prescribing and Medicines Administration (ePMA)

ePMA is a transformational project for the Trust and will deliver a broad range of benefits including patient safety and quality of care, clinical governance, operational productivity and medicines optimisation. The programme is planned to take two years to deliver with Pharmacy and Inpatient go live starting in March 2024 and Outpatient and Community go live starting in January 2025, with closure in April 2025. The full business case to restart this programme in April has now been finalised and submitted to the Trust Board for approval.

2. OTHER NEWS

2.1. International Women's Day

Celebrated on 08 March around the world, International Women's Day is a day when women are celebrated and recognised for their achievement, to raise awareness about discrimination and ensure action is taken to drive gender parity. As the largest employer of women in Europe, with more than three quarters of the of NHS staff made up of women, the NHS has a vital role to play in the global effort to build a more equal and sustainable future. It is vital that we all reflect on the incredible role women play right across the NHS, including having been at the

forefront of the fight against COVID, and pause to honour the role that every one of them plays in delivering amazing patient care. In our unrelenting focus on building a fair and just culture here at EPUT, we must never give up continuing to push for progress and fulfil our aim of achieving gender equality both across the NHS and across society as a whole.

2.2. Eating Disorder Awareness Week

An annual awareness week aimed at challenging myths and misunderstandings around eating disorders, was held earlier this month. According to the charity Beat, around 1.25 million people in the UK have an eating disorder, which could be one of a range of serious mental health conditions. Eating disorders are not always related to food. It is more about how a person is feeling. They can affect anyone, regardless of age, gender, ethnicity, or background. Our specialist Eating Disorders Service assesses and treats people with moderate to severe eating disorders, primarily helping people who are suffering with anorexia nervosa and bulimia nervosa and variations of these eating disorders. The team offer intensive day treatment services and specialist assessment, evidence-based psychological therapies and therapy groups. They also provide Eating Disorders Intensive Community Treatment and FREED (First episode Rapid Early intervention for Eating Disorders). FREED is for young people aged under 26 who have had an eating disorder for less than three years. To mark the week, some of our patients and staff shared their stories to raise awareness and encourage anyone who needs support to not be afraid to seek help.

2.3 Ramadan

March is this year's month of Ramadan, the ninth month in the Islamic calendar which marks the time when the first verses of the Qur-an were revealed to the Prophet Muhammad. Ramadan is a time of charity and benevolence and, for many Muslims, an opportunity for self-purification, reflection and a renewed focus on spirituality. I would like to wish all our Muslim colleagues from across the EPUT family a Ramadan Kareem.

3. PERFORMANCE AND OPERATIONAL ISSUES

3.1. Operations – Alex Green, Executive Chief Operating Officer

- 3 contracts with inadequate performance indicators showing improvement and 3 with no change
- Adult mental health inpatient and PICU flow and capacity remains challenged. Improvements delivered in average length of stay and inappropriate out of area placements
- IAPT access numbers remain inadequate; digital solutions beginning to have a positive impact
- Psychology waiting times stabilised. Significant improvement anticipated in March for DBT and STEPPS
- Data validation for the Lighthouse Children's Centre nearing completion; 29 young people waiting over 78 weeks all have booked appointments.

3.2. Finance – Trevor Smith, Executive Chief Finance and Resource Officer

- Month 11 Results are on plan (£0.8m YTD deficit).
- Revenue forecast remains at breakeven.
- Month 11 Capital YTD £1.1m underspend.

- Capital forecast agreed with ICS partners and set to deliver ICS Capital targets.
- Continued focus on preparation for 22/23 year end and finalisation of 23/24 financial plans including contract agreements with Commissioners and prioritised capital programme.
- Significant progress on a number of transformational and operational business cases including EPR OBC

3.3. People and Culture – Marcus Riddell, Acting Executive Director of People and Culture

- **Safe staffing –** We will be reducing our international recruitment intake, as we increase the number of students joining us, and improve our efforts to recruit UK based nurses. This will be driven by our care group workforce plans, with each care group now having specific recruitment, retention and culture objectives based on the needs of their services. There remains twice daily sitrep calls with Bed Management, Ward Managers, and Clinical Directors involved which provides oversight and a forum to escalate risks. In addition there are twice weekly Safety Senior huddles which are used to plan and mitigate staffing challenges.
- **Temporary Staffing (Agency & Bank) –** the Trust maintains a temporary (agency) staff usage of 10%. Recruitment and HR Business Partners continue their work with managers on recruitment strategy through Care Group and Accountability Framework meetings.
- **Vacancy** – We have brought registered nursing vacancy down from 805 in April 2022 to 397 in March 2023. 7% net growth in nurses in substantive roles over last year means we are anticipating our nursing vacancy rate to be 19.5% at year end. There were 100 new starters in February – 16 of which were registered nurses. Overall, our vacancy rate is 11%.
- **Sickness Absence** – Sickness has increased this month, but is in line with usual seasonal trends.
- **Training, Supervision and Appraisal –** Overall mandatory training compliance is 92%, remaining the same as last month. The Pre-COVID update frequencies compliance is 89%, again, remaining the same as last month.
- **Bullying and Harassment –** there were no bullying and harassment incidents in February 2023
- **Equality Diversity and Inclusion** – NHSE reviewed our Workforce Race Equality Standard (WRES) action plan and have rated it as outstanding. We have appointed Executive Sponsors for each of our Staff Networks, to ensure that senior leaders demonstrate their commitment to EDI in EPUT through supporting the work of these Networks.
- **NHS Staff Survey 2022 –** a final response rate of 42% was achieved. Highlights include decreases in staff experiencing discrimination on the grounds of age and gender, improvements in work life balance, access to learning and development and career progression. Areas for improvement include the experience of BME and disabled staff, staff perceptions of care, burnout, and speaking up. Public board will receive a full presentation on the survey and the actions being taken in May 2023.

Report prepared by

Paul Scott
Chief Executive Officer

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 March 2023**

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

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

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

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

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

Summary of Key Issues

Performance Reporting

This report presents the Board of Directors with a summary of performance for month 11 (February 2023).

The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) have reviewed performance for February 2023.

Six inadequate indicators (variance against target/ambition) have been identified at the end of February 2023 and are summarised in the Summary of Inadequate Quality and Performance Indicators Scorecard.

- Inpatient MH Capacity Adult & PICU
- IAPT Access Numbers
- Out of Area Placements
- Psychology
- Lighthouse Childrens Centre
- Temporary Staffing

There are two inadequate indicators which are Oversight Framework indicators for February 2023.

- Out of Area Placements
- Temporary Staffing (Agency)

There is one inadequate indicator in the EPUT Safer Staffing Dashboard for February 2023.

- Number of wards with fill rates of <90%

There are no open CQC action plans to report within the CQC scorecard. The Trust awaits feedback from the CQC following the recent Core Services inspection and Well Led inspection.

Within the Finance scorecard there are no items RAG rated inadequate for February.

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

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

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

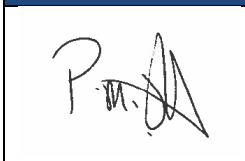
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	✓
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required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

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

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

Supporting Documents and/or Further Reading
Quality & Performance Scorecards

Lead



Paul Scott
Chief Executive Officer

Trust Board of Directors
EPUT Integrated Quality and Performance Score Cards
February 2023

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

Report Guide

Use of Hyperlinks

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

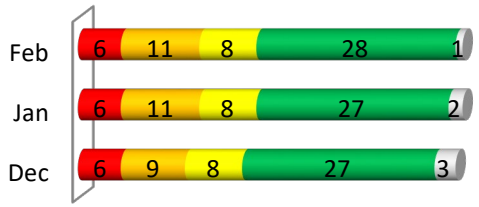
How is data presented?

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

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

SECTION 1 - Performance Summary

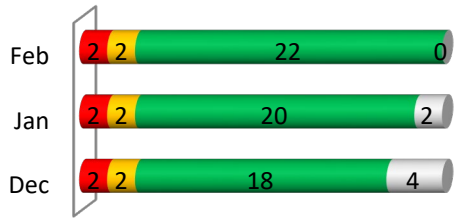
Summary of Quality and Performance Indicators



February Inadequate Performance

- Inpatient MH Capacity Adult & PICU
- IAPT Access Numbers
- Out of Area Placements
- Psychology
- Lighthouse Childrens Centre
- Temporary Staffing

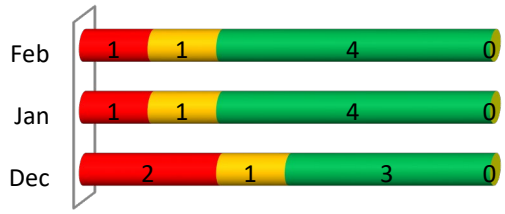
Summary of Oversight Framework Indicators



February Inadequate Performance

- Out of Area Placements
- Temporary Staffing (Agency)

Summary of Safer Staffing Indicators



One inadequate item identified within the Safer Staffing section for Fill Rates.

This data is collected from SafeCare.

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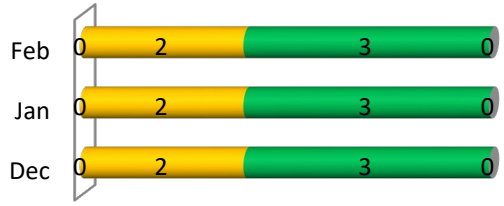
Summary of CQC Indicators

Core Services Inspection
The CQC completed an unannounced inspection of 6 of our core services, PICU, Acute Adults, Crisis, Older Adults, Substance Misuse and MH Community, between 22 & 24 November 2022.
The Trust is awaiting the draft feedback report following the inspection, which will undergo factual accuracy checks prior to publication on the CQC website.

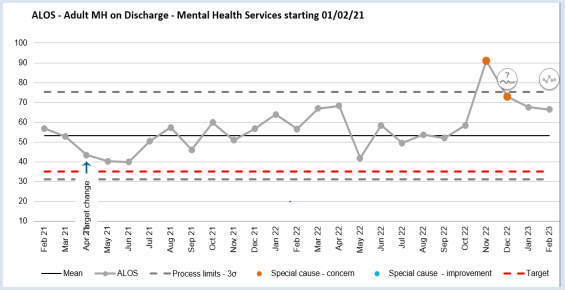
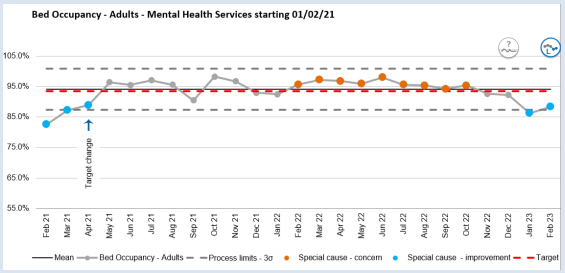
Well Led Inspection
The CQC commenced EPUT Well Led inspection on Monday 16 January, continuing until Friday 27 January 2023. No formal escalations or feedback has been received to date.
The Trust is awaiting the draft feedback report following the inspection, which will undergo factual accuracy checks prior to publication on the CQC website.

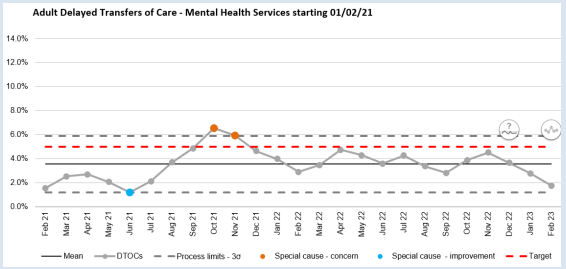
Finance Summary

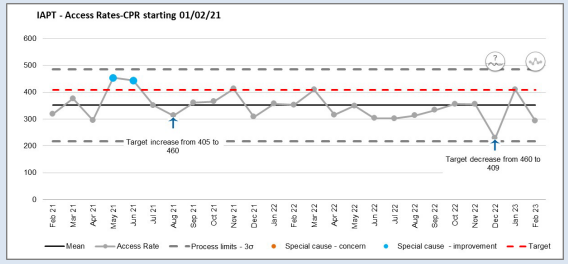
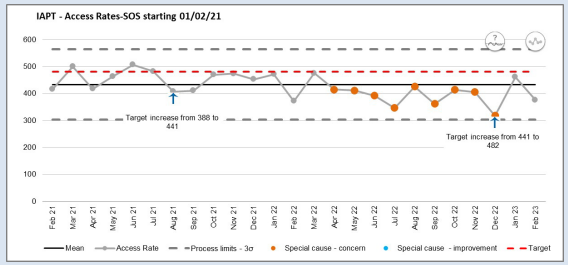


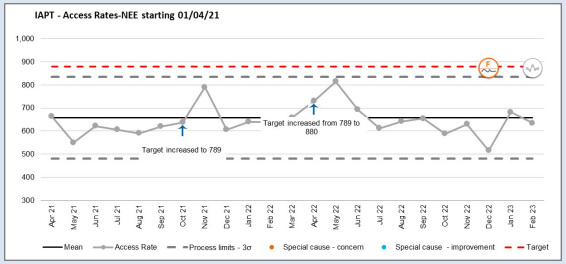
February Inadequate Performance
There are no Finance Indicators noted as inadequate.

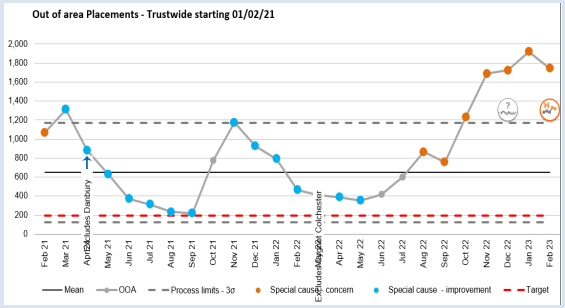
SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.9 Inpatient Capacity Adult & PICU MH Committee: Quality Indicator: Local Data Quality RAG: TBC	Weekly Multi Agency Discharge Events (MADE) and System Escalations continue to take place weekly with a 32% reduction on January for adults with a system level constraint to discharge. Ward and Trust level constraint escalation continues via the weekly joint inpatient and community meetings led by service managers in each locality and Consultant Flow meetings. A further Getting it right first time (GIRFT) conference is planned for May 2023 with work continuing on these principles, in addition, capacity and demand modelling has commenced. From December 2022 to April 2023 NHSE are holding a Mental Health discharge challenge, which requires all providers to self-assess against 10 key priorities to promote patient flow. These priorities include care formulation and planning within 72hrs of admission, Multi Agency Discharge Events (MADE), understanding themes and solutions for delays and daily reviews to ensure therapeutic benefit. The Trust continues to implement high impact changes from this MH discharge challenge.						
	2.9.2a Adult Mental Health ALOS on discharge less than NHS benchmark **Target: <35** (Adult Acute Benchmark 2020 35)	66.4 days		Below Target = Good 		Consistently failing target 71 discharges in February (20 of whom were long stays (60+ days)).	TBC
	2.9.4 % Adult Mental Health Bed Occupancy below national benchmark **Target: 93.4%** (Adult Acute Benchmark 2020 93.4%)	88.4%		Below Target = Good 			N/A

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.9.3 % Adult Mental Health Delayed Transfers of Care below national benchmark **Target: 5%** (Adult Acute 2020 Benchmark 5%)	1.8%	●	Below Target = Good 	●	Additional work is ongoing to ensure all delays are recorded on Systems. *KPI definition to be expanded to meet new NHSE criteria.	N/A

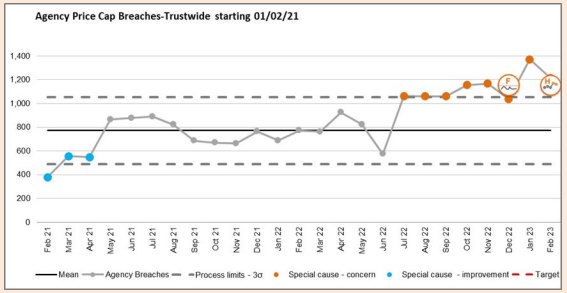
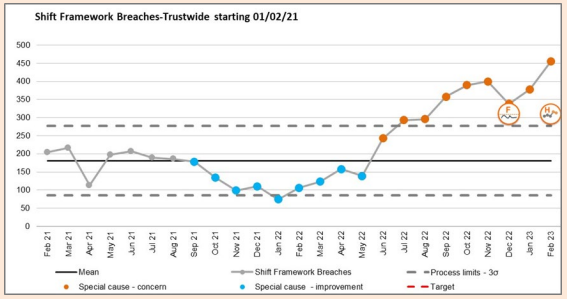
Effective Indicators							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.16 IAPT Committee: FPC Indicator: National Data Quality RAG: **Green**	**Inadequate** Access numbers across all three areas continue to be highlighted as inadequate due to non-compliance with targets. Castle Point and Rochford is currently performing at 293 accessing services in February, against a target of 409; decreasing again after hitting target for the 1st time this year last month. Southend is reporting 376 in February, against a target of 482; dropping again after improvement last month. North East Essex reports 635 accessing services in February, against a target of 880; this is a small reduction on January. The implementation and utilisation of Xyla Digital therapies continues with Service Leads noting already it's positive impact. Services are working to ensure referral pathways are in place and maintained for appropriate clients across social care, primary care, secondary care and physical health. Primary care pathways are supported by close working relationships with the Primary Care Mental Health team, Adult Community Psychological services and through the engagement of the IAPT service Primary Care Liaison Therapist. Communication plans are in place to ensure reinforcement of the service brand within the communities that we support and will engage new referrals. The implementation of automated referrals to IAPT via SystmOne for patients with a diagnosis of mild to moderate anxiety and depression or first prescription of mood stabilisers is a further action being taken to increase access to the service.						
	2.16.1 IAPT Access Rate CPR CCG **Target – 409**	293	●	Above Target = Good 	●	Access rate targets have now been changed to a number rather than a percentage following an update to the STP trajectories nationally.	
	2.16.2 IAPT Access Rate SOS **Target – 482**	376	●	Above Target = Good 	●		

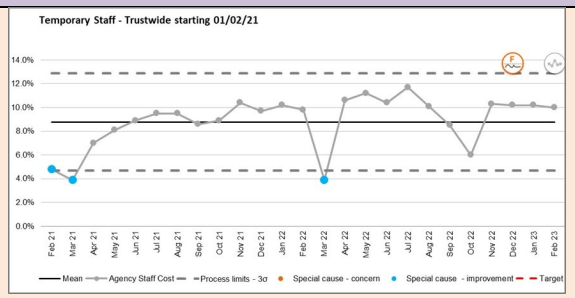
Effective Indicators							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.16.3 IAPT Access Rate NEE **Target – 880**	635	●	Above Target = Good 	●		

Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M11 Perf**	**RAG**	**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
4.5 Out of Area Placements Committee: FPC Indicator: Oversight Framework Data Quality RAG: Amber	**Requires Improvement** February has seen a positive reduction in out of area bed days from 1,919 to 1,743 (excluding Danbury & Cygnet). There were 23 new clients were placed OOA (22 Adult & One PICU) in February, and following the repatriation of 28 (27 Adult & one PICU), there were 63 remaining (57 Adult, one Older Adult & four PICU) OOA at the end of the month. This continues to be higher than previous years. The Trust continues to hold contracts with the Priory (Danbury ward) and Cygnet Colchester. NHSE/I confirmed these placements are to be classed as appropriate and are therefore not included in these numbers. In addition, the Trust is proposing an expansion of appropriate OOA beds, which is in it's early stages of planning. The Trust continues to hold itself accountable to it's overarching Flow action plan, which incorporates all actions from the purposeful admission programme, the GIRFT improvement programme, the out of area elimination & sustainability plan, the 85% occupancy ambition and the improvement trajectories plan. This continues to be led by the Associate Director of Flow and Operational Transformation and is regularly monitored and escalated through Care Unit meetings, Accountabilty Framework meetings, and the Finance & Performance Committee. Home treatment teams continue to offer alternatives to admission and enhanced community intervention to support individuals pending admission. The Trust continues its work to improve inpatient flow and through December 22 – April 23 NHSE are holding a Mental Health discharge challenge, which requires all providers to self assess against 10 key priorities to promote patient flow. The Trust continues to implement high impact changes from this MH discharge challenge.						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by end of March 2023**	1,743 Days		Below Target = Good 		Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Data excludes patients placed on Danbury Ward & Cygnet Colchester.	Mar 2023

Responsive Indicators		
RAG	**Ambition / Indicator**	**Position M11**
4.10 Psychology Committee: Quality Indicator: Local Data Quality RAG: **Blue**	4.10 Clients waiting on a Psychology waiting list	Within South East the number of people waiting for Psychology awareness Programme/Assessment for Adult Community Psychology and screenings for DBT/STEPPS remains around 4 -6 weeks on average. This has been achieved through the continuation of all staff having protected assessment slots, further added by additional CAP assessment capacity. Wait times for individual therapy remains around 9 months. The number of people being accepted into the service continues to be approximately a third less than this time last year. Waits for all groups including trauma stabilisation, online DBT and STEPPS are expected to reduce considerably by March 2023 due to the commencement of new groups starting throughout Jan23/Feb23. The longer waits for in person DBT is also mitigated by an in person DBT group which started from November 2022. As people move through the first group module others joined in February, reducing waits. Risk review calls are scheduled for everyone waiting for assessment at least every 12 weeks. Additional calls are scheduled to some people who are identified as more vulnerable. Within South West the number of people waiting for Psychology Awareness Programme/Assessment for Adult Community Psychology and screening for BT/STEPPS increased. Within Basildon & Brentwood the average wait time for individual therapy remains at 9 months, and within Thurrock this is 11 months. The longest wait time continues to be for individual schema therapy and EMDR therapy. The service has recently employed a Principal Counselling Psychologist who is EMDR trained, and a further EMDR clinician started in February 2023. Risk review calls continue to be scheduled for everyone waiting after an assessment and the waiting time for this has significantly reduced from over 12 months to every three months due to increase in staff working bank hours and ACP staff allocated wait list calls to complete. Waiting times, referrals, and staffing performance is monitored regularly through the Psychology Accountability Frameworks meetings.

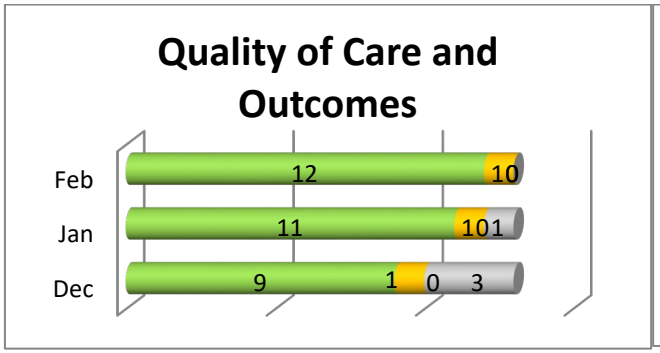
Responsive Indicators		
RAG	**Ambition / Indicator**	**Position M11**
4.11 Lighthouse Childrens Centre Committee: FPC Indicator: National	4.11 Clients waiting on a Lighthouse Centre waiting list	The services provided by the Lighthouse Children's Centre are delivered collaboratively with other system providers with EPUT as the contract host. We previously reported 29 patients waiting longer than 78 weeks. Since last month all patients waiting over 78 weeks now have an appointment booked before the end of April 23. The validation of the data received from MSEFT is nearly complete and it is expected that we will be able to provide a Trust RTT submission from the May 2023.

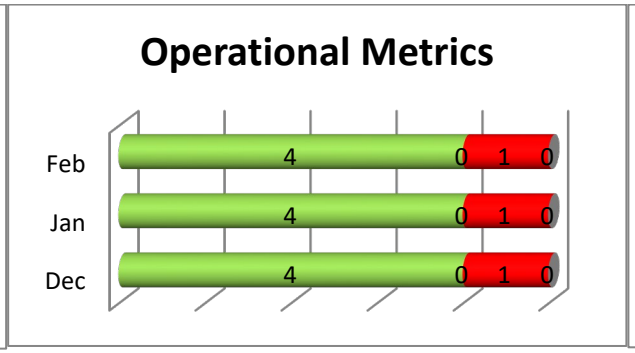
Well-Led Indicators							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.7 Temporary Staffing (Agency) Committee: FPC Indicator: Oversight Framework Indicator Data Quality RAG: Green	**Inadequate** There were 1213 agency cap breaches and 455 shift framework breaches in February. There were also 334 cases that breached both framework and price cap. In addition, the Trust maintains a temporary (agency) staff usage of 10.0%. The Operations and Medical directorates continue to have the highest spend on agency staff. Recruitment and HR Business Partners continue their work with managers on recruitment strategy and updates on usage is provided to them on a monthly basis through Care Group and Accountability Framework meetings. Workforce Implementation Groups are also being established throughout each Care Group to strategise and implement actions to improve recruitment, retention, and reduce temporary staff usage. All non-medical agency cap and shift framework breaches have Service Director approval. All medical breaches have been signed off by the Chief Medical Officer and the Chief Executive Officer.						
	5.7.1 Agency Cap Breaches Shift Price Cap **Target = 0**	1,213	●	Below Target = Good 	N/A	568 of these breaches were pertaining to the Medical staffing group	
	5.7.2 Shift Frame-work **Target = 0**	455	●	Below Target = Good 	N/A		

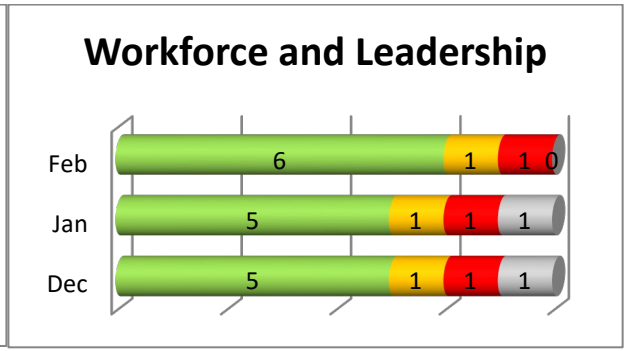
Well-Led Indicators							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	5.7.3 Proportion of temporary Staff (Provider Return) No Oversight Framework Target	10.0%.	●		N/A	The Operations and Medical directorates continue to have the highest spend on agency staff.	

SECTION 4 - OVERSIGHT FRAMEWORK

Click here to return to summary page





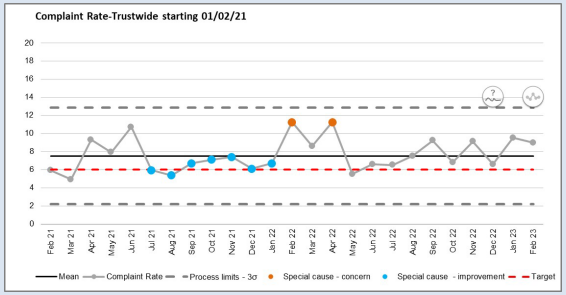


Inadequate

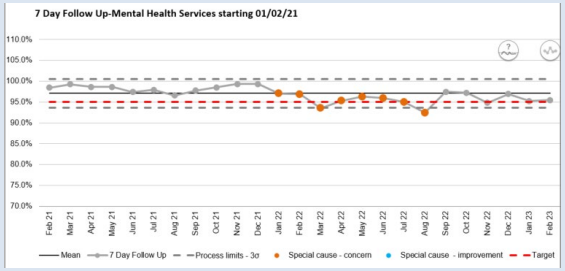
- Out of Area Placements
- Temporary Staffing (Agency)

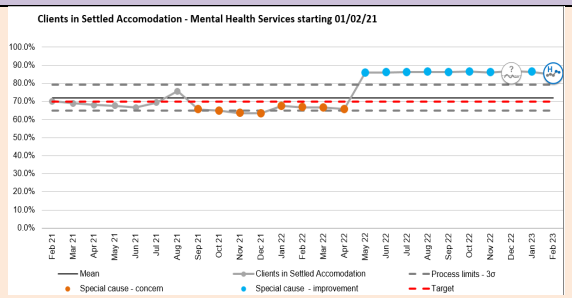
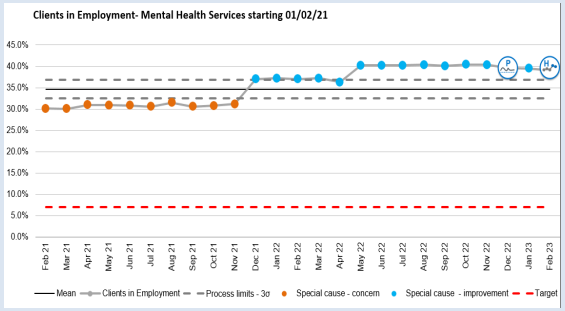
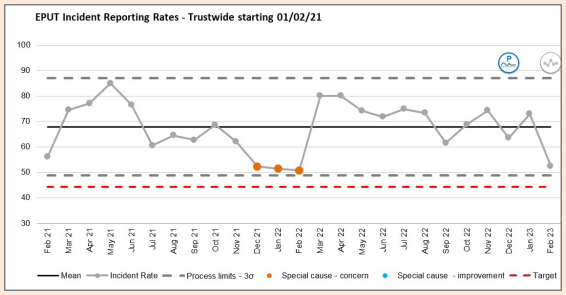
Requires Improvement

- Complaint Rate
- Staff Sickness

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1.1 CQC Rating Committee: FPC Data Quality RAG: **Green**	Achieve a rating of Good or better	Good		The Trust is fully registered with the CQC A restriction has been imposed onto the registration for the Adult Acute service.			
	No action plans past timescale			**Core Services Inspection** The CQC completed an unannounced inspection of 6 of our core services, PICU, Acute Adults, Crisis, Older Adults, Substance Misuse and MH Community, between 22 & 24 November 2022. The Trust is awaiting the draft feedback report following the inspection, which will undergo factual accuracy checks prior to publication on the CQC website. **Well Led Inspection** The CQC commenced EPUT Well Led inspection on Monday 16 January, continuing until Friday 27 January 2023. No formal escalations or feedback has been received to date. The Trust is awaiting the draft feedback report following the inspection, which will undergo factual accuracy checks prior to publication on the CQC website.			
4.1.1 Complaint Rate Committee: FPC Indicator: Oversight Committee Data Quality RAG: **Green**	4.1.1 Complaint Rate **OF Target TBC** Locally defined target rate of 6 each month	9.5		Below Target = Good 		Breakdown of complaints received in February: 1 x Assault/Abuse 21 x Clinical Practice 8 x Communication 1 x Discrimination 0 x Environment 0 x Security 9 x Staff Attitude 4 x System and Procedures	N/A
5.6 Staff FFT	National Quarterly Pulse Survey Results	The Staff FFT has been replaced with the National Quarterly Pulse Survey. In the most recent publication released in July, 449 responses were received in total. Response rates have seen a positive increase with 109 more respondents than Q1. A robust communications campaign has supported this and we also encouraged staff to fill in the survey at meetings, inductions and training. This support our drive to embed feedback and the NQPS as BAU and work will continue to develop the campaign after the National NHS Staff Survey has taken place. Quarter 4 will launch in January 2023.					

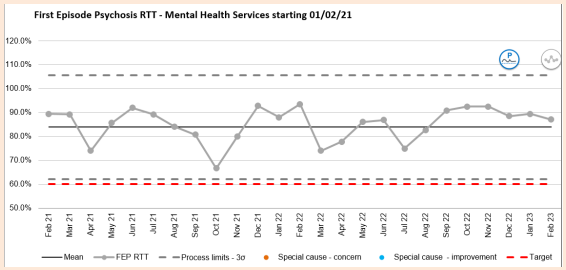
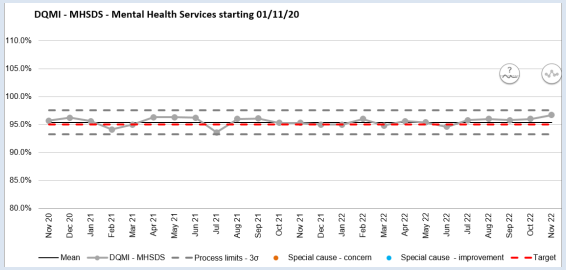
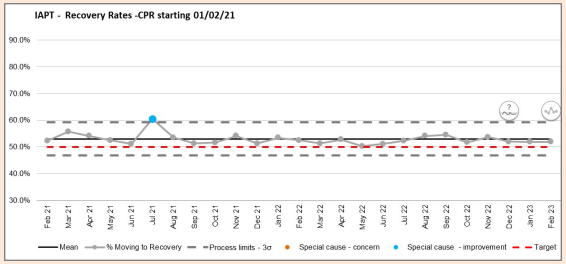
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: FPC Data Quality RAG: **Green**		We received 301 unique comments. Key themes of comments: 70 in relation to rest/break areas, 66 in relation to support for staff, 27 relating to working from home, 24 relating to management, 14 relating to staffing, and 22 in relation to training. Staff requesting adequate areas to rest and take breaks is still a notable theme through the comments.					
1.1 Never Event Committee: Quality Indicator: OF Data Quality RAG: **Blue**	0 Never Events **2021/22 Outturn 0**	0	●	Year to Date 0	●		N/A
1.6 Safety Alerts Committee: Quality Indicator: OF Data Quality RAG: **Green**	There will be 0 Safety Alert breaches **2020/21 Outturn 0**	0	●	Year to date there have been no CAS safety alerts incomplete by deadline.	●		N/A
3.1 MH Patient Survey ●	Positive Results from CQC MH Patient Survey	The 2021 survey results have now been published. 1,250 EPUT clients were invited to take part, and 324 responded. This is a response rate of 27%. EPUT achieved “about the same” for 26 questions in the 2021 survey when compared with other Trusts. 2 questions scored “somewhat worse than expected”. These 2 questions fell under the NHS Talking Therapies domain.					

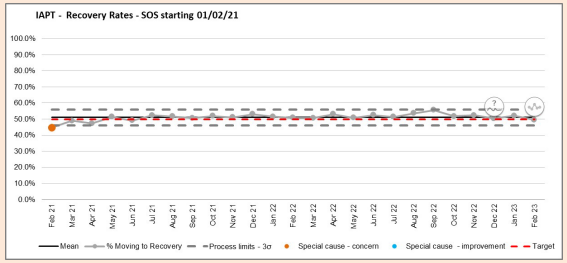
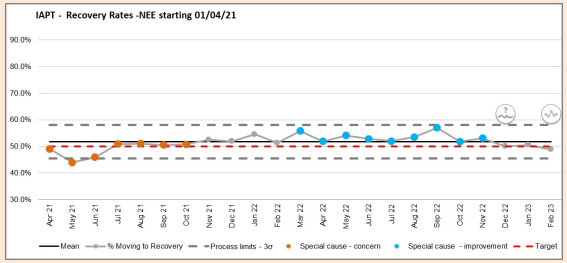
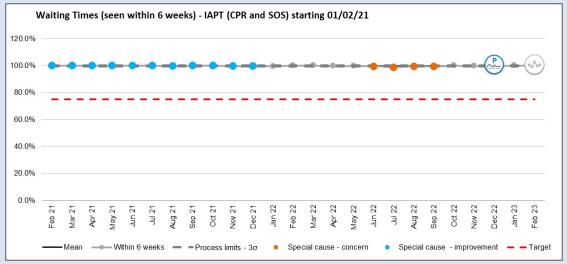
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Indicator: Oversight Framework Data Quality RAG: **Green**							
3.3 Patient FFT Committee: Quality Data Quality RAG: **Green**	3.3.1 Patient FFT MH response in line with benchmark Target = 88% (Adult Acute 2020 Benchmark 88%)	94.4%	●	I Want Great Care was implemented across the Trust from 23rd January 2022. We are awaiting further FFT configuration	●	94.4% for the positive score in February. This is currently not split between MH and CHS	
	3.3.2 Patient FFT CHS response in line with benchmark Target = 96%				●		
2.8.1 Mental Health Discharge Follow up Committee: Quality Data Quality RAG: **Blue**	2.8.1 Mental Health Inpatients will be followed up within 7 days of discharge **Target 95% Benchmark 98%** (Adult Acute 2020 Benchmark 98%)	95.5%	●	Above Target = Good 	●	85 / 89 discharges followed up within 7 days in February Discharge follow ups form part of EPUT's "10 ways to improve safety" initiative.	
2.4 MH Patients in Settled	We will support patients to live in settled accommodation	84.8%	●	Above Target = Good	●		N/A

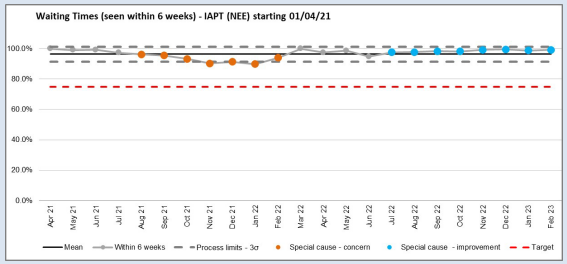
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Accommodation Committee: Quality Indicator: Oversight Framework Data Quality RAG **Green**	**Target 70% (locally set)**						
2.5 MH Patients in Employment Committee: Quality Indicator: OF Data Quality RAG: **Green**	We will support patients into employment **Target 7% (locally set)**	39.1%		Above Target = Good 			N/A
1.8 Incident Rates Committee: Quality Data Quality RAG: **Amber**	Incident Rates will be in line with national benchmark **>44.33** Benchmark	52.5		Above Target = Good 			

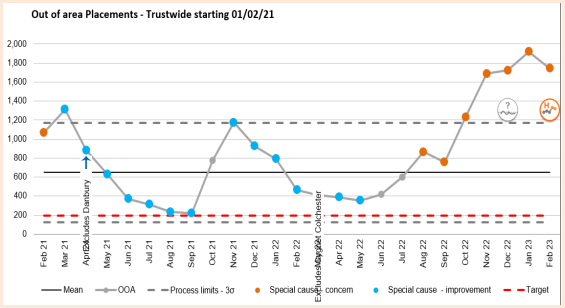
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
1.15 Admissions to Adult Facilities of under 16's Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	0 admissions to adult facilities of patients under 16	0	●	Zero admissions in February	N/A		N/A

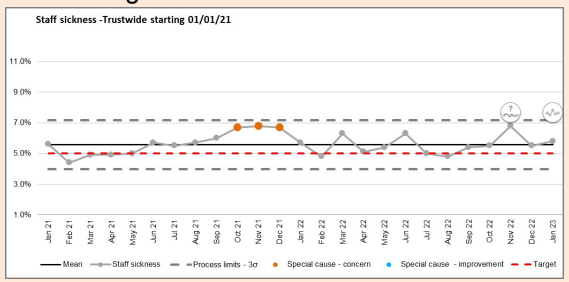
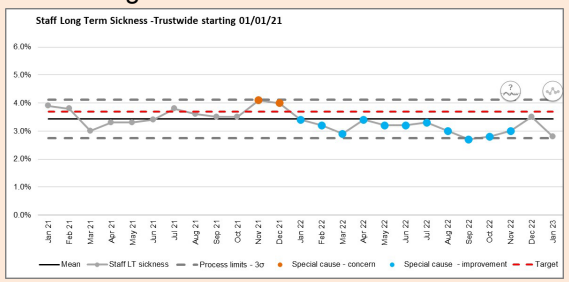
Click here to return to Summary

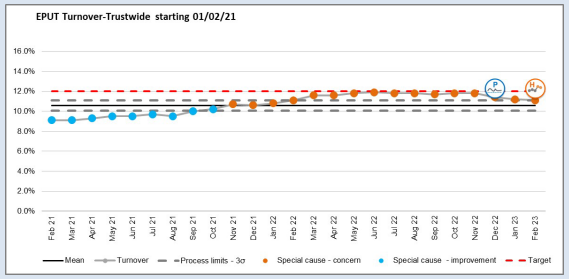
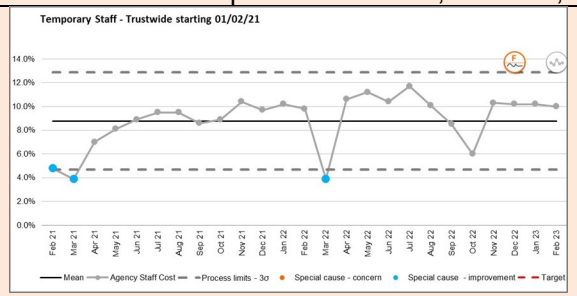
Operational Metrics							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.6 First Episode Psychosis Committee: Quality Data Quality RAG: **Green**	All Patients with F.E.P begin treatment with a NICE recommended package of care within 2 weeks of referral **Target 60%**	87.1%	●	Above Target = Good 	●	February performance represents: 27 / 31 patients. Southend CCG below target at 50.0%	N/A
2.2.1 Data Quality Maturity Index Committee: FPC Data Quality RAG: **Green**	2.2.1 Data Quality Maturity Index (MHSDS Score – Oversight Framework) **Target 95%**	96.7%	●	Above Target = Good 	●	Latest published figures are for November 2022. A Data Quality Improvement Plan for Mental Health has been produced to identify the areas of the MHSDS that we can improve upon.	
2.16.4/5/6 IAPT Recovery Rates Committee: FPC	2.16.4 IAPT % Moving to Recovery CPR **Target 50%**	51.9%	●	Above Target = Good 	●		

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: National Data Quality RAG: **Green**	2.16.5 IAPT % Moving to Recovery SOS **Target 50%**	49.5%	●	Above Target = Good 	●		
	2.16.6 IAPT % Moving to Recovery NEE **Target 50%**	48.8%	●	Above Target = Good 	●		
2.16.7/8 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.7 % Waiting Time to Begin Treatment – 6 weeks CPR & SOS **Target 75%**	100%	●	Above Target = Good 	●		

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.16.8 % Waiting Time to Begin Treatment – 6 weeks NEE **Target 75%**	99.3%	●	Above Target = Good 	●		
2.16.9/10 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.9 % Waiting Time to Begin Treatment – 18 weeks CPR & SOS **Target 95%**	100%	●	Above Target = Good	●		
	2.16.10 % Waiting Time to Begin Treatment – 18 weeks NEE **Target 95%**	100%	●	Above Target = Good	●		
4.5 Out of Area Placements ●	February has seen a positive reduction in out of area bed days from 1,919 to 1,743 (excluding Danbury & Cygnet). There were 23 new clients were placed OOA (22 Adult & One PICU) in February, and following the repatriation of 28 (27 Adult & one PICU), there were 63 remaining (57 Adult, one Older Adult & four PICU) OOA at the end of the month. This continues to be higher than previous years. The Trust continues to hold contracts with the Priory (Danbury ward) and Cygnet Colchester. NHSE/I confirmed these placements are to be classed as appropriate and are therefore not included in these numbers. In addition, the Trust is proposing an expansion of appropriate OOA beds, which is in its early stages of planning.						

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Amber**	The Trust continues to hold itself accountable to it's overarching Flow action plan, which incorporates all actions from the purposeful admission programme, the GIRFT improvement programme, the out of area elimination & sustainability plan, the 85% occupancy ambition and the improvement trajectories plan. This continues to be led by the Associate Director of Flow and Operational Transformation and is regularly monitored and escalated through Care Unit meetings, Accountabilty Framework meetings, and the Finance & Performance Committee. Home treatment teams continue to offer alternatives to admission and enhanced community intervention to support individuals pending admission. The Trust continues its work to improve inpatient flow and through December 22 – April 23 NHSE are holding a Mental Health discharge challenge, which requires all providers to self assess against 10 key priorities to promote patient flow. The Trust continues to implement high impact changes from this MH discharge challenge.						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by end of March 2023**	1,743 Days	●	Below Target = Good 	●	Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Data excludes patients placed on Danbury Ward & Cygnet Colchester	Mar 2023

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3.1 Staff Sickness Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Blue**	5.3.1 Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**	5.8%		Below Target = Good 		The sickness figures are reported in arrears to allow for all entries on Health Roster. Sickness has increased again this month, but is in line with usual seasonal trends. National data October 2022: The overall sickness absence rate for England was 5.6%. This is slightly higher than September 2022 (5.0%) and is slightly lower than October 2021 (5.7%). EPUT reported lower than the England average for this period at 5.3%. Anxiety/stress/depression/other psychiatric illnesses is consistently the most reported reason for sickness absence in October (22.4%). This has decreased slightly since September 2022 (24.9%).	
	5.3.2 Long Term Sickness Absence below 3.7% **Target 3.7%**	2.8%		Below Target = Good 	N/A		

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.2.2 Turnover Committee: FPC Data Quality RAG: **Green**	5.2.2 Staff Turnover (Benchmark 2020 MH 12% / 2017/18 CHS 12.1%) **OF Target TBC** **Target <12%**	11.1%		Below Target = Good 		Special Cause of concerning nature of higher pressure due to higher values. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.	N/A
5.7.3 Temporary Staffing (Agency) Committee: FPC Indicator: Oversight Framework Indicator Data Quality RAG: **Green**	The Trust maintains a temporary (agency) staff usage of 10.2%. The Operations and Medical directorates continue to have the highest spend on agency staff. Recruitment and HR Business Partners continue their work with managers on recruitment strategy and updates on usage is provided to them on a monthly basis through Care Group and Accountability Framework meetings. Workforce Implementation Groups are also being established throughout each Care Group to strategise and implement actions to improve recruitment, retention, and reduce temporary staff usage.						
	5.7.3 Proportion of temporary Staff (Provider Return) No Oversight Framework Target	10.0%			N/A	The Operations and Medical directorates continue to have the highest spend on agency staff.	
5.5 Staff Survey		The 2022 Staff Survey launched on the 22nd September 2022 and has now closed.					

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	5.5 Outcome of CQC NHS staff survey					This year the biggest change was bank only workers being able to participate. The results of the survey will be produced in spring 2023. **<u>Information from the 2021 Staff Survey</u>** The Staff Survey ran from September to November 2021. This year saw the biggest change in how results were formalised. The themes have been aligned to the People Promise which means in some areas we are unable to compare results against previous years. The Trust was measured against nine themes in the 2021 Survey. EPUT scored above average in three themes, in line with average on three themes, and below average against three themes. **Actions:** • Internal Communications Campaign to share results after embargo is lifted. This is to be a regular item moving forward to ensure engagement and staff feedback is a continuous topic and agenda item at EPUT. A clear focus on 'you asked, we delivered'. • Focus groups with staff to understand the survey results co-create solutions/ actions to tackle from areas of focus below, share good practise and work on improvements in their local areas. • Focus groups to support with the development of a trust wide action plan. • Update to Engagement Champions with a focus on their role in sharing results and supporting with 'you asked, we delivered'.	

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M11** Perf	RAG	**Trend**	**Nat** RAG	**Narrative**	**Recovery Date**

Areas of Focus:

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

Highlights of each theme:

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

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

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

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

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

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				

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

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

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

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

SECTION 5 - SAFER STAFFING SUMMARY

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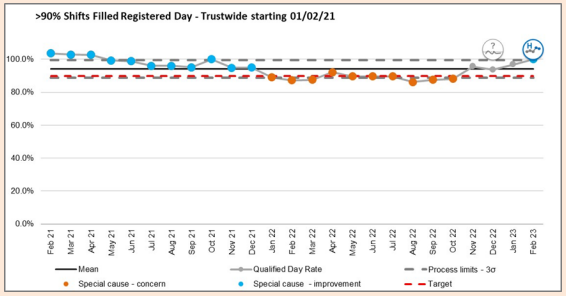
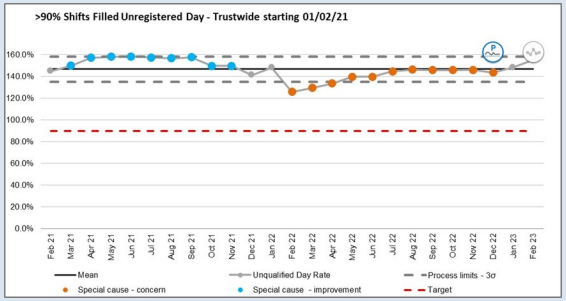
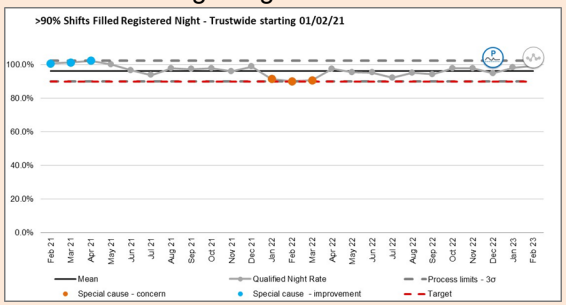
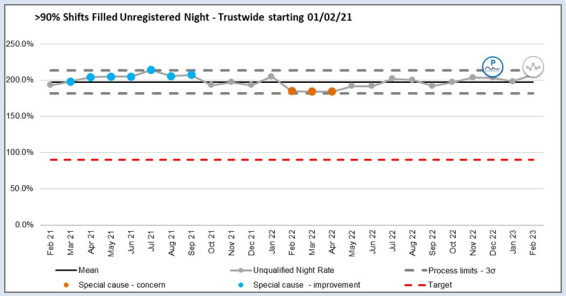
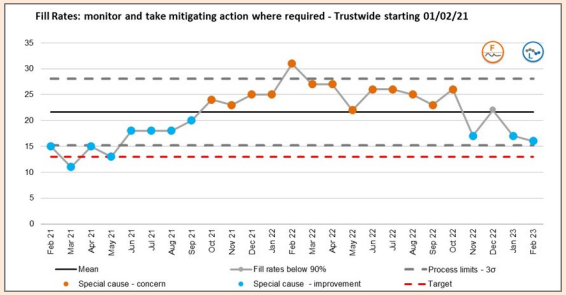
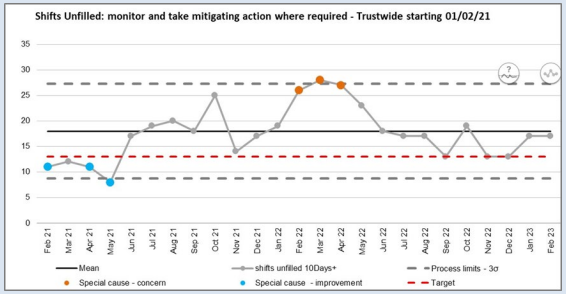
Safer Staffing							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards. Safe staffing performance continues to be monitored by the Quality SMT and Quality Committee.							
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	100.0%		Trend below target 		The following wards were below target in February: Adult: Ardleigh, Finchingfield, Chelmer, Galleywood, Gosfield Adult Assessment: Peter Bruff CAMHS: Longview, Larkwood CHS: Cumberlege Centre Specialist: Alpine	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	155.2%		Trend above target = good 		The following wards were below target in February: Adult: Finchingfield, Galleywood CHS: Cumberlege, Poplar SMH Specialist: Rainbow	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Qualified Staff 	We will achieve >90% of expected night time shifts filled	99.5%		Trend above target = good 		The following wards were below target in February: Adult: Ardleigh, CHS: Cumberlege CAMHS:, Larkwood, Longview Nursing Home: Clifton Lodge, Rawreth Court Specialist: Rainbow Older: Beech	N/A
Night Un-Qualified Staff 	We will achieve >90% of expected night time shifts filled	207.5%		Trend above target = good 		The following wards were below target in February: CHS: Beech, Cumberledge	N/A
Fill Rate 	We will monitor fill rates and take mitigating action where required	16		Below Target = Good 	N/A	The following wards had fill rates of <90% in February: Adult: Ardleigh, Gosfield, Finchingfield, Galleywood, Chelmer Adult Ass: Peter Bruff CAMHS: Larkwood, Longview Nursing Homes: Rawreth Court, Clifton Lodge Specialist: Alpine, Rainbow CHS: Cumberledge, Poplar, Beech	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M11**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
						Older: Beech(Rochford)	
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	17		Below Target = Good 	N/A	The following 17 wards had more than 10 days without shifts filled in February: Adult: Ardleigh, Willow, Chelmer, Finchingfield, Gosfield, Cherrydown Adult Assessment: Peter Bruff CAMHS: Longview, Larkwood, Poplar(Rochford) Older: Henneage, Ruby, Tower PICU: Hadleigh Unit Specialist: Alpine, Edward House CHS: Avocet	N/A

Fill Rates

	Day Rates		Night Rates		Day Rates		Night Rates		Day Rates		Night Rates		Day Rates		Night Rates	
	Nov-22				Dec-22				Jan-23				Feb-23			
	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED
TARGET >90%																
MH ADULT ACUTE																
ARDLEIGH WARD	60.8%	122.5%	74.7%	134.0%	45.8%	113.2%	62.5%	127.8%	47.6%	109.4%	58.9%	120.6%	53.4%	115.9%	82.2%	108.2%
CEDAR	108.5%	249.6%	107.0%	241.7%	102.9%	225.2%	107.6%	244.3%	119.6%	230.9%	118.7%	267.4%	137.0%	216.7%	111.7%	261.0%
WILLOW	115.3%	198.7%	108.2%	301.9%	108.0%	251.9%	97.3%	236.7%	115.5%	218.0%	105.2%	202.1%	115.9%	217.3%	108.0%	217.2%
CHELMER WARD	94.4%	365.5%	96.2%	633.0%	85.2%	367.3%	91.0%	658.3%	94.4%	398.9%	97.6%	746.6%	83.9%	491.3%	93.8%	911.9%
FINCHINGFIELD WARD	52.8%	82.9%	200.1%	177.1%	36.2%	77.1%	177.3%	201.7%	37.5%	76.7%	195.8%	180.3%	40.1%	86.0%	192.0%	186.8%
GALLEYWOOD WARD	53.8%	82.1%	98.3%	99.2%	63.5%	53.9%	93.3%	83.3%	58.5%	57.2%	99.9%	63.4%	59.4%	71.5%	99.9%	130.7%
GOSFIELD WARD	99.9%	230.0%	106.5%	412.4%	115.5%	234.5%	106.5%	428.3%	84.0%	234.7%	121.5%	450.0%	85.4%	264.8%	125.5%	474.9%
KELVEDON	117.5%	250.5%	108.7%	319.6%	142.3%	237.7%	114.5%	301.6%	144.1%	228.5%	135.5%	300.0%	169.3%	244.3%	136.4%	359.1%
STORT WARD	106.8%	215.8%	106.9%	449.4%	111.0%	226.3%	109.9%	446.7%	105.6%	190.5%	110.2%	322.6%	107.9%	187.5%	94.9%	318.0%
CHERRYDOWN	103.6%	319.0%	99.9%	463.3%	101.3%	336.5%	101.1%	442.8%	104.6%	345.4%	98.4%	485.2%	116.0%	353.3%	101.6%	473.2%
MH ASSESSMENT UNIT																
BASILDON MHAU	98.6%	346.0%	103.6%	411.9%	126.0%	345.6%	106.1%	418.5%	122.4%	462.2%	106.8%	550.4%	133.3%	478.4%	117.5%	544.8%
PETER BRUFF UNIT	68.3%	246.8%	98.4%	314.4%	63.9%	254.7%	98.4%	283.0%	69.4%	239.0%	101.6%	246.2%	73.1%	154.1%	118.9%	154.7%
MH OLDER ADULT																
BEECH (ROCHFORD)	97.5%	180.4%	106.3%	353.8%	97.7%	180.2%	84.9%	396.0%	98.6%	177.6%	77.6%	386.9%	93.8%	164.2%	73.3%	349.7%
GLOUCESTER	101.8%	112.0%	100.1%	138.6%	111.2%	131.2%	100.0%	183.1%	105.1%	110.7%	100.1%	152.7%	112.3%	149.8%	107.1%	215.8%
HENNEAGE WARD	70.5%	270.4%	93.4%	442.6%	69.0%	257.1%	84.8%	393.0%	78.5%	298.6%	96.7%	509.7%	136.4%	322.9%	99.4%	606.4%
KITWOOD WARD	120.3%	170.0%	143.3%	201.7%	122.1%	173.1%	138.4%	206.5%	134.5%	184.8%	148.4%	214.5%	96.2%	206.2%	142.1%	200.0%
MEADOWVIEW	90.1%	219.5%	99.9%	294.4%	100.6%	196.1%	100.0%	277.9%	119.5%	168.2%	100.1%	259.0%	115.8%	215.5%	98.2%	356.0%
RODING WARD	98.8%	140.1%	153.0%	115.0%	105.9%	139.6%	154.8%	140.3%	121.4%	175.9%	145.2%	173.0%	100.5%	156.3%	150.0%	128.8%
RUBY WARD	82.1%	249.6%	190.0%	171.5%	72.6%	234.4%	193.4%	182.0%	79.5%	379.0%	190.3%	330.8%	109.7%	456.4%	200.5%	473.4%
TOPAZ WARD	130.9%	126.6%	100.0%	450.3%	148.7%	153.3%	103.4%	465.7%	144.9%	146.8%	105.1%	482.8%	167.6%	151.1%	102.4%	483.5%
TOWER	112.8%	149.2%	83.6%	170.7%	106.4%	150.5%	62.4%	172.9%	94.4%	152.8%	60.2%	177.6%	104.1%	172.8%	92.9%	174.8%
MH ADULT PICU																
CHRISTOPHER UNIT	155.9%	182.4%	96.5%	237.7%	158.8%	160.4%	97.4%	201.7%	173.4%	141.2%	98.3%	174.2%	153.2%	126.3%	99.9%	183.2%
HADLEIGH PICU	119.7%	282.3%	135.4%	521.0%	108.7%	299.1%	112.8%	510.9%	101.0%	219.4%	108.2%	408.5%	153.2%	126.3%	105.2%	491.0%
MH ADULT REHAB																
IPSWICH ROAD	95.4%	95.6%	107.9%	197.0%	93.5%	94.2%	99.0%	187.5%	102.5%	98.2%	103.9%	200.0%	119.7%	100.0%	100.6%	196.4%
CAMHS SERVICES																
LARKWOOD	89.3%	198.6%	70.0%	151.1%	77.4%	171.2%	62.3%	150.7%	97.4%	132.6%	65.2%	103.3%	86.9%	208.7%	58.3%	115.5%
LONGVIEW	90.8%	162.8%	69.4%	248.6%	70.1%	165.8%	65.3%	258.1%	67.9%	167.4%	78.6%	246.7%	65.7%	219.7%	71.2%	349.8%
POPLAR	99.0%	236.2%	95.0%	277.1%	101.9%	234.0%	91.1%	301.7%	99.7%	251.0%	98.6%	283.8%	103.7%	77.0%	102.8%	190.5%

	Day Rates		Night Rates		Day Rates		Night Rates		Day Rates		Night Rates		Day Rates		Night Rates	
	Nov-22				Dec-22				Jan-23				Feb-23			
	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED
TARGET >90%																
SPECIALIST SERVICES																
EDWARD HOUSE	81.7%	156.2%	100.0%	142.6%	82.3%	156.1%	103.3%	133.1%	89.9%	157.2%	100.0%	144.4%	100.0%	143.1%	103.8%	140.6%
ALPINE	98.7%	131.6%	92.9%	104.6%	83.2%	104.9%	78.0%	110.6%	98.9%	107.5%	105.1%	108.3%	88.6%	101.7%	96.6%	103.8%
AURORA	99.4%	97.5%	100.0%	100.0%	110.1%	89.2%	100.0%	103.6%	110.5%	99.5%	103.5%	115.2%	101.9%	99.7%	96.4%	114.3%
CAUSEWAY	137.1%	128.6%	99.5%	114.1%	113.4%	117.3%	91.2%	108.2%	122.8%	132.1%	97.3%	116.1%	161.0%	134.0%	96.1%	126.6%
DUNE	98.3%	123.3%	95.2%	103.0%	95.0%	135.6%	100.1%	116.1%	111.7%	112.0%	101.8%	98.3%	98.2%	115.1%	100.1%	101.6%
FOREST	136.2%	112.9%	88.2%	96.7%	138.9%	105.3%	91.4%	93.6%	128.1%	121.3%	102.1%	108.2%	117.3%	125.2%	96.8%	112.1%
FUJI	97.9%	213.2%	102.6%	201.8%	85.8%	204.0%	92.9%	201.1%	95.0%	201.0%	91.8%	190.6%	96.6%	214.6%	96.4%	211.8%
LAGOON	94.4%	111.1%	97.1%	108.6%	92.0%	133.9%	104.0%	144.4%	92.2%	141.7%	110.3%	144.0%	96.8%	130.2%	94.3%	145.5%
ROBIN PINTO UNIT	144.2%	114.4%	101.7%	220.3%	130.2%	111.0%	106.5%	238.7%	140.0%	143.5%	100.0%	305.2%	136.5%	154.5%	112.5%	273.6%
WOODLEA CLINIC	131.7%	134.0%	142.9%	142.1%	124.2%	137.5%	183.9%	122.8%	119.4%	131.2%	193.5%	104.9%	112.0%	133.6%	200.0%	100.0%
RAINBOW UNIT	105.4%	92.7%	51.7%	118.2%	89.9%	48.5%	48.4%	68.2%	96.7%	58.1%	51.6%	72.0%	101.2%	88.4%	49.9%	112.8%
LEARNING DISABILITY SERVICES																
HEATH CLOSE	94.1%	133.3%	96.4%	110.0%	97.5%	122.8%	102.3%	136.6%	94.7%	120.4%	99.9%	117.9%	102.4%	116.7%	101.4%	112.7%
NURSING HOMES																
CLIFTON LODGE	126.6%	114.0%	93.6%	228.9%	114.2%	115.5%	88.7%	238.7%	108.7%	124.1%	91.9%	234.1%	120.1%	129.4%	89.3%	241.9%
RAWRETH	96.6%	94.9%	53.5%	192.4%	90.9%	87.6%	53.6%	192.0%	121.0%	114.5%	51.8%	111.7%	117.4%	118.1%	53.8%	110.5%
COMMUNITY HEALTH SERVICES																
CUMBERLEGE ICC	55.9%	54.5%	65.5%	79.3%	64.9%	54.6%	64.5%	81.2%	63.1%	57.7%	65.6%	80.6%	67.2%	52.9%	65.5%	79.9%
AVOCET	113.9%	87.0%	98.3%	116.1%	124.2%	83.9%	99.8%	110.8%	109.4%	114.3%	97.3%	152.5%	98.4%	120.5%	95.2%	160.3%
BEECH WARD	93.1%	88.8%	98.3%	86.1%	87.2%	86.5%	98.7%	84.3%	96.9%	97.5%	101.6%	86.8%	94.3%	92.7%	99.6%	88.1%
PLANE	100.7%	102.2%	106.7%	104.4%	107.0%	118.3%	100.0%	102.1%	103.2%	115.1%	96.8%	98.9%	101.0%	106.7%	100.0%	99.7%
POPLAR UNIT	96.9%	76.3%	101.7%	119.5%	87.1%	73.3%	98.6%	115.7%	94.1%	75.8%	98.4%	128.8%	103.7%	77.0%	98.5%	115.4%

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SECTION 5 – CQC

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There are no Trust CQC Action Plans open. EPUT continues to await feedback on the below inspections.

RAG	Ambition / Indicator	Narrative
CQC Actions	There will be 0 CQC actions past timescale	**Core Services Inspection** The CQC completed an unannounced inspection of 6 of our core services, PICU, Acute Adults, Crisis, Older Adults, Substance Misuse and MH Community, between 22 & 24 November 2022. The Trust is awaiting the draft feedback report following the inspection, which will undergo factual accuracy checks prior to publication on the CQC website. **Well Led Inspection** The CQC commenced EPUT Well Led inspection on Monday 16 January, continuing until Friday 27 January 2023. No formal escalations or feedback has been received to date. The Trust is awaiting the draft feedback report following the inspection, which will undergo factual accuracy checks prior to publication on the CQC website.

SECTION 6 - Finance

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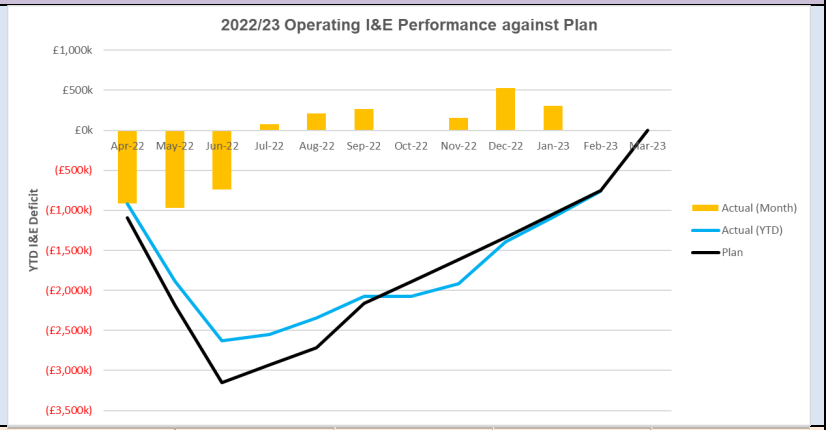
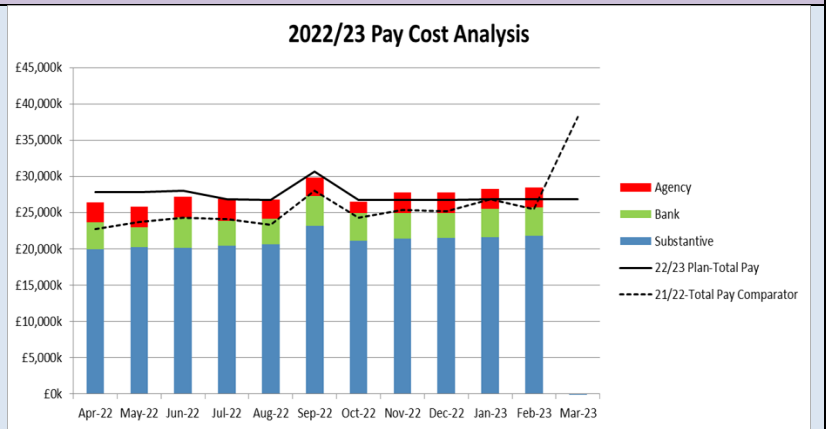
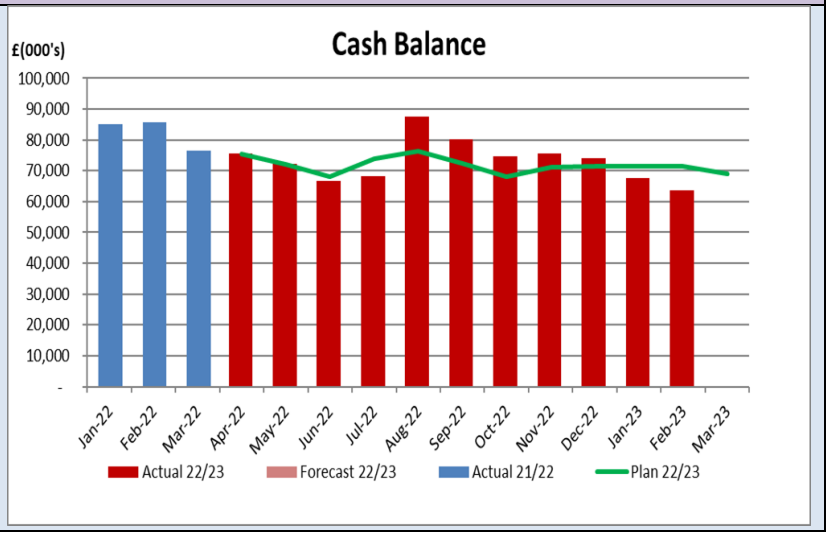
<table>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position</th><th>Trend</th></tr>
<tr><td>Income and Expenditure</td><td>Income and Expenditure</td><td>During the period the Trust reported a £0.3m surplus, in-line with plan. The Year to Date position is a (£0.8m) deficit also consistent with plan. The Trust continues to forecast a year end breakeven position and delivery of its plan.</td><td> 
</td></tr>
<tr><td>Efficiency Programmes</td><td>Efficiency programme</td><td>The Year to Date position is £12.1m against the plan of £15.1m, £3m behind plan.</td><td>M11 22-23 Table
<table>
<tr><th></th><th>Efficiencies £000</th><th>YTD Plan £000</th><th>YTD Delivery £000</th><th>YTD Variance £000</th></tr>
<tr><td></td><td>£000s</td><td>£000s</td><td>£000s</td><td>£000s</td></tr>
<tr><td>Identified</td><td>7,087</td><td>5,575</td><td>3,106</td><td>(2,469)</td></tr>
<tr><td>Unidentified</td><td>10,203</td><td>9,542</td><td>8,995</td><td>(547)</td></tr>
<tr><td>Total</td><td>17,289</td><td>15,117</td><td>12,101</td><td>(3,015)</td></tr>
</table></td></tr>
</table>

RAG	Ambition / Indicator	Position	Trend
Temporary Staffing	Temporary Staffing Costs	In month temporary staffing was £6.7m (£6.6m in M10); bank spend £3.9m (M10 £3.9m) and agency spend £2.8m (M10 £2.8m). Increased deployment of International Recruitment nurses to operational areas continues to happen and is assisting in maintaining reduced temporary staffing costs	
Maximising Capital Resources	Maximising Capital Resources	The Trust has incurred capital expenditure of £10.2m at M11 and is recording an underspend of £1.1m against the reforecast plan. The Trust has agreed the year end forecast with System partners which will enable overall delivery of the System capital plan.	

Capital

	Annual Plan	YTD Original Plan			YTD Reforecast Plan		
		Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000
2021/22 Carry Forward	2,319	2,319	1,172	1,147	1,578	1,172	406
Business As Usual	3,873	3,927	2,231	1,696	2,775	2,231	544
Strategic Schemes	5,064	4,551	4,777	-225	4,932	4,777	155
Charge against Allocation	**11,256**	**10,797**	**8,180**	**2,617**	**9,285**	**8,180**	**1,105**
Critical Cybersecurity	39	39	39	0	33	39	-7
High Dependency Units	0	0	303	-303	350	303	48
Mental Health ED	0	0	1,237	-1,237	1,237	1,237	0
The Lakes - HBPOS	0	0	284	-284	0	0	0
New Leases (fleet)	877	877	96	781	0	96	-96
PFI Residual Interest	113	104	104	0	104	104	0
Net CDEL	**12,285**	**11,817**	**10,242**	**1,575**	**11,008**	**9,959**	**1,050**
Variance (%)				13%			10%

RAG	Ambition / Indicator	Position	Trend
Cash Balance	Positive Cash Balance	Cash balance as at the end of M11 was £63.5m against a plan of £71.5m, £8m below plan. The variance includes the timing issues associated with receipt of capital funding which will now be received in M12 and not in M11 as planned. The Trust has £20m invested with the National Loans Fund on a rolling basis and to date has earned interest of £1.4m.	

END

		Agenda Item No: 7b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 March 2023**

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

Purpose of the Report		
This report provides a summary of key 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.

This report is the first Committee Chair's Report and aims to streamline the reporting process and ensure consistency across all Standing Committees of the Board of Directors.

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.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main report.

Lead
Janet Wood, Chair of Audit Committee Loy Lobo, Chair of Finance & Performance Committee Manny Lewis, Chair of People, Equality & Culture Committee Dr. Rufus Helm, Chair of Quality Committee Professor Sheila Salmon, Chair of Board Safety Oversight Group

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Agenda Item: 7b
Board of Directors Part 1
29 March 2023

COMMITTEE CHAIR'S REPORT
MARCH 2023

1.0 INTRODUCTION AND PURPOSE OF THE REPORT

The Board of Directors regularly delegates authority to the Standing Committees in line with Trust 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 identified issues.

This report is the first combined Chair's Exception Report and aims to streamline the reporting process and ensure consistency across all Standing Committees of the Board of Directors.

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

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

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

2.0 AUDIT COMMITTEE

Chair of the Committee:	**Committee meetings held:**
Janet Wood, Non-Executive Director	16 March 2023

Agenda Item	**Key Assurance Items**	**Alert/ Assurance/ Action/ Information**

Internal Audit and Local Counter Fraud Services (LCFS)	• Audits finalised
	  ○ National cost collection (substantial assurance
	  ○ Estates and facilities performance (moderate assurance)
	• Draft Fraud Functional Standards – Green rating overall with managing conflict of interests moving from Amber to Green
	• Assurance that handover arrangements are in place for move to new provider in April 2023
		Assurance / Information

External Audit	• 2022/23 Audit Plan presented, cyber incident, IFRS 16 (leases) and Independent Inquiry extended timescale identified as new audit risks • Assurance of year end capacity to achieve deadlines – EY and internally	Information
Cyber Security	• Assurance on the management of Strategic Risk 6 – Cyber Security – no new risks were identified	Assurance
Freedom to Speak Up/Whistleblowing	• Annual assurance report on effectiveness of arrangements.	Assurance
Standing Items	• Losses and special payments totalling £43K noted • Competitive quotation waivers totalling £2,087K (#40) noted (details of each scrutinised) • Write offs/impairments totalling £34K noted	Information
Committee Housekeeping	• Annual review of Terms of Reference with a few minor changes to be recommended to Board as part of the Committees annual report. • Self-Assessment checklist completed • 2023/24 work plan approved	Information
Governance Update	• Assurance report on governance arrangements, noting that the Quality Committee review continued to be delayed (timeline end of April ’23) and the risk management electronic system decision to be made (March ’23).	Alert

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

3.0 FINANCE & PERFORMANCE COMMITTEE

Chair of the Committee:	**Committee meetings held:**
Loy Lobo, Non-Executive Director	23 February 2023 23 March 2023

Agenda Item	**Key Assurance Items**	**Alert/ Assurance/ Action/ Information**
Quality & Performance Report (Feb/Mar)	• It was noted the Trust has a good grip on clients waiting for Psychology, with DBT and STEPPS groups commencing which reduces waits. A robust risk review program is in place for those waiting and all clients receive regular contact. • The committee noted all clients waiting over 78 weeks within the Lighthouse Children's Centre now all have appointments booked before the end of April 2023. The validation of data received from MSEFT is almost complete and our RTT reporting will be robust once reporting begins from the new financial year. • Members noted progress against out of area placements and average length of stay. The Trust has appointed a new Director of Operational Performance who provided assurance of a forward thinking approach to manage flow and capacity within inpatient services. Twice daily sitrep calls remain beneficial and new clinically led MDT's are in place to review the length of stay of every inpatient.	Assurance

4.0 PEOPLE, EQUALITY & CULTURE COMMITTEE (PECC)

Chair of the Committee:	Committee meetings held:
Manny Lewis, Non-Executive Director	23 February 2023

Agenda Item	Key Assurance Items	Alert/ Assurance/ Action/ Information
Time to Care Programme	The Committee received an update on the Time to Care Programme, noting the following progress: • Ongoing engagement with staff, patients and families • New ward staffing approach, data analysis and 1st drafting of the staffing model • Draft role profiles for new / redesigned roles • Review of the recruitment process • Launch of the Ward Manager Development Course, with module 1 completed in December 2022 • Benefits realisation plan • Time To Care learning and methodologies captured And the next steps: • Staffing model refinement and implementation planning • Integration of plans into the operational and 5-year plans • Collaborative approach to implementation and benefits monitoring. • Continuation of engagement with key groups (EPUT staff, Patient Safety Leads and Patient Family and Carer Involvement Group, ICS colleagues and regulators).	Assurance Link to Risk R2: People
Workforce Dashboard	The Committee received an overview of the workforce dashboard, noting: • An improving picture on sickness absence (5.22% in November ’22 compared to 5.53% end of January ’23). • COVID sickness absence continues to have impact. • Assurance that as part of the Just Learning Culture there is a process in place whereby any decision to enter a formal employee relations process are reviewed by representatives of the Ethnic Minority Network and for professional staff by the clinical lead.	Assurance Link to WRES and WDES Data

Pharmacy – Staffing Progress	Dr Hilary Scott, Director of Pharmacy attended the meeting to provide an update on Pharmacy Services, noting: • June 2022 investment agreed to support Pharmacy recruitment and alignment to the Care Unit structure. • The service operating to its business continuity plan for a period of time, with a focus on medicines supply, key clinical input and safety critical work. • Vacancies equating to 25.5 whole time equivalents (WTEs) as at 14 Feb '23, of which 4.0 WTE being at offer stage and interviews pending for a further 11.7 WTE posts. • 13 WTE posts filled with agency and bank staff / shifts (noting the financial implication of utilising agency) • All Band 3 Pharmacy Support Worker post are now filled. • Continuation of review and development of pharmacy roles.	Assurance Link to Risk CRR98 Pharmacy Resource
Recruitment & Retention Update	The Committee received an update on recruitment and retention noting data highlights for 2022: • The recruitment of 192 registered nurses • Loss of 42 registered nurses • Month on month a net position of increasing our registered nurse head count by 12.5 WTE. • 147 nurses gained their NMC registration with the Trust and have chosen EPUT as a place to work and grow. • 210 colleagues finding permanent positions within EPUT, having worked on our bank and expressed an interest in joining us permanently. 2023 Forecast: • Vacancy of 105 WTE for health care assistants with the pipeline in place this will come down to 54 WTE (from a starting position in 2022 of nearly 200 vacancies). • Vacancy of 415 WTE for registered nurses with the domestic pipeline this will come down to 358 WTE, also noted 20 newly qualified nurses joining EPUT. • International nurses are gaining their NMC status on a monthly basis which will decrease the vacancy factor further in 2023. The Committee also noted improvements for the New Induction Pack and a continued focus on retention of staff.	Assurance Link to Risk SR2: People

International Recruitment	The Committee received an update on the International Recruitment Programme noting that the 2022 target had been met and 75% having passes their OSCE exams and 47% having received their NMC registration (pin).	Assurance Link to Risk SR2: People
Workforce Improvement & Planning	The Committee received an update on workforce planning noting the three strategic priorities of workforce planning (Time to Care, Recruitment domestic and international, apprenticeship programmes and local recruitment campaigns); leadership & Management (Ward manager development programme, leadership development programme, coaching, high performing teams development and restorative supervision & trauma informed service); and culture (development of the people and culture strategy including the behaviours framework, EDI framework and staff wellbeing).	Information Link to Risk SR2: People
Emergent and topic issues	The Committee noted that the Here for You Service had been funded for 2023/24.	Information

5.0 QUALITY COMMITTEE

Chair of the Committee	Committee meetings held:
Dr. Rufus Helm	9 February 2023 9 March 2023

Agenda Item	Key Assurance Items	Alert/ Assurance/ Action/ Information
Quality & Performance Scorecard (Feb)	• It is notable that there has been an improvement in safer staff fill rates. Workforce initiatives are underway to improve Psychology service waiting times and the Trust Flow and Capacity Team continues an intensive program of oversight and planning to improve in-patient capacity. • The Committee requested additional measures of service quality be included in the Quality Performance Report. These include reporting of 'I Want Great Care' to ensure the patient experience is clearly understood. For greater assurance on workforce capacity Safe Staffing versus planned staff numbers is to be measured and for clearer oversight of service capacity, community referral 12 week waiting times will be included in the report. • To improve patient safety a significant initiative by the Falls Task and Finish Group is underway to ensure optimal pathways of care are pursued following a patient falls incident.	Assurance / Action
CQC Exception Reports	• Safeguarding visits will allow patients to feedback on whether they feel safe within Trust services, an important element of assurance for the Trust and regulators. • Work is being led by the Trust to better meet the rights of people living with a mental illness. The work focuses on Independent mental health advocates and is being undertaken in partnership with Essex County Council. The aim is to work towards an approach where advocacy is assumed rather than requested.	Information
Oxevision Standard Operating Procedure (SOP) (Feb)	• The Committee received, noted and discussed the Oxevision SOP (action on our CQC improvement plan). It is noted that the SOP is a dynamic tool that will require regular updating as practice and issues of consent develop in response to the deployment of patient observation tools. It is critical that staff feel confident in using the tool, that they are confident in discussing its rationale and in gaining meaningful consent for its use. Also critical is staff awareness that Oxevision is an additional layer of patient observation and does not replace established practice and policy on patient observation. The Committee recommended that in future reviews of the SOP and associated patient and carer information that service users must be included in the review process.	Information / Action

Sub-Committee Assurance Report (Mar)	• Assurance was provided that adherence to the Mental Health Act (MHA) timescales continues to be monitored as a priority. CQC feedback in this area has been satisfactory. The CQC recommended a MHA deep dive, triangulating a range of available data sources as a complimentary assurance exercise to that undertaken by the regulator. The deep dive will be presented to the Committee as soon as available. • One point of notable innovation is the implementation of a swarm huddle within 24 hours of an incident. This will ensure rapid learning and action to reduce risk and improve patient safety, these help ensure staff have a better recollection of what occurred during the incident and provide immediate staff support.	Information
Learning From Deaths Quarterly Overview (Mar)	• The new format was well received by the Committee. The report links across the Trust governance structures including PSIRF, the Learning Partnership Collaborative and the Learning and Oversight Collaborative Sub-Committee. The QC noted that the format also helps build the organisational Culture of Learning ambition. • Recognising the significant importance of the innovative approaches to learning from incidents and deaths, the QC will hold a deep dive development session for members. The QC also requested oversight of the Lessons Learned Bulletin for additional assurance on the format and content of messages being disseminated to staff. • An example of how this approach can be used to drive significant change could come through the Clinical Senate use of data from incidents and best practice to make recommendations on future changes to workforce roles.	Assurance *Full agenda item at Board as per national requirement.*
Board Assurance Framework Action Plan (Mar)	• An Intensive Support Group was held as part of the PSIRF process following a ligature incident. The importance of using this investigative approach was demonstrated when it revealed that the bed was appropriately used, however a more individualised approach understanding the individual risk factors may have helps reduce risk of harm. • Introduction of the Safe Ward Model, which is based on an engagement approach to care rather than a more observational approach. The introduction of the Deputy Directors of Quality and Safety and ensuring that demand and capacity are woven into Time to Care and patient flow initiatives should enable a reduction in the current BAF score.	Assurance Link Risk SR1: Safety

Patient / Family Member Story (Mar)	• A family member's experience of using dementia services for his father. In general the carers experience was positive with particular praise for one of the staff members of the Dementia Team. Areas of improvement included better sign posting of services and explanation in how to get support over bank holidays. The QC recommended that the story be shared with commissioner colleagues to help support improvements in signposting services.	Assurance
Quality & Performance Scorecard (Feb)	• There were some gaps in performance data; however, these are temporary workforce capacity issues associated with the Datix Team rather than systemic operational issues.	Alert
CQC Exception Report (Feb)	• Slippage identified in the CQC action plan associated with the improved electronic functionality of review of rosters to assess excessive working hours. This is a proactive approach where advisory notices are generated to support managers and staff to maintain safe working patterns. In addition, the new safeguarding visits and welfare conversations will be an additional supportive opportunity to help identify why some staff are work excessive hours. • Potential area of risk with CQC regulatory reviews, which will be more risk-based using the data they receive. The Trust needs to be confident that the data reviewed internally matches that seen by the CQC. For assurance, the QC requested that there is a mapping exercise with Power BI data.	Alert / Action
Emergency Preparedness, Resilience & Response (EPRR) Quarterly Report (Feb)	• It is important that there is more focus on business continuity plans and completing any associated actions required for improvement. The QC also noted that feedback had not been provided for the most recent major incident review. The Trust will take steps to ensure internal feedback is available for learning.	Action
Sub-Committee Assurance Report (Mar)	• The report identified some issues with the capacity of staff to actively participate in the sub-committees; however mitigation is in place with practical changes to meeting dates to reduce clashes. • The Committee recommended seeking additional assurance on the re-establishment of the Multi-Professional Learning Group, with a review of governance and lines of reporting.	Action

6.0 RECOMMENDATIONS / ACTION REQUIRED

The Board of Directors is asked to:

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

		Agenda Item No: 7d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 March 2023**

Report Title:	**Safety First, Safety Always Annual Report (Year 2)**					
Executive/ Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Natalie Hammond, Executive Nurse					
Report discussed previously at:	Board Safety Oversight Group (BSOG)					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	Patient safety is the number one priority for the Trust and touches all areas of the organisation. The appended report shows the progress we have made in implementing our strategy, *Safety First, Safety Always.* It demonstrates how we are mitigating risks facing the Trust at all levels – from ward to Board. • Demand for mental health services, locally and nationally (21% increase since 2016). • Impacts of the pandemic on population mental health – for every 1% increase in long-term unemployment, the suicide rate of a population increases by 0.83%. • The increasing complexity of patients' needs alongside the increasing volume of demand. • Lasting operational impact of both the pandemic and of running one of the largest vaccination programmes • The specific impact of the pandemic on some of our safety measures, such as restraint and seclusion • Systemic workforce shortages, with the most significant shortages being in mental health, learning disability and community nursing • Need to increase stakeholder confidence and to show action in response to the Essex Mental Health Independent Inquiry	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		

Describe what measures will you use to monitor mitigation of the risk	

Project reports only:	
If this report is project related please state whether this has been approved through the Transformation Steering Group	N/A

Purpose of the Report		
This report provides the Board of Directors with an update on implementation of the Trust's strategy for patient safety, 2 years after consultation with partners and approval by the Board.	**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 appended report summarises the extensive programme of activity that has taken place across the Trust to support the implementation of the *Safety First, Safety Always* strategy. Improvement in patient safety is led by the Executive Nurse but responsibility for safety sits with every single person in the Trust, from ward level to Board level. As such, the report summarises a wide-ranging programme of activity that has been delivered across the entire Trust and with partners at local, regional and national levels.

Board members are asked to note:

- That significant progress that has been made across many indicators of patient safety, even against a challenging backdrop of exceptional influencing factors.
- The particular successes within physical health and restrictive practice (e.g. 95% reduction in prone restraint), against a backdrop of rising and complex demand and operational challenges.
- The innovations that have rolled out across the Trust – from use of new technologies such as Oxehealth vital signs monitoring to co-production with service users – and the measurable impact these are having.
- The step change we have made in engaging people with lived experience.
- The awards and recognition achieved at organisational level and by individual members of staff.
- That there is more to do build patient, family and stakeholder confidence that EPUT is a safe organisation. We are proud of the hard work and achievements of our staff, but humble in the recognition that there is more to do and that safety never stops.

The Board of Directors should note / discuss:

- Our priorities for Year 3 of the report and beyond, and how we can best work together to achieve these.
- How our data collection and reporting processes may need to evolve to give us the insight we need for assurance and to continue to drive improvement in safety and quality.
- The resources that may need to be made available to deliver both of the above, given the financial constraints the Trust faces next year.

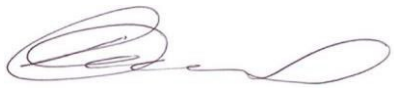
Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

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
Safety Strategy 2 Year Report

Lead
 Natalie Hammond Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

SAFETY FIRST, SAFETY ALWAYS

Essex Partnership University NHS Foundation Trust

TWO YEAR REPORT

EPUT

FOREWORD

We launched our patient safety strategy, *Safety First, Safety Always*, in 2021 with an ambition to provide the safest possible care for our patients.

This commitment applies in all settings, whoever and wherever people receive our care. Our first and most vital priority was to set out and deliver improvements in inpatient care, so that patients and their families can feel assured that they will be well looked after and protected from harm whenever they are in our care.

Our Executive Team and local leadership teams are wholly committed to delivering this vision of making Essex Partnership University Trust (EPUT) the safest possible organisation. This is the agenda that drives everything we do and the evidence shows that is having a real, visible and measurable effect in the organisation.

At the end of the second year of the strategy we must recognise that while there has been progress there is more to do to build the confidence of patients, families and partners.

Our 'Safety First Safety Always' strategy will continue to adjust to reflect learning within the organisation alongside recommendations arising from the Essex Mental Health Independent Inquiry (EMHII) which commenced in April 2021.

It is also important that we reflect on the successes we have achieved with our staff, patients, communities and partners.

Staff across the Trust have shown extraordinary commitment throughout the pandemic and beyond, giving far more than could be asked of them. Against a backdrop of both unprecedented demand and workforce challenges, staff across the Trust have embraced the *Safety First, Safety Always* message.

Our work has gained national recognition in some areas, including our national award-winning apprenticeship in Clinical Psychology, which is helping to address the workforce challenges of the present and future.

As we move into year 3 of the strategy, there is more to do and we look forward to doing this in collaboration with patients, carers, families and partners to make EPUT the safest possible organisation for delivering patient care.

INTRODUCTION

OUR STRATEGY FOR ENSURING INPATIENT SAFETY

The Safety First, Safety Always strategy was agreed by Trust Board in February 2021, following widespread engagement with Trust staff, Non-Executive Directors, Governors and partners.

The strategy set out our ambition to be an organisation that consistently places patient safety at the heart of everything it does.

We recognised that this could only be achieved through a transformation of culture and an organisation-wide mindset of Safety First, Safety Always. This strategy also reflects our learning from the past and the themes arising from historic incidents over the past 20 years.

We set out five key ambitions and outcomes:

- ☑ **Patients and families feel safe in EPUT's care**
- ☑ **Stakeholders have confidence that EPUT is a safe organisation**
- ☑ **No preventable deaths**
- ☑ **A reduction in Patient Safety Incidents for Investigation (PSII)**
- ☑ **A reduction in self-harm**

This report highlights the progress we have made against the priorities within the safety strategy and against the four priority areas for quality improvement in the Mental Health Safety Improvement Plan.

It also sets out our ambition for the third year of the strategy and beyond to ensure that EPUT is a leader in providing outstanding patient safety and care.

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ESTABLISHING THE CONTEXT

BACKGROUND TO THE STRATEGY AND WHAT WE PLANNED TO ACHIEVE

EPUT

LOCAL AND NATIONAL CONTEXT

Demand for services is rising across the NHS. Government announced an additional £500m in 2021 as part of its Mental Health Recovery Action Plan, but this falls far short of the historic and projected increase in demand. The additional funding represents 4% of national spend on mental health services, whereas there has been a 21% increase in demand since 2016.

COVID-19 has presented significant operational challenges and unknown consequences for future demand on services. The pandemic required us to redirect staff and resources, both directly to administer the vaccination programme across a population of 1.8 million, and to respond to the increased demand on mental health services from the initial outbreak to present.

The end of the pandemic is not the end of its effects. Research shows that a 1% increase in long-term unemployment increases the suicide rate of a population by 0.83%. While the **long-term effects of COVID on mental health** are not yet known, the evidence points to an increase in demand on services that could last up to 18 years, alongside the challenge of a diminishing workforce.

Alongside the pandemic, we have experienced challenges in Child and Adult Mental Health Services (CAMHS), with a cohort of patients with particularly complex needs. Some patients have been deemed suitable for intensive clinical intervention and secure services. This has presented challenges to the good progress that had been made towards reducing the use of restrictive practice, which had otherwise been on a downward trajectory since May 2020.

Staff at EPUT and nationally have made extraordinary efforts during the pandemic and have given more than could have been asked of them. But putting more pressure on staff is not a sustainable solution and there are systemic workforce issues to be addressed in the NHS. There is a national nursing shortage, with the most significant shortages in mental health, learning disabilities and community nursing. We are seeing the effects of this in the form of unprecedented industrial action, which many nurses nationally concerned they do not have the resources to provide acceptable levels of care.

The Trust is working closely with the Essex Mental Health Independent Inquire (EMHII) and is actively identifying learning from past incidents dating back to the year 2000.

Despite these very significant challenges, the outlook is optimistic. We have made very encouraging progress in a number of areas of patient safety and are embedding the learning from successes into good practice and continuous improvement throughout the organisation.

SAFETY AND COVID-19 THE EFFECTS OF THE PANDEMIC

- The Trust redirected significant resources to respond to COVID-19, from the initial outbreak to present day
- We successfully delivered a vaccination programme across a population of 1.8million people, at a time when demand for mental health services was at an all-time high
- We have moved the dial on some of our key safety indicators, despite the pressure of COVID working against them
- At the end of year 1 of the strategy, we reported an 88% reduction in the use of prone restraints since January 2020. Taking into account data up to November 2022, use of prone restraints has now decreased by almost 95%. There was no use of prone restraints across the Trust in September and November 2022
- Other types of physical intervention are a more complicated picture, with the data showing a variable trend. During the pandemic, we often had to move patients to maintain social distancing and to prevent infection. Staff treated each instance of assisting patients between locations as a 'physical intervention' but the majority of these were not restraints in the usual sense. This was done in the context of staff being encouraged to report more and to speak up

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REVIEWING OUR PROGRESS

WHAT WE'VE DELIVERED FOR OUR PATIENTS AND POPULATION

EPUT

5 KEY OUTCOMES

1. Patients and families feel safe in our care
2. Stakeholders have confidence we are safe
3. No preventable deaths
4. A reduction in self-harm
5. A reduction in patient safety incidents

OUTCOME 1: PATIENTS AND FAMILIES FEEL SAFE IN OUR CARE

480%
INCREASE IN LIVED EXPERIENCE AMBASSADORS SINCE 2021

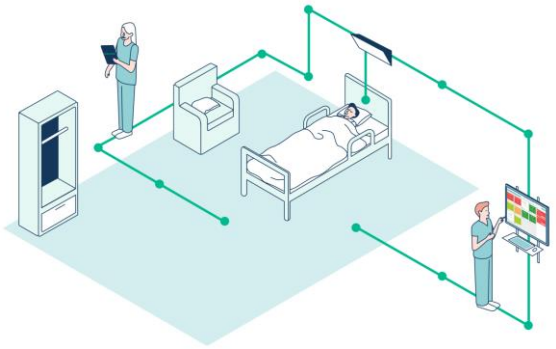
"I THINK OXEVISION MAKES US FEEL VERY SAFE ON THE WARD."
– MENTAL HEALTH INPATIENTS SERVICE USER

Roll out of

iWantGreatCare
Transforming Healthcare

will ensure that the patient voice is heard, understood and acted upon.

"This is the best ward I have been to. The environment is therapeutic. I would be happy to pay for my stay here."
– MENTAL HEALTH INPATIENTS SERVICE USER



"THE TIDE IS FINALLY CHANGING. THANK YOU." – LIVED EXPERIENCE AMBASSADOR

OUTCOME 2: STAKEHOLDERS HAVE CONFIDENCE WE ARE A SAFE ORGANISATION

"OUR RELATIONSHIP WITH EPUT AS A STRATEGIC PARTNER HAS ENABLED US TO ENSURE THAT PATIENT VOICE IS INTEGRAL TO ALL THE DECISION-MAKING" – HEALTHWATCH ESSEX

"THIS WAS A VERY POWERFUL AND PRACTICAL WORKFORCE INITIATIVE WHICH HITS THE PURPOSE OF THIS AWARD ON THE HEAD" – HSJ AWARDS JUDGES' VERDICT

SAFETY SUMMITS ARE BRINGING TOGETHER PARTNERS TO TAKE A WHOLE-SYSTEM APPROACH TO SAFETY, QUALITY AND IMPROVEMENT

WINNER OF THE

FOR HEALTHCARE LEADERS
HSJ
AWARDS

WORKFORCE INITIATIVE OF THE YEAR

The Great British Workplace Wellbeing Series with WELLITY

HERE FOR YOU SERVICE NOMINATED FOR NATIONAL AWARD

OUTCOMES 3&4: NO PREVENTABLE DEATHS REDUCTION IN SELF-HARM

80%

OF PATIENTS WHO HAVE SELF-HARMED SAID THEIR URGE TO DO SO REDUCED AS A RESULT OF A SELF-HARM REDUCTION PILOT PROJECT

94%

OF STAFF SAY THAT OXEVISION ENABLES THEM TO IDENTIFY INCIDENTS THEY MAY NOT HAVE KNOWN ABOUT

"IT'S GOOD TO KNOW THAT OXEVISION CALLS FOR HELP WHEN YOU NEED IT, BUT ALSO WHEN YOU DON'T THINK YOU NEED HELP."
- MENTAL HEALTH INPATIENTS SERVICE USER

Reviewed key themes for learning over a 20 year period. This information has helped to inform our work around preventable deaths and a reduction in self harm

OUTCOMES 5: REDUCTION IN PATIENT SAFETY INCIDENTS

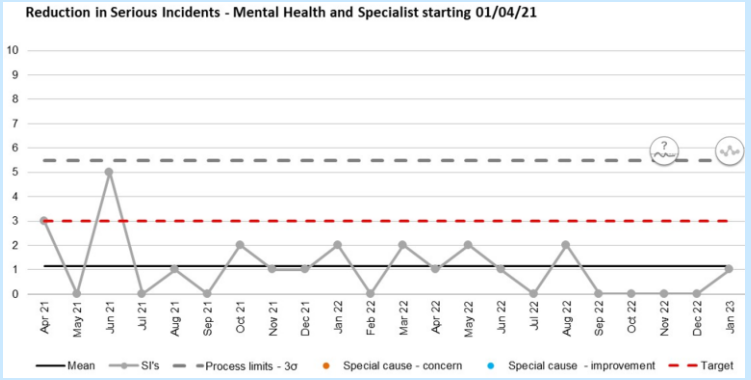
80%
REDUCTION IN SECLUSION INCIDENTS SINCE NOVEMBER 2020

95%
REDUCTION IN USE OF PRONE RESTRAINTS SINCE JANUARY 2020

AS AN EARLY ADOPTER OF PSIRF, WE'RE EMBEDDING LEARNING FROM PATIENT SAFETY INCIDENTS ACROSS THE TRUST – AND SUPPORTING OTHER TRUSTS WITH THEIR IMPLEMENTATION

90%
STAFF STATED THAT OXEVISION HAD ENABLED THEM TO PREVENT A POTENTIAL INCIDENT FROM OCCURRING

A SUSTAINED REDUCTION IN SERIOUS INCIDENTS

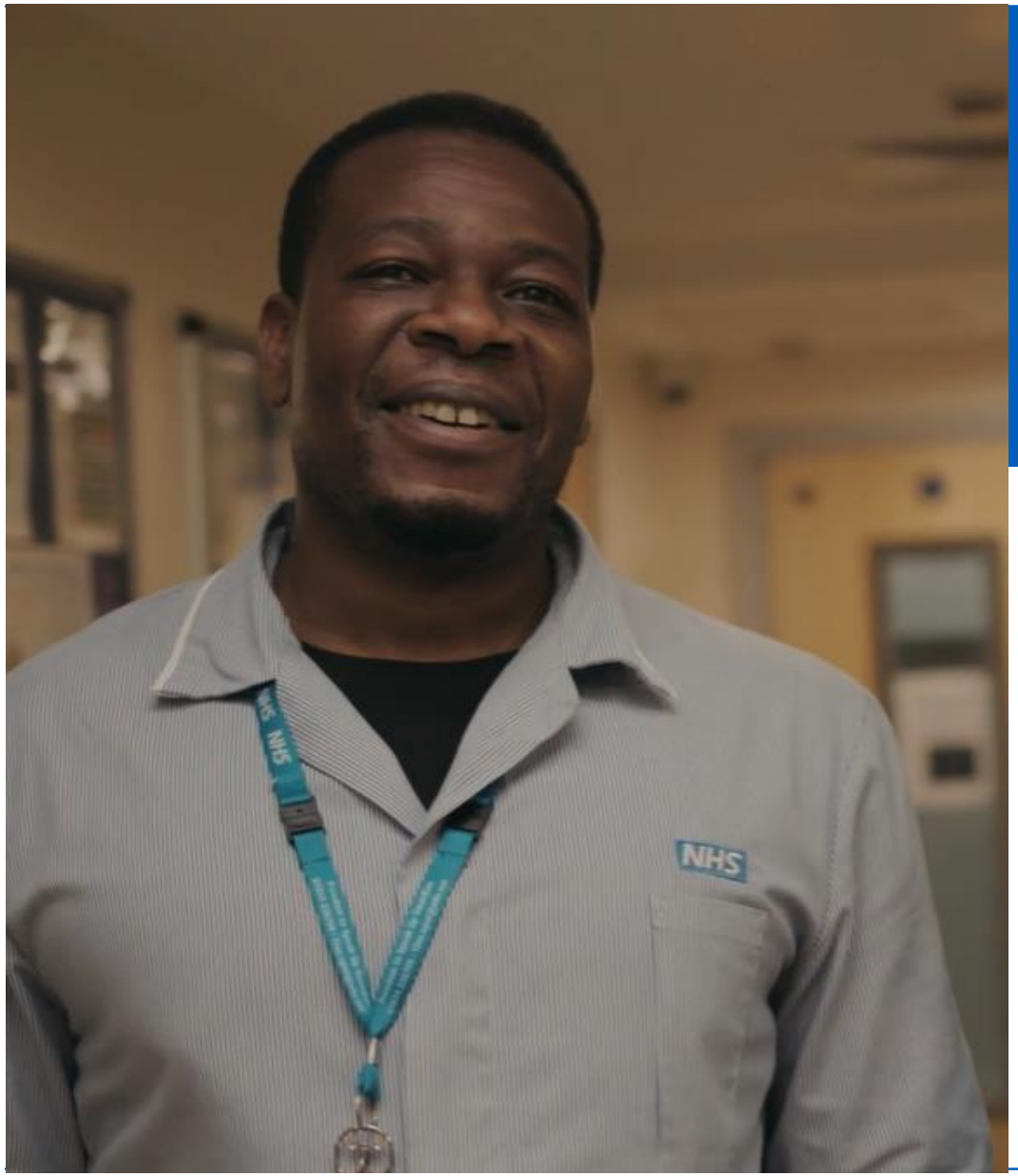


THE SEVEN PRIORITIES

OUR OVERARCHING FRAMEWORK FOR SAFETY IMPROVEMENT

The strategy focused on seven priority areas for safety improvements across the Trust. These were selected as cross-cutting themes that were relevant to all staff regardless of role to drive safety in a collaborative and systematic way:

1. **Leadership** - Ensuring there is buy-in, ownership and accountability across the Trust for putting Safety First, Safety Always and delivering this through leadership at all levels from ward to board
2. **Culture** - Creating a culture of accountability and ownership, where safety, quality and improvement is everyone's responsibility
3. **Continuous Learning** - Establishing an approach to learning and development that is ongoing by sharing lessons, reflecting and empowering staff. This includes learning from the past and focusing on any recommendations and learning arising from the EMHII
4. **Wellbeing** - Creating a working environment where staff feel safe, happy and empowered to provide the best quality of care
5. **Innovation** - Facilitating and inspiring patient safety initiatives through new ways of working
6. **Enhancing Environments** - Ensuring our buildings and estates support the Safety First, Safety Always agenda
7. **Governance and Information** - Building the foundations for safety through governance, processes and availability of information that put safety first



7 THEMES TO ENSURE SAFETY FIRST, SAFETY ALWAYS

1. LEADERSHIP
2. CULTURE
3. INNOVATION
4. CONTINUOUS LEARNING
5. WELLBEING
6. ENHANCING ENVIRONMENTS
7. GOVERNANCE AND INFORMATION

LEADERSHIP

In our ambition to be an industry leader in patient safety, our staff are advocates for Safety First, Safety Always throughout the organisation.

Leadership in patient safety takes place at all levels of the Trust – from ward to board – ensuring patient safety is everyone's responsibility.

Image shown: EPUT RISE Graduation Ceremony

LEADERSHIP AND COVID-19

SAFETY THROUGH THE PANDEMIC AND BEYOND

- There are regular site visits by Directors and Non Executive Director visits, providing staff with the opportunity to raise concerns and for risks to be identified
- An 'L50' meeting of the organisation's 50 senior leaders provides an opportunity to collaborate, cascade key messages and ensure that leaders are all working to the same priorities
- These sessions have been used to engage the Trust's wider leadership team on the safety strategy, to share successes, consolidate learning and plan the next wave of improvement actions
- Wednesday Weekly is a weekly newsletter that provides all staff with updates. This supplements the all-staff briefings and ensures that staff who can't attend are still kept in the loop. A regular learning lessons newsletter is also produced and shared on the intranet and via Wednesday Weekly
- 'The Grill' provides an opportunity for our Staff Engagement Champions to engage with senior leaders and discuss questions of interest to the workforce

- In parallel to our response to the pandemic, we also transformed our leadership capability
- Significant changes have been made to our Executive Team, starting with the appointments of a new Chief Executive and Chief Finance Officer
- New roles have also been created at Executive Team level, including an Executive Director of Strategy, Transformation and Digital and a Senior Director of Corporate Governance. These roles support our ambition to transform safety through innovation, information and good governance
- Leadership is more visible in our organisation than ever before. All-staff updates were held fortnightly throughout the pandemic and have continued on a regular basis. These sessions, which average 300 attendees, facilitate two-way feedback, supporting a culture of openness and one where safety is everybody's responsibility

TARGET OPERATING MODEL

CREATING EMPOWERMENT AND ACCOUNTABILITY

- We've organised the Trust so that our staff have time to build effective local partnerships
- The Care Units have been established with dedicated leadership teams to own safety, quality and improvement at a local level – and to take accountability for driving these forward
- Local leadership teams now include an Operational Director supported by Deputy Directors for Quality and Safety, and Deputy Medical Directors. This ensures that the Care Units have the capacity and expertise to drive continuous improvement and innovation
- We've appointed a senior safety specialist who advocates for patient safety across the Trust
- Our Target Operating Model is driving the transition to distributed leadership and creating a culture of accountability and empowerment at all levels in the Trust
- By giving our new Care Units greater responsibility for clinical and operational practice, we will move decision making closer to patients, empowering our staff to provide outstanding care and involving patients, families and carers in the decisions that affect them
- This approach will allow our staff to be agile in responding to changing patient needs and changes in the external environment

CARE UNITS

- PSYCHOLOGICAL SERVICES
- URGENT CARE AND INPATIENT SERVICES
- SPECIALIST SERVICES
- COMMUNITY NORTH EAST ESSEX
- COMMUNITY WEST ESSEX
- COMMUNITY MID AND SOUTH ESSEX

BUSINESS UNITS: (PEOPLE AND CULTURE, FINANCE, INFORMATION TECHNOLOGY)

ACCOUNTABILITY FRAMEWORK

PUTTING CARE CLOSER TO PEOPLE

The Accountability Framework has devolved decision making to those best placed to make decisions for and with patients, while setting a clear set of guiding principles for all our staff and a framework for raising visibility of issues.

Five clear domains of decision making set out the accountabilities of staff at all levels:

- **Quality and safety**
- **Performance**
- **Workforce and culture**
- **Finance**
- **External relations**

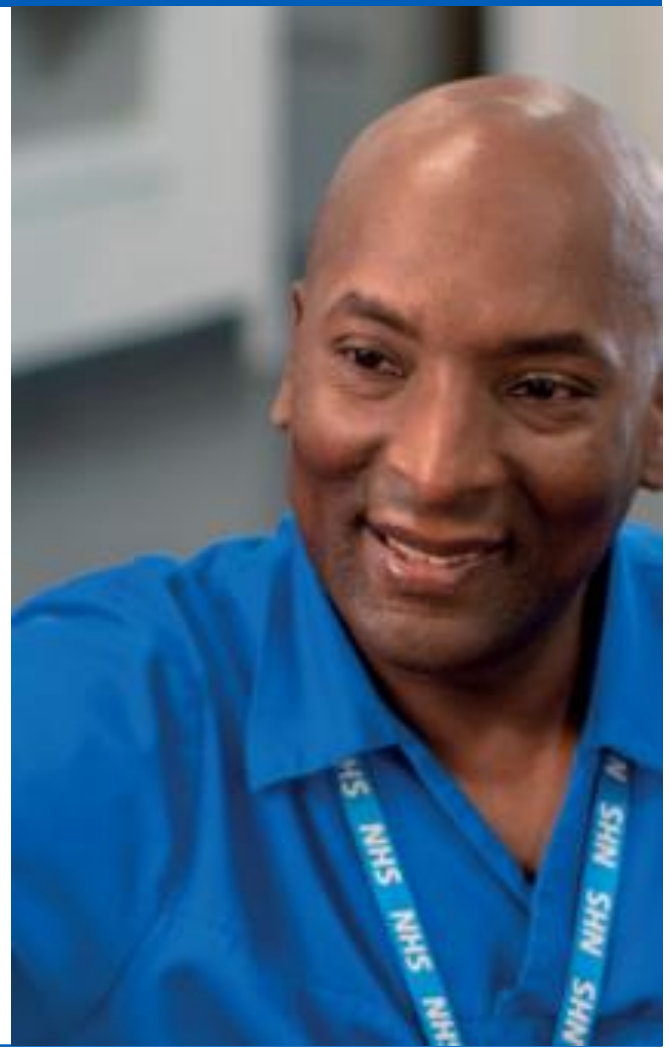
This framework is key to our Target Operating Model, supporting the Care Units to take decisions in patients' best interests and make informed decisions in an agile way at local level.

The Accountability Framework is now the primary vehicle through which Care Unit delivery within the Trust is monitored, managed and improved.

We are still testing and improving the approach, but it has already supported measurable improvements in reducing the number of absconsions, physical interventions and ligature incidents.

As we learn from the successes of embedding the framework within Care Units, we plan to update it and roll it out across our corporate services Business Units, to ensure a consistent approach for decision making and organisational accountability.

In an independent review of stakeholder perceptions in 2021-2022, stakeholders recognised the largescale change taking place at EPUT. There was awareness of the new operational structures, care units and strategic objectives. There was clear recognition of EPUT's new attitude and approach, describing a marked change in culture and improved stakeholder relationships.



CULTURE

We have continued to build our environment of Safety First, Safety Always, incorporating a Just Culture to drive a workplace of safety for patients and one of physical and psychological safety at work for our staff.

Creating an ethos of strong accountability – but not of blame – has encouraged staff to speak up, raise concerns and report incidents. This kind of transparency, equality and fair treatment creates better environments for our staff, patients, their families and our partners.

JUST CULTURE

RESPECT, FAIRNESS AND TRUST AS THE FOUNDATIONS OF PATIENT SAFETY

In promoting and creating a positive workplace culture of civility and respect we will improve staff experiences, wellbeing and retention, ultimately leading to improvements in patient care and safety.

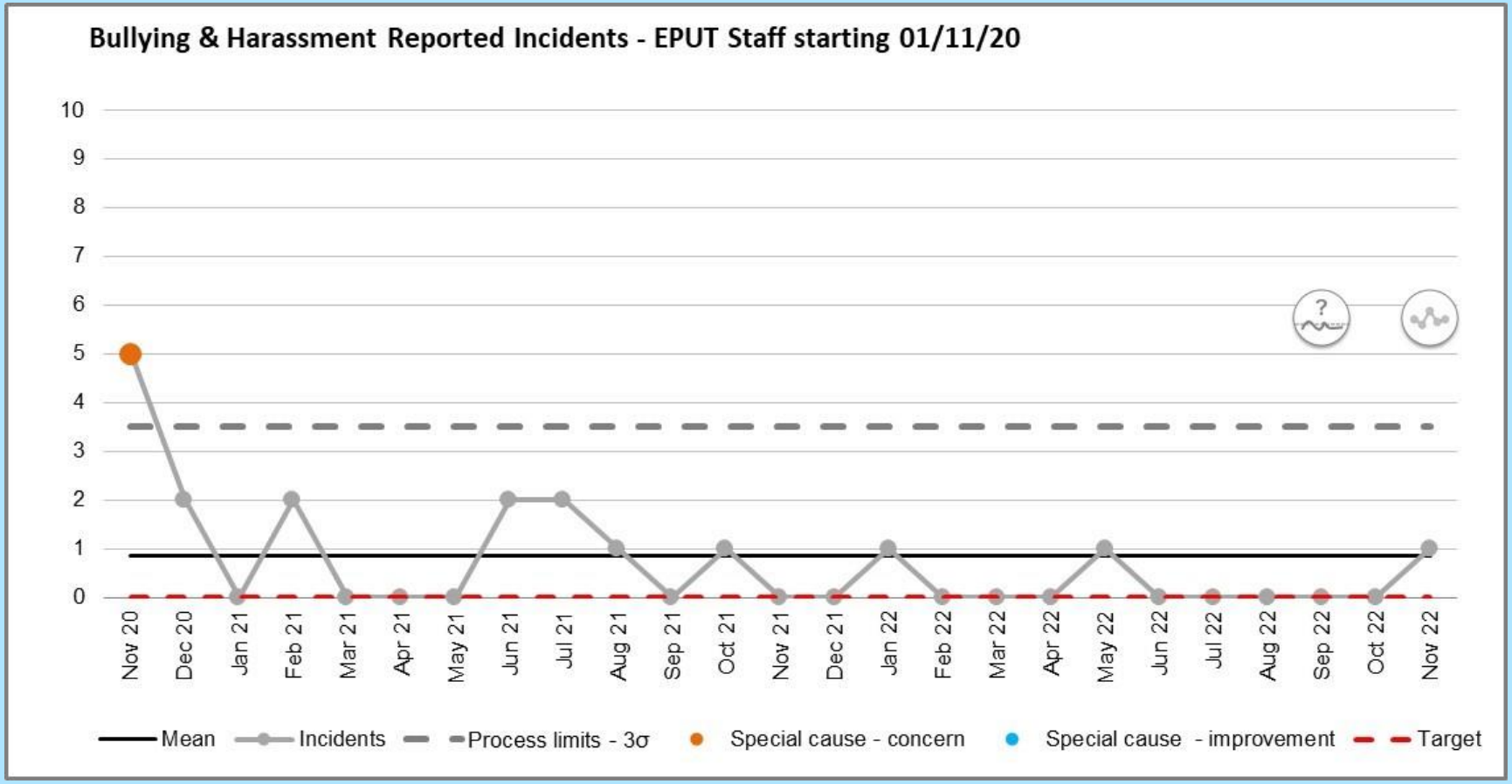
Crucially, we will also give staff the confidence to speak up and speak out without fear of unfair treatment, whenever they witness or experience something that could jeopardise patient safety or quality of care. Notable achievements so far:

- The Trust's Disciplinary Policy has been redesigned in line with a Just, Learning and Caring Culture
- A Conduct Investigation Toolkit has been produced to ensure all involved in an investigation know what to expect and where to get support
- There were no claims made at an Employment Tribunal during 2021/22 which relate to conduct
- Only 0.4% of the substantive workforce was subject to a conduct investigation in 2021/22. This is a 60% reduction since 2020/2021
- We've appointed a 'Freedom to Speak Up Guardian' who will allow staff to raise concerns to senior leadership anonymously
- In 2023, a new Behavioural Framework will be released, based on Trust's values. This sets out the standards of behaviours we all need to follow and uphold in our day-to-day roles, and will support the promotion of behaviours conducive to improving safety and driving the culture of learning

60% REDUCTION IN CONDUCT INVESTIGATIONS SINCE 2021

BULLYING AND HARASSMENT *SIGNIFICANT IMPROVEMENT*

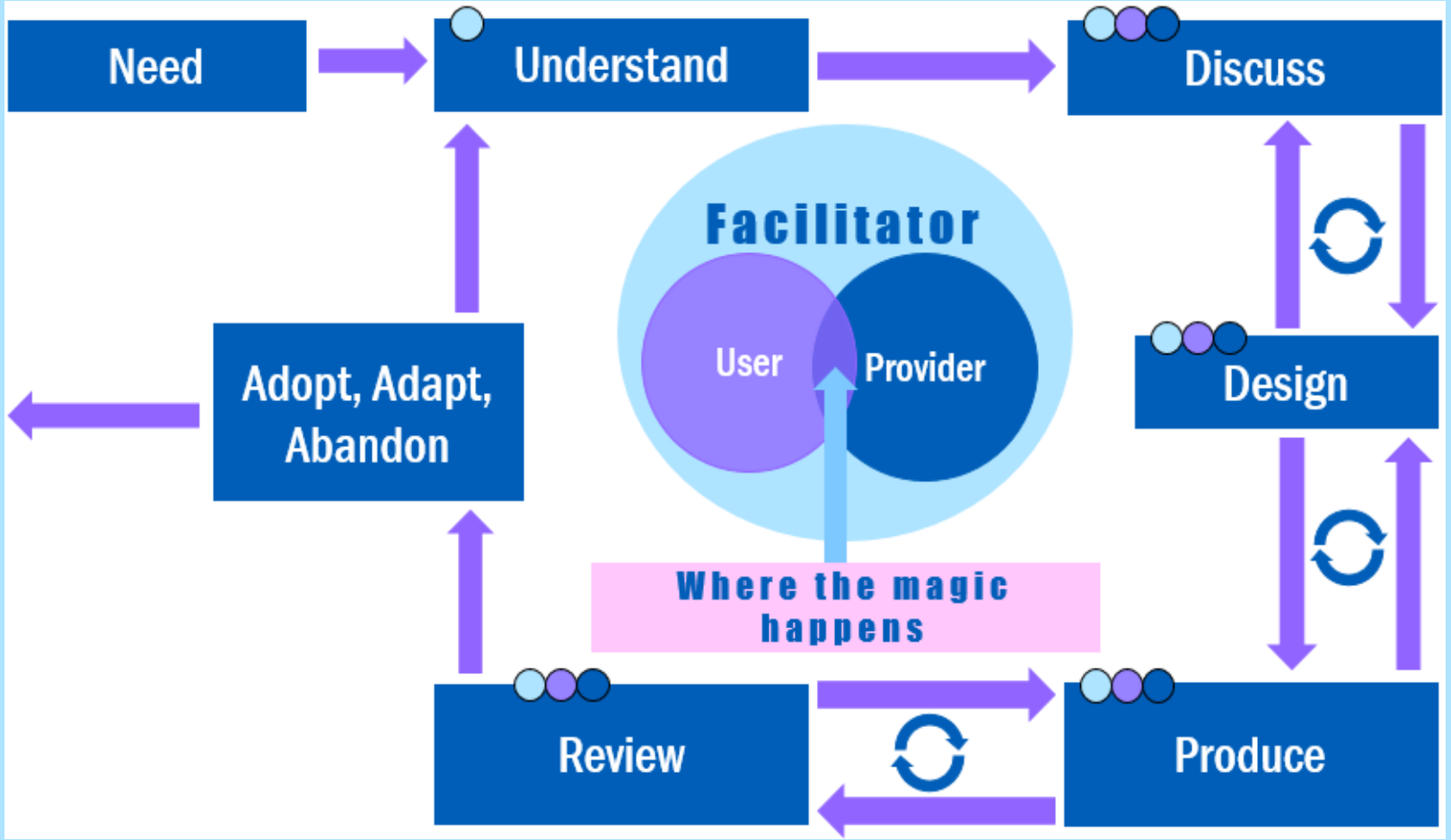
Bullying and harassment incidents have fallen significantly in the last 24 months, with a maximum of one incident a month since August 2021 and several months with no incidents.



CO-PRODUCTION

CREATING A CULTURE OF SAFETY THROUGH CO-PRODUCTION

'Co-production is when you as an individual influence the support and services you receive, or when groups of people get together to influence the way that services are designed, commissioned and delivered' - The Care Act



The Co-production Model for EPUT

CO-PRODUCTION

CREATING A CULTURE OF SAFETY THROUGH CO-PRODUCTION

We recognise our service users as strategic partners with crucial knowledge and understanding to support our continuous improvement.

We have built an approach to co-production led by a facilitator to ensure that neither the provider or the user are at risk of bias (this is supported by our co-production model).

We currently have five Patient Safety Partners at EPUT, they support improvement work across the Trust and meet monthly to provide their Lived Experience perspective on how we can improve patient safety.

Patient Safety Partners conduct safety walk-arounds supported by a series of quality and safety questions they have developed based on their lived experience.

Co-production in action:

The involvement group was formed as part of the Mental Health Urgent Care Department (MHUCD) in the summer of 2022 and is formed of people with lived experience of mental health and physical disabilities, people who care for others with lived experience and relevant Voluntary Care Sector (VCS) organisations. Engagement has been widespread, including:

- Development of the business case, including examples of the impact of the service on our patients
- Development of communication materials for the service
- Development of the estates architectural designs, including accessibility considerations and furniture designs
- Involvement in interview panels for the recruitment of the MHUCD workforce
- Development of training for staff

PATIENT SAFETY PARTNERS

CO-PRODUCTION IN ACTION

EPUT has recruited five Patient Safety Partners to support the Trust in achieving its Safety Strategy. They are the voice for patients, their families and carers. They gather and raise their concerns and views in the governance and management process to improve patient safety across EPUT.

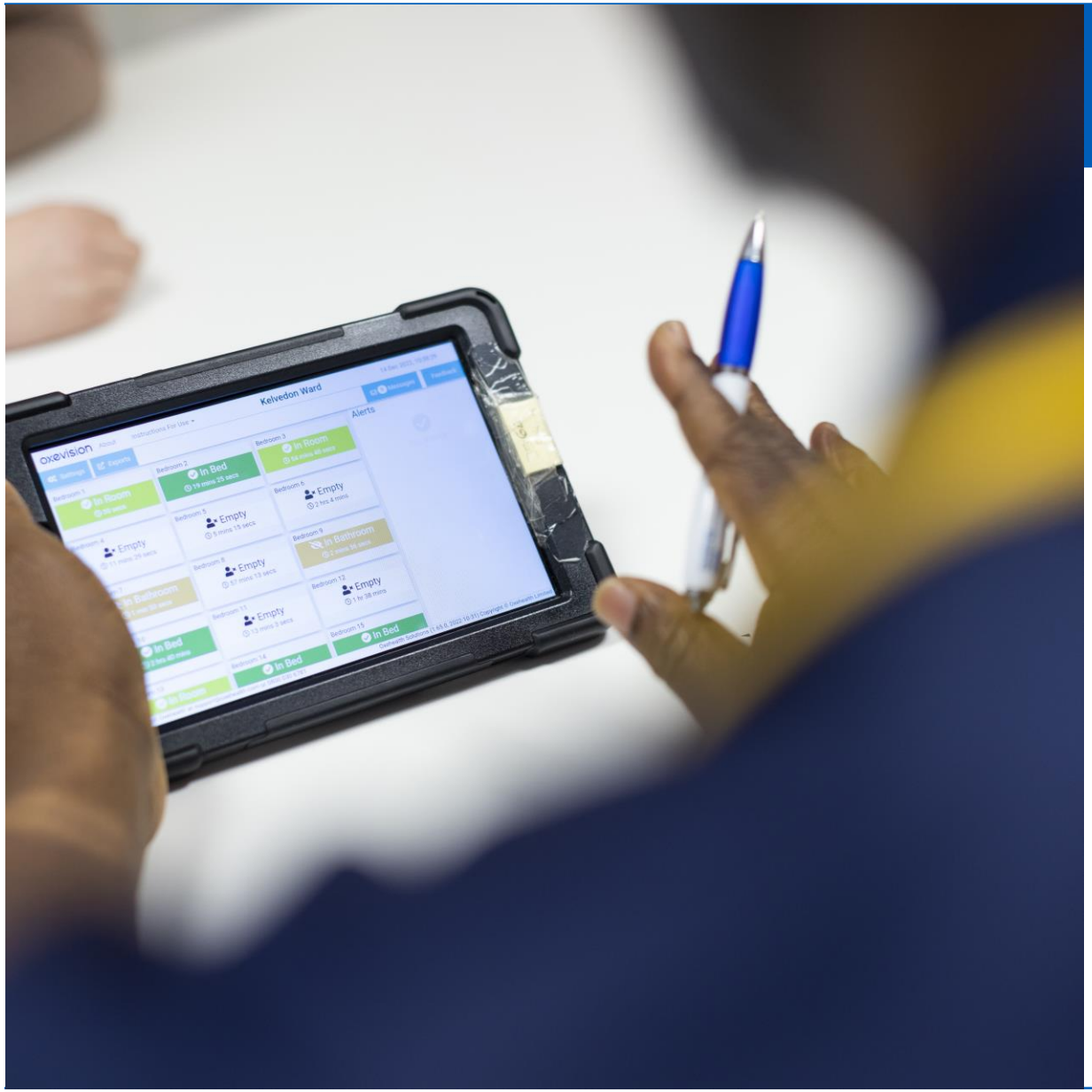
Patient Safety Partners recognise the importance of involving patients, their families and carers in all aspects of healthcare. The partners support and challenge the Trust, acting as a critical friend to ensure that the diverse perspectives of patients, families and carers are fully represented. They will influence the future development of services from the point of view of service users.

The Patient Safety Partners will conduct "safety walk-arounds" to visit teams and talk with patients and carers to gather their views on safety.

The feedback of patients, their families and carers will be shared with the team supporting them in improving patient safety and experience within our services. The findings will inform how safety issues should be addressed and provide an appropriate challenge to ensure learning and positive organisational change.

From Right to Left – Dr Nicola Armstrong, Siobhan O'Connell, Mark Dale, Rosario Gullotta and Moriam Adekunle

Patient Safety Partner uniform



INNOVATION

Innovation includes new ways of working and technologies that could enhance patient safety. We also look to engage more with our partners, patients, carers and families to improve our services and their safety.

Image shown: Oxehealth's Oxevision and Oxeobs being used on a tablet

AWARD WINNING APPRENTICESHIP SCHEME FOR CLINICAL PSYCHOLOGISTS

"This award goes to show that all of that incredible hard work and innovative thinking has had a valuable effect. "

The NHS needs to increase its psychology workforce by 60% by 2024. However, figures show that only 18% of psychology graduates are accepted onto Clinical Psychology courses via traditional training routes.

This is the challenge that EPUT set out to tackle as part of a Trailblazer Programme with our partners at East London Foundation Trust and Sheffield Health and Social Care Foundation Trust.

Clinical Psychology leads from all three Trusts came together to develop the Clinical Associate in Psychology (CAP) training programme. The programme was created with a vision to grow a sizeable, sustainable and diverse psychology workforce representative of the communities it supports.

By building partnerships with universities, the initiative creates locally relevant training programmes alongside strategic workforce plans, to ensure that the mental health workforce of the future has the capacity and sustainability it needs.

The wider health sector recognised the power of this programme, which won the **HSJ Award for Workforce Initiative of the Year 2022.**

FOR HEALTHCARE LEADERS
HSJ
AWARDS

AWARD WINNING APPRENTICESHIP SCHEME FOR CLINICAL PSYCHOLOGISTS

Clinical Associates in Psychology (CAP) aims to increase the national number of qualified psychologists and offer talented graduates who might have faced barriers to training the opportunity to train on the job. And the evidence shows that it's working:

- EPUT now has 44 Clinical Associates in Psychology, who have recently completed or are currently in training through the apprenticeship programme. A further five have completed their training and progressed to other posts
- CAPs are working on our inpatient wards, in community teams, perinatal services, Early Intervention in Psychosis (EIP) and are planned in many other services

"This was a very powerful and practical workforce initiative which hits the purpose of this award on the head".

– HSJ Awards Judges' Verdict

FOR HEALTHCARE LEADERS
HSJ
AWARDS

DIGITAL STRATEGY

This strategy was formed through over 400 direct engagements with EPUT staff

We developed a new five-year digital strategy which was signed off in February 2022.

This strategy was formed through over 400 direct engagements with EPUT staff using a series of workshops and interviews which set out a blueprint for the digital future of EPUT. There was an agreement from those consulted on the following core objectives:

- A single electronic patient record (EPR)
- An electronic prescribing and medicines administration (EPMA) capability
- A need for joined up people systems and staff management processes supported by digital – a consistent theme across front line staff as well as the People and Culture team
- A need for a strong focus on enabling technology at the front line
- The development of the Health information Exchange (HIE)

The Digital Strategy Group, chaired by the Executive Director of Strategy, Transformation and Digital is directing 13 strategic schemes.

This strategy is an enabler for change and has committed over £2m of capital towards the schemes that are important to the Trust's transformation.

These include:

- EPR levelling up programme
- Development and deployment of power BI as the gateway to data driven decision making
- Upgrades to ESR to streamline and drive efficiency for staff and managers
- Enablement of the EPUT culture of learning agenda
- Further expansion of trust Wi-Fi
- Ensuring a futureproof digital infrastructure

DIGITAL STANDARD OPERATING PROCEDURES

This work aims to co-author a suite of gold standard standard operating procedures (SOPs) to reduce unwarranted variation in order to reduce clinical risk and serious incidents.

SOPs will be made available to staff on a bespoke platform to support adherence and compliance monitoring.

The key benefits of this are:

- A reduction in unwarranted variation in clinical and administrative processes
- Reduction in time and resources wasted
- Improved support for staff working in challenging and high stress environments

Staff will be able to easily access SOPs that are relevant to them through the digital solution.

Updating SOPs will be simplified with a process to alert appropriate users and advertise the changes made.

Compliance monitoring will be improved with managers having the ability to assess compliance of areas and individuals.

The system will be auditable and allow us to provide evidence of the SOP that was in place on a given day in the past.

This digitalised approach will also improve the on boarding process, providing new staff with easy access to the best practice as defined by the organisation

STRATEGIC PARTNERSHIP WITH OXEHEALTH

EPUT has collaborated with Oxehealth to implement a safety monitoring system on our wards. The Oxevision system allows us to take remote measurements of patient vital signs, but is not a substitute for in person observations.

We have also been working together to develop an electronic observations feature with the objective of increasing the frequency and quality of inpatient observations.

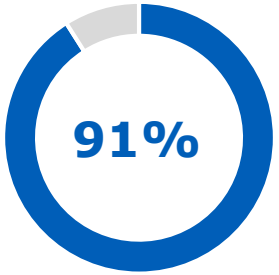
Better and more frequent observations will improve the safety and outcomes of our patients, including a reduction in falls and self harm.

The system has been installed on 23 wards, five health-based places of safety and five sites with seclusion rooms.

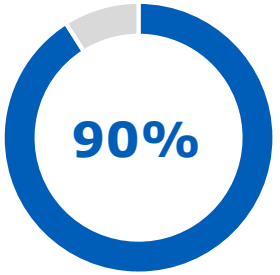
A recent study at EPUT by Oxehealth showed that patients and staff have responded positively to Oxevision.

"I think Oxevision makes us very safe on the ward. I find it hard to ask for help when I need it, or even admit to staff that I might need help. It's good to know that Oxevision calls for help when you need it, but also, when you don't think you need help."

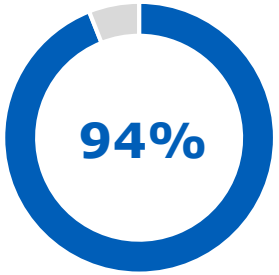
– Former Mental Health Inpatient



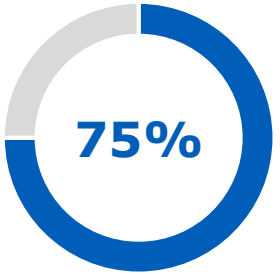
Staff agreed patient safety had improved



Staff stated that Oxevision had enabled them to prevent a potential incident from occurring



Staff stated they could identify incidents they may not have known about before



Patients felt Oxevision helps staff to keep them safer

MANAGEMENT AND SUPERVISION TOOL

MaST

MaST is an easy to use software platform which analyses data and information from multiple sources to help our teams make informed care pathway and resource allocation decisions to provide safe and effective care.

Community mental health teams in Castle Point, Rayleigh, Rochford, Brentwood and Thurrock have been using the digital Management and Supervision Tool.

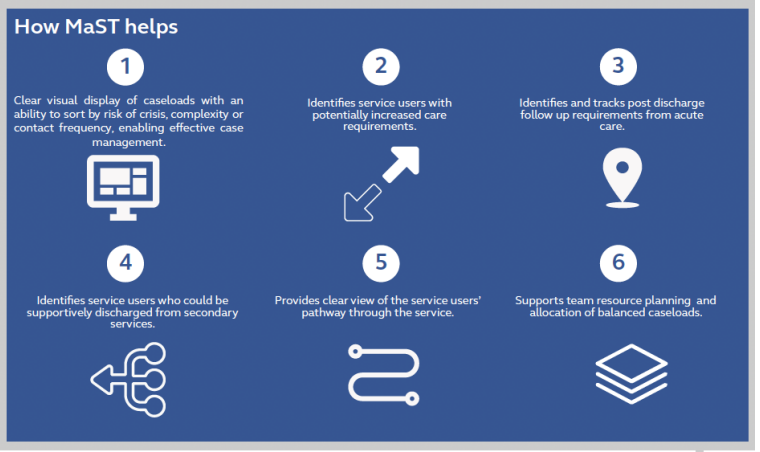
One of the key challenges nurses face is balancing large and complex caseloads. In just 10 minutes a day, MaST helps nurses prioritise their patients' care and flags any issues in urgent need of attention. MaST employs an algorithm which takes into account a number of different factors that might influence a patient's needs – like housing, medications, disabilities and other health conditions – and highlights where a patient may need additional support.

The dashboard highlights patients who may be at increased risk of crisis. It also flags when patients have not been contacted recently, or need a follow-up appointment.

Feedback from our staff has been positive:

"We use MaST within our team, and I have found the information dashboards very helpful. They are easy to use and give us an overview of our caseloads and any outstanding tasks. We use MaST regularly in our clinical supervisions."

"By rolling out MaST across our community mental health teams, we are empowering our nurses to manage their priorities and provide safe, effective care to our patients."



SELF-HARM REDUCTION PILOT

'The feedback we have received from both staff and patients has been very positive; with comments about the impact it has had on the ward culture and atmosphere'

The aim of the pilot was to diminish serious incidents (including self-harm and suicide attempts) relating to boredom by increasing recreational activities to provide daily structure for inpatient service users, freeing up clinical staff to increase therapeutic intervention offers, supporting patients in managing their self-harming behaviours and enhancing staff's skills.

Sensory Modulation training is complete, rooms and resources are available and Occupational Therapy (OT) staff are carrying out interventions.

Psychology have completed dialectical behavioural therapy (DBT) training and provided in-house training for ward staff on managing difficult behaviours associated with trauma.

Activity Coordinators have been recruited on virtually all adult inpatient wards in the Trust. Including weekends.

Positive patient outcomes

- 100% of respondents reported they attend activities on the ward
- 40% attend an activity more than once a day and 26.7% attend at least once a day
- 62.5% have found the activities to be very helpful for their mental health. 37.5% found the activities helpful
- 68.8% felt there were enough activities on at the weekend
- 31.3% of respondents reported they currently self-harm or have previously used self-harm as a coping strategy. Of those, 60% found activities on the ward helpful in reducing urges to self-harm and 20% found the activities very helpful
- 40% reported that ward activities help to reduce the severity of self-harming and a further 40% reported the severity of self-harming has partly reduced

EPUT NEUROMODULATION SERVICE (ENS)

EPUT has launched the first Neuromodulation service in the East of England

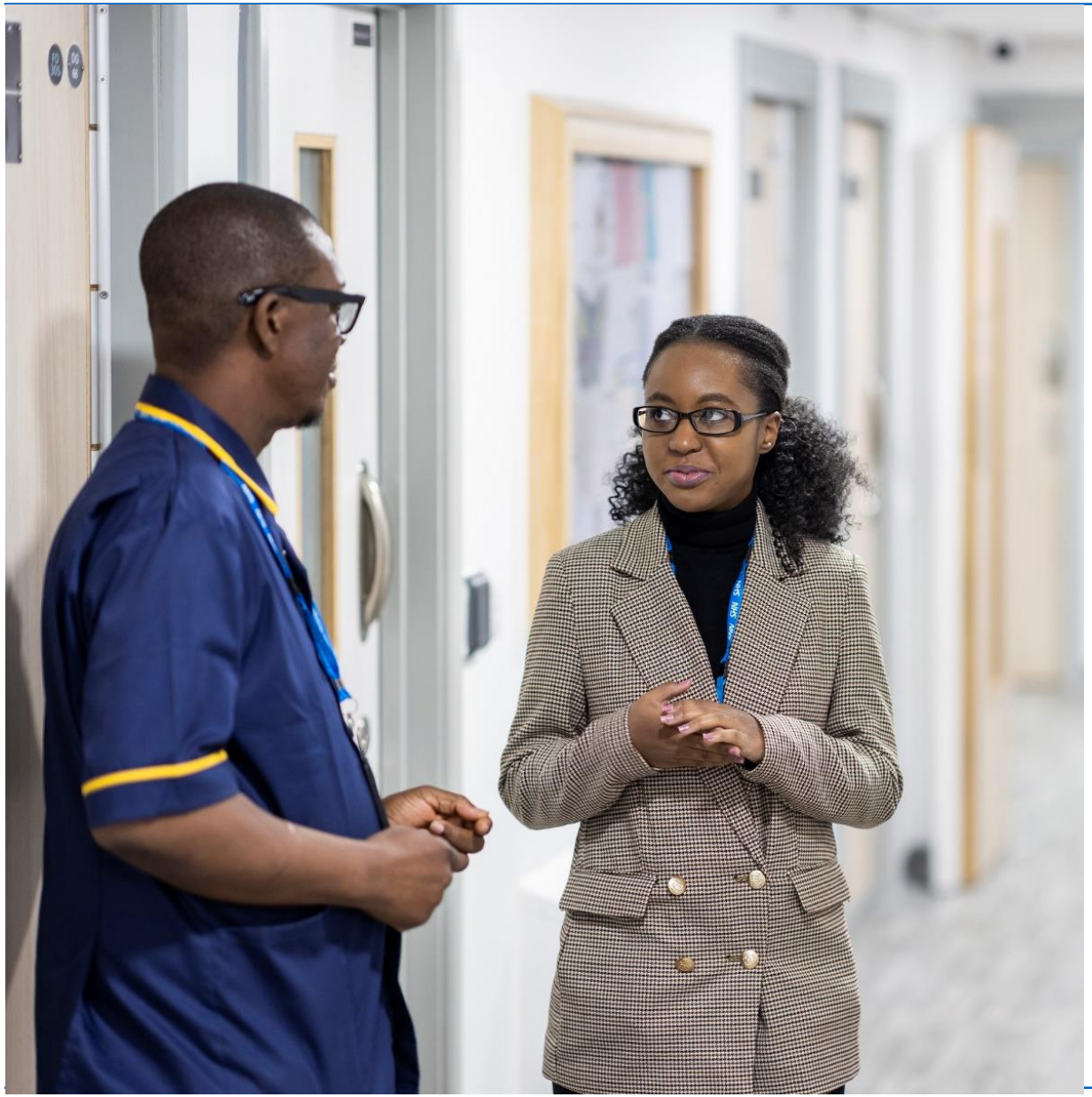
Essex Partnership University NHS Foundation Trust (EPUT) launched the first specialist Neuromodulation service in the East of England.

Advances in Neuromodulation are transforming the lives of patients with Treatment Resistant Depression (TRD) who have tried different types of anti-depressant medication but experienced no improvement in symptoms.

Neuromodulation uses targeted delivery of either chemical, electro-magnetic or electrical stimulation to alter nerve activity in the part of the brain that regulates mood, helping to reduce and relieve symptoms of depression and anxiety.

Thomas, a patient at Essex Neuromodulation Service, has seen a significant improvement in his mental health as a result of regular treatment. He said: "I was in a pretty bad way when I was first referred but I can now say very definitely that I am in a much better place. The treatment is giving me the ability to start focusing on my wellbeing and looking after myself again. It has got me doing things I enjoy again like reading and cooking."

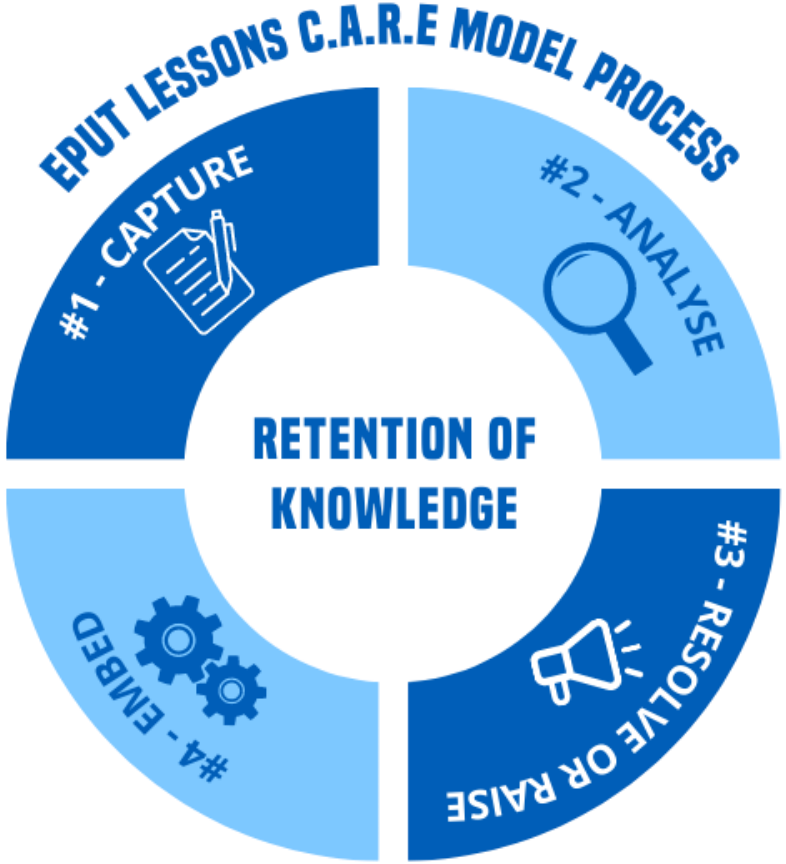
The pioneering new clinic based at Brentwood Resource Centre in Greenwich Avenue offers Repetitive Transcranial Magnetic Stimulation (rTMS) and Vagus Nerve Stimulation (VNS) alongside the Trust's existing Electroconvulsive Therapy clinics in Colchester, Basildon and Chelmsford, bringing all Neuromodulation treatments under one umbrella service.



CONTINUOUS LEARNING

We recognise that safety and improvement are continuous processes and so is the learning that underpins them. We have been developing an approach to learning where we see every event as an opportunity to learn and ensure lessons are shared across the trust and with partners, not just applied within the single area the incident occurred.

CULTURE OF LEARNING



At EPUT, we are ensuring that learning is an 'Always Event' where we all have a responsibility to seek improvement, learn from mistakes or good practice and adopt positive changes to provide excellent and safe care.

EPUT's Culture of Learning (ECOL) is focussing on ensuring our organisation has the right capabilities and environment to adapt and respond to challenges, and recognise opportunities to learn lessons in an agile and effective way.

The programme set out to improve how information is cascaded by increasing visibility, accessibility and awareness of lessons learned, best practice articles and other learning material.

We have been taking a collaborative approach to learning supported by the launch of the Learning Collaborative Partnership Group (LCP) in July 2022.

Left: To support learning within the Trust, we developed the C.A.R.E model.

Six Safety Action Alerts have been cascaded to staff since March 2022 and the ECOL intranet page has been viewed 5600 times since July 2022. These sources prove staff with the most up to date guidance and learning.

Quality and Safety Champions have been established, raising awareness of Trust policy and best practice across the organisation.

ECOL is now part of the Trust induction for new starters. We have also been holding Trust-wide live events to share learning on topics like ligature risk and drug abuse.

In 2023 we aim to:

- Publish a Trust-wide Learning Lessons e-training package
- Launch Learning Matters live sessions
- Develop a database platform that allows the investigation and documentation, management and analysis of lessons

PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK

HOW EARLY ADOPTION HAS PUT US AHEAD IN PATIENT SAFETY

EPUT participated in the early adoption of the Patient Safety Incident Response Framework (PSIRF).

PSIRF intends to reduce the likelihood of similar incidents recurring compared to the outgoing Serious Incident (SI) Framework.

This new approach acknowledges that outcomes are most impacted by processes and systems, the investigations therefore focus primarily on these areas.

We have received positive feedback on incidents investigations conducted under PSIRF with the coroner describing one report as ”exemplary”.

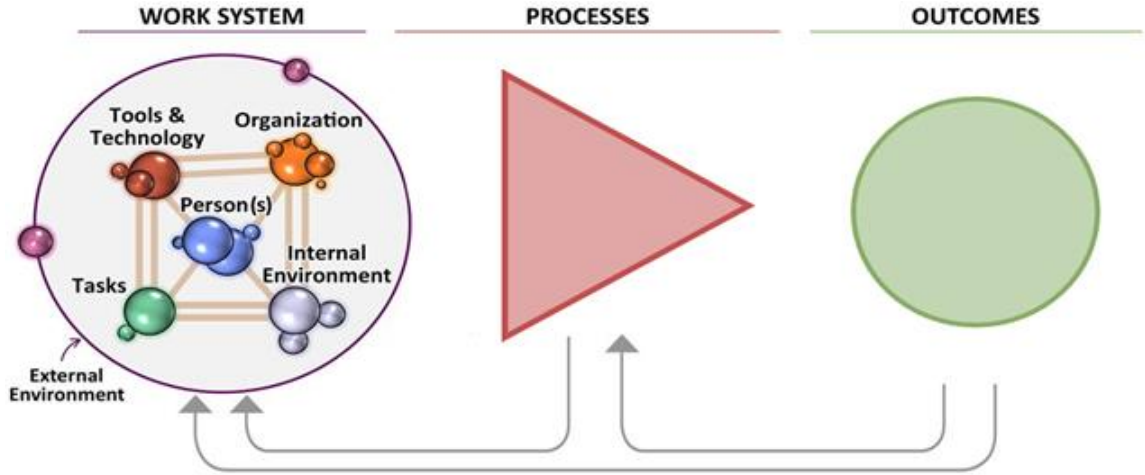
PSIRF encourages looking at incidents together in Safety Improvement Plans (SIPs) to find common themes rather than looking at incidents in isolation.

The Trust also produces Immediate Safety Actions to respond to short term learning from incidents.

The SIPs that EPUT have developed will implement learning from incidents across the Trust, rather than just at the sites where the incidents occurred.

We are currently providing other trusts with support for their PSIRF adoption based on our learning as an early adopter.

The model below is from the Safety Engineering Initiative for Patient Safety which supports the approach taken in PSIRF. This documents the link between outcomes, processes and the supporting work systems.



MANDATORY TRAINING

Wider Training Review

We're dedicating resource to complete an entire review of training in 2023 to ensure that we provide colleagues with the most suitable knowledge to effectively support and protect the safety of our patients.

This wider review will evaluate the facilities requirements for our growing training needs, the appropriate training depending on position and that this reflects any regulatory requirements.

Mandatory training is compulsory training that is determined essential by the organisation for the safe and efficient delivery of services. This training is designed to reduce organisational risks and comply with our local or national policies and government guidelines.

COVID restrictions meant in person mandatory training sessions were postponed or cancelled and we recognised an emerging risk to training compliance. To address this a project focussing on mandatory training was scoped and initiated in partnership with the Transformation and the Education Teams.

The work identified a number of quick wins to boost compliance rates across all courses, but also raised key concerns specific to Trauma and Self Injury (TASI) training and the extra time, resource and governance this back log will take to resolve.

TASI

A TASI training plan was approved by the Executive Team, with all elements other than a suitable long-term use venue in place to commence this work. The Executive Team recently approved the re-prioritisation of a Training Room 1 @ The Lodge to expedite TASI recovery from January of 2023.

As a result of the planning undertaken to date, we procured a further 12 months TASI accreditation from BILD (British Institute of Learning Difficulties)

Approval was received to recruit two additional TASI trainers with the team to deliver a full programme of training across all Trust sites.

In addition we have increased the availability of mandatory training by running additional sessions and providing staff with paid overtime to complete training.

LEARNING FROM DEATHS

Learning from deaths and ensuring that we use this learning to inform future practice is a key part of strengthening our safety culture. In April 2022, the Trust implemented new processes to facilitate learning from the deaths of people receiving care.

The aim of these revised processes, which replaced the previous mortality review arrangements, was to:

- Learn from our experiences of the previous policy
- Simplify our processes
- Ensure focus on learning outcomes
- Align with PSIRF arrangements
- Embed robustly in every day operation of frontline clinical services

The new processes involves an initial review (stage 1) of the clinical records and circumstances of the death by the local service to determine any learning and whether the death should be referred on for a more detailed clinical case note review (stage 2).

Examples of actions that have been taken by local services in response to the learning identified from stage 1 include:

- Enhanced internal local team communication processes put in place
- Addition of a flag on the service clinical information system to denote when next of kin details have not been completed in the record to ensure the clinician continues to seek this information in contacts with the client
- Sharing of learning with partner care providers
- Exploring how different teams involved can work together more effectively to support patients who are receiving community psychology and community mental health services

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. Also being used to inform subject matter for quarterly learning events being designed and delivered for each Care Unit by DDQSs.

WELLBEING

Patient safety begins with a workforce who are happy, healthy, safe, and supported to do their job. We have been supporting the wellbeing of our staff so that they are enabled to provide the best care for our patients, carers and families.

TIME TO CARE

The challenges EPUT currently face cannot be addressed through incremental change. A new and ambitious approach is required to set firm foundations for the future.

The Time to Care programme was established with the aim of releasing significant and quantifiable time to care on inpatient mental health wards. This is to be achieved through:

- A **Staffing Model Redesign** to increase capacity, safety and quality on the wards
- **Process Improvement**, identifying quick wins, plus medium and longer-term solutions and embedding effective processes and training
- **Data and Technology** to improve the use of current data and technology to support teams and delivery of care
- **Engagement, Inclusivity and Wellbeing**, co-designing and implementing proposals with staff and Lived Experience representatives

So far, the Time to Care programme has delivered a number of initiatives, including:

- A Ward Manager Development Programme, designed and developed by over 20 EPUT leaders
- A SMART Bed Management tool
- Co-production of a behavioural charter and new pharmacy posters to improve working relationships
- Digital System Optimisation and Compliance Assessment
- Access to Shared Care Records
- Creation of a Safe Staffing Dashboard (shown below)

HERE FOR YOU – NOMINATED FOR A NATIONAL AWARD

The Great British Workplace Wellbeing Series with WELLITY

Great British Workplace Wellbeing Awards 2022 – Nominated in the category 'Team of the Year'

Here For You is a confidential mental health and wellbeing service available to all health, social care and voluntary sector workers across Essex and Hertfordshire.

The service is made up of psychologists, psychological therapists and mental health professionals, and is delivered in partnership by EPUT and Hertfordshire Partnership University NHS Foundation Trust. Our EPUT staff are both providers and utilisers of the service.

The Here for You service is able to support individual staff by facilitating confidential and sensitive access to appropriate services, directly supporting staff wellbeing and recovery.

Here for You also works with teams after a staff or patient safety incident, working with trauma and building a culture of psychological safety.

The service supports wider staff wellbeing by providing psychologically informed guidance and support through resources and webinars.

The service aims to be both responsive to reduce staff distress and proactive to enhance staff wellbeing.

Since starting, the service has carried out more than 1,900 rapid clinical assessments.

The Here for You System

CAVELL STAR AWARD WINNERS

We have been proud to celebrate the achievement of two of our nurses from the Epping Forest District Nursing Team who have been presented with a Cavell Star Award in recognition of their hard work and dedication to patients.

The Cavell Star Awards is a national programme that celebrates the dedication of nurses, midwives, nursing associates and healthcare assistants and recognises the care they provide to patients, families, and colleagues.

Colleagues have described them as "loyal teammates" who care when you are having a tough day and put their arms around the whole team.

They said: "Amanda and Tracy are trusted colleagues who ensure their patients are always safe, comfortable and informed."

"They go the extra mile to make patients' families also feel part of the care journey."

"They don't only go above and beyond for their patients; they also go out of their way to support other members of staff."

Cavell Star Awards

EQUALITY, DIVERSITY AND INCLUSION

EPUT's race equality action plan has been rated outstanding by NHS England.

Bullying and Harassment

Our focus has been, and continues to be, on taking an intersectional approach to tacking bullying and harassment by implementing a robust campaign which will enable us to make transformative changes to the culture in the workplace.

This year has seen a strong start in increasing awareness of bullying and harassment in the workplace, including:

- Delivery of a webinar to over 140 members of staff
- Upcoming workshops targeted at middle managers across EPUT
- Refreshing and updating the Bullying at Work guide and policy
- Working with relevant teams to implement the updated Zero Tolerance policy
- Guidance for management on appropriately handling issues raised

Development of Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES) Action Plans

- The Action Plans are produced to monitor the activity and progress against indicators of the WRES and WDES Breakdown and Metrics and close the gaps between white and Black and Ethnic Minority (BME) and Disabled staff of their experience in the workplace. They include objectives and assigned nominated leads with responsibilities and tasks to make the delivery of the plan impactful for employees
- Our WRES action plan has been rated outstanding by NHS England for the first time. This is the highest level we could have achieved and it has been awarded for good use of positive action, measured interventions and using data and evidence to support change
- In 2021-2022, there has already been some improvement for our BME staff on five of the WRES Indicators, and for our Disabled Staff on eleven of the WDES indicators

ENHANCING ENVIRONMENTS

Our buildings and facilities play a crucial role in safety. A safe environment limits the opportunities for patient harm and a therapeutic environment is essential for supporting our service user's recoveries. We have been working to improve the standard and quality of our estates across the Trust.

Image shown: The Crystal Centre in Chelmsford after refurbishment

MENTAL HEALTH URGENT CARE DEPARTMENT

We have developed a 24-hour Mental Health Urgent Care Department that will be integral to the Urgent Care Pathway and integrated with wider services including Assessment Unit and Crisis alternatives.

There are many benefits associated with this approach to mental health urgent care:

Patients in crisis will get the most appropriate care at the earliest opportunity allowing us to prevent further deterioration of their mental health.

"Thank you for all your support and kindness over the last few days. As lovely as you all are I hope I don't have to see you again, not within this setting anyway! Fingers crossed I am on the mend." – EPUT Diversion Service User

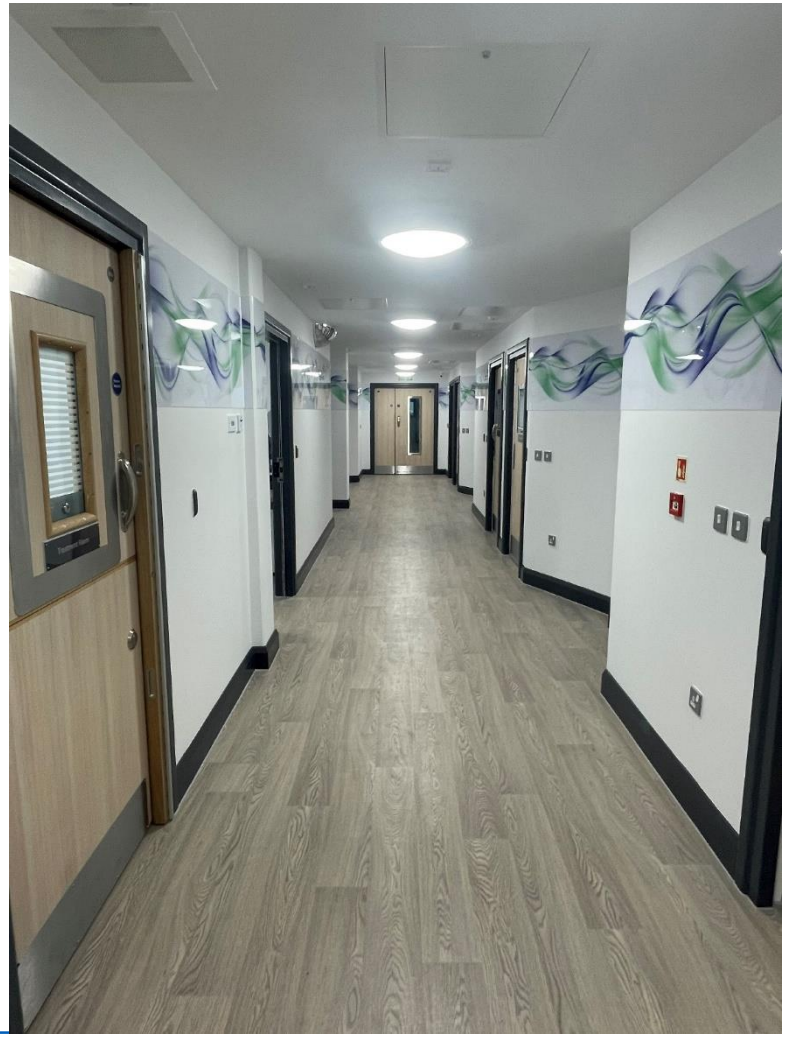
Patients will be seen in an environment more conducive to the assessment of patients in crisis resulting in better patient experience, a reduction in self harm and improved visibility for observations

Improved patient flow and reduced length of patient stay will result in fewer patients absconding, this is currently around 300-500 at local emergency departments.

While the full implementation of the Urgent Care Department is planned for next year, we have trialled a diversion pathway at Basildon Hospital as an initial pilot.

The diversion pathway went live in late January 2022 and provided a suitable space for the assessment of patients attending the Basildon Emergency Department. Some of the benefits and successes of this trial were:

- Diversion rate of between 18% and 22% of mental health attendances at Basildon emergency department
- Occupation rate of the 2 diversion rooms between 95% and 99%
- Supporting the system through the recent OPEL 4 pressures



LIGATURE RISK REDUCTION

As a result of the focus on our estates, we've seen a ~30% reduction in the number of fixed-point ligatures in 2022 compared to 2020.

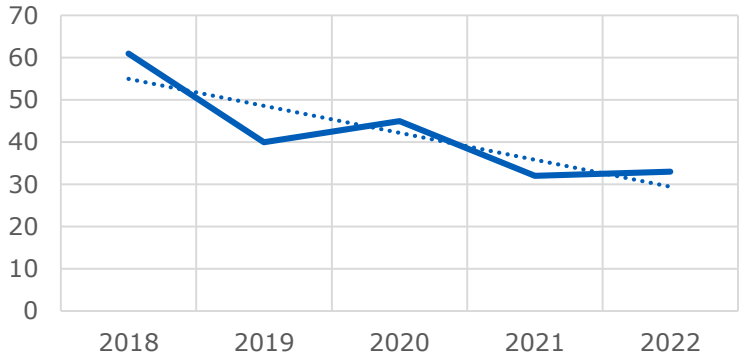
A data-led, thematic investigation of ligature incidents helped us to identify and mitigate risks for patients. The investigation identified:

- The environmental and non-environmental factors in ligature risk
- Awareness of policy and procedures
- Commonalities in the day(s) of the week and times that incidents were occurring

This analysis was used to identify the improvements and interventions that would have the biggest impact on safety. In particular, we expanded the focus of improvement work to include training and raising awareness of the policy.

The evidence-led nature of this work was key, because it demonstrated the case for a shift in focus from the physical environment only to policy, training, awareness and compliance.

Work on the estate has already seen a 30% reduction in fixed ligature points. Our ambition is to remove all fixed ligature points across all sites.



Fixed-point ligatures per year

Work on the training and policy is expected to further result in:

- A reduction in the number of overall ligatures
- A reduction in levels of harm associated with ligatures
- Improved staff wellbeing
- Reduction in incidents referring to policy and training issues

LIGATURE RISK REDUCTION

The Trust has completed 32 ligature-related estates projects since April 2022, including:

- Installation of 68 fire call switch toppers at Rochfield House
- Replaced 399 door hinges across the Trust, with a further 52 scheduled to be fitted by 31/03/23
- 560 radiator covers replaced across the Trust
- Installing new ligature-reduced garden furniture at Rainbow Ward, Christopher Unit and Finchingfield Ward
- Installing Access Control on Cedar Ward and Willow Ward
- Installing 32 shower timing devices across the Derwent Centre
- Installing 60 soft bins to trial. Due to the success of the trial a programme to roll these out across the Trust has been established
- Refurbishing the Linden Centre Health Based Place of Safety
- Installing soft doors in all ensuites at Grangewater
- Installing 100 noticeboards across the Trust in patient areas
- Delivering additional security blankets to all wards uplifting to five per ward from three per ward

AWARD WINNING REFURBISHMENT PROJECT AT BASILDON

A key component of our Estates improvement plan has been a £12.5 million investment to eliminate the remaining dormitory accommodation at Basildon Mental Health Unit, as recommended by the CQC.

The refurbishment includes the leading safety improvements available along with decoration that has also been carefully selected to improve mental wellbeing and encourage creativity.

Throughout the design process, both service users and staff were instrumental in contributing to improving patient experience and providing a safer environment.

The project won the Best Patient Safety Initiative category in the Building Better Healthcare Awards. It was also shortlisted in the Best Interior Design and Best External Environment categories.

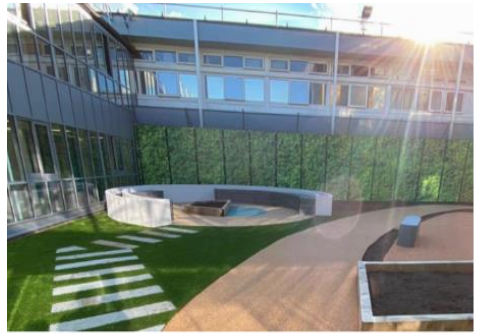
The improvements have also received positive feedback from our service users:

"I feel so much safer already knowing I have my own room. Not having to share with other people will make such a difference to me and my recovery"

"This is the best ward I have been to; it is like a hotel. I would be happy to pay for my stay here. The ward environment is therapeutic"

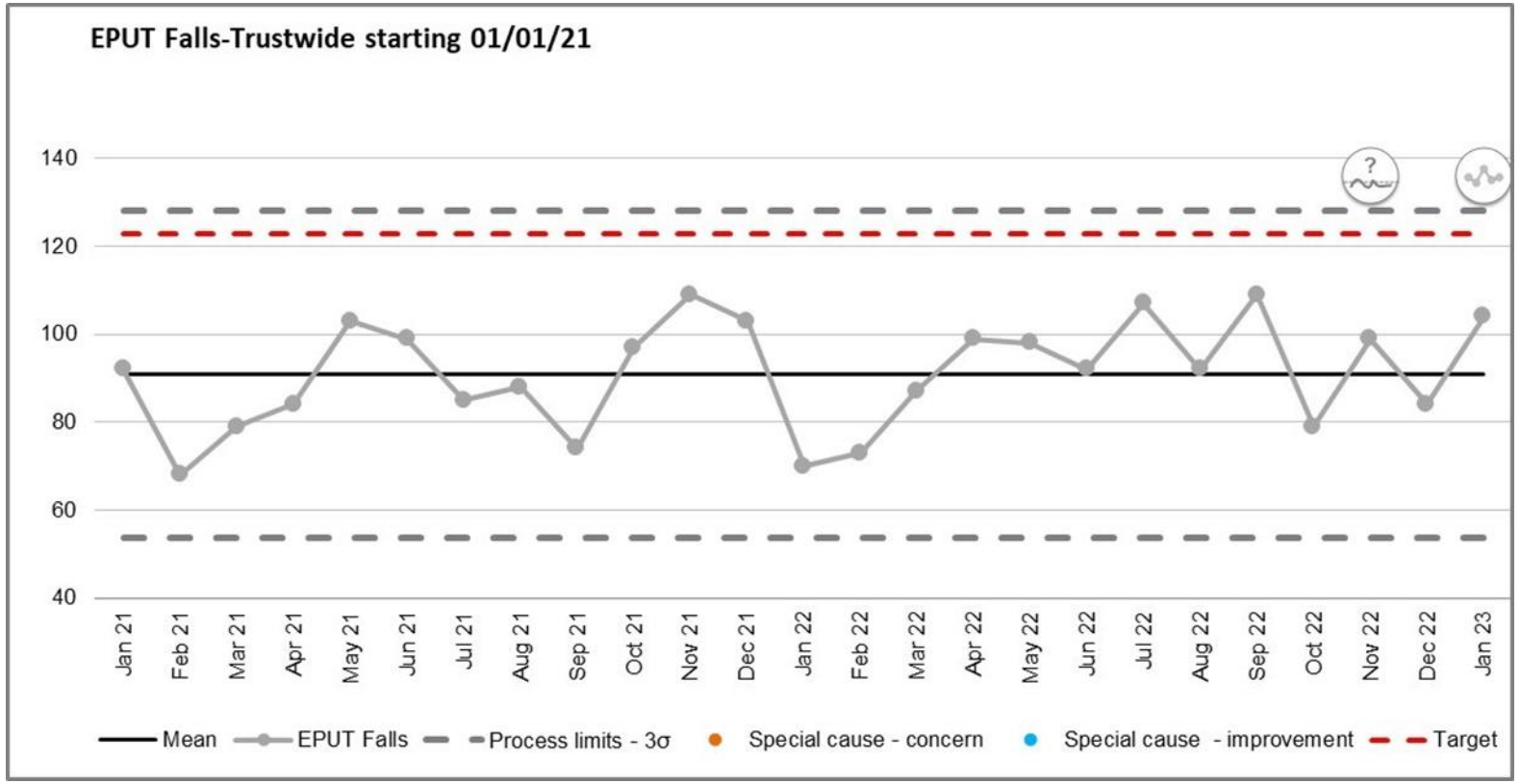
"This will make such a difference. Previously I shared with someone who liked the light on, and it meant I couldn't sleep properly."

BUILDING BETTER HEALTHCARE AWARDS 2022



PREVENTING FALLS

CONSISTENTLY BETTER THAN TARGET



Patient falls across the Trust have been significantly better than target over a sustained period.

There is some variation from month to month, which is to be expected, but we have maintained patient falls at a level that is both significantly below target and close to the mean.

GOVERNANCE AND INFORMATION

The foundations of a safe organisation are built on solid governance, process and access to information. Our work has been focussed on providing decision makers across the organisation with access to as near to live data as possible so that data driven decisions can be made as well as allowing decisions to be made as locally as possible.

EXECUTIVE AND BOARD SAFETY OVERSIGHT GROUPS

The Executive Safety Oversight Group (ESOG) was formed in November 2020 and is chaired by the Trust CEO. Membership includes the Executive Team and the Director of Transformation, the Director of Safety and Patient Safety Specialist, the Deputy Director of Compliance.

The primary focus of the group is to oversee and provide assurance on the development, planning and delivery of the safety strategy, encompassing (but not limited to) physical environment, staffing & management structures, leadership & culture and record keeping.

The group also oversees the development and delivery of action plans relating to: CQC reports, HSE reports, PHSO reports and any other expert or external review recommendations.

The Board Safety Oversight Group (BSOG) was formed in November 2020 and is chaired by a member of the Trust Board. Membership includes the ESOG members, the Trust Secretary and two further Non-Executive Directors.

The BSOG provides assurance to the Trust Board that the safety strategy is being delivered to the agreed time, cost and quality parameters.

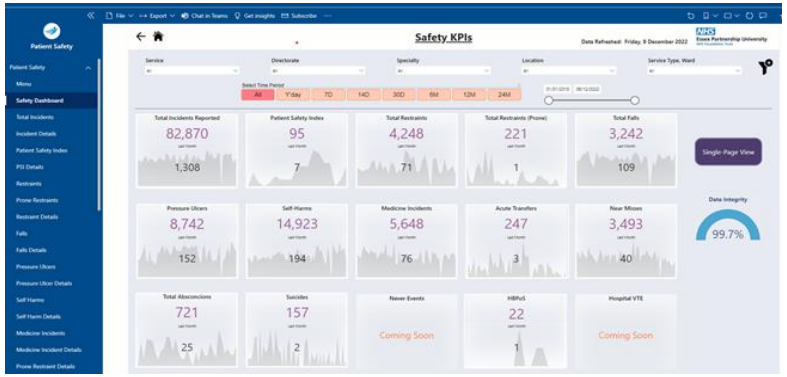
It also ensures adequate processes and governance are in place to safely enable successful delivery of the safety strategy alongside effective and sufficient availability of resources to support the safety strategy priorities.

SAFETY DASHBOARD

The success of this approach will be measured through a significant reduction in the repetition of similar patient safety incidents

We have developed a Safety Dashboard with the purpose of learning from adverse events and good practice, building on the approach used in NATO, the Ministry of Defence and Aviation Industries.

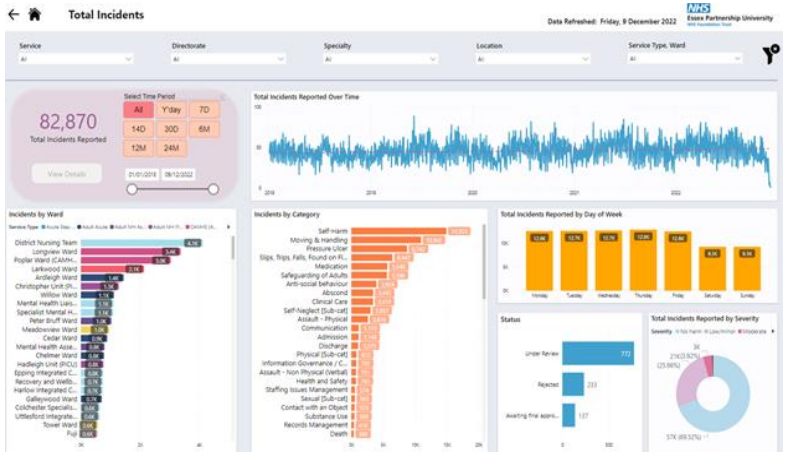
This dashboard integrates with the Datix and other data sources in the Trust. It currently provides data on Safety and Quality KPIs, Operations and Patient Experience. This approach to reporting supports a transition to proactive rather than reactive decision making by enhancing our learning capability.



High Level Safety Dashboard showing the Trusts Key Performance Indicators

The success of this approach will be measured through a significant reduction in the repetition of similar patient safety incidents in the Trust as identified in the trust Patient Safety Incident Response Plan.

To get the most from these dashboards, we will set and measure some KPIs to demonstrate compliance with the outcomes of the safety strategy and intervention from our learning lessons capability.



The dashboard allows us to dive deeper into our data to discover new learning

ELECTRONIC PATIENT RECORD

IN PROGRESS
2022 - PRESENT

Objective

To ensure that EPUT meets its fundamental objective of safe care to our patients there is a need to de-complicate the multiple electronic patient record systems.

The aspiration is to deliver a modern, robust and sustainable single EPR across EPUT. Taking this a step further, the digital team are working in collaboration with system partners to consider what a converged EPR opportunity could enable by bringing together mental health services, community health services and acute care settings into one electronic record.

Progress

Stakeholder engagement workshops were conducted prior to an options appraisal. A strategic outline business case was produced in August 2022 and approved by the Trust Board.

A business case is under development to select an EPR system that will:

- Enable the rationalisation and modernisation of the Trust's existing EPRs
- Support the Trust's clinical and administrative processes
- Improve the safety and delivery of patient care
- Improve patient experience and outcomes
- Enable patients to share and own their records

ELECTRONIC PRESCRIBING AND MEDICINES ADMINISTRATION

IN PROGRESS

JANUARY 2019 - PRESENT

Objective

In the last two years, EPUT reported over 2,300 medication related errors.

In a sample of nearly 13,700 EPUT medications orders over 24 months, 4.6 percent were found to contain one or more prescribing error.

Research shows that an ePMA system can provide:

- 60% reduction in prescribing errors
- 10% reduction in pharmacy workload
- 5% reduction in omitted dosages
- 63% reduction in clinical incidents
- 63% reduction in potential Adverse Drug events (ADEs)
- 206% rise in the accuracy of discharge medicine prescribing

Progress

A bid was submitted in January 2019 for funding made available to achieve the NHS Long Term Plan commitment of replacing paper prescribing with electronic by 2024.

An initial outline business case for ePMA was approved in 2019 with a full business case post the Covid-19 pandemic being presented to the Trust Board in March 2023. Once approved the programme is anticipated to take 2 years to deliver.

The trust awarded a contract to EMIS Health in January 2020, with the contract signed in March 2020.

EMIS

Currently we are working with EMIS to upgrade the pharmacy system from v10.15 to v10.22 which will bring performance improvements to pharmacy management and administration.

Our vision is to have an ePMA platform that integrates with our EPR systems.

NHS
Essex Partnership University
NHS Foundation Trust

LOOKING TO THE FUTURE

OUR PLANS FOR YEAR 3 OF THIS STRATEGY

EPUT

OUR CONTINUED AREAS OF FOCUS

OUR FOCUS FOR YEAR 3 AND BEYOND

During the lifecycle of the *Safety First, Safety Always* strategy, our performance has continued to progress across many of our key metrics. Despite this, we know the journey is not complete and we continue to push for improvement and innovation to provide consistently safe care. Safety never stops and as we enter the final year of the strategy, our focus will be on five priority areas:

Patient Voice in Safety

We will ensure patients and families are involved in our quality improvement

- Increasing our number of people with lived experienced engaged in improvement
- Further development of *I Want Great Care*

Creating a Culture of Safety

Embedding the highest professional standards to become a Patient First organisation

- Creation and implementation of EPUT's People Charter
- Continuing to enable a reporting culture to encourage our people to speak up

Data Informed Safety

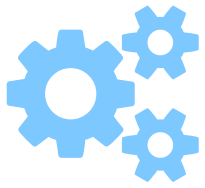
We will use data to inform of safety decision making and oversight

- Better use of our safety dashboard data from Board to Ward
- Widespread engagement with lessons learned collected and shared across services
- Learning from past incidents and the Essex Mental Health Independent Inquiry (EMHII) and their conclusions on culture will be applied to our future areas of focus

Partnerships and Safety

We will build our system partnerships to best deliver patient safety

- Build our work of Patient Safety Partners to co-design and co-produce services
- Essex Police Mental Health Team
- Mental Health Urgent Care Department
- Deepening our partnership with primary care



Embedding Lessons in Safety

We will continue to embed what we have learned since the launch of this strategy to ensure consistent good practice across our Trust.

- Better evidence tracking of benefits realised through new ways of working
- Continued use of PSIRF and promoting our role supporting other Trusts implementing the framework
- Rollout of SIPs across all service areas
- Implementation of any learning from the EMHII

PATIENT VOICE IN SAFETY

YEAR 3

IMPROVEMENT PRIORITY

Objective

Ensuring the patient voice is listened to, understood and acted on is key to embedding safe, good quality care throughout the organisation in all our care settings.

Priority Initiatives for Year 3

- Further development of *I Want Great Care* to enhance the quality, quantity and application of patient feedback to care practices
- Instil a culture of systematically capturing and embedding patient feedback in everything we do
- Further increasing the number of people with lived experience engaged in our improvement work
- Increasing the number of our Patient Safety Partners, strengthening their voice and enhancing their role in safety and quality improvement

CULTUTRE OF SAFETY

YEAR 3

IMPROVEMENT PRIORITY

Objective

Embedding the highest professional standards to become a Patient First organisation.

Priority Initiatives for Year 3

- Creation and embedding of the Trust's People Charter
- Continuing to foster a culture of reporting and speaking up
- Instilling a sense of empowered leadership throughout the wards
- Identify any learning or recommendations emerging from the EMHII
- Rolling out Quality Together to ensure a shared culture of accountability, working with system partners and patients
- Truly embedding our process and practice improvements at ward level and throughout every care setting
- Enhancing the outcomes of our work using Quality Improvement methodologies

DATA-INFORMED STRATEGY

YEAR 3

IMPROVEMENT PRIORITY

Objective

Making the best use of data to inform decision making, oversight and continuous improvement.

Priority Initiatives for Year 3

- Review our Business Intelligence capability and develop a new future-state model
- Turning our data into insight to improve the quality of prioritisation and decision making
- Embedding use of Safety Dashboard data from ward to board
- Development of ward-level quality assurance framework that provides oversight and evidence on safety of care

PARTNERSHIPS AND SAFETY

YEAR 3

IMPROVEMENT PRIORITY

Objective

Building system partnerships and working ever more closely with colleagues to provide the safest possible care.

Priority Initiatives for Year 3

- Build on the work of our Patient Safety Partners to co-design and co-produce services
- Using Quality Together to improve collaboration with ICBs and other system partners
- Essex Police Mental Health Team
- Mental Health Urgent Care Department
- Deepening our partnership with primary care
- Increasing the presence and visibility of Independent Mental Health Advocates

EMBEDDING LEARNING

YEAR 3

IMPROVEMENT PRIORITY

Objective

We will continue to embed what we have learned since the launch of this strategy to ensure consistent good practice across our Trust.

Priority Initiatives for Year 3

- Improved evidence tracking of benefits realised through new ways of working
- Continued use of PSIRF and promoting our role supporting other Trusts implementing the framework
- Rollout of SIPs across all service areas
- Identify any learning or recommendations emerging from the EMHII
- Continuing to get the basics rights and upholding the highest professional standards
- Evidencing the ‘feedback loop’ from patients, families and partners in our improvement work
- Benchmarking our safety work against national leaders in health and across industries

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APPENDIX

EPUT

AWARDS

CELEBRATING THE WORK OF OUR STAFF

2022

Apprenticeship scheme wins national award

Dedicated staff recognised in national awards

Partnership Award for Mid Essex Rough Sleeper Initiative Outreach Scheme

Basildon Mental Health Unit has won a national award

EPUT scoops regional NHS Parliamentary Award

Tendring roving support bus is a national award winner

Here For You shortlisted for national award

EPUT colleagues shortlisted in two Nursing Times Workforce Award categories

EPUT's COVID vaccination service for seafarers recognised as one of the best in the world

Dedicated Trust staff celebrate success at the Positive Practice in Mental Health Awards – CAMHS Inpatient Services winner of Addressing Inequalities in Mental Health

2021

Essex Partnership University hospital ward wins national award for outstanding palliative and end of life care

EPUT awarded gold accreditation from Employer Recognition Scheme

GLOSSARY OF TERMS

ADE: Adverse Drug Events

BSOG: Board Safety Oversight Group. A Executive and non-executive meeting chaired by a member of the Trust Board. Membership includes the ESOG members, the Trust Secretary, and two non-executive directors.

CAMHS: Children and adolescent mental health service

CAP: Clinical Associate in Psychology.

Care Units: The structure we have used in our Target Operating Model to organise and manage our services. Care Units have been established with dedicated leadership teams to own safety, quality and improvement at a local level

Co-production: When an individual influences the support and services they receive, or when groups of people get together to influence the way that services are designed, commissioned or delivered

CQC: Care and Quality Commission

ECOL: EPUT Culture of Learning

EMHII: Essex Mental Health Independent Inquiry

EPMA: Electronic Prescribing and Medicines Administration

EPR: Electronic Patient Record

ESOG: Executive Safety Oversight Group. An Executive meeting chaired by the Chief Executive with the remit to oversee safety improvement work and provide assurance the planning and delivery of the safety strategy.

HIE: Health Information Exchange. This enables care professionals to view shared care records

HPFT: Hertfordshire Partnership Foundation Trust

HSE: Health and Safety Executive

HSJ: Health Service Journal. An industry news service that covers policy and management in the NHS.

iWantGreatCare: An online platform for patients, service users and families to provide reviews and ratings on the services we provide. All feedback is anonymous.

KPI: Key Performance Indicator

L50: A meeting of the organisation's 50 senior leaders

LPC: Learning Collaborative Partnership Group

MaST: A management and supervision tool used across out community mental health teams to better manage data on patients to speed up decision making

MHUCD: Mental Health Urgent Care Department

OPEL 4: Operational Pressures Escalation Levels Framework

PHSO: Parliamentary and Health Service Ombudsman

Physical restraint: Any direct physical contact where the intention of the person intervening is to prevent, restrict or subdue movement of the body, or part of the body of another person

PSIRF: Patient Safety Incident Response Framework

Safety Summit: A meeting that brings together partners from across the system to jointly discuss safety, quality and improvement

SIP: Safety Improvement Plan

SOPs: Standard Operating Procedures

TASI: Trauma and self injury

Time to Care: A programme of projects being implemented across the Trust to increase time available of staff to deliver care to patients on our inpatient mental health wards

WDES: Workforce Disability Equality Standard

WRES: Workforce Race Equality Standard

		Agenda Item No: 7e
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 March 2023**

Report Title:	Learning from Deaths – Quarterly Overview of Learning and Data (Quarter 3 2022/23)					
Executive/ Non-Executive Lead:	Professor Natalie Hammond, Executive Nurse & Dr Rufus Helm, Non-Executive Director					
Report Author(s):	Michelle Bourner, Learning From Deaths Co-Ordinator					
Report discussed previously at:	Learning from Deaths Oversight Group (Chair: Dr Nuruz Zaman) Learning Oversight Sub-Committee (Chair: Moriam Adekunle) Quality Committee (Chair: Dr Rufus Helm)					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Project reports only:	
If this report is project related please state whether this has been approved through the Transformation Steering Group	N/A

Purpose of the Report		
In line with the National Guidance on Learning from Deaths, the attached report presents to the Board of Directors: • 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 new Learning from Deaths arrangements (Appendix 1); • Data relating to deaths recorded on Datix (the Trust's incident management system) for Q3 2022/23 (1st October – 31st December	**Approval**	
	Discussion	
	Information	✓

2022) and updated data for previous quarters this year (Appendix 2); and • Updated data for deaths relating to previous years (Appendix 3).		

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report;
2 Request any further information or action; and
3 Comment on the new format of the report.

Summary of Key Issues

1. The Trust implemented a new Learning from Deaths Policy and Procedural Guidelines from 1st 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 a number of immediate actions that are being taken as a result of the 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 of Director 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 Q3 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. As at the date of preparation of the report, a total of 250 deaths from 01/04/22 – 31/12/22 have been subjected to a Stage 1 learning from deaths review by a local service manager to ascertain learning and identify those for further detailed review. This is a local review stage that did not form part of the previous Mortality Review arrangements and has thus increased local 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 being 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 all data in this report is taken as at 07/02/23. Any updates to information after this date will be included in future reports.

7. The format of the quarterly report has been changed this quarter both in style and content - to focus on the outcomes of the processes (ie the learning identified and actions being taken) whilst still providing mortality surveillance assurances and compliance with the reporting requirements of the National Guidance on Learning from Deaths (March 2017). Members are asked to comment on the revised format so that any requested refinements can be made to 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: **Capital £** **Revenue £** **Non Recurrent £**			N/A
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

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
ICB	Integrated Care Boards	DNA	Did Not Attends

Supporting Documents and/or Further Reading

Attached –
Report: Learning from Deaths – Quarterly Overview of Learning and Data (Quarter 3 2022/23)
Appendix 1 – Context of mortality data and surveillance under the Trust's Learning from Deaths Policy
Appendix 2 – Summary of 2022/23 mortality data
Appendix 3 – Summary of previous years mortality data

Links -

"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*
PowerPoint Presentation (england.nhs.uk)

Lead
 Natalie Hammond **Executive Nurse**

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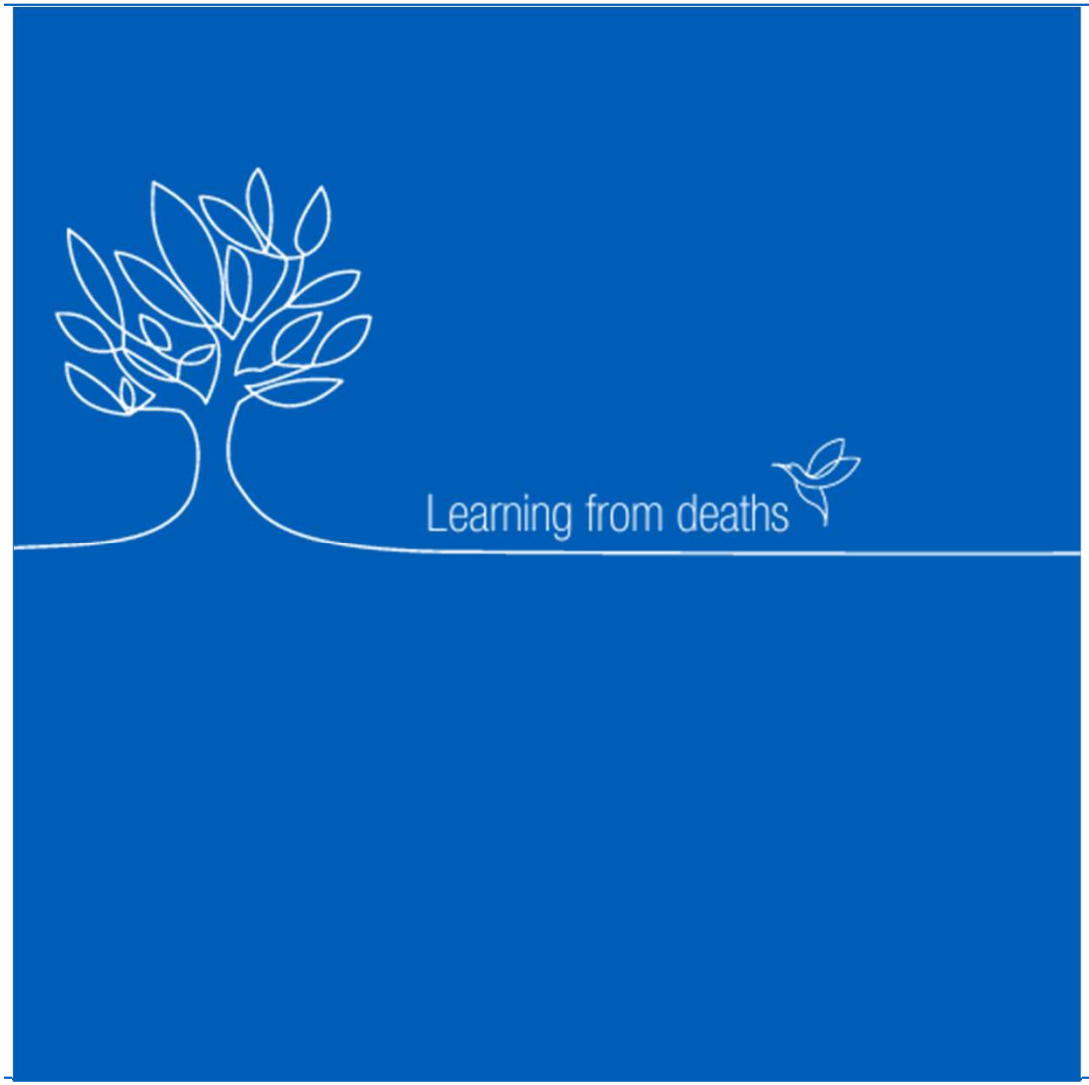
QUARTERLY OVERVIEW OF LEARNING AND DATA

Learning from deaths

QUARTER 3 - 2022/23

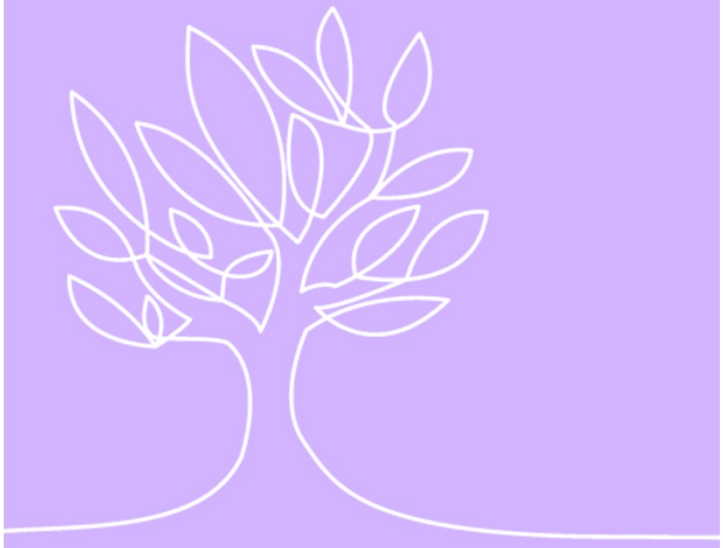


PURPOSE OF REPORT

This report sets out:

- An overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements since 1st April 2022;
- Information relating to the context of mortality data and surveillance under the Trust's new Learning from Deaths arrangements (Appendix 1);
- Data relating to deaths recorded on Datix (the Trust's incident management system) for Q3 2022/23 (1st October – 31st December 2022) and updated data for previous quarters this year (Appendix 2); and
- Updated data for deaths relating to 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 01/04/22 – 31/12/22

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 Patient Safety Incident Response Framework reviews
- Examples of actions being taken to address and action learning from learning from deaths reviews

Sources of learning (01/04/22 – 31/12/22):

- Stage 1 local service reviews undertaken on Datix – **250 completed**
- Stage 2 clinical case note reviews – **56 commissioned**
- PSIRF reviews – **35 commissioned**
- Stage 2 reviews / PSIRF reviews completed – **34 completed**
- EDAP reviews – **24 underway**
- LeDeR reviews - **8 underway**

Examples of good practice identified in reviews

- Many deaths are expected deaths - positive feedback from families and carers in terms of end of life care
- Good quality record keeping
- Regular reviews, assessments discussed in timely manner
- Good communication with patients and relatives, regular correspondence from secondary services to GP
- Review undertaken of internal team processes for communication following Stage 1 review
- Evidence of services sharing learning with partners (eg home care providers / agencies, hospices)
- Evidence of annual physical health review as per expected practice
- High degree of professionalism and compassion demonstrated
- Care person centred and next of kin involved where appropriate
- Good documentation of MH services liaison with GP, cardio and diabetic team to ensure physical health monitored (and blood test / ECG completed on last admission)
- Good communication between teams with patient and with wife / family members

Learning themes emerging from Stage 1 reviews (1)

- 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 (eg notification of death):
  - Within teams (ie across team members)
  - Between Trust teams (inc between inpatient and community settings, between providers of mental health and physical health care)
  - With partner agencies – acute, GP, social care, voluntary sector
- 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:
  - Management of physical health of patients on EPUT inpatient units
  - Monitoring of physical health of patients in community
- Opportunities to strengthen **record keeping** to provide comprehensive record (eg need to document follow up calls / visits, document reasons for closure of any referral, document next of kin details); avoid duplication; requirement for regular review and updating
- Opportunities to increase **proactive follow up of disengagement** – eg with people who do not attend appointments or who there is difficulty making contact with by phone / visit etc

Learning themes emerging from Stage 1 reviews (2)

- A number of individuals were **awaiting assessment** at time of death (either awaiting the offer of an appointment at time of death, appointment date was in the future or patient had not attended / not engaged when attempts were made to see)
- **Managing referrals** – eg timescales of outside agencies to provide support; onward referring team to ensure assurance received than referral is being followed up by receiving team
- Opportunities to strengthen process for **re-engaging** with patients after they spend a period of time in prison
- Opportunities to increase **face to face / video call assessments** post-COVID as recognised that telephone assessments are not as effective because appearance forms an important part of the mental health assessment
- **End of life care** learning
- Exploring impact of **falls** of inpatients on trust wards
- Examples of **specific actions** – exploring opportunities to strengthen linkages between STEPP programme (psychology services intervention) and mental health team with responsibility for the individual / achieving timely access to medications by the Home First Team

Learning themes emerging from Stage 2 reviews (12 approved to date)

- **Record keeping** (5/12) – eg documenting plan of care or risk assessment, ensuring clear documentation of events, outcomes and resultant care plans; and of communication between teams, documenting outcomes of referrals
- **Strengthening proactive follow up to disengagement** (4/12) – eg strengthening proactive follow up of disengagement / Did Not Attends (DNAs), considering appropriate frequency of contact when responses not received and how this should be escalated if contact cannot be made
- **Dual diagnosis learning** (3/12) - eg considering contacting other services involved in care to determine if complete disengagement or selective, ensuring active encouragement to engage with alcohol services where this is identified as an issue, strengthening joint working between EDAP and MH services
- **Personality disorder specialist service** (2/12) – eg for patients with diagnosis of EUPD, seeking specialist input from PD Service and how this can be accessed
- Individual learning points include:
  - Physical health monitoring
  - Meeting Trust standards on follow up
  - Availability of Trust local operational protocol on intranet
  - Addressing any delays between referral and appointment
  - Learning for acute Trust regarding discharge
  - Timing of handover of care
  - Process for following up queries on prescribing by primary care

Learning themes emerging from PSIRF reviews

Similar themes are emerging from the review of deaths under the Patient Safety Incident Response Framework (PSIRF) as follows:

- Communications
- Record keeping
- Involvement of families and carers
- Clinical care
- Referrals
- Disengagement
- Medications
- Reviews
- Internal Trust policy / processes
- Staffing

Examples of actions being taken in response to learning from deaths (1)

- **Local immediate actions by services** – eg strengthening of internal team communications processes / sharing learning with partner care providers / updating clinical system to provide triggers to ensure records complete
- 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" Microsoft Teams development sessions** – eg record keeping, identification and care of the deteriorating patient (physical health on inpatient wards)
- Thematic learning being used to inform the Trust's **Safety Improvement Plans**. The approach to developing these plans is currently being finalised and will be subject to separate reports. Proposed areas for focus are currently:
  - Mental Health Inpatient Ligature
  - Inpatient Falls
  - Transition of children and young people to adult services
  - Record keeping
  - Multi-Disciplinary Team Communication
  - Patient and service user disengagement
  - Policy and standard operating procedure application
  - Medication incidents
  - Clinical handover

Examples of actions being taken in response to learning from deaths (2)

- Sharing **of local learning** from Stage 2 reviews being co-ordinated by Deputy Directors of Quality and Safety (DDQSs), working with local clinical / service leaders to identify and implement change. Also being used to inform subject matter for quarterly learning events being designed and delivered for each Care Unit by DDQSs.
- **Specific actions** arising from reviews being pursued – eg:
  - Exploration of implementing a central Trust wide system for storing all local level service protocols to ensure consistent availability to access by all staff
  - Exploration of process within EPUT to enable escalation of queries in relation to prescribing by an external primary care provider
  - Exploration, with ICBs, of process for strengthening communication between EPUT teams and acute Trust when EPUT patients are admitted to / discharged from in-patient wards in acute Trusts and for sharing learning
- Multi-disciplinary work being facilitated to address **Trust wide issues** - eg :
  - Physical health – learning from deaths lead linking with Trust leads for physical health and the care of the deteriorating patient to ensure learning informs work in these areas
  - Time limited task and finish group being established with membership from EPUT and the Prison Healthcare Services to consider how processes to ensure re-engagement with clients following a period in prison could be strengthened
  - On-going Dual Diagnosis Learning Implementation Group being established to consider specific learning emerging from the review of deaths of clients with dual diagnosis and the implementation of specific actions that can be taken within mental health and drug and alcohol services to make improvements to address learning identified

MORTALITY DATA - Context

- The context for the collection and reporting of mortality data under the new Trust Learning from Deaths arrangements (2022/23) 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.
- However, regardless of the mandatory requirements for a formal review detailed in Appendix 1, 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 Q1 – Q3 2022/23.
- It should be noted that all data in this report is taken as at 07/02/23. 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 2022/23 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 subjected to review
  - the level of review to which they 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.

Summary of Quarter 3 2022/23 mortality data (1)

- **Total number of deaths:** There were a total of 95 deaths reported on Datix for Q3 2022/23 (including those not falling within the scope for mandatory reporting). 68 of these deaths fell within the scope of the Learning from Deaths Policy. There are no significant variances between reported deaths Q1 – Q3.

- **Inpatient / Nursing Homes deaths:** Of the 95 deaths reported in Q3, 7 were inpatient deaths and 3 were nursing home deaths. All 7 of the inpatient deaths and all 3 of the nursing homes deaths have been confirmed as due to natural causes.

- **LeDeR reporting validation:** All Learning Disability deaths in Q3 (and previous quarters) have been reported to the national LeDeR programme.

- **Level of review:** The increase in the proportion of deaths being subjected to a Stage 2 Clinical Case Note Review (19%) and decrease in those being closed at Stage 1 desktop review (42%) or at Stage 3 full PSIRF arrangements (12%), as compared to the previous mortality review arrangements, has continued. This is an intended outcome of the new arrangements as it enhances the ability to learn from deaths. However, it has had resourcing implications as more staff have been required to undertake these reviews.

Summary of Quarter 3 2022/23 mortality data (2)

- **Stage 1 reviews:** A total of 250 deaths from 01/04/22 – 31/12/22 have been subjected to a Stage 1 learning from deaths review by a local service manager. This enables learning to be identified as well as identifying those deaths which should be subjected to a further detailed review. This is a local review stage that did not form part of the previous Mortality Review arrangements and has thus increased local 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. There were a total of 29 Stage 1 reviews awaiting completion at the point of extracting the data - this is being pursued with relevant managers, with the support of Quality and Safety Group chairs.
- **Stage 2 reviews:** A total of 13 deaths in Q3 have been identified for Stage 2 mortality clinical case note review thus far. A new small sub-group reporting to the Learning from Deaths Oversight Group was established in January and is undertaking the scrutiny and approval of completed Stage 2 reviews. To date, 17 have been considered by this Group; 15 of these have been approved. The remaining Stage 2 reviews are underway and will be completed / presented for scrutiny over the coming weeks.
- **Problems in care assessment –** There are no deaths thus far in 2022/23 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 150 out of the 290 deaths. This data will be updated in future reports as reviews are completed and the likelihood is determined.

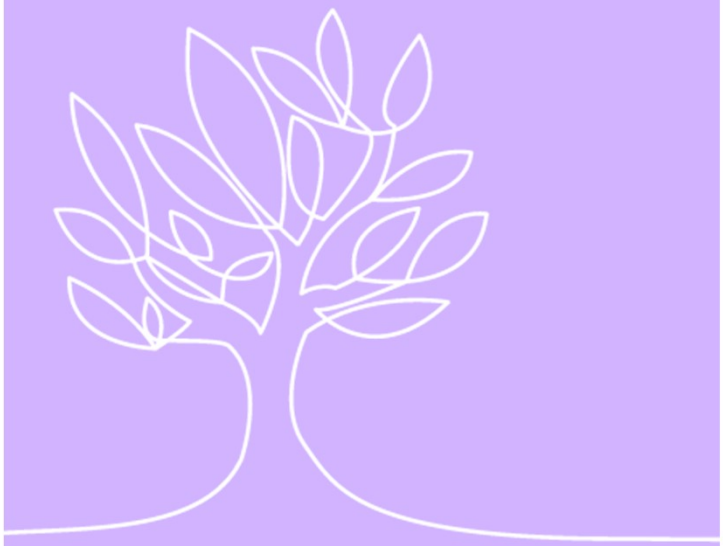
Assessment of Q3 data against historic scope (for mortality surveillance)

- An analysis has been undertaken of the Q1 – Q3 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 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. Any potential outliers in terms of numbers are explored in more detail and validated.
- Currently the number of deaths falling within the previous scope is significantly lower than previous quarters. This is potentially related to the fact that there are a larger number of Stage 1 reviews requiring completion at this stage (n. 29) and thus they have not been assigned to a category. However, even if all those awaiting completion indicated a death that would fall within the previous scope categories, this would only take figures to within the region of previous quarters and thus figures do not indicate a cause for concern. Figure 1 in Appendix 2 indicates that the number of deaths in scope in Q1 – Q3, using the previous scope, fall within control limits.

Summary of previous years' mortality data (2017/18 – 2021/22)

- A summary of mortality data for previous years (2017/18 – 2021/22) is attached at **Appendix 3** detailing the mandated requirements of the National Learning from Deaths Guidance.
- This indicates that there are only a small number of deaths remaining open (n. 2020/21: 3 2021/22: 22).
- All are being actively progressed (full details included in Appendix 3).
- 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 mandated mortality data and data to support mortality surveillance.
- It also provides assurance that the learning emerging is being acted upon and that the analysis of the data indicates that there are no matters of concern in terms of mortality data surveillance for Q3.
- Given the outcomes outlined, it provides 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.
- The Board of Directors is asked to note the information presented, seek further information or clarity where required and agree any actions resulting from the presentation of this information.
- The Board of Directors is also asked to comment on the revised format of the report so that further refinements can be made for future presentations.

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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 Q1 – Q3 2022/23. 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.
- 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. The data for Q1 – Q3 has therefore been analysed in its totality under the new arrangements, as well as 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 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) have not to date been subject to this determination as the methodology encourages focus on quality learning outcomes. This is reflected in the data in Appendix 2 & 3. However, consideration is being given to if/how it would be possible to introduce a methodology to make this determination whilst not impacting on the PSIRF methodology.
- 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 – this work is underway for Q3.
- It should be noted that all data in this report is taken as at 07/02/23. Any updates to information after this date will be included in future reports.

APPENDIX 2 2022/23 mortality data (1)

Table 1: SUMMARY OF 2022/23 MORTALITY DATA	Q1	Q2	Q3	Q4	YTD
DATA ON NUMBER OF DEATHS					
Total deaths reported on Datix	99	96	95		290
Total deaths reported on Datix in scope of learning from deaths policy	60	61	68		189
Total inpatient deaths	6	6	3		15
Total nursing homes deaths	5	7	7		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)	93	91	66		250
Total deaths awaiting completion of Stage 1 review	6	5	29		40
Total deaths closed at Stage 1 and learning ascertained	45	42	36		123
Total deaths referred on for Stage 2 clinical case note review	20	23	13		56
Total deaths referred on for Patient Safety Incident Response Framework (PSRIF) review (Stage 3)	14	16	5		35
Total deaths for which Stage 2 review or PSIRF review complete and learning ascertained	19	15	0		34
Total deaths undergoing Essex Drug and Alcohol Partnership (EDAP) multi-agency collaborative review processes	11	4	9		24
Total deaths undergoing LeDeR (national learning disability mortality review) processes	3	4	1		8
Total deaths for which level of review under determination	6	7	31		44
DATA ON PROBLEMS IN CARE (PIC) DETERMINATION					
Assessed as more likely than not due to PIC	0	0	0		0
Assessed as not more likely than not due to PIC	59	45	36		140
Assessment of likelihood of death being due to PIC still underway	40	51	59		150

APPENDIX 2 2022/23 mortality data (2)

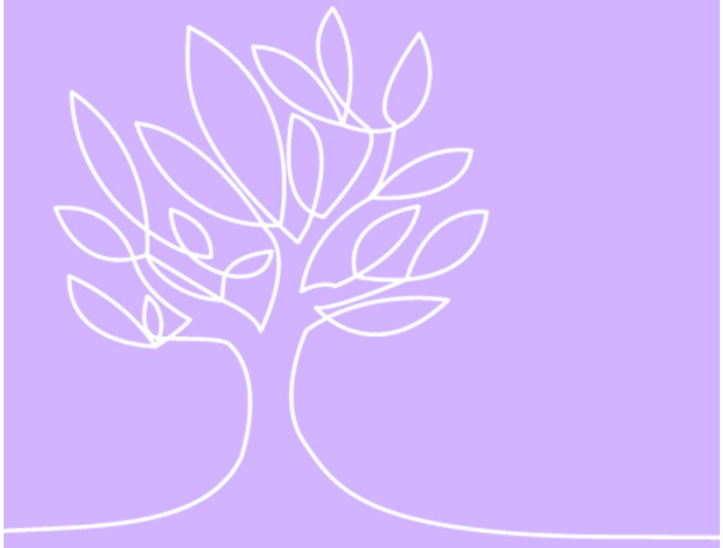
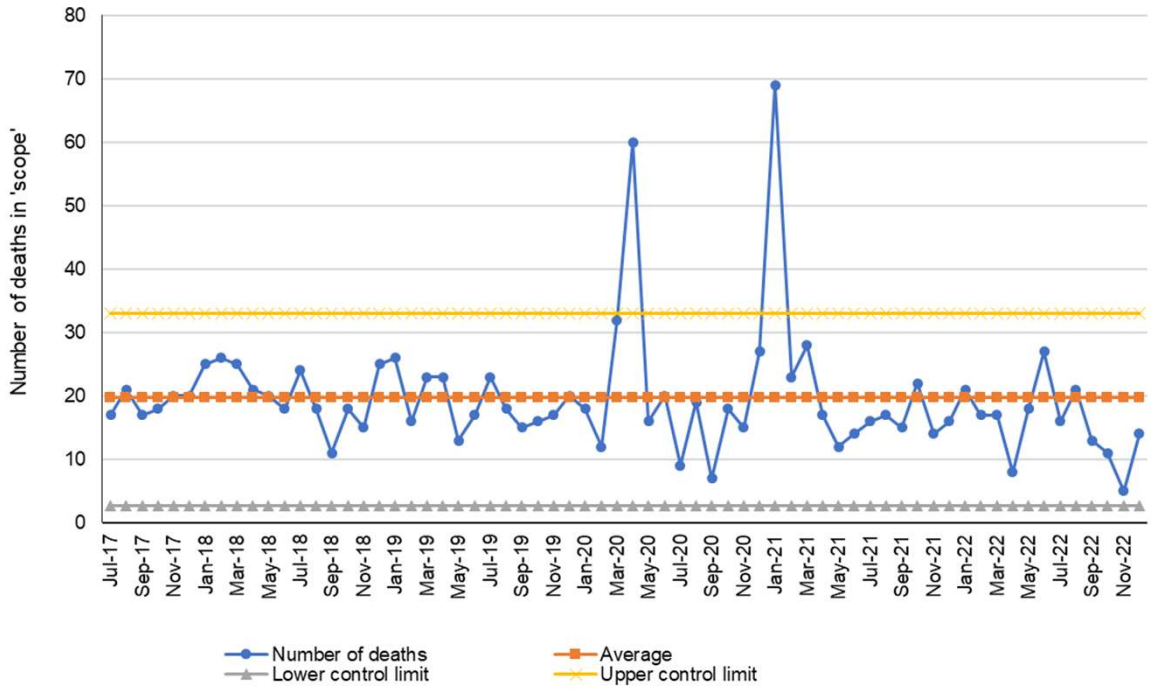


Table 2: Comparison of levels of review Q1 – Q3 2022/23 to previous years

Level of review	Number of deaths Q1 – Q3	As a percentage of total deaths Q1 – Q3	Average percentage in previous years
Closed at Stage 1	123	**42%**	**64%**
Stage 2 review underway (Clinical Case Note Review)	56	**19%**	**6%**
Review taking place under PSIRF processes	35	**12%**	**29%**
Review taking place under EDAP processes	24	**8%**	**-**
Review taking place under LeDeR	8	**3%**	**-**
Under determination	44	**15%**	**-**
Total	**290**		

APPENDIX 2 2022/23 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. Figure 1 below indicates that the number of deaths in scope in Q1 – Q3, using the previous scope, fall within control limits.



APPENDIX 3 – Previous years' mortality data

Table 3: 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	% 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%	3.5%
2019/20	228	228	64%	7%	0.5%	29%	2%
2020/21	311	308	73%	3%	0%	23%	0%
2021/22	195	173	62%	1%	0%	26%	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

Breakdown of open deaths

2020/21: The 3 deaths remaining open are part of a thematic review currently underway of non-Patient Safety Incident deaths of patients with a Severe Mental Illness diagnosis

2021/22: The 22 deaths remaining open are as follows:

- 6 deaths are part of the thematic review currently underway of non-Patient Safety Incident deaths of patients with a Severe Mental Illness diagnosis
- 5 deaths are open under PSIRF – 3 of which are anticipated to be closed shortly (2 with Directors for sign off and 1 undergoing quality assurance check); 1 on-going and 1 stopclocked due to police investigation.
- 11 deaths not Datix reported but identified via clinical information system as non- Patient Safety Incident deaths of individuals with Severe Mental Illness diagnosis to be Datix reported and subjected to initial desktop review prior to determining whether they should be subjected to more detailed review.

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 7f
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 March 2023**

Report Title:	**Equality, Diversity & Inclusion (EDI) Annual Board Report 2023**					
Executive/ Non-Executive Lead:	Marcus Riddell – Acting Executive Director of People & Culture					
Report Author(s):	Lorraine Hammond – Director of Employee Experience					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Project reports only:	
If this report is project related please state whether this has been approved through the Transformation Steering Group	N/A

Purpose of the Report		
This report provides the Board of Directors: • An update on the EDI projects, reporting and initiatives that have taken place between April 2022 and March 2023.	**Approval**	
	Discussion	✓
	Information	✓

• Highlights from EPUT's Equality Delivery System (EDS), Workforce Race Equality Strategy (WRES), Workforce Disability Equality Strategy (WDES), Public Sector Equality Duty (PSED) and Gender Pay Gap reporting. • The EDI Team's key focusses based on this feedback. • A short summary of accessibility in our services (*written in collaboration with the Director of Patient Experience*) and the actions of our Staff Networks during this period.		

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

- Our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data shows that the reported experiences of bullying and harassment are disproportionate for both Black, Asian and Minority Ethnicity (BME) staff and staff members with a disability or long-term condition.
- Our Equality and Inclusion Strategy (2022-25) was developed across this year, with input from our Staff Networks, WDES and WRES Data and EPUT staff stakeholders. This will be used to drive improvements with key performance indicators and has been approved at Board level.
- We are now a Disability Confident Leader following a review of services with our Disability and Mental Health Network.

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			
WRES	Workforce Race Equality Standard	WDES	Workforce Disability Equality Standard
BME	Black, Asian and Minority Ethnicity	LTC	Long-term condition
EDS	Equality Delivery System	MSE	Mid and South Essex
HWE	Herts and West Essex	ICS	Integrated Care System
HR	Human Resources / Employee Relations	EDI	Equality, Diversity and Inclusion
PSED	Public Sector Equality Duty		

Supporting Reports/ Appendices /or further reading

Appendix A: - EDI Governance Structure
Appendix B: - Equality and Inclusion; service access, provision and workforce
Appendix C: - Staff Equality Network update 2022 - 23

Further Reading:

- EPUT Equality Strategy 2022-25
- EPUT WRES and WDES Reports 2022
- EPUT Equality Delivery System reporting template (EDS 2022-23)
- EPUT Public Sector Equality Duty reporting (2022-23)

Lead

Marcus Riddell
Acting Executive Director of People and Culture

Agenda Item: 7f
Board of Directors Part 1
29 March 2023

EQUALITY AND INCLUSION, ANNUAL REPORT 2022 - 23

1. Purpose of the Report

The purpose of this report is to provide Trust Board with an overview of Equality and Inclusion progress in the last twelve months. **The report covers the period 1 April 2022 to 31 March 2023.**

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2. Executive Summary

This report provides assurance to the Board that the Trust is able to report against the general public sector equality duty as outlined in the Equality Act 2010. To have due regard for the need to eliminate unlawful discrimination, harassment and victimisation; to advance equality of opportunity; and to foster good relations between people who share a protected characteristic and those who do not.

The report and appendices evidence key highlights and progress on the equality agenda across the last twelve months. We do this through the Equality Delivery System and our Trust objectives, the WRES / WDES. We also publish externally here. https://eput.nhs.uk/about-us/equality-and-diversity

3. Context

EPUT is proud of its work around equality, diversity and inclusion (EDI). We aim to promote an inclusive culture that combines equality, inclusion, wellbeing and psychological safety for our staff and encourages them to act as allies within our services.

We as a Trust aim to address health inequalities in our localities to ensure that we are providing parity of care and accessibility for those from marginalised and minority communities, as well as ensuring our staff are allies to these communities and have the appropriate resources and training to provide person centered care.

4. Governance

Equality is governed by the EDI Sub-Committee, led by the Executive Director of People and Culture and supported by senior representatives. The group monitors progress on delivering EDI whilst identifying risks, which are then escalated as appropriate. It also serves to share good practice and celebrate progress:

The key aims of the EDI Sub-Committee are:

- Ensure that the Trust remains compliant with Public Sector Equality Duties and the Equality Act.
- Provide assurance and support in respect of compliance and delivery of the Equality Delivery System (EDS) action plan, as well as WRES and WDES action plans.
- To provide assurance and evidence that the Trust is meeting the equality and diversity

elements of the Care Quality Commission Fundamental Standards as well as CQC suggested actions.

- To promote Equality, Human Rights and Inclusion throughout the Trust, and to evidence this in line with Trust Equality Objectives

The EDI Sub-Committee Governance Structure is set out in **APPENDIX A**

5. Equality Objectives and the Equality Delivery System (EDS)

As part of the Trust's public sector duties, EPUT must publish its equality objectives every four years. Following a process of consultation with key stakeholders during August 2022 and November 2022, we developed three Equality Objectives (2022 - 2025) as follows:-

Equality Objective 1: "Everyone should take an active role to reduce inequalities."

Equality Objective 2: "Respecting one another to build an open and equitable culture that celebrates diversity."

Equality Objective 3: "We want everyone to have a voice."

Implementation of the EDS is a mandatory requirement for both NHS commissioners and NHS providers. The main purpose of the EDS is to guide NHS organisations, in discussion with local partners and local people, in reviewing and improving the services and functions they provide for people from marginalised and minority communities.

As NHS England have developed a new format for the EDS and intend this to be completed collaboratively within ICS groups, this year has been seen as an implementation year. One of the key features being that Domain 1 focuses on two specific services within our organisation (an EPUT Perinatal Service and a Children and Young Peoples Mental Health Service).

Due to our commitments with multiple ICS groups, we as an organisation are working with system partners to develop this for 2023-24, but this year have completed it independently and will be sharing this with our system partners. Our EDS (2022-23) action plan and grading report will be published on the Trust website and will be available on the EDI Hub on the Trust intranet by the end of March 2023.

The EDS (2022-23) was graded by Stakeholders in March 2022 across three domains (*Commissioned or provided services, Workforce health and wellbeing, Inclusive Leadership*), with stakeholder groups for each domain giving their feedback on the work we as an organization have done during this period as well as suggestions for actions for the upcoming year (2023-24).

Commissioned or Provided Services
Rated by a virtual service user volunteer group held by the Patient Experience Team.

Workforce Health and Wellbeing
Rated by EPUT staff stakeholders at an all-welcome virtual event.

Inclusive Leadership

Rated by an EPUT Staffside representative as an independent third party.

We as an organisation received a "developing" grade based on combined stakeholder feedback, with Inclusive Leadership scoring the lowest out of the three domains. The feedback will be part of an EDS action plan as part of our development across the year.

6. Public Sector Equality Duty (PSED) reporting

The Trust is legally required to monitor, analyse and publish EDI data as part of its commitment to the Public Sector Equality Duty (2018) on an annual basis. This information compares the Trust to Census data to ensure we as an organisation are representative of the communities we serve, as well as promotions, leavers and HR concerns broken down by the protected characteristics listed in the Equality Act (2010). This workforce data is available to review in our Public Sector Equality Duty Report (2022-23), and action based on this data is part of Section 11 in this report.

7. Equality and Inclusion highlights, 2022-23

- Our Director of Employee Experience is the Senior Responsible Officer (SRO) for Inclusion in both MSE and HWE ICSs strengthening the relationships to create a consistent approach for ED&I across Essex

- Following WRES and WDES Data showing us that Bullying and Harassment continues to be a priority for the Trust. We have rolled out the No Space for Abuse campaign in EPUT in collaboration with Essex Police and our Violence and Aggression Prevention and Reduction (VAPR) Team. This both provides staff with guidance on how to report racism or any form of discriminatory behaviour, as well as clear messaging that this is not accepted from people accessing our services. In addition, to provide staff affected by racial and violent abuse support, a new 'debrief process' has been implemented for Managers and senior staff in the Inpatient Units, where they will need to complete a form whilst as well as raise a DATIX.

- Continuation of our EPUT RISE program, focusing on career development for ethnic minority staff across the Trust aimed at multiple bandings and skill levels.

- Development of our Equality and Inclusion Strategy (2022-25), and approval at Board Level for implementation into the Trust.

- Executive Director Sponsors joining Staff Equality Networks, providing support to Network Chairs and acting as champion for the Network.

- Inclusive Career Development Workshop developed and presented in collaboration with Herts and West Essex ICS.

- De-Bias toolkit developed in collaboration with Mid and South Essex ICS, aimed at HR and recruitment leads to mitigate potential bias in our recruitment processes as an organisation.

- Anti-Bullying Event held as part of EDI Week (November 10th 2022) held in collaboration with Mid and South Essex ICS. Part of this being the development of a pilot "micro-incivilities workshop" aimed at staff managers in all services.

- Our WRES Action plan for 2022-23 was rated as "Outstanding" by NHS England; *"Good use of positive action, measured interventions and using data and evidence to support change."*

8. Service Access and Provision

EDI is embedded into everything the Trust does and seen as the responsibility of everyone in the organisation. The aim is for the Trust to be a leader in championing this in our care. The aim of embedding equality and inclusivity into our services is to ensure they are valued, treated with respect and dignity, are treated equitably and have the best possible patient journey. Further detail is available in **APPENDIX B**

9. Workforce

We want to promote an inclusive culture, combining Equality and Inclusion with both staff wellbeing and psychological safety. We are passionate about our staff understanding the key concepts of equality and inclusion, as well as their benefits.

We work closely with members of our workforce who have lived experience from many different perspectives, and work in collaboration with them to raise awareness of national awareness events to help us promote this positive workplace culture. We also work in collaboration with these staff, our Staff Equality Networks and over 350 Staff Engagement Champions across the Trust to develop and improve resources, create and present training programs and help us make improvements to our existing systems and policies / procedures to ensure that they are inclusive. Further detail is available in **APPENDIX B**

10. Staff Equality Networks

Our Staff Equality Networks have been a vital function within the Trust. Throughout this period, they have shared their lived experience and continued to develop actions aimed at promoting and improving inclusivity in our services for our workforce, as well as supporting staff from their respective groups and allies wishing to learn more. Further detail is available in **APPENDIX C**

11. Key focusses for Action and Improvement in Equality & Inclusion for 2023-2024

Following the grading of our progress on the EDS, and after identifying barriers and trends from the previous year, the following are key focusses for 2023 – 24:

- Involvement of the Executive Team to promote EDI at a senior level based on EDS feedback, driving actions on our WRES and WDES action plans and the Equality and Inclusion Strategy.

- Ensure that Staff Equality Networks receive support from Executive Directors acting as sponsors to guide these groups whilst also championing inclusion in our workforce.

- To improve the EDI training offer available to all staff, as well as developing specific guidance aimed at middle-managers in the organisation to promote inclusion. Commissioning a mandatory Transformational Cultural Programme focussed on our Leaders *(L50 / L300).*

- To address bullying and harassment concerns raised by our WRES / WDES Data, and to review the support available for those experiencing racism, discriminatory behaviour or abuse. Developing a Racial Discrimination Steering Group with key stakeholders from across the Trust committed to driving this agenda.

- To develop a Gender Equality Network in line with our existing Staff Equality Networks.

- Retention of staff across all demographic groups, with it being a key element of the People Strategy

- To build upon our existing data sources to ensure we are responding to trends, achieving our KPI's and addressing hotspot areas where discriminatory behaviour is an issue. Improving the quality of staff's Electronic Staff Record information and promote the completion of this with new starters in the organisation to ensure EPUT's demographic data is robust.

- To work alongside system partners and our own Recruitment and Employee Relations teams to To ensure that our Recruiting and Hiring processes are inclusive and in line with NHS England's "No More Tick Boxes" guidance and to remove potential systemic discrimination from our Employee Relations processes.

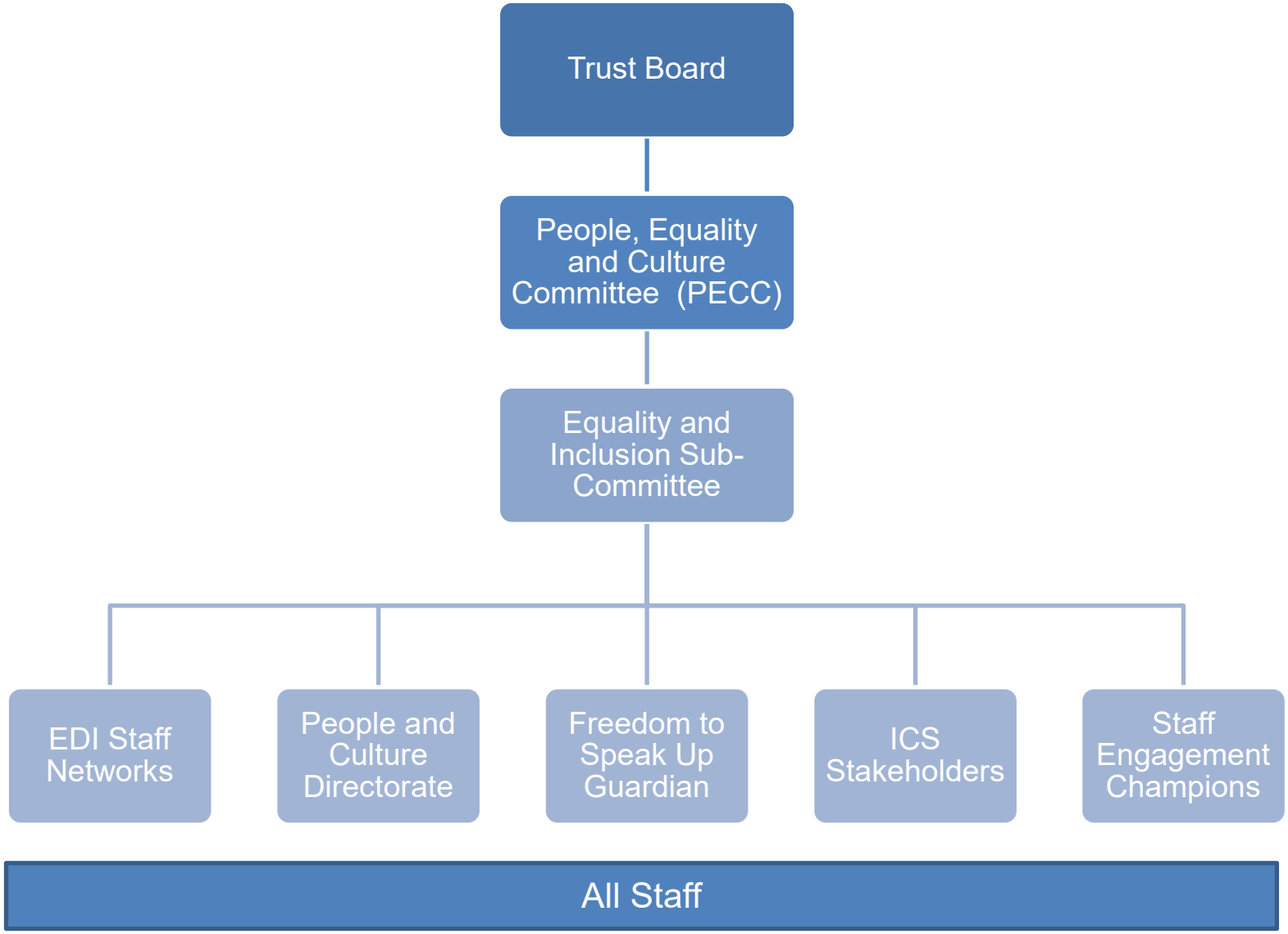
- To address disproportionate levels of bullying and harassment reported by the ER Data in the PSED, as well as similar findings in our WRES and WDES Action Plans.

Report prepared by

Name **Lorraine Hammond**
Job Title **Director of Employee Experience**
Date **March 2023**

On Behalf of:
Name **Marcus Riddell**
Job Title **Acting Executive Director - People and Culture**

APPENDIX A: EQUALITY AND INCLUSION GOVERNANCE STRUCTURE 2022 - 23



APPENDIX B - EQUALITY AND INCLUSION; SERVICE ACCESS, PROVISION AND WORKFORCE

SERVICE ACCESS AND PROVISION

Accessible Information Standard (AIS)

The Accessible Information Standards require all NHS and Adult social care systems to have a consistent approach to identifying, recording, flagging, sharing and meeting the needs of anyone accessing our services. It is part of our induction for all new staff, and information is available for all staff on the Trust intranet.

Faith and Chaplaincy Services

We have worked closely with our Chaplaincy services throughout this period, in particular providing guidance on how staff members can observe their faith and spirituality. Our Chaplaincy service have supported us in providing guidance in how we as a Trust can best support the spiritual and faith needs of those accessing our services.

Interpreting and Translation Services

The Trust has a contract in place with Language Empire to provide interpreting and translation services for our patients and service users. Supplying our service users with translation / interpreting helps bridge any language or cultural gaps between our patients and their healthcare providers. It also allows service users to communicate accurate information to clinicians and practitioners.

Equality Impact Assessments

The Trust has processes in place to ensure that equality impact assessments are completed for all policies and key decisions, to good quality standards. This includes all decision-making processes and Proposals presented to official committees. We are currently working to improve this model to make it easier to access, understand and complete by staff, as well as making it a mandatory part of submission to Trust Board.

Complaints Process and our Patient Advice and Liaison Service (PALS)

The Trust complaints policy sets out a framework for listening, responding and improving when patients and service users, their families or carers raise concerns. In addition to this, a process has been set up with the complaints department to ensure that AIS are embedded in the complaints process. As part of the complaints and PALS (Patient Advice & Liaison Service) process, we consider if issues raised are related to equality or diversity. Trained Complaint Investigators thoroughly and independently review all issues raised, and where injustice or wrongdoing is identified, we take immediate steps to resolve the problem. Our Lessons Learned Team records and track lessons learned and actions taken, and ensure that learning is shared across the Trust. E&I related incidents or concern data is also reported to our Equality and Inclusion Sub-Committee to help us identify trends and develop improvements.

Friends and Family Test

The Trust has in place a unified patient survey provided through the *"I want Great Care" platform (IWGC), which is idependent, impartial and anonymous.* This draws together the national NHS Friends and Family Test (FFT) and a further series of local questions around key areas we identified together with people who use our services. A specific question asking service users if they felt they were treated equally and if not, how we could improve on this is included on every FFT form. In addition to this, we now capture patient demographics by default so we can better understand an inequalities of experience through segmentation of the data by characteristics. An online dashboard is available for operational managers to access their service's FFT results, including the specific

equality and inclusion question. They are then able to discuss the feedback with their team or individuals, where appropriate, using it as an opportunity to reflect on practice and look for improvements. Managers are encouraged to use positive feedback to share and reinforce good practice, as well as encourage further participation in the survey. Any concerns identified in the FFT comments are fed back by the Patient Experience Team to the relevant team/service to action appropriately. Whilst the use of IWGC is relatively new to the trust, its adoption is increasing, and the data is enabling us to support and drive things like the national Patient and Carer Race Equality Framework (PCREF).

The Trust also participates in the annual National Community Mental Health Survey, which is sent to patients who received treatment from the Trust from September to November each year to complete and return. The survey asks a number of questions around care and treatment and these results are presented the following year, with a comparison against other Trusts. Any areas within the Trust that require improvement are raised with Operations and any actions to be taken are monitored and evidenced throughout the year.

ICB Health Inequalities

We are working across the systems supporting partners to lead and deliver change across all areas where inequalities of access, experience, and outcomes have been identified. This is being led as collaborative joint effort by the director of patient experience and director of staff experience. This is emergent in nature as we stabilize and evolve partnership working across the system but as an example of this we will be working across MSE ICP to improve physical health checks for people with severe mental illness as we know there is an inequality of access and outcomes to address. This can and will also be driven by EDS22 as we take forward the new model for identifying inequalities of experience, access, and outcomes across our services.

Patient and Carer Race Equality Framework (PCREF)

The PCREF is a new initiative from NHS England to address inequalities of experience, access, and outcomes for black and minority ethnic groups. It is a competency framework to assess a service provider's performance in this area, supporting the development of improvement plans for our services. Although still in pilot stage, EPUT is an early adopter and one of 10 pilot sites across England. The PCREF is identified in the strategy, has an executive sponsor, and will be driving forward equality across our services from 2023 onwards.

Patient Led Assessments of Care Environments (PLACE)

In 2022 the patient experience team took on the delivery of PLACE across our services. This is now included as an activity under the Reward and Recognition policy. The impact of this being that last year we had record numbers of people with lived experience undertaking the assessments. Further to this the focus last year was very much on accessibility, and this is another tool in our box for accessing inequalities of services, particularly the physical environment.

Equality Monitoring Policies

We currently adhere to the Equality Monitoring Policy and Procedure (CP27 and CPG27 respectively). This shows the Trust's commitment to support the implementation of the national requirements on ethnicity monitoring (DSCN 02/2001, DSCN 03/2001 and DSCN 21/2000), in which the ethnicity of our service users and staff are recorded based on key ethnicity groups. This also includes the Sexual Orientation Monitoring standard (a non-mandated standard that requests we record sexual orientation in a similar standard) to ensure that the way we request this data from staff and patients is done in an inclusive manner.

WORKFORCE

Public Sector Equality Duty report (Workforce)
Each year we produce a detailed analysis of our workforce by each of the protected characteristic groups and then a range of HR interventions. The most recent report is available on the Staff Intranet at the beginning of a new financial year.

Gender Pay Gap
EPUT has a statutory obligation to report annually on the gender pay gap and is required to publish its gender pay gap data including mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile. The gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are.

- 31st March 2022: the GPG mean was calculated at 13.06% - this result means that men on average are being paid 6.21% higher than women.

- EPUT data indicates a total of 1.82% of males received a bonus compared to 0.38% of females within the reporting period.

- Across the UK, men earned on average 14.9% more than women did in 2022, according to the Office of National Statistics, meaning that EPUT's gender pay gap is below the national average.

- EPUT is performing well in comparison with neighboring providers

- EPUT is the top performing NHS Provider in Mid & South Essex ICS

Workforce Race Equality Standards (WRES)
The Workforce Race Equality Standards are a mandatory requirement for NHS Employers looking at the experience of Black, Asian and Minority Ethnicity (BME) staff compared to their white counterparts. Our most recent published report is available on both the Trust website, and details from the recently updated Staff Survey have been included for comparison.

Workforce Disability Equality Standard (WDES)
The Workforce Disability Equality Standards are a mandatory requirement for NHS Employers looking at the experience of staff who are disabled or who have long-term health conditions compared to non-disabled counterparts in the organisation. Our most recent published report is available on the Trust website, and details from the recently updated Staff Survey have been included overleaf for comparison and will be included in the 2023 WRES and WDES reports.

Key Finding	WRES	2021 score	2021 Average	2022 score	2022 Average	2023 Score	2023 Average
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	White	60.9%	61%	62.6%	58.7%	61.6%	62.3%
	BME	41.2%	48.9%	48.9%	44.4%	52.7%	49.6%
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	22.2%	18.1%	21.1%	22.5%	21.6%	17.3%
	BME	26.7%	22.9%	28%	27.6%	26.0%	22.8%

Key Finding	WDES	2021 score	2021 Average	2022 score	2022 Average	2023 Score	2023 Average
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	Dis / LTC	53.0%	54.4%	56.2%	54.4%	54.7%	56.0%
	Non Dis	58.6%	60.2%	61.4%	60.2%	62.0%	61.5%
Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	Dis / LTC	22.4%	20.2%	23.4%	20.2%	24.4%	18.9%
	Non Dis	15.5%	12.3%	15.2%	12.3%	15.6%	12.1%

Disability Confident Scheme

We have has successfully completed accreditation as a Disability Confident Leader. This means as an organisation we are making sure that people who work for us who have a disability have a fair chance within the Trust as the Disability Confident scheme supports employers in making the most of the talents of disabled people and what they can bring to a workplace. For more information, please visit: *disabilityconfident.campaign.gov.uk*

Mindful Employer

EPUT are proud to be a signatory to the Charter for Employers who are Positive about Mental Health. Mindful Employer is about supporting employers to support mental wellbeing at work. It is led by employers and is for employers. It is about increasing awareness of mental health, demonstrating commitment to the mental wellbeing of all staff and showing that organisations are working towards putting their principles into practice. For more information, please visit: *www.mindfulemployer.net*

APPENDIX C – STAFF EQUALITY NETWORK UPDATE 2022 - 23

The following are examples of some of each Network's key achievements, based on actions developed by their membership groups. A full account of actions and progress can be found on each Network's respective action logs.

As of March 2023, Executive Directors will be acting as executive sponsors for these Networks, supporting and guiding their development and projects:

- EMREN Network – **Paul Scott / Zephan Trent**
- LGBTQ+ Network – **Natalie Hammond / Marcus Riddell**
- Faith and Spirituality – **Milind Karale**
- Disability and Mental Health Network – **Alex Green / Trevor Smith**

General Actions: All Networks

- Network Chairs provided guidance and support to staff throughout this period, as well as leading on EDI events during this period with assistance from EPUT's EDI and Communication Teams.
- Regularly held Bi-Monthly sessions virtually throughout 2022-23, as well as appearances on Trust live update alongside senior staff to promote upcoming events in the EDI Calendar and share their lived experience.
- Network chairs regularly take part in Equality and Inclusion Sub-Committee sessions, sharing Network feedback.
- Network chairs participated in events across EDI Week (November 2022), including a live event aimed at addressing and taking action against bullying, harassment and discriminatory behaviour in partnership with Mid and South Essex ICS.

Ethnic Minority and Race Equality (EMREN) Staff Equality Network

- Working in collaboration with the EDI Team to develop and support the Workforce Race Equality Standard report and action plan from 2022 – 2023.
- Organizing a suite of online events, articles and engagement across Black History Month (October 2022).

Lesbian, Gay, Bi, Trans and other sexual or gender minority groups (LGBTQ+) Staff Network

- Continuation of LGBTQ+ Awareness Training, teaching key concepts in gender identity, sexuality, supporting people from these communities in our workforce, and those accessing our services. The Network bid for funding via NHS Charities to provide Rainbow EPUT Lanyards for attendees to show their allyship.
- Organizing a suite of online events, articles and engagement across LGBT+ History Month (February 2023) LGBTQ+ Pride Month (June 2022).

Faith and Spirituality Staff Network

- Took part in Faith and Spirituality Week and Faith and Spirituality Appreciation day in collaboration with Spiritual Care, providing a suite of online events and resources for staff (November 2022).
- Supported the promotion and guidance for managers wishing to support staff and patients during Ramadan and other faith observances in the EDI Calendar.

Disability and Mental Health Staff Network

- Promoted Disability History Month (November 2022), and other Disability and Mental Health related events throughout the year, providing staff stories, articles and videos through the Trust Intranet.
- Achieved *Disability Confident Leader* Status for EPUT.
- Developed a short training video aimed at managers implementing reasonable adjustment passports.
- Working in collaboration with the EDI Team to develop and support the Workforce Disability Equality Standard report and action plan from 2022 – 2023.

		Agenda Item No: 7g
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 March 2023**

Report Title:	**Public Sector Equality Duty Report 2022-23**					
Executive/ Non-Executive Lead:	Marcus Riddell – Acting Executive Director of People & Culture					
Report Author(s):	Lorraine Hammond – Director of Employee Experience					
Report discussed previously at:	Not previously presented					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Project reports only:	
If this report is project related please state whether this has been approved through the Transformation Steering Group	N/A

Purpose of the Report		
This report provides the Board of Directors: • With a breakdown of Workforce Demographics from **1 April 2021 - 31 March 2022**, with comparisons against local census data to identify areas of poor and strong representation. As well as data for leavers, recruitment, promotions and employee relations processes. • This report is part of our legal duty under the Equality Act (2010) and must be published annually before the end of the financial year with board approval.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required
The Board of Directors is asked to: **1** To approve the Public Sector Equality Duty (PSED) 2022-23 report so it can be published on our website for public viewing. **2** To review the data, key themes and trends discussed. **3** To approve EDI next steps based on this feedback.

Summary of Key Issues
• We were representative of our localities in our workforce in regards to Religious Belief, Sexual Orientation and Marital or Civil Partnership Status. • During this period, 26% of our workforce were Black, Asian or from a Minority Ethnicity group (BME), approximately 20% higher than census data for the locality. • During this period, 39% of all employee relations cases involved BME members of our workforce. This is disproportionate and has been a focus of our EDI work across this year. • 79% of our workforce were female and 21% male, which is commensurate with the NHS as a whole but more representative of female employees in comparison to census data. • 4% of our workforce declared a Disability during this period in comparison to approximately 20% on the Census, but it should be noted that ESR data only accounts for staff in post who have chosen to declare a Disability. • During this period, 44% of staff promoted were from a BME background, a positive indicator of the efficacy of our WRES actions for career progression and development. • During this period, 4% of leavers were LGB compared to 2% of LGB leavers last year. This could be in part due to increased declarations from staff. • We saw an increase in staff turnover during this period, and we have a high proportion of staff in the 40-60 age group with similar leaver rates for all age groups. Retention of staff will be a key element of the People Strategy.

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

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

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

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

Acronyms/Terms Used in the Report			
WRES	Workforce Race Equality Standard	WDES	Workforce Disability Equality Standard
BME	Black, Asian and Minority Ethnicity	LTC	Long-term condition
EDS	Equality Delivery System	MSE	Mid and South Essex
HWE	Herts and West Essex	ICS	Integrated Care System
ER	Employee Relations	EDI	Equality, Diversity and Inclusion
PSED	Public Sector Equality Duty	GPG	Gender Pay Gap
PECC	People and Culture Committee	RISE	Resilience, Intelligence, Strength and Excellence
AfC	Agenda for Change	OLM	Online Learning Module
ONS	Office of National Statistics	ESR	Electronic Staff Record
LGB	Lesbian, Gay or Bisexual		

Supporting Reports/ Appendices /or further reading

Further Reading:

- EPUT Equality Strategy 2022-25
- EPUT WRES and WDES Reports 2022
- EPUT Equality Delivery System reporting template (EDS 2022-23)

Lead

Marcus Riddell
Acting Executive Director of People and Culture

EPUT Public Sector Equality Duty Report
March 2023

CONTENTS

INTRODUCTION

The Trust is legally required to monitor, analyse and publish equality, diversity and inclusion data as part of its commitment to the Public Sector Equality Duty (2018) by March on an annual basis. The information covers the protected characteristics within the Equality Act 2010 (Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy & Maternity, Race (Ethnicity), Religion & Belief, Sex and Sexual Orientation).

In summary, those subject to the general equality duty must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The Act explains that the second aim (advancing equality of opportunity) involves, in particular, having due regard to the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics.
- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people.
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

This report will illustrate EPUT's commitment and development by complying with the duties of the Public Sector Equality Duty (PSED):

1) Reporting of Gender Pay Gap within our organisation.
2) Compliance with the General Equality Duty by breakdown of employee demographic
3) By listing our aims and objectives to further achieve the aims of the PSED.

This report will present data (taken from 1st April 2021 – 31st March 2022) relating to: staff in post, starters, promotions, leavers, recruitment, employee relations and appraisals. This will include both contractual arrangements (permanent, fixed term and bank workers) and all pay bandings. Analysing the data allows us to establish progress and areas of concern, which can then be fed into directorate action plans as well as the EDI Framework, which is monitored by the Equality and Inclusion Sub-Committee and People Equality and Culture Committee (PECC).

Each year we are required to publish this information on our public website by 31st March.

1. THE EQUALITY DELIVERY SYSTEM AND OUR EQUALITY OBJECTIVES

The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

In March 2023 two virtual equality and inclusion workshops were held, engaging our stakeholders (staff and patients) with examples of our achievements from 2022-23 and encouraging feedback to influence our goals and priorities for 2023-24.

As NHS England have developed a new format for the EDS and intend this to be completed collaboratively within ICS groups, this year has been seen as an implementation year. Due to our commitments with multiple ICS groups, we as an organisation are working to develop this structure for 2023-24, but this year have completed it independently and will be sharing this with our system partners. Our EDS (2022-23) action plan and grading report is published on the Trust website and will be available on the EDI Hub on the Trust intranet in March 2023.

The most recent version of this is available alongside other key Equality and Inclusion Documents (available at https://eput.nhs.uk/about-us/equality-and-diversity)

2. THE WORKFORCE RACE EQUALITY STANDARD AND WORKFORCE DISABILITY EQUALITY STANDARD

Our work around Race Equality and Disability Equality is captured in two separate reports, which are produced annually each September and set out our performance across a range of metrics. The most recently published Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports are available here: https://eput.nhs.uk/about-us/equality-and-diversity/delivering-equality/

3. GENDER PAY GAP REPORTING

The gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are. It is important to stress that the Gender Pay Gap is different to Equal Pay.

Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. We are committed to a diverse workforce and the fair treatment and reward of all staff irrespective of gender. Our latest Gender Pay Gap reports are available here: https://eput.nhs.uk/media/32ga4vxa/eput-gender-pay-gap-report-mar-21.pdf

4. SUMMARY OF MILESTONES FOR 22 – 2023

Equality and inclusion remains a priority within the Trust and we are proud of the progress we have made towards our equality objectives in this period. Below are listed some of our main achievements in not only eliminating discrimination, but also promoting equality and inclusion in the workplace and ultimately into our services and patient care:

- Following WRES and WDES Data showing us that Bullying and Harassment needed to be addressed, we implemented the *No Space for Abuse* campaign in EPUT in conjunction with Essex Police and our Violence and Aggression Prevention and Reduction (VAPR) Team. This provides staff with both guidance on how to report racism or any form of discriminatory behaviour, as well as clear messaging that this is not accepted from people accessing our services.
- Continuation of our EPUT RISE programme, focusing on career development for black, asian and minority ethnicity (BME) staff across the Trust aimed at multiple bandings and skill levels. Participants are also taught mentoring skills as part of the programme to support less experienced members.
- Development of our Equality and Inclusion Strategy (2022-25), and approval at Board Level for implementation into the Trust.
- Executive Director Sponsors to join Staff Equality Networks, providing support to Network Chairs and acting as champion for the Network.
- Inclusive Career Development Workshop developed and presented in collaboration with Herts and West Essex ICS.
- Development and training of ER and Recruitment leads via the implementation of a De-Bias toolkit developed in collaboration with Mid and South Essex ICS, based on NHS England's *"No Tick Boxes"* Guidance.
- Anti-Bullying Event held as part of EDI Week (November 10th 2022) held in collaboration with Mid and South Essex ICS.

5. REPORTING

This report covers 1 April 2021 – 31 March 2022 (hereafter referred to as the reporting period).

The workforce data that is contained within this report has been obtained from various sources e.g. Electronic Staff Record (ESR), OLM Learning and records, and the NHS Jobs system. The staff profile is a snapshot from **31 March 2022**.

The data includes all pay bands and staff groups including Agenda for Change (AfC) bands 1-9, Director and Senior Manager pay scales, Trust pay scales and Medical Staff pay scales. We also include bank staff. There is a small minority of staff who do not fit into these pay bands and are referred to in the category of "other".

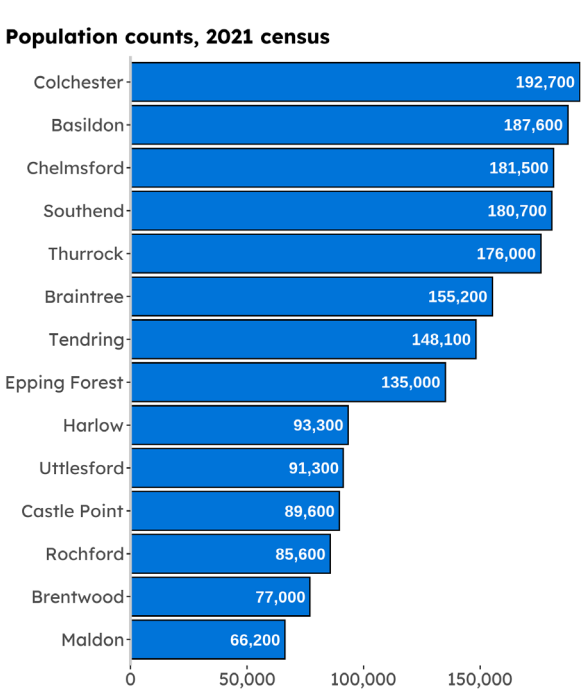
6. LOCAL DEMOGRAPHICS

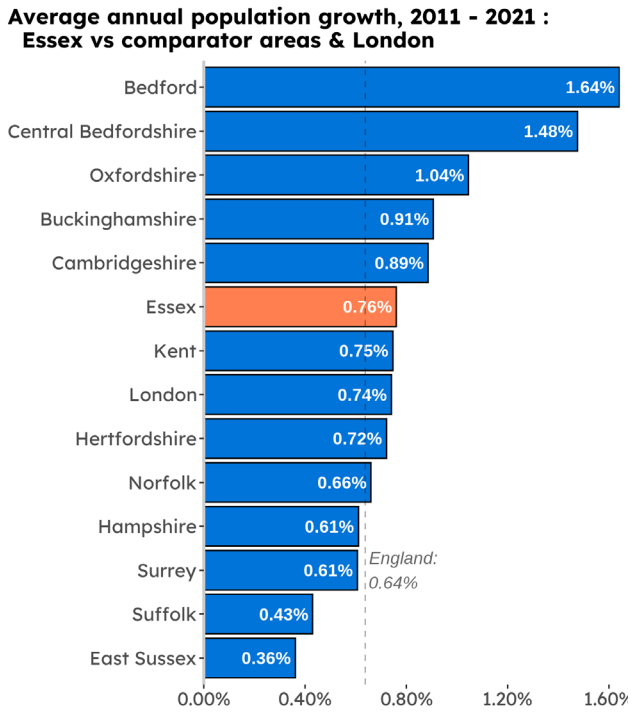
The benchmarking information in this report is taken from the National Census Information for 2021.

The overall analysis demonstrates that the Trust's demographic profile when compared with the community profile shows us that in general, our workforce is representative of the community it serves. Where there are variations these are highlighted. This will be compared to the Census data 2021 in future reporting when it is made available.

The below data form part of the first set census of the population for England and wales. The population on Essex on Census day 2021 was 1,503,300, not including Southend or Thurrock.

- The most populous districts in the county are Colchester, Basildon, and Chelmsford
- The least populous are Maldon, Brentwood, and Rochford
- The population of Essex has seen an increase of 109,713 over the last 10 years (since Census 2011) – an average annual growth rate of 0.76%
- Over the last 10 years, the population of Essex has grown at a faster rate than England (0.64% growth per year). Essex's growth rate is similar to London (0.74% growth per year), though this may be in part due to the impact of the pandemic on where people were living on Census Day
- Every district & unitary within Greater Essex has seen their population increase since the 2011 Census. The areas with the highest average annual growth rate are Uttlesford, Harlow, and Thurrock. The areas with the lowest average annual growth rates are Castle Point, Rochford, and Southend





6.1 Ethnic Minority Groups

Collecting data on ethnicity groups is complex because of the subjective, multifaceted and changing nature of ethnicity identification. We as an organisation use Office of National Statistics (ONS) categories and membership is something that is self-defined and subjectively meaningful to the person concerned. This data is collected in line with EPUT's Equality Monitoring Policy and Procedure (CP27 / CPG27).

The terminology used to describe ethnicity groups has changed markedly over time, and however defined or measured, tends to evolve in the context of social and political attitudes or developments. Ethnic groups are also very diverse, encompassing common ancestry and elements of culture, identity, religion, language and physical appearance. The table below shows the ethnicity breakdown of the population we serve (as taken from the 2021 (census).

Essex - All ethnicity categories	Population
White British	1,264,877
White Irish	11,165
White Gypsy or Irish Traveller	2,161
White other	**35,653**
Mixed/Multiple ethnic group: White and Black Caribbean	6,936
Mixed/Multiple ethnic group: White and Black African	2,801
Mixed/Multiple ethnic group: White and Asian	6,173
Mixed/Multiple ethnic group: Other mixed	4,975
Mixed/Multiple ethnic group: total	**20,885**
Asian/Asian British: Indian	12,456
Asian/Asian British: Pakistani	3,462
Asian/Asian British: Bangladeshi	2,747
Asian/Asian British: Chinese	6,361
Asian/Asian British: Asian	9,834
Asian/Asian British total	**34,860**
Black/African/Caribbean/Black British: African	12,143
Black/African/Caribbean/Black British: Caribbean	4,556
Black/African/Caribbean/Black British: Other Black	2,010
Black/Black British (Total)	**18,709**
Other ethnic group: Arab	2,042
Other ethnic group: Any other ethnic group	3,235
Other Ethnic Groups (Total)	**5,277**
BME	**79,731**
BME %	**5.72%**

6.2 Other Demographics

Key findings for other demographic groups are compared against data provided from the last 2021 Census: National Demographic profile summarised in the table below:

2021 Census	National 2021 Results
Age	• Highest proportion of Age is 50 – 64
Ethnicity	• Asian, Asian British or Asian Welsh: 3.7% • Black, Black British, Black Welsh, Caribbean or African: 2.5% • Mixed or Multiple ethnic groups: 2.4% • White: 90.4% • Other ethnic group:1.0%
Disability	• Disabled under the Equality Act: Day-to-day activities limited a lot: 6.8% • Disabled under the Equality Act: Day-to-day activities limited a little: 9.9% • Not disabled under the Equality Act: Has long term physical or mental health condition but day-to-day activities are not limited: 7.1% • Not disabled under the Equality Act: No long term physical or mental health conditions: 76.2%
Gender or Sex	• 51.3% Female • 48.7% Male
Gender Reassignment	• Gender identity the same as sex registered at birth: 94.6% • Gender identity different from sex registered at birth but no specific identity given: 0.1% • Trans woman: 0.1% • Trans man: 0.1% • Non-binary: 0.0% • All other gender identities: 0.0% • Not answered: 5.0%
Marriage & Civil Partnership	• Never married and never registered a civil partnership: 33.9% • Married or in a registered civil partnership: 47.7% • Married: 47.5% • In a registered civil partnership: 0.2% • Separated, but still legally married or still legally in a civil partnership: 2.1% • Divorced or civil partnership dissolved: 9.6% • Widowed or surviving civil partnership partner: 6.6%
Pregnancy & Maternity	• No pregnancy or maternity status was collected during this Census
Religion & Belief	• No religion: 42.1% • Christian: 47.9% • Buddhist: 0.4% • Hindu: 1.0% • Jewish: 0.5% • Muslim: 1.6% • Sikh: 0.2% • Other religion: 0.5% • Not answered: 5.7%
Sexual Orientation	• Straight or Heterosexual: 91.3% • Gay or Lesbian: 1.1% • Bisexual: 0.9% • Pansexual: 0.2% • Asexual and “Queer”: 0.0% • All other sexual orientations: 0.0% • Not answered: 6.5%

7. STAFF IN POST

The total headcount for Essex Partnership University NHS Foundation Trust (the Trust) on 31 March 2022 was 8884. This figure includes all permanent, fixed term and bank workers plus leavers during this period. This figure includes all geographical areas of the Trust during this reporting period. Bank workers are included in this report as we consider them an integral part of our workforce.

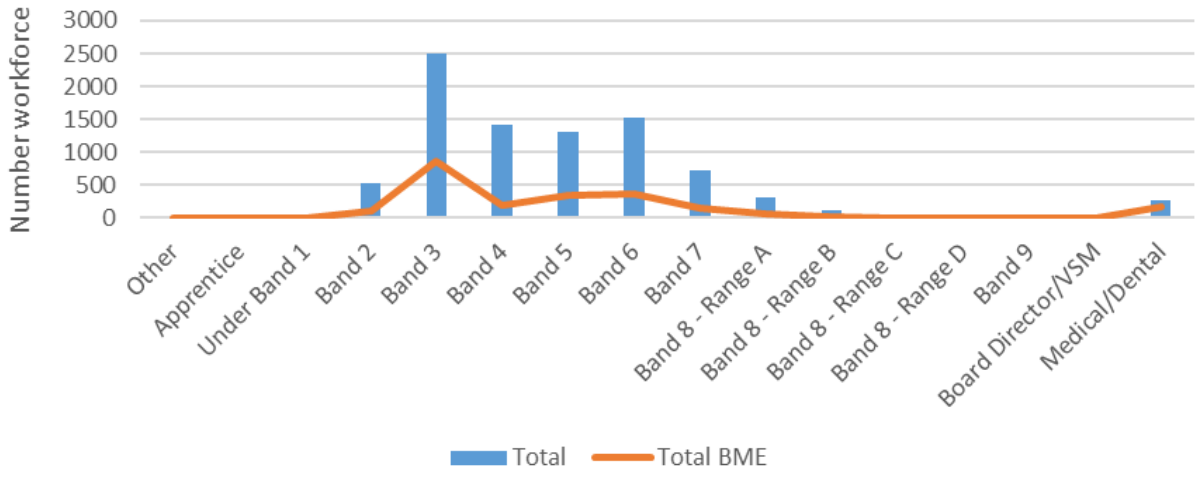
7.1 Ethnicity Profile of Staff in Post

The following ethnicity codes will be used as part of the data below, codes D – S represent ethnic minority groups and the term "BME" will be used to refer to this group for reporting purposes. A further explanation of Ethnicity Origin Codes and why these are used is available as part of our Equality Monitoring Policy (CP27 – Appendix A)

Code	Ethnic Origin	Code	Ethnic Origin
A	White - British	K	Asian or Asian British - Bangladeshi
B	White - Irish	L	Asian or Asian British – Any other Asian background
C	White-Any other White background	M	Black or Black British – Caribbean
D	Mixed – White & Black Caribbean	N	Black or Black British – African
E	Mixed – White & Black African	P	Black or Black British – Any other Black background
F	Mixed – White & Asian	R	Chinese
G	Mixed – Any other mixed background	S	Any other ethnic group
H	Asian or Asian British-Indian	U	Unknown / Not Stated
J	Asian or Asian British - Pakistani	Z	Unknown / Not Stated

Code	A	B	C	D	E	F	G	H	J	K	L	M	N	P	R	S	U	Z	Total
Number of Staff	5657	117	576	34	34	38	57	270	59	49	158	97	1153	186	20	122	109	148	8884
%	64	1	6	0.4	0.4	0.4	1	3	1	0.6	2	1	13	2	0.2	1	1	2	100%

The table above shows the ethnicity percentage breakdown of our workforce. **This shows that 26% of our workforce is from a BME background, which in comparison to our local population (5.72%, Census 2021) is positive).** Percentages were rounded up with scores below 1% rounded to one decimal place to accurately reflect the overall percentage.



The Chart above breaks the workforce down further by ethnicity and band. **The total percentage of staff from BME backgrounds overall was 26% which indicates a positive 1% increase from the 2022 report**. The most highly populated banding for BME staff was Medical & Dental (63%), Apprentice level (50%) and Band 3 (34%). In comparison to 2021 data, we can see a shift from BME band 2 to BME Band 3; this suggests an increase in promotion from Band 2 to Band 3.

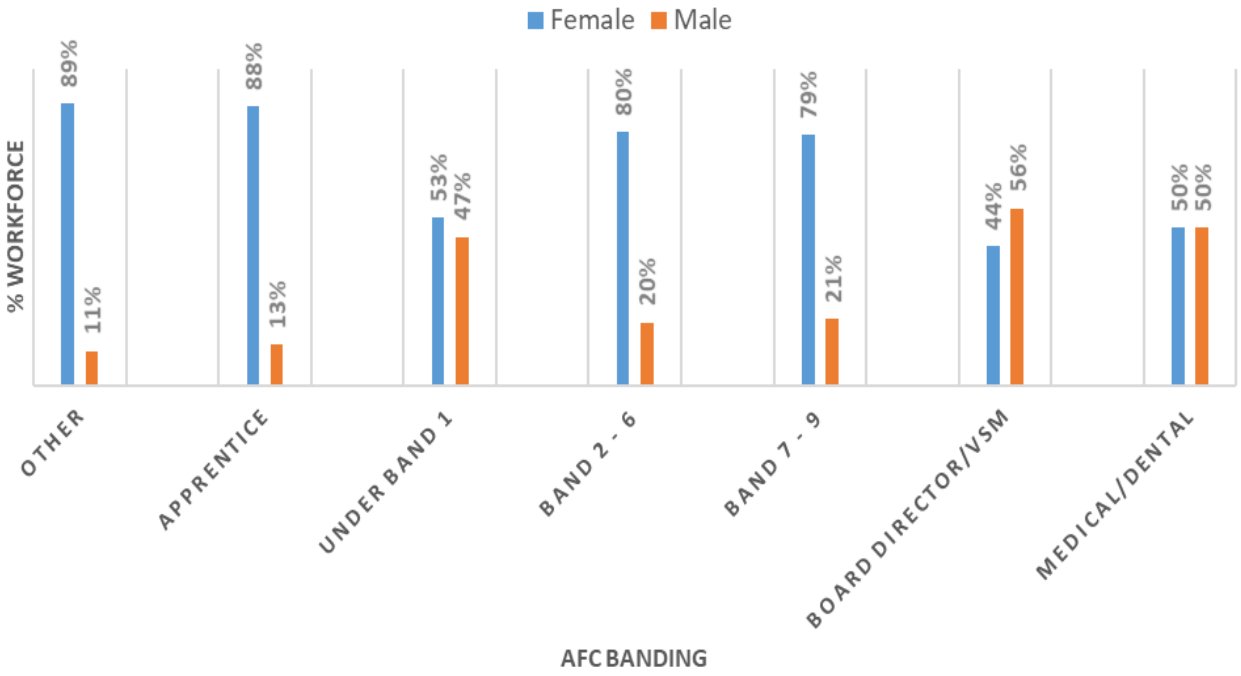
7.2 Disability of Staff in Post

	AFC Banding								
ESR Status	Other	Apprentice	Under Band 1	Band 2 - 6	Band 7 - 9	Board Director / VSM	Medical/ Dental	Total Workforce	Total %
No	11	15	11	5858	904	14	205	7018	79%
Not Declared	5	0	3	733	223	0	37	1001	11%
Prefer Not To Answer	0	0	0	13	1	0	0	14	0%
Unspecified	1	0	0	384	69	0	13	467	5%
Yes	1	1	3	313	59	2	5	384	4%
Total	18	16	17	7301	1256	16	260	8884	100%
% of the band stating disability	6%	6%	18%	4%	5%	13%	2%	4%	

The table above shows the disability breakdown of the Trusts workforce. **384 (4%)** of staff identified as disabled during this reporting period, slightly higher than the previous year. This is lower than the 20% identified in the Census. We are aware that ESR data only accounts for staff in post who have chosen to declare a Disability. Work continues in the Trust to encourage our workforce update and feel confident in raising that they may have disabilities or long-term conditions, and to provide an environment where they feel supported in doing so and will receive appropriate reasonable adjustments.

We as a Trust are a Disability Confident Leader, and this supports us in our recruitment and support of those with disabilities and long-term conditions.

7.3 Gender Breakdown of Staff in Post



The chart above shows the gender breakdown of the Trust's workforce. The Trust has a predominantly female workforce (6979); we can see a slight increase of our female workforce by 1% from the previous year's report. **During this period, 79% of our workforce were female and 21% were male.** This is commensurate with the NHS as a whole, which is predominantly female, and higher than local demographics

It should be noted this report recognises the difference between anatomical sex and gender identity, and whilst there are a range of terms used to describe this spectrum, they are not currently options on ESR. Therefore, this reports staff responses only as recorded on ESR, and does not differentiate between transgender and cisgender staff members.

In comparison from the previous report, we saw see a change at senior management levels, **During this period, 44% of EPUT's senior management were female and 56% male.** As opposed to the previous years report showing 63% senior management (Female) and 37% senior management (Male).

7.4 Religious Belief of Staff in Post

AFC Band	I do not wish to disclose my religion/belief	Atheism	Christianity	Buddhism	Hinduism	Islam	Jainism	Judaism	Other	Sikhism	Un specified	Total
Other	3	6	7	0	0	0	0	0	1	0	1	**18**
Apprentice	0	7	7	0	0	0	0	0	2	0	0	**16**
Under Band 1	3	8	2	0	0	1	0	0	3	0	0	**17**
Band 2	112	62	226	5	2	12	0	1	42	0	65	**527**
Band 3	453	320	1299	10	40	76	0	5	199	1	100	**2503**
Band 4	249	291	651	4	19	22	0	4	110	1	72	**1423**
Band 5	259	180	671	2	21	24	0	5	104	3	47	**1316**
Band 6	314	258	685	9	26	32	0	0	131	4	73	**1532**
Band 7	200	98	287	6	18	13	0	3	62	1	30	**718**
Band 8a	68	70	134	2	5	4	0	1	15	2	16	**317**
Band 8b	29	20	45	1	5	5	1	0	9	1	9	**125**
Band 8c	13	4	20	0	2	1	0	1	4	1	4	**50**
Band 8d	15	0	17	0	2	0	0	0	2	0	1	**37**
Band 9	1	2	5	0	0	0	0	1	0	0	0	**9**
Board Director/VSM	3	2	7	0	1	1	0	0	2	0	0	**16**
Medical/Dental	106	15	49	5	27	41	1	2	8	1	5	**260**
Total	**1828**	**1343**	**4112**	**44**	**168**	**232**	**2**	**23**	**694**	**15**	**423**	**8884**
%	**21%**	**15%**	**46%**	**0.5%**	**2%**	**3%**	**0.02%**	**0.3%**	**8%**	**0.2%**	**5%**	**100%**

The table above shows the religious belief breakdown of the Trust's workforce for all pay bands. It shows that the most highly represented religious belief within the workforce was **Christianity at 46%**. There was a high proportion of staff choosing not to disclose their religious belief (21%), whilst representation from other faith groups appears low. This may reflect the current Census with the rise in "No Religion" as a category across the UK.

7.5 Sexual Orientation of Staff in Post

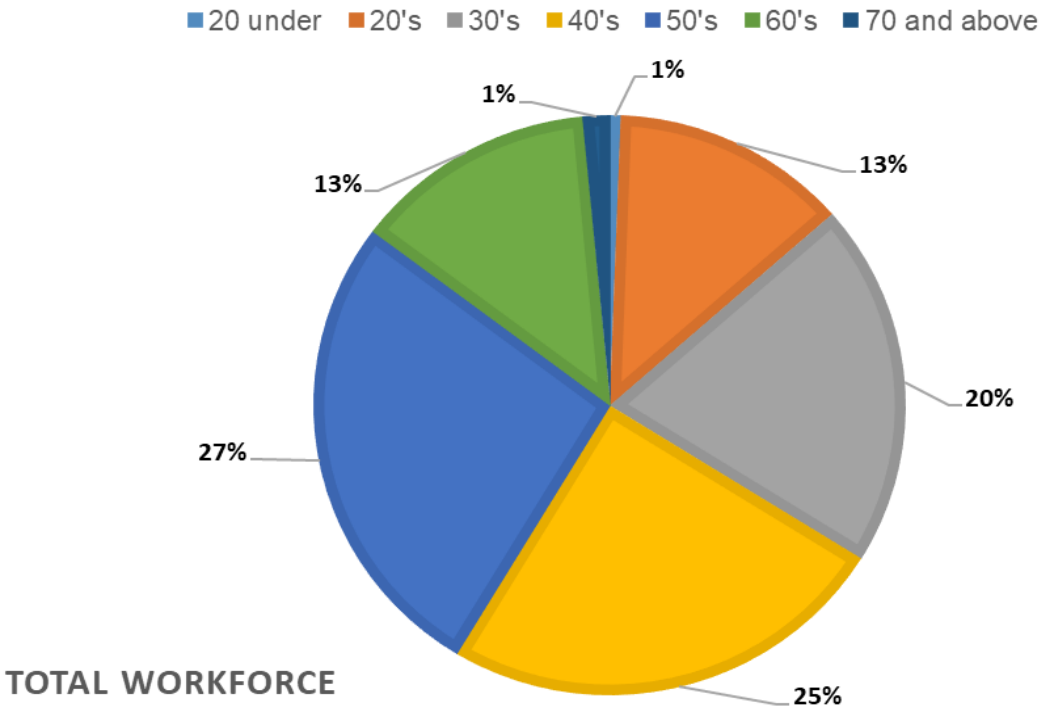
AFC Band	Bisexual	Gay or Lesbian	Heterosexual	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	Undecided	Unspecified	Total
Other	1	0	14	2	0	0	1	**18**
Apprentice	1	0	14	1	0	0	0	**16**
Under Band 1	3	0	10	3	1	0	0	**17**
Band 2	5	2	366	88	1	0	65	**527**
Band 3	24	35	2016	326	3	2	97	**2503**
Band 4	18	33	1129	173	2	0	68	**1423**
Band 5	11	17	1019	222	2	0	45	**1316**
Band 6	12	20	1218	208	1	0	73	**1532**
Band 7	7	12	527	142	0	0	30	**718**
Band 8a	1	9	247	44	0	0	16	**317**
Band 8b	1	1	92	21	0	0	10	**125**
Band 8c	1	2	36	8	0	0	3	**50**
Band 8d	0	1	20	15	0	0	1	**37**
Band 9	0	0	9	0	0	0	0	**9**
Board Director/VSM	0	1	13	2	0	0	0	**16**
Medical/Dental	3	4	172	76	0	0	5	**260**
Total	**88**	**137**	**6902**	**1331**	**10**	**2**	**414**	**8884**
%	**1%**	**2%**	**78%**	**15%**	**0.1%**	**0.02%**	**5%**	**100%**

The table above shows the sexual orientation breakdown of the Trust's workforce for all pay bands. The highest proportion of staff declaring their sexual orientation is **Heterosexual (78%) which is a 2% increase from the previous year's report.**

3.1% of the workforce declared their sexual orientation as Lesbian, Gay, Bisexual or Other (LGB+) which has remained the same as the previous year's report (2021). There was a reduction in the percentage of staff choosing to not declare their sexual orientation; this decreased to 15%.

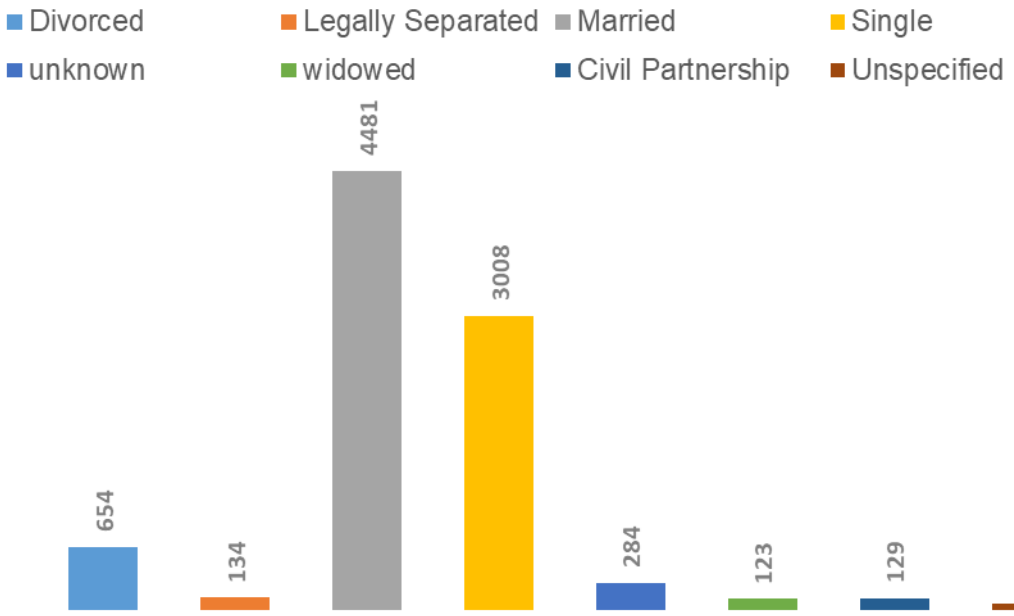
We as a Trust recognise that the current ESR data collected on a national level falls short on the recording of gender identity for our Transgender and Non-Binary staff members, and will include this in future reports as this is currently being reviewed at a national level and will be added to these systems by NHS England.

7.6 Age Profile of Staff in Post



The above chart shows the percentage of workforce by age banding. **The most highly populated age bands were made up of those aged in their 40's and 50's. This equates to 52% of our workforce**. We as a Trust are continuing to develop our staff in younger age bands, as well as, retaining the key skills we already have in our workforce and encourage retired and return to enhance the experience and expertise within EPUT.

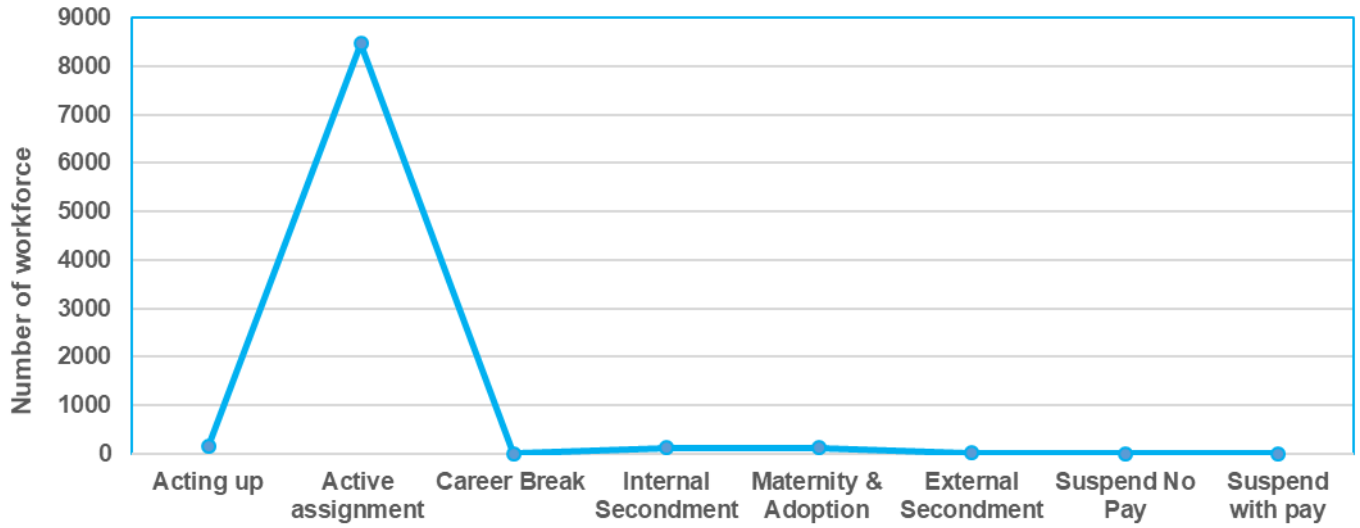
7.7 Marital Status of Staff in Post



The chart above shows the marital status for all staff in post. The highest status was 'Married' with **'Single'** after this. **However since the previous report we have seen a slight decrease in the number of those listing themselves as divorced from 692 to 654**, along with a decrease in the number reported being married from 4710 (2021) to 4481 (2022). We have also seen a decrease in those declaring Single status.

7.8 Maternity & Adoption Status of Staff in Post

FC Band	Acting Up	Active Assignment	Career Break	Internal Secondment	Maternity & Adoption	Out on External Secondment - Paid	Suspend No Pay	Suspend With Pay	Total
Total	146	8466	8	122	127	10	1	4	8884
%	2%	95%	0.1%	1%	1%	0.1%	0.01%	0.05%	100%



At the time of this report, the Trust had 127 employees on maternity or adoption leave, which equates to 1% of the workforce. During this period, there was also an increase in internal secondments across the Trust increasing from 94 (2021) to 122 (2022), along with an increase in staff "acting up" from 108 (2021) to 146 (2022) supporting further learning and development within the Trust.

8.0 NEW STARTERS

There were 2250 new starters in EPUT during this reporting period, which was lower than the previous year (4027).

8.1 Ethnicity Breakdown of New Starters

	Ethnicity Code – (D-S are codes for BME staff, listed in section 7.1)																				
AFC Band	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**J**	**K**	**L**	**M**	**N**	**P**	**R**	**S**	**U**	**Z**	**TOTAL**	**No. BME**	**% BME**
Other	6	0	0	0	0	0	0	0	0	0	0	1	2	0	0	0	0	0	**9**	**3**	**33%**
Apprentice	6	1	1	0	0	0	0	0	0	0	0	3	3	0	0	0	0	0	**14**	**6**	**43%**
Under Band 1	62	0	12	2	1	3	0	0	1	0	2	1	4	0	0	1	0	1	**90**	**15**	**17%**
Band 2	108	3	11	4	2	1	1	5	0	1	2	3	54	8	0	1	6	4	**214**	**82**	**38%**
Band 3	314	4	24	2	2	3	3	5	5	9	8	5	58	15	0	3	3	4	**467**	**118**	**25%**
Band 4	261	9	33	2	3	1	4	27	6	4	9	7	30	9	3	5	13	6	**432**	**110**	**25%**
Band 5	252	6	28	0	2	2	3	10	1	3	6	6	53	8	2	4	10	9	**405**	**100**	**25%**
Band 6	207	10	17	2	0	3	5	14	4	3	7	5	37	8	2	4	12	7	**347**	**94**	**27%**
Band 7	70	3	13	0	0	0	2	5	2	1	2	0	12	2	0	2	1	2	**117**	**28**	**24%**
Band 8a	31	2	8	0	0	0	1	0	0	1	3	1	2	0	0	0	0	0	**49**	**8**	**16%**
Band 8b	15	1	2	0	0	0	0	0	1	1	1	0	1	0	0	0	0	0	**22**	**4**	**18%**
Band 8c	3	1	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	**6**	**2**	**33%**
Band 8d	6	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	1	0	**9**	**2**	**22%**
Band 9	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**2**	**1**	**50%**
Board\ Director\ VSM	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**	**0**	**0%**
Medical\ Dental	7	0	7	0	0	0	0	7	5	2	1	0	8	2	1	9	16	1	**66**	**35**	**53%**
TOTAL	**1,350**	**40**	**156**	**12**	**10**	**13**	**19**	**76**	**25**	**25**	**41**	**32**	**266**	**52**	**8**	**29**	**62**	**34**	**2,250**	**608**	**27%**

The table above shows the ethnic breakdown of all new starters during this reporting period. **The total percentage of all new starters from ethnic minority backgrounds during this reporting period was 27%,** which is a slight increase from the previous year (20%). It is higher in comparison to our locality demographic (5.2%).

The Trust recognises there is more work and progression in appointing ethnic minority backgrounds; consult EPUT's WRES (2022-23) report and action plan for the Trust's actions to improve the experiences of BME staff groups within our workforce.

8.2 Disability Breakdown of new starters

	AFC Banding								
Disability declaration on ESR	**Other**	**Apprentice**	**Under Band 1**	**Band 2-6**	**Band 7-9**	**Board / Director / VSM**	**Medical / Dental**	**TOTAL**	**%**
No	7	13	67	1,698	182	1	52	**2,020**	**90%**
Not Declared	1	0	7	49	3	0	0	**60**	**3%**
Preferred Not To Answer	0	0	5	3	0	0	0	**8**	**0.4%**
Unspecified	0	0	0	17	1	0	10	**28**	**1.2%**
Yes	1	1	11	98	19	0	4	**134**	**6%**
Total Headcount of starters	**9**	**14**	**90**	**1,865**	**205**	**1**	**66**	**2,250**	**100%**
% of new Starters who declared disability as "Yes"	**11%**	**7%**	**12%**	**5%**	**9%**	**0%**	**6%**	**6%**	

The table below shows the disability breakdown of all new starters for this reporting period. It shows that overall 6% **of new starters stated that they have a disability**, which is an increase in comparison to the previous year (3%)

Consult EPUT's WDES (2022 - 23) report and action plan for the Trust's actions to improve the experiences of staff in our services with disabilities and long-term-conditions.

8.3 Gender Breakdown of New Starters

		Gender		
AFC Banding	**Data**	**Female**	**Male**	**TOTAL**
Other	Headcount	7	2	**9**
	Percentage	78%	22%	100%
Apprentice	Headcount	13	1	**14**
	Percentage	93%	7%	100%
Under Band 1		53	37	**90**
	Percentage	59%	41%	100%
Band 2-6	Headcount	1526	339	**1865**
	Percentage	82%	18%	100%
Band 7-9	Headcount	158	47	**205**
	Percentage	77%	23%	100%
Board\Director\VSM	Headcount	1	0	**1**
	Percentage	100%	0%	100%
Medical\Dental	Headcount	40	26	**66**
	Percentage	61%	39%	100%
Total Headcount of starters		**1,798**	**452**	**2,250**
Total % of starters		**80%**	**20%**	**100%**
Staff in Post %		**79%**	**21%**	**100%**

The table below shows the gender breakdown for all new starters. It shows that **80%** new starters were female and **20%** were male, this is reflective of the trusts overall workforce and significantly higher than our local population.

8.4 Religious Belief of New Starters

	Religious Belief											
AfC Band	I do not wish to disclose my religion / belief	Atheism	Christianity	Buddhism	Hinduism	Islam	Jainism	Judaism	Other	Sikhism	Unspec.	Total
Other	0	0	0	0	0	0	0	0	0	0	0	**0**
TOTAL	403	460	1,030	7	50	83	1	4	189	8	15	**2,250**
%	18%	20%	46%	0.3%	2%	4%	0.04%	0.2%	8%	0.4%	1%	**100%**
Staff in Post %	21%	15%	**46%**	0.5%	2%	3%	0%	0.3%	8%	0.2%	5%	**100%**

The table above shows the religious belief of all new starters. It can be seen that the highest representation of religious belief within new starters was **Christianity**. This is reflective of local demographics, however, the table also highlights that we have a high number of new starters who chose not to disclose this information (21%).

8.5 Sexual Orientation of New Starters

Sexual Orientation								
AfC Band	Bisexual	Gay or Lesbian	Heterosexual	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	Undecided	Unspecified	TOTAL
TOTAL	45	41	1,928	217	6	0	13	2,250
%	**2%**	**2%**	86%	10%	0.3%	0%	1%	100%
LGB Starters: 4%								

The table above shows the sexual orientation of all new starters by band for this reporting period. The highest representation for sexual orientation in new starters was **'Heterosexual'**.

We as a Trust recognise that the current ESR data collected on a national level falls short on the recording of gender identity for our Transgender and Non-Binary staff members. We will include this in future reports when this is added to these systems, as this has been a concern raised with NHS England by our LGBTQ+ Staff Network.

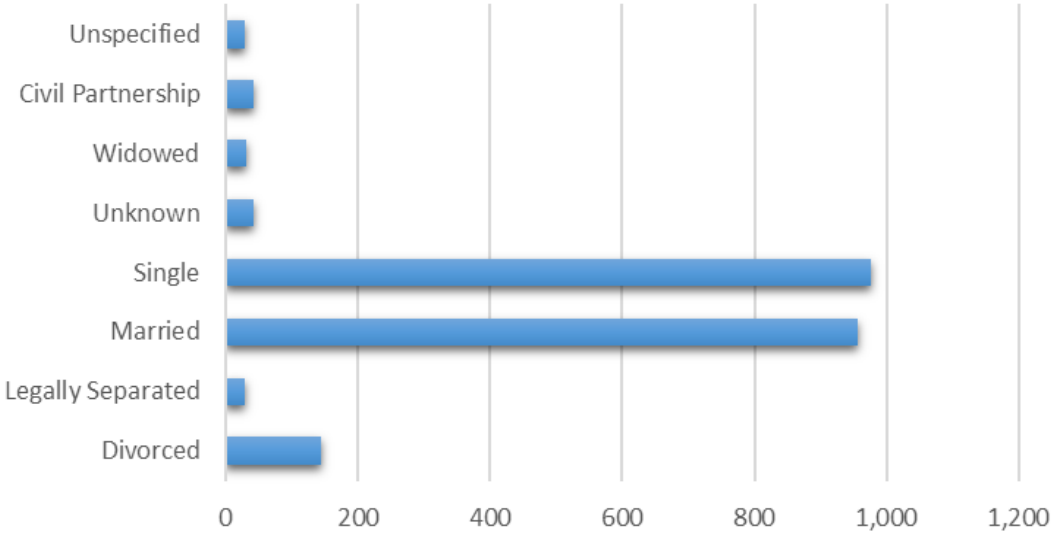
Based on this data, 4% of our new starters were from an LGB background, the same as our results from the previous year.

8.5 Age Profile of New Starters

	Age Band							
Afc Band	**20 under**	**20's**	**30's**	**40's**	**50's**	**60's**	**70 and above**	**TOTAL**
Other	0	0	2	1	4	2	0	**9**
Apprentice	1	4	6	3	0	0	0	**14**
Under Band 1	11	78	1	0	0	0	0	**90**
Band 2	8	53	36	54	42	19	2	**214**
Band 3	9	126	98	98	85	48	3	**467**
Band 4	1	143	118	67	70	29	4	**432**
Band 5	0	80	85	90	77	72	1	**405**
Band 6	0	40	110	83	69	42	3	**347**
Band 7	0	11	35	32	28	11	0	**117**
Band 8a	0	4	17	12	11	5	0	**49**
Band 8b	0	0	7	8	6	1	0	**22**
Band 8c	0	0	1	1	2	2	0	**6**
Band 8d	0	0	3	2	2	2	0	**9**
Band 9	0	0	1	0	1	0	0	**2**
Board Director/VSM	0	0	0	0	1	0	0	**1**
Medical/Dental	0	23	27	6	2	8	0	**66**
Total	**30**	**562**	**547**	**457**	**400**	**241**	**13**	**2250**
%	**1%**	**25%**	**24%**	**20%**	**18%**	**11%**	**0.6%**	**100%**

The table below shows the age profile of all new starters. The data shows the highest percentage of new starters are those aged in their **20's - 40's.**

8.6 Marital Status of New Starters



The graph above shows the marital status of new starters. The most highly declared category for marital status was **'Single'. We can see a slight increase on 'Single' new starters as opposed to previous years the highest number being 'Married' this could be based on the Age profile of new starters within the Trust being hirer for the 20' category.**

9.0 PROMOTIONS

There were 449 promotions during this reporting period (compared to 487 in 2019 - 20).

9.1 Ethnicity Breakdown of Promotions

(Ethnicity Code – D-S are codes for BME staff, listed in section 7.1)																					
AFC Band	A	B	C	D	E	F	G	H	J	K	L	M	N	P	R	S	U	Z	TOTAL	No. BME	BME % of Band
Apprentice	1	0	0	0	0	0	0	0	0	0	0	2	1	0	0	0	0	0	**4**	**3**	**75%**
Under Band 1	6	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**8**	**0**	**0%**
Band 2	212	5	38	1	8	2	4	14	3	6	16	9	323	63	1	11	10	6	**732**	**461**	**63%**
Band 3	112	3	6	1	2	1	0	1	0	0	1	1	5	0	0	0	1	2	**136**	**12**	**9%**
Band 4	41	0	2	0	0	1	0	1	0	0	2	0	3	0	0	0	0	0	**50**	**7**	**14%**
Band 5	115	1	8	1	1	1	1	1	1	0	4	1	29	4	0	4	0	3	**175**	**48**	**27%**
Band 6	95	2	9	1	1	0	0	2	0	1	1	2	23	2	1	3	0	2	**145**	**37**	**26%**
Band 7	33	1	4	1	0	0	4	1	0	0	0	1	8	1	0	0	0	0	**54**	**16**	**30%**
Band 8a	14	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	**18**	**1**	**6%**
Band 8b	3	1	1	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	**7**	**2**	**29%**
Band 8c	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**N/A**
Band 8d	3	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**5**	**0**	**0%**
Band 9	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**1**	**100%**
Board Director/VSM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**N/A**
Medical/Dental	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	2	0	0	**3**	**3**	**100%**
TOTAL	**635**	**13**	**74**	**5**	**12**	**5**	**9**	**21**	**4**	**7**	**25**	**16**	**395**	**70**	**2**	**20**	**11**	**14**	**1338**	**591**	**44%**

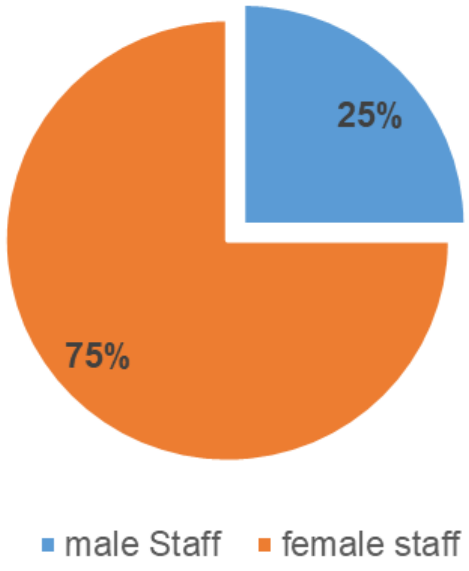
The table above shows the ethnicity breakdown of promotions for this reporting period. **This shows that 44% of the staff promoted were from a BME background**, a significant increase from the previous year (24%) and a strong indicator of positive development in our recruitment and shortlisting processes.

9.2 Disability Breakdown of Promotions

	Disability status on ESR						
AFC Band	**No**	**Not Declared**	**Unspecified**	**Yes**	**TOTAL**	**Promotions %**	**Staff in Post %**
Apprentice	4	0	0	0	4	0%	6%
Under Band 1	8	0	0	0	8	0%	18%
Band 2	642	75	5	10	732	1%	3%
Band 3	120	7	6	3	136	2%	3%
Band 4	39	4	0	7	50	14%	5%
Band 5	155	10	1	9	175	5%	5%
Band 6	116	18	5	6	145	4%	5%
Band 7	42	6	2	4	54	7%	4%
Band 8a	15	2	1	0	18	0%	6%
Band 8b	3	2	2	0	7	0%	7%
Band 8c	0	0	0	0	0	N/A	2%
Band 8d	2	3	0	0	5	0%	5%
Band 9	1	0	0	0	1	0%	11%
Board Director/VSM	0	0	0	0	0	N/A	13%
Medical/Dental	2	1	0	0	3	0%	2%
Total	1149	128	22	39	1338	3%	4%

The table above gives the disability breakdown for staff promoted during this reporting period. 3**%** of the staff that were promoted declared that they had a disability; this is 1% decrease in comparison to last year's report.

9.3 Gender Breakdown of Promotions



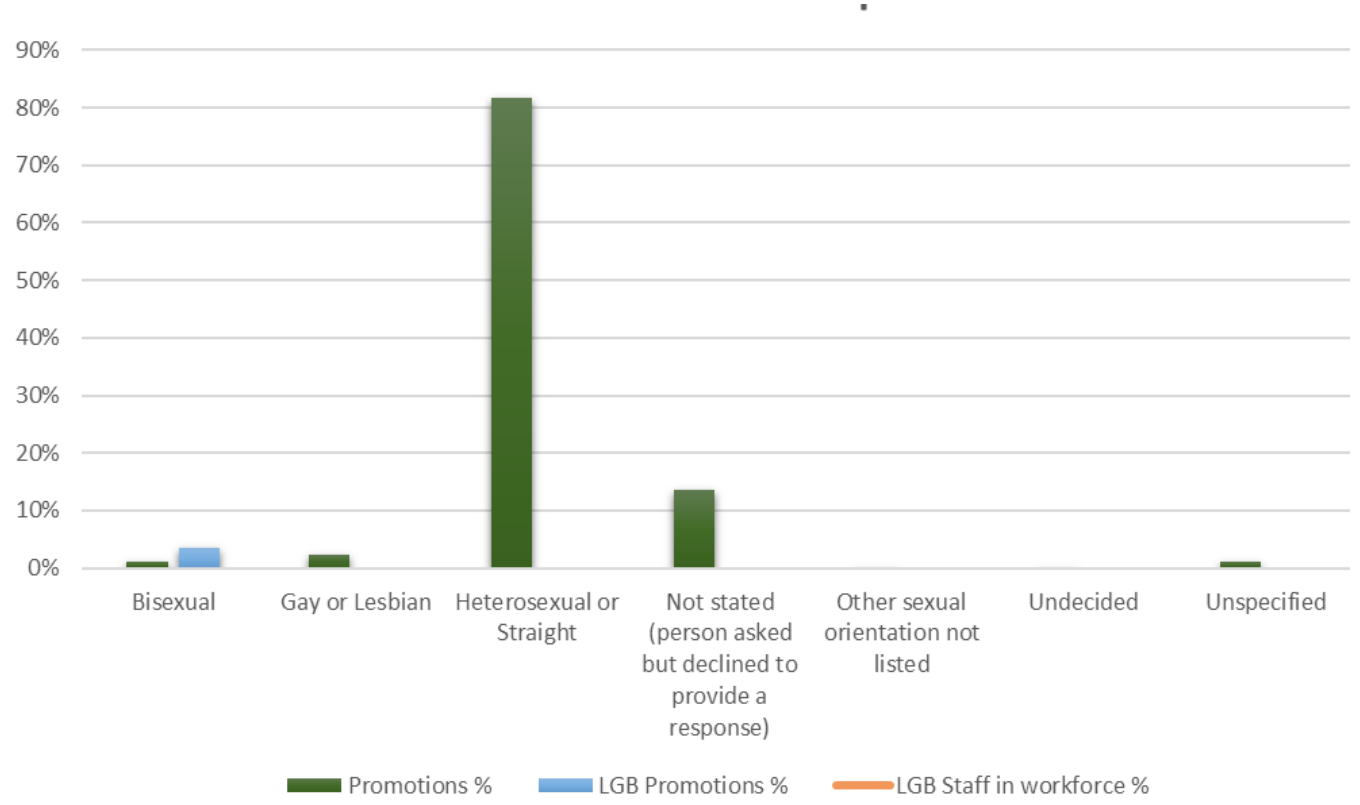
The pie chart above shows the percentage breakdown for male and female staff promotions during this reporting period**. 75% of the promotions were female, 25% were male.** This is in line with the demographics of the Trust and the NHS, but significantly higher than the local population.

9.4 Religious Belief of Promotions

AFC Band	I do not wish to disclose my religion/belief	Atheism	Christianity	Buddhism	Hinduism	Islam	Jainism	Judaism	Other	Sikhism	Unspec.
Apprentice	0	0	4	0	0	0	0	0	0	0	0
Under Band 1	0	5	1	0	0	0	0	0	2	0	0
Band 2	115	50	475	3	12	31	0	0	42	0	4
Band 3	22	34	59	0	0	1	0	0	14	0	6
Band 4	6	20	18	1	0	0	0	0	5	0	0
Band 5	20	38	86	1	3	5	0	1	18	1	2
Band 6	25	19	74	2	2	3	0	1	17	0	2
Band 7	9	15	23	1	1	0	0	0	3	0	2
Band 8a	6	1	7	0	0	1	0	0	3	0	0
Band 8b	1	0	4	0	0	0	0	0	0	0	2
Band 8c	0	0	0	0	0	0	0	0	0	0	0
Band 8d	2	1	1	0	0	0	0	1	0	0	0
Band 9	0	0	1	0	0	0	0	0	0	0	0
Board Director/VSM	1	0	0	0	0	0	0	0	0	0	0
Medical/Dental	2	0	0	0	0	1	0	0	0	0	0
TOTAL	**208**	**183**	**753**	**8**	**18**	**42**	**0**	**3**	**104**	**1**	**18**
Promotions %	**16%**	**14%**	**56%**	**1%**	**1%**	**3%**	**0%**	**0%**	**8%**	**0%**	**1%**
Staff in Post %	**21%**	**15%**	**46%**	**0%**	**2%**	**3%**	**0.02%**	**0.3%**	**8%**	**0.2%**	**5%**

The table below gives the religious belief breakdown of promotions for this reporting period. The table shows that the highest number of promotions came from the faith category **'Christianity',** which is representative of the underlying workforce. It is encouraging to see promotions in lower bands for all faith and spirituality groups, including lower populations in the organisation (Islam, Other, Hinduism.)

9.5 Sexual Orientation of Promotions



The graph above gives the sexual orientation for promotions during this reporting period. 3**%** (the same as the previous year's report) of all promotions were undertaken by LGB staff, which is higher than the overall workforce figure.

9.6 Age Range Breakdown of Promotions

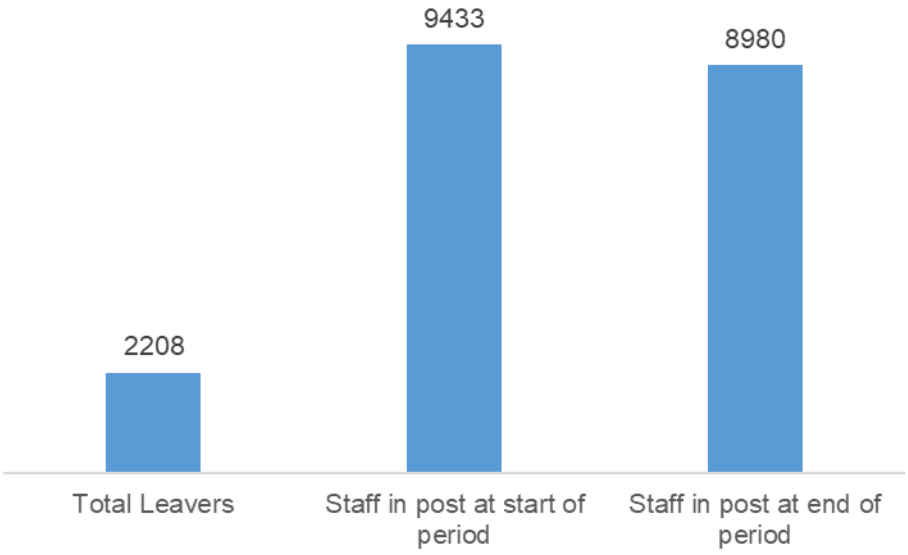
	Age Band												
AFC Band	**16-20**	**21-25**	**26-30**	**31-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**61-65**	**66-70**	**71 +**	**TOTAL**
Apprentice	1	0	1	0	2	0	0	0	0	0	0	0	**4**
Under Band 1	0	8	0	0	0	0	0	0	0	0	0	0	**8**
Band 2	14	71	58	74	81	111	105	99	70	34	13	2	**732**
Band 3	2	9	17	9	17	20	22	20	15	3	2	0	**136**
Band 4	1	13	10	7	3	4	5	5	2	0	0	0	**50**
Band 5	0	20	33	22	15	28	22	17	12	5	1	0	**175**
Band 6	0	4	24	19	21	27	21	16	7	4	1	1	**145**
Band 7	0	1	2	13	8	8	8	7	4	3	0	0	**54**
Band 8a	0	0	1	4	2	3	1	4	2	1	0	0	**18**
Band 8b	0	0	0	0	0	1	6	0	0	0	0	0	**7**
Band 8c	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Band 8d	0	0	0	0	0	2	1	2	0	0	0	0	**5**
Band 9	0	0	0	1	0	0	0	0	0	0	0	0	**1**
Board Director/VSM	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Medical/Dental	0	0	0	1	0	2	0	0	0	0	0	0	**3**
TOTAL	**18**	**126**	**146**	**150**	**149**	**206**	**191**	**170**	**112**	**50**	**17**	**3**	**1338**

The table above gives the age range of promotions during this reporting period. Whilst there appear to be no trends, the data has lower numbers for younger and older adults in our workforce with promotions

appearing to happen most frequently for our workforce between 26 – 60 years of age. Overall, there appear to have been more promotions than the last reported year.

10.0 LEAVERS

Turnover is calculated by dividing the total number of leavers in a period by a combined figure of staff in post at the beginning and end of the period. Our overall turnover rate was 16%, an increase on previous years report (9%). At the time of reporting, there were 2208 leavers in the Trust for this reporting period. 43% of exits were planned and 57% were unplanned exits.



Planned / Unplanned Turnover	Reason for Leaving	TOTAL
Planned	Employee Transfer	0
	End of Fixed Term Contract	26
	End of Fixed Term Contract - Completion of Training Scheme	20
	End of Fixed Term Contract - End of Work Requirement	7
	End of Fixed Term Contract - Other	14
	Flexi Retirement	0
	Merged Organisation - Duplicate Record	1
	Mutually Agreed Resignation - Local Scheme with Repayment	0
	Redundancy - Compulsory	4
	Retirement - Ill Health	7
	Retirement Age	162
	Voluntary Early Retirement - no Actuarial Reduction	6
	Voluntary Early Retirement - with Actuarial Reduction	7
	Bank Staff not fulfilled minimum work requirement	687
	End of Fixed Term Contract - External Rotation	2
Planned Total		**943**
Unplanned	Death in Service	9
	Dismissal - Capability	4
	Dismissal - Conduct	8
	Dismissal - Some Other Substantial Reason	17
	Dismissal - Statutory Reason	1
	Voluntary Resignation - Adult Dependants	5
	Voluntary Resignation - Better Reward Package	21
	Voluntary Resignation - Child Dependants	4
	Voluntary Resignation - Health	43
	Voluntary Resignation - Incompatible Working Relationships	14
	Voluntary Resignation - Lack of Opportunities	10
	Voluntary Resignation - Other/Not Known	916
	Voluntary Resignation - Promotion	61
	Voluntary Resignation - Relocation	51
	Voluntary Resignation - To undertake further education or training	27
	Voluntary Resignation - Work Life Balance	74
Unplanned Total		**1265**
TOTAL		**2208**

10.1 Ethnicity Breakdown of Leavers

	Ethnicity Code – (D-S are codes for BME staff, listed in section 7.1)																Unknown / Not Declared		Totals and Percentages			
AfC Band	A	B	C	D	E	F	G	H	J	K	L	M	N	P	R	S	U	Z	TOTAL	No. BME	BME %	BME % Overall Workforce
Other	6	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	9	1	11%	17%
Apprentice	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	2	1	50%	50%
Under Band 1	20	0	7	1	0	2	0	0	1	0	1	1	1	0	0	0	0	0	34	7	21%	12%
Band 2	131	1	8	1	3	0	1	5	1	2	1	6	78	18	1	5	8	3	273	122	45%	18%
Band 3	370	3	26	7	2	3	5	15	5	2	6	1	58	8	1	4	5	8	529	117	22%	34%
Band 4	448	10	49	2	5	4	5	7	4	2	6	4	21	6	3	1	9	4	590	70	12%	13%
Band 5	220	4	13	1	3	1	3	4	2	0	6	3	54	7	0	2	8	12	343	86	25%	26%
Band 6	157	8	14	0	0	0	2	1	0	3	3	4	22	5	3	1	13	4	240	44	18%	24%
Band 7	52	0	8	0	0	0	0	0	2	1	0	1	7	3	0	3	2	2	81	17	21%	21%
Band 8 - Range A	24	2	7	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	36	3	8%	19%
Band 8 - Range B	6	1	2	0	1	0	0	1	0	1	0	0	2	0	0	0	1	0	15	5	33%	19%
Band 8 - Range C	3	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	6	1	17%	16%
Band 8 - Range D	5	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	0	0%	14%
Band 9	3	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	5	1	20%	0%
Board Director/VSM	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0%	25%
Medical/Dental	10	0	4	0	1	1	0	3	4	1	2	0	6	0	0	3	1	1	37	21	57%	63%
Total	1456	31	143	13	15	11	17	38	19	12	25	21	251	47	8	19	48	34	2208	496	22%	26%

The table above shows the ethnic breakdown of leavers for this reporting period. **22%** of leavers were from ethnic minority groups, which is slightly lower than the workforce BME population of **26%**.

10.2 Disability Breakdown of Leavers

	Afc Banding							
Disabled	**Other**	**Apprentice**	**Under Band 1**	**Band 2 - 6**	**Band 7 - 9**	**Board Director / VSM**	**Medical/Dental**	**TOTAL**
No	3	2	23	1706	106	0	33	1873
Not Declared	4	0	3	117	26	1	2	153
Prefer Not To Answer	0	0	4	5	0	0	0	9
Unspecified	1	0	0	65	14	0	1	81
Yes	1	0	4	82	4	0	1	92
TOTAL	**9**	**2**	**34**	**1975**	**150**	**1**	**37**	**2208**
Leavers % of staff stating that they have a Disability	**11%**	**0%**	**12%**	**4%**	**3%**	**0%**	**3%**	**4%**
Staff in post % stating they have a disability	**6%**	**6%**	**18%**	**4%**	**5%**	**13%**	**2%**	**4%**

Based on the data above**, 4% of all leavers during this period identified themselves as having a disability on ESR**; this is lower than in comparison to 5% in the previous year.

10.3 Gender Breakdown of Leavers

		Gender		
AFC Banding	**Data**	**Female**	**Male**	**TOTAL**
Other	**Headcount**	5	4	**9**
	Percentage	56%	44%	100%
Apprentice	**Headcount**	2	0	**2**
	Percentage	100%	0%	100%
Under Band 1	**Headcount**	22	12	**34**
	Percentage	65%	35%	100%
Band 2-6	**Headcount**	1548	427	**1975**
	Percentage	78%	22%	100%
Band 7-9	**Headcount**	119	31	**150**
	Percentage	79%	21%	100%
Board\Director\VSM	**Headcount**	1	0	**1**
	Percentage	100%	0%	100%
Medical\Dental	**Headcount**	20	17	**37**
	Percentage	54%	46%	100%
Total Headcount		**1,717**	**491**	**2,208**
Total %		**78%**	**22%**	**100%**
Staff in Post %		**79%**	**21%**	**100%**

Of all leavers during this period – **78%** were female and **22%** were male, which is proportionate to the overall workforce.

10.4 Religious Belief of Leavers

AfC Band	I do not wish to disclose my religion / belief	Atheism	Christianity	Buddhism	Hinduism	Islam	Jainism	Judaism	Other	Sikhism	Unspecified	TOTAL
Other	3	1	4	0	0	0	0	0	0	0	1	9
Apprent.	0	0	1	0	0	1	0	0	0	0	0	2
Under Band 1	6	14	9	0	0	1	0	0	4	0	0	34
Band 2	38	45	152	0	3	7	0	0	18	0	10	273
Band 3	106	111	239	0	6	8	1	1	42	0	15	529
Band 4	82	168	258	0	6	13	0	1	52	2	8	590
Band 5	72	49	176	1	5	7	0	1	21	2	9	343
Band 6	53	47	106	2	2	6	0	1	14	0	9	240
Band 7	24	9	37	1	1	1	0	0	2	0	6	81
Band 8a	12	5	10	0	0	0	0	1	6	1	1	36
Band 8b	2	2	5	1	0	1	0	0	1	0	3	15
Band 8c	3	2	0	0	0	0	0	0	0	0	1	6
Band 8d	2	0	4	0	0	0	0	0	1	0	0	7
Band 9	1	1	3	0	0	0	0	0	0	0	0	5
Board Director / VSM	1	0	0	0	0	0	0	0	0	0	0	1
Medical / Dental	14	4	10	0	0	8	0	0	0	0	1	37
Total	419	458	1014	5	23	53	1	5	161	5	64	2208
Leavers %	19%	21%	46%	0.2%	1%	2%	0.05%	0.2%	7%	0.2%	3%	100%

The highest percentage of leavers is from the **Christianity** category. Which is proportionate to the overall workforce.

10.5 Sexual Orientation of Leavers

	Sexual Orientation							
AFC Band	Bisexual	Gay or Lesbian	Heterosexual or "Straight"	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	Undecided	Unspecified	TOTAL
Other	0	0	5	3	0	0	1	**9**
Apprentice	0	0	1	1	0	0	0	**2**
Under Band 1	2	4	24	4	0	0	0	**34**
Band 2	3	3	223	34	1	0	9	**273**
Band 3	7	16	415	77	0	0	14	**529**
Band 4	8	14	482	79	0	0	7	**590**
Band 5	5	5	270	54	0	1	8	**343**
Band 6	2	3	193	34	0	0	8	**240**
Band 7	3	2	52	19	0	0	5	**81**
Band 8a up to Board / Director / VSM	1	2	49	14	0	0	4	**70**
Medical/Dental	0	0	29	7	0	0	1	**37**
TOTAL	**31**	**49**	**1743**	**326**	**1**	**1**	**57**	**2208**
% of Total Leavers	**1%**	**2%**	**79%**	**15%**	**0.05%**	**0.05%**	**3%**	**100%**
Leavers LGB %	**4%**							
Staff in post LGB %	**3%**							

The table above shows that 4% of leavers were LGB compared to 2% of LGB leavers last year. This could be in part due to increased declarations from staff due to our work in the Trust. Whilst this is proportionate to the overall Trust, it may indicate that we are not meeting the needs of this community.

We as a Trust recognise that the current ESR data collected on a national level falls short on the recording of gender identity for our Transgender and Non-Binary staff members, and will include this in future reports as this is due to be added to these systems by NHS England. This has been a concern raised with NHS England by our LGBTQ+ Staff Network.

10.6 Age Range Breakdown of Leavers

	Age Band							
Afc Band	**20 under**	**20's**	**30's**	**40's**	**50's**	**60's**	**70 and above**	**TOTAL**
Other	0	0	0	1	3	1	4	**9**
Apprentice	0	1	1	0	0	0	0	**2**
Under Band 1	3	30	1	0	0	0	0	**34**
Band 2	6	69	45	71	46	31	5	**273**
Band 3	9	107	88	96	132	89	8	**529**
Band 4	1	150	107	88	121	113	10	**590**
Band 5	0	46	66	76	74	78	3	**343**
Band 6	0	30	49	62	60	39	0	**240**
Band 7	0	3	21	11	27	18	1	**81**
Band 8a	0	1	11	6	12	5	1	**36**
Band 8b	0	0	3	5	6	1	0	**15**
Band 8c	0	0	1	1	2	2	0	**6**
Band 8d	0	0	1	0	4	2	0	**7**
Band 9	0	0	1	0	3	1	0	**5**
Board Director/VSM	0	0	0	0	0	1	0	**1**
Medical/Dental	0	9	14	4	4	5	1	**37**
TOTAL	**19**	**446**	**409**	**421**	**494**	**386**	**33**	**2208**
%	**1%**	**20%**	**19%**	**19%**	**22%**	**18%**	**1%**	**100%**

The table below shows the age range breakdown for all leavers. There appears to be an equal rate of leavers across these age bands, with staff groups aged between 20 – 60 all having similar rates of leaving. The leaver's age has increase to 60 as opposed to the previous year where we saw the age gap was set at 50.

11.0 RECRUITMENT

The Trust uses Trac / NHS Jobs for all its recruitment activity. Recruiting managers do not have access to view the applicant's personal details or monitoring information on their completed applications, including the equality streams.

It should also be noted that new additions to TRAC as part of General Data Protection Regulations (GDPR) have limited the data available for this period. Whilst 2022-23 presented pressures that prevented the EDI team from accessing this data, as this was requested outside of the one-year window. The creation of the PSED for 2023-24 will begin in Q2 mitigate this and provide greater context for the reporting that follows. Using WRES / WDES Data, the following updates are available:

- During this period, **8878** members of staff (including Bank Staff) were listed as employed by the Trust.
- During this period, **9693** potential candidates were shortlisted, **1148** were appointed from shortlisting.

WRES 2022-23	Results
White Staff shortlisted	2396
Staff from BME ethnicity groups shortlisted	1446
White Staff appointed	780
Staff from BME ethnicity groups appointed	327
Likelihood of appointment from shortlisting based on data (White)	**33.55%**
Likelihood of appointment from shortlisting based on data (BME)	**22.61%**
WDES 2022-23	
Non-disabled staff shortlisted	8781
Staff with a disability or long-term condition shortlisted	576
Non-disabled staff during this period appointed	1002
Staff with a disability or long term condition appointed	81
Likelihood of appointment from shortlisting based on data (non-disabled)	**11.41%**
Likelihood of appointment from shortlisting based on data (disability or LTC)	**14.06%**

This data suggests disparities in the likelihood of being appointed from shortlisting based on ethnicity during this period. The EDI Team has already been working closely with the Recruitment Team and our System partners to ensure our recruitment process is free from bias.

12.0 EMPLOYEE RELATIONS (ER)

Data in this category includes the number of staff subjected to a disciplinary hearing, the number of staff submitting formal grievances and the number of staff who have been the subject of investigation and capability procedures. The data also covers allegations made of bullying and harassment (Dignity at Work).

For this report, the data includes live cases at the time of the reporting period. The data includes all staff (permanent and bank workers) across all pay bands.

Type / Category (reporting only)	2020 / 2021	2021 / 2022
Capability	12	26
Dignity at Work	27	38
Conduct	54	44
Temporary Worker Conduct	28	52
Flexible Working	42	160
Grievance	13	20
Temporary Worker Complaint	13	8
TOTAL	**189**	**348**

The table above reports a significant increase in 2021 / 2022 across many of these categories, it should be noted that during this reporting period, the Employee Relations Team has undertaken extensive work to address this process, with a goal to reduce the number of staff entering formal processes.

12.1 Ethnic breakdown of staff using or subjected to these procedures

Ethnicity	Capability	Dignity at Work	Conduct	Temporary Worker Conduct	Flexible Working	Grievance	Temporary Worker Complaints	TOTAL	% of all cases
A	17	20	20	4	108	8	3	**180**	**52%**
B	1	2	0	0	0	2	1	**6**	**2%**
C	1	2	3	2	13	0	0	**21**	**6%**
D	0	0	0	0	3	0	0	**3**	**1%**
E	1	4	0	2	0	1	0	**8**	**2%**
F	0	0	0	0	1	0	1	**2**	**0.5%**
G	0	0	1	0	1	0	0	**2**	**0.5%**
H	1	0	2	0	4	0	0	**7**	**2%**
J	0	0	1	0	0	1	0	**2**	**1%**
K	0	0	1	0	2	1	0	**4**	**1%**
L	0	0	2	2	2	1	0	**7**	**2%**
M	0	0	0	0	3	0	0	**3**	**1%**
N	2	8	9	29	16	3	2	**69**	**20%**
P	1	1	4	10	2	2	1	**21**	**6%**
R	0	0	1	0	0	0	0	**1**	**0%**
S	1	0	0	2	2	0	0	**5**	**1%**
U	0	0	0	1	0	0	0	**1**	**0%**
Z	1	1	0	0	3	1	0	**6**	**2%**
TOTAL	**26**	**38**	**44**	**52**	**160**	**20**	**8**	**348**	**100%**
BME Total	**6**	**13**	**21**	**45**	**36**	**9**	**4**	**134**	**39%**

The table on the previous page shows that, overall, most employee relations cases involve white British workers (52%), **with (39%) being attributed to workers from an ethnic minority background.**

During the period 2020 – 2021, 42 flexible working applications were received in comparison to 160 applications during 2021 – 2022.

During 2020-2021 there were just 54 substantive cases and 28 temporary worker conduct cases; during the period 2021-2022 there has been 348 reported cases under formal disciplinary with 134 being from BME staff. This has been an ongoing focus of both our WRES action planning, as well as encouraging further involvement of the Ethnic Minority and Race Equality Staff Network (EMREN).

12.2 Disability breakdown of staff using or subjected to these procedures

Declaration of Disability on ESR	Capability	Dignity at Work	Conduct	Temporary Worker Conduct	Flexible Working	Grievance	Temporary Worker Complaints	TOTAL	%
No	11	23	33	42	121	15	4	**249**	**71%**
Not Declared	11	13	8	10	30	4	3	**79**	**23%**
Yes	4	2	3	0	9	1	1	**20**	**6%**
TOTAL	**26**	**38**	**44**	**52**	**160**	**20**	**8**	**348**	**100%**

The table above includes staff from all bands including medical staff and those in both permanent and bank role. The Trust has seen a sufficient increase in majority of the categories in comparison to 2020/2021. The sufficient increase has been within Flexible working, in 2020/2021 reported to have 42 flexible working cases however, this has tripled in 2021/2022 to 160. These results could be the effect of recent changes to employment law for flexible working legislations and that many staff can work remotely in their roles.

12.2 Gender breakdown of staff using or subjected to these procedures

Type / Category (reporting only)	Female	Male
Capability	16	10
Dignity at Work	32	6
Conduct	20	24
Temporary Worker Conduct	30	22
Flexible Working	125	35
Grievance	13	7
Temporary Worker Complaints	8	0
TOTAL	**244**	**104**
%	**70%**	**30%**
Trust Staff in Post %	**79%**	**21%**

The table above shows the gender breakdown of staff using or subjected to these procedures during this reporting period. It should be noted that where the totals do not add up, it is because of an option where staff have chosen not to share their gender, but it is unknown if this is due to them having an alternative gender identity. It should be noted that there are very similar rates of “Conduct” procedures for both Male and Female staff despite the male group being nearly a quarter of the workforce.

12.4 Religious Belief breakdown of staff using or subjected to these procedures

AfC Band	I do not wish to disclose my religion / belief	Atheism	Christian	Hinduism	Islam	Judaism	Other	Sikhism	Unspe.	Total
Capability	9	4	9	1	0	0	1	0	2	**26**
Dignity at Work	15	2	18	0	0	0	1	0	2	**38**
Conduct	6	10	15	5	1	0	6	0	1	**44**
Temporary Worker Conduct	12	1	29	0	7	0	3	0	0	**52**
Flexible Working	42	21	71	0	2	1	15	1	7	**160**
Grievance	2	2	10	1	3	0	0	0	2	**20**
Temporary Worker Complaints	3	0	4	0	1	0	0	0	0	**8**
TOTAL	**89**	**40**	**156**	**7**	**14**	**1**	**26**	**1**	**14**	**348**
%	**26%**	**11%**	**45%**	**2%**	**4%**	**0.5%**	**7%**	**0.5%**	**4%**	**100%**

The table above shows the religion and faith breakdown of staff using or subjected to these procedures during this reporting period. It should be noted that Christianity is the highest declared religion on ESR, with "I do not wish to disclose my religion or belief" as the second highest category.

12.5 Sexual Orientation breakdown of staff using or subjected to these Procedures

Sexual Orientation	Capability	Dignity at Work	Conduct	Temporary Worker Conduct	Flexible Working	Grievance	Temporary Worker Complaints	TOTAL	%
Not stated (person asked but declined to provide a response)	7	8	10	14	18	2	2	**61**	**17%**
Heterosexual or Straight	17	27	33	36	130	15	6	**264**	**76%**
Bisexual	0	0	0	1	2	0	0	**3**	**1%**
Gay or Lesbian	0	1	0	1	4	1	0	**7**	**2%**
Unspecified	2	2	1	0	6	2	0	**13**	**4%**
TOTAL	**26**	**38**	**44**	**52**	**160**	**20**	**8**	**348**	**100%**

The table above shows the data for the Trust's workforce and from all pay bands. The analysis shows that 17% (in comparison to **25% in the previous year)** of those workers who have been subject of these ER procedures have chosen not to disclose their sexual orientation, a reduction from the previous year's result and an indicator of improved declaration rates.

12.6 Age range of individuals using or subjected to these procedures

	Capability	Dignity at Work	Conduct	Temporary Worker Conduct	Flexible Working	Grievance	Temporary Worker Complaint	Grand Total	%
16-20	0	0	1	0	3	0	1	**5**	**1%**
21-25	0	1	2	4	5	2	1	**15**	**4%**
26-30	1	2	5	1	21	2	0	**32**	**9%**
31-35	2	7	7	5	20	1	1	**43**	**12%**
36-40	3	4	2	5	29	2	0	**45**	**13%**
41-45	0	3	9	9	25	2	0	**48**	**14%**
46-50	2	5	5	7	17	3	1	**40**	**11%**
51-55	7	3	5	9	17	6	2	**49**	**14%**
56-60	8	8	4	5	15	1	0	**41**	**12%**
61-65	3	3	1	4	7	0	1	**19**	**5%**
66-70	0	2	3	3	1	0	0	**9**	**3%**
71 +	0	0	0	0	0	1	1	**2**	**2%**
TOTAL	**26**	**38**	**44**	**52**	**160**	**20**	**8**	**348**	**100%**

The data above shows that the majority of these individuals were in the 31 – 60 years of age range, which is aligned with the population of the Trust's overall workforce.

13.0 CONCLUSION

It is encouraging to see an improvement in declaration rates for many protected groups, a possible indicator that staff feel more able to be open about themselves in the workplace due to the increased EDI and Staff Engagement efforts throughout this period. Whilst this data for the most part shows that our organisation is representative of the communities it serves, it should be noted that this data also highlights some key issues in our workforce. Whilst this is something the EDI Team was already addressing during this data period and continues to do so, it ties into work already taking place as part of the various measures and reporting for Sections 1-6.

2023-24 will focus on building upon the foundation of improvements we have already put in place for supporting Equality and Inclusion in our workforce.

Key focusses for 2023-24 will be:

- Involvement of the Executive Team to promote EDI at a senior level, drive actions on our WRES and WDES action plans and the Equality and Inclusion Strategy. Ensure that Staff Equality Networks continue to receive support from Executive Directors acting as sponsors to guide these groups whilst also championing inclusion in our workforce.

- To improve the EDI training offer available to all staff, as well as developing specific guidance aimed at middle-managers in the organisation to promote inclusion. Commissioning a mandatory Transformational Cultural Programme focussed on our Leaders *(L50 / L300).*

- To address bullying and harassment concerns raised by our WRES / WDES Data, and to review the support available for those experiencing racism, discriminatory behaviour or abuse. Developing a Racial Discrimination Steering Group with key stakeholders from across the Trust committed to driving this agenda.

- To develop a Gender Equality Network in line with our existing Staff Equality Networks.

- Retention of staff across all demographic groups, with it being a key element of the People Strategy

- To build upon our existing data sources to ensure we are responding to trends, achieving our KPI's and addressing hotspot areas where discriminatory behaviour is an issue. Improving the quality of staff's Electronic Staff Record information and promote the completion of this with new starters in the organisation to ensure EPUT's demographic data is robust.

- To work alongside system partners and our own Recruitment and Employee Relations teams to To ensure that our Recruiting and Hiring processes are inclusive and in line with NHS England's "No More Tick Boxes" guidance and to remove potential systemic discrimination from our Employee Relations processes.

- To address disproportionate levels of bullying and harassment reported by the ER Data in the PSED, as well as similar findings in our WRES and drive positive changes throughout the year as part of our Equality and Inclusion Strategy / WRES and WDES Action Plans.

Report prepared by
Name: Lorraine Hammond
Job Title: Director – Employee Experience
Date: March 2023

On behalf of
Name: Marcus Riddell
Job Title: Acting Executive Director of People and Culture

		Agenda Item No: 7h
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 March 2023**

Report Title:	**Equality Delivery System (EDS) reporting template 2023**					
Executive/ Non-Executive Lead:	Marcus Riddell, Acting Executive Director of People & Culture					
Report Author(s):	Lorraine Hammond, Director of Employee Experience Matt Sisto, Director of Patient Experience					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	✓

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

Project reports only:	
If this report is project related please state whether this has been approved through the Transformation Steering Group	N/A

Purpose of the Report		
This report provides the Board of Directors: • The Equality Delivery System reporting template as part of EPUT's EDI duty under the Equality Act (2010) • A short summary of actions from the previous EDS (2021-22) • A short summary of actions, initiatives and projects in the Trust across three key domains.	**Approval**	✓
	Discussion	
	Information	

• Actions as a result of these grading's and stakeholder feedback from virtual sessions.		

Recommendations/Action Required
The Board of Directors is asked to: 1 Note the contents of the reporting template 2 Approve this for public display on the EPUT Website as part of our Public Sector Equality Duty.

Summary of Key Issues
• The EDS is a tool designed by NHS England and a mandatory requirement that organisations display this and their most current PSED report on their website on an annual basis. • The EDS is a new version of the former EDS2, and asks NHS Trusts to compile evidence of Workforce EDI, Wellbeing and Patient Access across three domains following the guidance of NHS England: • **Domain 1, Commissioned or Provided Services**: Graded on 27/02/2023 by service user volunteers in a virtual session conducted by the Patient Experience Team. These stakeholders felt that EPUT was "*Achieving*" in its actions. • **Domain 2, Workforce Health and Wellbeing:** Graded on 02/03/2023 by EPUT staff stakeholders, an open virtual event conducted by the Equality Advisor. These stakeholders felt that EPUT was *"Achieving"* for this domain • **Domain 3, Inclusive Leadership:** Graded on 02/03/2023 by an independent representative. For this, a volunteer from Staffside completed this grading. This stakeholder felt EPUT was "*Underdeveloped / Developing*" for this domain. • Across these domains, we have been ranked *"Developing"* based on these scores, although it should be noted that our score was two points away from being rated as *"Achieving"* • The action plans developed based on this grading and feedback is at the end of the EDS Template, and lists our commitments alongside our WRES and WDES Action Plans and our overall Equality and Inclusion Strategy 2022-25

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			
WRES	Workforce Race Equality Standard	WDES	Workforce Disability Equality Standard
BME	Black, Asian and Minority Ethnicity	LTC	Long-term condition
EDS	Equality Delivery System	MSE	Mid and South Essex
HWE	Herts and West Essex	ICS	Integrated Care System
HR	Human Resources / Employee Relations	EDI	Equality, Diversity and Inclusion
PSED	Public Sector Equality Duty	LGBTQ+	Lesbian, Gay, Bi, Transgender and any other sexual orientation or gender identity minority groups.
POEM	Patient Rated Outcome and Experience Measure	CYPHMS	Children and Young Peoples Mental Health Services
PREMS	Patient Recorded Experience Measure	iWGC	"I Want Great Care" survey provider.

Supporting Reports/ Appendices /or further reading

NHS Equality Delivery System (EDS)

Further Reading:

- EPUT Equality Strategy 2022-25
- EPUT WRES and WDES Reports 2022
- EPUT Public Sector Equality Duty reporting (2022-23)

Lead

Marcus Riddell
Acting Executive Director of People and Culture

NHS Equality Delivery System (EDS)

Name of Organisation	**Essex Partnership University NHS Foundation Trust**	**Organisation Board Sponsor/Leads**
		(Board Sponsors) **Marcus Riddell** (Acting Executive Director of People and Culture) Zephan Trent (Executive Director of Strategy, Transformation and Digital (Leads) **Lorraine Hammond**, (Director of Employee Experience) **Matt Sisto** (Director of Patient Experience)
Name of Integrated Care System	*(EPUT is part of three ICS groups, providing services over each)* • Mid and South Essex ICS • Herts and West Essex ICS • Suffolk and North East Essex ICS	

EDS Lead	**Gary Brisco** (Equality Advisor) **Amy Poole** (Head of Patient Experience)	**At what level has this been completed?**	
		List organisations	
EDS engagement date(s)	**March 2023**	**Individual organisation**	Essex Partnership University NHS Foundation Trust (EPUT). • **(Domain 1)** Patient and Carer Stakeholder Session held on 27th February 2023 • **(Domain 2)** Staff Stakeholder Session held on 2nd March 2023 • **(Domain 3)** Staffside Representative graded between 27/02/2023 and 07/03/2023
Partnership* (two or more organisations)		As EPUT is part of three ICS partnerships, it was decided that this would be done internally this year with a view to complete this collaboratively in 2023.	
Integrated Care System-wide*			

Date completed	08 March 2023	**Month and year published**	March 2023

Date authorised	TBC 2023	Revision date	TBC 2023

Completed actions from previous year (2021-2022)	Related equality objectives
• Patient and Carer Forums redesigned as “listening events” with inclusion for those accessing non-mental health services, designed to improve patient access and experience. • COVID-19 Vaccination Service engaged with local communities to identify health inequalities and encourage uptake of vaccinations within marginalised communities. • Clinical Guidance implemented to provide inclusive care for Transgender and Non-Binary patients in our services. • Equality and Inclusion Sub-Committee reviews Patient Advice and Liaison Service as well as service user complaints to identify key trends. • Interpreting services were reviewed by Equality and Inclusion sub-committee to ensure these are supporting patients and carers. • Regular collaboration with Health watch and Patient Experience Team. Healthwatch Representative provides feedback on the Trust, as well as indications of ongoing trends to Patient Experience Director. • Inclusion of Staff Pronouns on ID Badges for new starters. • Implementation of Sunflower Lanyards for service users and staff, with training to support those wearing them. • Inclusion of Patient Pronouns on PARIS online system.	**Domain 1:** Commissioned or Provided Services.
• Implementation of “Here for You” a dedicated Psychology service for EPUT staff. • Implementation of Employee Experience Managers to deliver positive experiences to EPUT staff by interactions and raising engagement levels, to support wellbeing of staff and identify trends in services. • Developed updated a guidance for how and where to access support, including our confidential advice and counselling service for work/personal related concerns • Delivered a large number of events focused on staff wellbeing / challenging discriminatory behaviour, positively received and attended by all staff, including regular wellbeing events, all staff webinars, awareness days etc. • Appointed Director of Employee Experience and Inclusion for EPUT, also acting as SRO for inclusion (Mid and South Essex ICS). • Participation in the KickStart Scheme and carried this forward to support our own internship program. • Delivered a large number of events focused on equality and inclusion, attended by staff and with positive reception, including regular wellbeing events, all staff webinars, staff training sessions and focus sessions. • Training sessions regularly provided for staff including LGBTQ+ Awareness, Race Equality, Allyship and Reasonable Adjustments.	**Domain 2:** Workforce Health and wellbeing.

Completed actions from previous year (2021-2022)	Related equality objectives
• Equality and Inclusion a key part of EPUT Staff Induction. Sessions developed in collaboration with EPUT Staff Networks.	
• Review of Staff Networks and Equality and Inclusion Sub-Committee and how these feed learning into our People, Equality and Culture Committee (PECC) and Trust Board. • Review and Update of Ethnic Monitoring Policy to "Equality Monitoring Policy" to include Sexual Orientation Standard Guidance. • Monthly "Staff Engagement Champions" sessions, including the "The Grill", which provides an opportunity for executive team leaders to share their progress on EDI / Staff Wellbeing projects, as well as engaging with staff offering a Q&A session. • Strengthening Equality Impact Assessments as part of Trust policy and procedure. • Updated WDES and WRES action plans (2021 - 22) and presented results to stakeholders. • 2021 Gender Pay Gap report completed, showing a reduction in 5% from 2017 – 2021, Gender Pay Gap is below national average. • Autonomy given to Staff Networks, with their work feeding into the Equality and Inclusion Sub-Committee and support for events and projects from communications team. Regular meetings between Exec. Director of People and Culture and Network Chairs. • Executive sponsors identified and implemented for all current Staff Networks. • Significant reduction in representation gap at Board Membership for Senior Level BME staff (WRES 2021)	**Domain 3:** Inclusive Leadership / Workplace inclusion.

Domain	Outcome	Evidence	Rating	Owner
		• Results for PLACE 2022 are due to be published by NHS England at the end of February 2023. Assessors were asked to consider how those with visual and physical impairments may access buildings, whether surfaces were non-reflective, and whether flooring was, smooth, safe to walk, accessible for use wheelchair and clutches on. Initial internal analysis of results have led to improvement actions for EPUT to make wall and floor colours contrasting in colour to help those with visual impairments. Therefore, actions from PLACE 2022 have strong emphasis on improving accessibility. • Referral to Perinatal services come via GPs. Therefore, route of referral and access to initial appointment at GP surgery would likely be a better determent of accessibility to the perinatal services. However, the Perinatal services manager has taken steps to ensure that there is guaranteed assessment of every patient regardless of referral. Continue….		

Domain	Outcome	Evidence	Rating	Owner
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	• Perinatal services has a fixed ethnicity coding upon referral into service, which provides a reliable understanding of the Ethnicity makeup of both Patients and Staff. The team monitor local population demographics against staff demographics to ensure there is reliable representation of the local community within the teams. The team are regularly analysing access into the service to try to understand why it appears that certain demographical groups are more prone to crisis. Once possible reasoning of why particular groups are more vulnerable; the team plan to work on devising earlier intervention actions as preventative and protective measures against crisis in more susceptible groups. • The Perinatal service has put together community leader and engagement group sessions to educate and support members of the Refugee and Asylum Seeker refugees on accessing perinatal services. • The Perinatal service has a consultant in place to assist in commissioning Equality and Diversity into the perinatal work stream. • The Perinatal services routinely carry out open dialogue workshops in which members of the community can attend and ask questions about the service, regardless of whether they have already been referred into the service. This allows any individual concerns around access to be recognised by the team, potentially even prior to referral. • Information videos from the perinatal service have been translated into various different languages and can be translated into other languages (not already covered) upon request. • The Lighthouse service has a lift in the main building and slope into reception for wheelchair users. • The Lighthouse service receives referrals via schools and Children and Young Peoples Mental Health Services (CYPHMS). Therefore, route of referral and access to initial appointment into CYPHMS may provide a more effective evaluation of accessibility to service. • The Lighthouse service promotes use of and has easy access to a translation organisation to allow any non-English speaking patients to be accompanied by a translator and ensure all information is correctly understood.	1	**Matt Sisto** (Director of Patient Experience)

Domain	Outcome	Evidence	Rating	Owner
	1B: Individual patients (service users) health needs are met	• There are extensive clinical governance structures in place to ensure health needs are met for patients accessing both the perinatal services and Lighthouse service. These include monitoring serious Incidents for any themes and trends related to Equality and Diversity. • The Perinatal service takes a "whole service approach". This involves applying systems thinking methods and practice to better understand service challenges and helps to identify collective actions by consistently engaging and observing the journeys of patients. Staff co-create care plans with patients to understand their needs and whether their needs have changed since referral. • The Perinatal service is currently awaiting ethics approval for an interviewing process following discharge from services to directly ask patients themselves whether they feel their health needs were successfully met. • The Lighthouse service assesses health needs via the referral criteria, risk and complexity. Whether health needs have been met, it is indicated by the patient via the *"I want Great Care"* question set. Children can also complete the PREMS themselves via the version of the question set specifically designed for children and young people.	2	**Matt Sisto** (Director of Patient Experience)

Domain	Outcome	Evidence	Rating	Owner
	1C: When patients (service users) use the service, they are free from harm	• Patient Safety Partners are working within EPUT to support and contribute to EPUT's governance and management processes for patient safety. It is the role of Patient Safety Partners to communicate rational and objective feedback focused on ensuring that Patient Safety is maintained and improved within EPUT as part of the Safety First, Safety Always initiative. • Serious Incidents and reports of harm to babies' form part of the Perinatal Services, incidents and reports are routinely monitored for themes and trends, which may relate to Equality and Diversity. The Perinatal Services operate a duty system, which filters out crisis and urgent referrals; referrals are analysed for themes and trends relating to Equality and Diversity. • There are clinical governance structures in place to protect the safety of patients in both the Perinatal Services and the Lighthouse Service. This provides strategic clinical leadership and clinical oversight, which is consistently implemented to deliver safe and effective services. The clinical oversight and assurance includes ensuring products and services are developed to recognised safety standards and are signed off as clinically safe to go live. EPUT's safety team are responsible for providing clinical insight and input into incidents and issues within both selected services. • The Lighthouse service has regular safety meetings to review and discuss patients who have had a delay in admission of over 52 weeks into the service. • The Lighthouse service operates Parent Network forums, community feedback sessions and Q&A sessions, which allow themes, and trends relating to safety to be identified, discussed and actioned. • The Lighthouse service works collaboratively with partner organisations that may be able to provide support, which may help monitor/reduce specific harm. The Lighthouse service is able to make referrals to organisations that assist with drug and alcohol abuse as well, financial and housing advice. • The Lighthouse service operates a duty line, which allows any immediate risks of harm to be bought to the attention of clinicians as soon as possible.	2	**Matt Sisto** (Director of Patient Experience)

Domain	Outcome	Evidence	Rating	Owner
	1D: Patients (service users) report positive experiences of the service	• Perinatal services use POEM (Patient Rated Outcome and Experience Measure) which is a national perinatal outcome that was developed by the Royal College of psychiatry perinatal quality network. • The POEM is provided to every patient within perinatal services; a tool developed to capture satisfaction over time and detect fluctuations within a service. The POEM is themed around communication, care environment, information provision, and baby care. Patients and partners/family members are invited by services to complete the POEM when the patient is discharged from inpatient or community perinatal care. It is intended as a continuous routine evaluation. Patients are sent the POEM via a web link. The POEM supports the services approach to an operationalising the CORE 10: "Clinical Outcomes in Routine Evaluation" which comprises tools and thinking to support monitoring of change and outcomes in routine practice in psychotherapy, counselling and any other work attempting to promote psychological recovery, health and wellbeing. • 61% of patients within the Perinatal services agreed that staff provide the right amount of support • Each service within EPUT has a primary route of feedback via iWGC. This is the trusts contracted provider of PREMS (Patient Recorded Experience Measure). The platform is accessible in different languages and is presented through varying methods depending on what may be most suitable to the patient demographic. • Every individual with connection/interest in EPUT can attend the EPUT forum, which is held once a quarter by the Patient Experience and Volunteers team as an opportunity to ask people and communities what matters most to them and where "citizens" feel EPUT should be targeting their energy. This gives all patients the opportunity to provide feedback on their experiences of care. • The Lighthouse service operates Parent Network forums, community feedback sessions, Question, and Answer sessions, which allow themes, and trends relating to safety to be identified, discussed and actioned. • Children can also complete the PREMS themselves via the version of the question set specifically designed for children and young people. • On average, the lighthouse service scores 3.5 out of 5 for patient experience.	2	**Matt Sisto** (Director of Patient Experience)
Domain 1: Commissioned or provided services overall rating			**7**	

Domain	Outcome	Evidence	Rating	Owner
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• EPUT published a Wellbeing toolkit as part of our overall Wellbeing Framework in the Trust. Educating managers and teams of wellbeing offers both internally and externally. • EPUT provides support for staff through our Employee Assistance Program (provided by Optima Health), providing confidential and free support to improve wellness and wellbeing. Providing guidance and support for mental and physical conditions. • EPUT staff intranet pages have many health and wellbeing pages with links and resources. These include manager support, physical activity, sleep, healthy eating, staying hydrated, stopping smoking, alcohol and drugs, resilience, mindfulness, finance and much more. • Wellbeing Resources designed to support staff in their own wellbeing are available, with examples including the Sleep School app and Cycle to Work Scheme. • Optima Health provide free staff health checks for Blood Pressure, Cholesterol and BMI across the Trust with bookable slots to reserve places. • Access to Fast-Track Physio via Optima Health to provide support for physical conditions requiring physiotherapy. • "ACT for You" workshops teach staff Acceptance and Commitment therapy training techniques, teaching participants skills to support psychological flexibility and resilience. • Wellbeing is embedded into staff appraisals and supervision process, with a dedicated psychological support service available in the Trust ("*Here for You"*). • Reasonable Adjustments Passports are available for all staff in EPUT, with a no-diagnosis model to ensure adjustments can be implemented quickly. • Mental Health First Aiders has been implement across the Trust; staff have volunteered to become MHFA and received full training. MHFA are available throughout EPUT. • Access to Work Support is available to individuals who are experiencing difficulties at work due to depression, anxiety, stress and/or other mental health conditions. With trained professionals able to support employees in resuming their role. • Implementation of a specific function to capture staff demographic data on our electronic staff record to encourage disclosure and to update data of any changes.	2	**Lorraine Hammond**, (Director of Employee Experience)

Domain	Outcome	Evidence	Rating	Owner
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• EPUT has seen an increase in Bullying and Harassment; this has been indicated on the WRES, with higher than average scores for bullying, harassment and abuse from staff and service users as well as higher reports of discrimination from a manager or colleague. • EPUTE has Improvements Bullying and Harassment scores from those identified in the WDES; however, the WDES showed below-average rates that needed to be addressed within EPUT. • Bullying and Harassment collaborative event held across Mid and South Essex ICS, with staff sharing lived experience, guidance on how to challenge and mitigate discriminatory behaviour and racism and the launch of EPUT's new Equality and Inclusion Strategy with actions to address this. • Implementation of new DATIX systems to capture incidents of racial abuse or discrimination, which triggers a debriefing process from the manager to ensure employee wellbeing. • "No Space for Abuse" program launched in collaboration with Essex Police, encouraging responsibility to challenge racism and discriminatory behaviour.	2	**Lorraine Hammond,** (Director of Employee Experience)
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• Wellbeing is embedded into staff appraisals, with a dedicated psychological support service available in the Trust for staff that provides confidential support. (Here for You). • "No Space for Abuse campaign" in the Trust promotes that staff should support each other when they witness discriminatory and that any racism or discriminatory behaviour or abuse should be challenged and recorded via DATIX systems. • VAPR Team and Equality Advisor contacts those who have reported racism and discriminatory behaviour via DATIX the system, this offers direct support and signposting / wellbeing resources. • Implementation of new DATIX system captures incidents of racial abuse or discrimination, which triggers a debriefing process from the manager to ensure employee wellbeing. • Further support is offered following a report via the employee experience managers, offering an additional service for wellbeing, resources and support to managers and staff. • Implementation of a professional training suite sourced from a dedicated provider, with a long-term goal of an EDI portal for staff learning. • Micro-incivilities Workshop pilot sessions held in conjunction with Pearn Kandola, developed collaboratively with Mid and South Essex ICS.	2	**Lorraine Hammond,** (Director of Employee Experience)

Domain	Outcome	Evidence	Rating	Owner
	2D: Staff recommend the organisation as a place to work and receive treatment	• Throughout the year, events like LGBTQ+ Pride Month, Black History Month and Disability History Month show the stories of EPUT staff who have progressed in the Trust, these stories are positive and promoted through our Trust Communications. • Staff Survey (2021 Q21c and Q21d) indicate a 4% decline in staff who would recommend their organisation as a place to work. It was recorded in the survey 6.5% decrease in staff recommending the care provided by EPUT to a friend or relative. • Staff Survey (2021 Q22d. 2/3) suggested a below average responses of EPUT staff wishing to move to a new NHS Trust or move into new roles outside of the NHS. • Staff Survey (2021 Q22d. 9) reports an above-average rate of EPUT staff not considering leaving their current role. • Quarterly Pulse Surveys (similar to NHS Staff Survey) it was encouraging to see on average, approximately 60% of respondents chose “agree” or “definitely agree” with these statements *“ I would recommend my organisation as a place to work”* and *“If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation”* • “You asked, we Delivered” campaign based on NHS Staff Survey Feedback, proactively engaging staff to see what drove our results and how we can improve. Focus groups held in these sessions engaged with staff to collect stakeholder feedback.	2	**Lorraine Hammond,** (Director of Employee Experience)
Domain 2: Workforce health and well-being overall rating			**8**	

Domain	Outcome	Evidence	Rating	Owner
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• Senior leaders in the organisation have completed Cultural Intelligence Training. • The executive team are responsible for driving the action plans of the WRES and WDES, with assigned members embedding these metrics through their own work streams. • Senior Leaders in the organisation regularly promote inclusion awareness campaigns via Live Staff Update, which is available to all EPUT staff, EDI projects are promoted in the Executive Director's newsletter to all staff. • We are also working with the Transformation Project Team to develop an integrated implementation and delivery plan for EDI to be included in all work streams across the Trust. This EDI Strategy has been developed with stakeholders based on WRES, WDES and internal stakeholder focus groups. • Regular "Staff Engagement Champions" sessions in Trust have "The Grill", where executive team leaders can share their progress on EDI / Staff Wellbeing and engage staff. • Each of the Staff Networks has an Executive Sponsor to drive the objectives and offer the support.	1	**Lorraine Hammond,** (Director of Employee Experience)
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• The Trust Board approves statutory reporting for the WDES, WRES, GPG and PSED as well as the EDS. • All six sets of minutes from Board of Directors meetings for this period contain a section on "reflection on equalities as a result of decisions and discussions". Where health and organisational inequalities are noted and discussed. WRES and WDES discussed at length on September 28th 2022, as well as the goal to improve with further data and a focus on health inequalities affecting service user communities. • Trust's Equality Strategy (2022-25) approved at Board Level.	1	**Lorraine Hammond,** (Director of Employee Experience)

Domain	Outcome	Evidence	Rating	Owner
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• EPUT holds an Equality and Inclusion Strategy within organisation, which clearly lists organisation's goals based on WRES, WDES and Stakeholder feedback sessions. • Equality and Inclusion Strategy lists KPI's to track progress of improvement in areas including amount of DATIX incidents raised, and staff appointment rates. • Executive Director Sponsors joined Staff Equality Networks, providing support to Network Chairs and acting as champion for the Network.	2	**Lorraine Hammond,** (Director of Employee Experience)
Domain 3: Inclusive leadership overall rating			**4**	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): Oladipo Ogdenbe (Staffside Chair)	**Independent Evaluator(s)/Peer Reviewer(s):** N/A

Domain 1: Commissioned or provided services overall rating	**7 / 12**
Domain 2: Workforce health and well-being overall rating	**8 / 12**
Domain 3: Inclusive leadership overall rating	**4 / 9**
EDS Organisation Rating (overall rating): 19 (**Developing**)	
Organisation name(s): **Essex Partnership University NHS Foundation Trust (EPUT)**	

- Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
- Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
- Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
- Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
Gary Brisco (epunft.equality@nhs.net)	Five (EDS2 2019 to present)
EDS Sponsor	**Authorisation date**
Lorraine Hammond, Director of Employee Experience	TBC

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	**1A:** Patients (service users) have required levels of access to the service	• Explore ways in which the Accessible Information Standard can be more explicitly utilised within each service.	• Continue to promote Accessible Information Standard (AIS) in EPUT. • Feature AIS as part of EPUT Patient Experience training to support access.	**September 2023**
	1B: Individual patients (service users) health needs are met	• Continue implementation of "Time to Care" programme in EPUT to improve patient care in services and recognising protected characteristics in patient care.	• Support and contribute in the implementation of "Time to Care" program (both EDI and Patient Experience Teams)	**September 2023**
	1C: When patients (service users) use the service, they are free from harm	• Ensure work of Patient Safety Partners is promoted throughout EPUT.	• Share learnings / next steps taken from serious incidents with patients, families and carers.	**September 2023**
	1D: Patients (service users) report positive experiences of the service	• Ensure EDS agenda is built into the "I want Great Care" reporting and training manager role.	• Share themes and trends from data with patients, carers and family through "you said, we did" promotions.	**September 2023**

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	**2A:** When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• Ensure manager training and resources available to promote health and wellbeing offer to staff, and their responsibilities as manager for supporting implementation.	• Utilise wellbeing feedback to review Trust resources, identify gaps and encourage promotion of existing offer.	**December 2023**
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• Significantly improve the culture and experience for all staff by reducing bullying and harassment.	• Continue anti-bullying and harassment work alongside our Violence and Aggression prevention and reduction (VAPR) team. • Embed the 'Just Culture - Civility and Respect' principles across the Trust. • Implement the Anti-Racist Strategy (ARS) and principles across the Trust.	**Ongoing**
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• Improve awareness of existing support available to staff members. • Implement processes to support those experiencing discriminatory violence or abuse.	• Ensure that racial incidents reported via DATIX system lead to a debrief and wellbeing check from line manager or supervisor. • Analyse this ongoing data for trends to identify and address hotspot areas.	**Ongoing**
	2D: Staff recommend the organisation as a place to work and receive treatment	• Ensure EPUT staff are able to contribute their feedback on the organisation, and promote how this feedback is used in decision-making. • All leavers will have a "stay" and/or "exit" interview.	• Continue "You Asked, We Listened" campaign, showing Staff Survey feedback and EPUT responses / projects developed based on this feedback. • Publish National Quarterly Pulse Survey data and share with staff.	**December 2023**

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	**3A:** Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• Ensure visible commitments from executive team in EDI agenda of the organisation in line with EPUT EDI Strategy (2022-25)	• Implement Executive Team sponsors for Staff Equality Networks, to ensure they are working close with EDI projects and demonstrating commitment and support. • Increase promotion of EDI actions from Board and system leaders, sharing progress and successes in 2023, facilitated by the Communications Team.	**July 2023**
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• Ensure EPUT Board Papers continue to address EDI and Health Equalities, as well as address key reports throughout the year (WRES, WDES, PSED)	• Organisational Executive Leaders to have EDI objectives in annual appraisal. • Review Board Papers to ensure clearance process for board papers has includes a point for inequalities to be considered and amendments made as required	**Ongoing**
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• Implement Executive Team sponsors for Staff Equality Networks, to ensure they are working close with EDI projects and demonstrating commitment and support.	• Equality Impact Assessment process to be reviewed and implemented to ensure easy access and completion by staff, and to ensure that board papers for approval contain EIA's when required. • EDI to be part of EPUT's Accountability Framework.	**Ongoing**

NHS
Essex Partnership University
NHS Foundation Trust

Agenda item #8a

29 March 2023

Board of Directors Part 1

Board Assurance Framework

Denver Greenhalgh
Senior Director of Corporate Governance

EPUT

CONTENTS

Board of Directors March 2023

NHS
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Purpose of Report

The report provides a high level summary of the strategic risks and high level operational risks (corporate risk register). 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.

- Section 2: Provides a high level summary of the Strategic Risks and the Corporate Risk Register (high level operational risks). Noting two changes to risk score for SR8 (Use of Resources) with an increased risk exposure; and CRR95 (Delivery of the new vaccination programme) with a reduction in risk exposure.
- Section 3: Note that there were no new risk identified which met the threshold of inclusion within the Board Assurance Framework nor the Corporate Risk Register. The Board is asked to note that there is entry for the ongoing industrial action as this is a live issue being managed in line with our Business Continuity policy and procedures.
- Section 4: Note the de-escalation (closure) of Corporate Risk CRR95 – Delivery of the new vaccination programme. The 2022/23 programme has been completed with the Lodge remaining open for the 'evergreen' offer. Delivery of future programmes would follow practiced procedures and therefore the risk to successful delivery has reduced to an 8 and now below threshold for inclusion in the Corporate Risk Register. Any new risks identified for future programmes will be managed at Directorate level.
- Section5: Provides a progress report for each strategic risk provided by the relevant senior responsible officer. Noting the deterioration of the risk score for SR8 (Use of Resources) Financial outlook for 2023/24 onwards challenging with COVID funding significantly reducing, efficiency targets, cost pressures and additional investment requirements driving the reassessment.
- Section 6: Provides a progress report for each high level operational risks contained within the Corporate Risk Register provided by the relevant senior responsible officer. Noting the reduction of risk score for CRR95 (Delivery of the new vaccination programme) with a reduction in risk exposure (commentary above).

Recommendations/ action required :

The Board is asked to received and note the report containing progress updates.

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

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02 - BAF Dashboard

March 2023

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Strategic Risks

NHS
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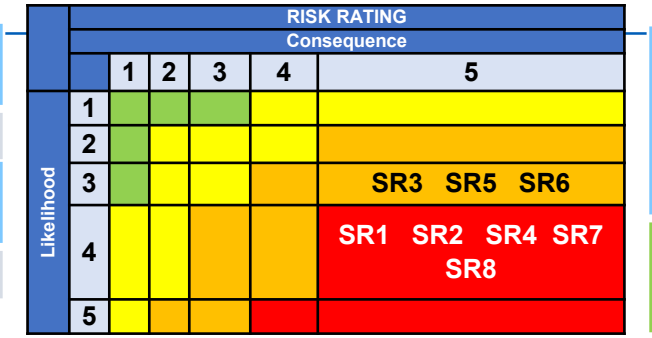
Existing Risks	Recommended New Risks	Recommended for Downgrading	Recommended for Closure
8	0	0	0

Risk Score Increases	Risk Score Decreases	No change in Risk Score	Risks Reviewed by owners	On RR more than 12 months
1	0	7	8	6



% Risks with Controls Identified	% risks with assurance identified	% risks with actions overdue
100%	100%	0%

ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score 20+ (Existing risks)								
SR1	1	Safety	Safety, Experience, Compliance, Service Delivery, Reputation	NH	5x4=20	20 → 20 → 20	Rising demand for services; Government MH Recovery Action Plan; Covid-19; Challenges in CAMHS & complexities; Systemic workforce issues in the NHS	• Annual Report for Safety Strategy to be presented to Board of Directors March 23, reflecting on progress made over two year period and setting out plans for the final year of the strategy • Patient Safety Incident Response Plan refreshed and on track for delivery by May 23
SR2	2	People	Safety, Experience, Compliance, Service Delivery, Reputation	SL	5x4=20	20 → 20 → 20	National challenge for recruitment and retention	• Rolling programmes in place for recruitment, international recruitment, bank and agency conversation, and student conversion/ transition to registered staff members • Time to Care Programme continues with a focus on year one priorities Smart working group aiming to publish long-term strategy by June 23 • Optimisation of electronic staff record now expected by June 23 • Vacancy factor reduced from 10.5% to 9.8% in period
SR4	All	Demand and Capacity	Safety, Experience, Compliance, Service Delivery, Reputation	AG	5x4=20	20 → 20 → 20	Covid-19. Long-term plan. White Paper. Transformation and innovation. National increase in demand on services. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	• Embedding of Care Units through operational and governance structures complete • Mental Health Emergency Department launched with revenue agreed with MSE for 2023/24 in line with business case • Care Unit Strategies published with EPUT five-year strategy. Annual touch points with monitoring through accountability framework

Strategic Risks (continued)

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ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score 20+ (Existing risks)								
SR7	All	Capital	Safety, Experience, Compliance, Service Delivery, Reputation	TS	5x4=20	20 → 20 → 20	Need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	• Prioritised capital plan presentation to March Board as part of Operational Plan and Finance Budget. Draft provided to Finance & Performance Committee Feb 23 • Forecast outturn reports full utilisation of 2022/23 capital • Refreshed Estates and Digital Strategies will identify overall resource requirements
SR8	All	Use of Resources	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x4=20	15 → 15 → 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	• Increase in score approved due to Covid funding reductions, efficiency requirements and cost pressure management and mitigation.. • Budget setting progressing across operational, clinical and corporate functions. • Restructuring of finance teams is underway, Business Partner approach has received positive response from operational colleagues. • New actions set for 2023/24
Score <20 (Existing risks)								
SR3	All	Systems and Processes/ Infrastructure	Safety, Compliance, Service Delivery, Experience, Reputation	ZT/TS	5x3=15	15 → 15 → 15	Capacity and adaptability of support service infrastructure including Estates & Facilities, ITT /Digital Systems, Finance, Procurement and Business Development/ Contracting to support frontline services. Recovery from HSE and Covid-19. Need to release clinical time.	• Proposal to extract Digital Strategy into separate strategic risk for May Board • EPR convergence unification project across Mid Essex and EPUT has significant operational and deployment implications as it is a major transformational journey • Business case to Board concerning the need to modernise IT as an enabler to meeting our strategic objectives
SR5	1	Independent Inquiry	Compliance, Reputation	NL	5x3=15	15 → 15 → 15	Government led independent inquiry into Mental Health services in Essex	• Inquiry in phase 2 evidence collection • CEO has written to and met with the Chair of Inquiry and risk will be under review following discussion at Board • Rolling programme of response to information requests • Communications to all staff encouraging evidence
SR6	All	Cyber Attack	Safety, Compliance, Service Delivery, Experience, Reputation	ZT	5x3=15	15 → 15 → 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	• Executive Operational team financial sign off of early release of funding for purchase of replacement legacy devices (circa 750 iPhones and 150 iPads) • BDO internal audit on cyber security Dec 22 – overall outcome Moderate confidence level – action plans in place. Areas identified for upcoming BDO audit • All actions on track

Corporate Risks

NHS
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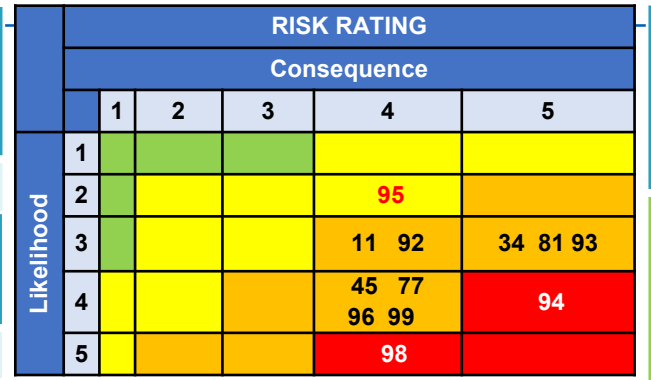
NHS Foundation Trust

Existing Risks	Recommended New Risks	Recommended Downgrading from SRR to CRR	Recommended Downgrading From CRR to DRR	Recommended for Closure
12	0	0	0	1

Risk Score Increases	Risk Score Decreases	No change in Risk Score	Risks Reviewed by owners	On RR more than 12 months
0	1	11	11	8



% Risks with Controls Identified	% risks with assurance identified	% risks with actions overdue
100%	100%	0%

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR94	Engagement and supportive observation	Safety, Compliance	AG	5x4=20	20 20 20	CQC found observation learning not embedded	• A new action plan can now be seen and continues to be finessed from the work being undertaken by the Engagement and Supportive Observation Workstream • Four actions completed and 10 on track for completion
CRR98	Pharmacy Resource	Safety	NH	4x5=20	20 20	Escalation by ECN	• Slight improvement on recruitment • Exploring use of safety dashboard to assist as a control to monitor incidents • Key activities continue to be delivered in line with the agreed business continuity plan • Filling posts with trainees with support through to qualification (grow our own)
CRR11	Suicide Prevention	Safe	MK	4x3=12	12 12 12	Implementation of suicide prevention strategy	• Glenn Westrop appointed as DDQS with suicide prevention in portfolio • Suicide Prevention Strategy aligned with Safety First Safety Always Strategy and shared through system transformation programmes and system wide suicide prevention group • Continuous communications planning in place
CRR34	Suicide Prevention - training	Safe	MK	5x3=15	15 15 15	Implementation of suicide prevention strategy	• STORM training is a rolling programme • Discussions continue in relation to use of STORM licences for temporary staff • Expansion of the number of trainers is in progress
CRR45	Mandatory training	Safe	SL	4x4=16	16 16 16	Training frequencies extended over Covid-19 pandemic leaving need for recovery	• Recovery plan in place including continuous review of training locations • Extension request for review of Mandatory Training Policy to September (subject to approval by Policy Oversight and Ratification Group) as time needed for mandatory training working group and concurrent pieces of work to enable full review

Corporate Risks (continued)

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ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Existing Risks cont'd							
CRR77	Medical Devices	Safe, Financial, Service Delivery	NH	4x4=16	16 16 16	Number of missing medical devices compared to Trust inventory	• All actions on track for completion – deep dive exercise in progress • Business case approved by ET 14 March with recruitment process for Medical Devices Safety Officer and dedicated administrative support in progress • Policy currently under review including development of a Standard Operating Procedure
CRR81	Ligature	Safe, Compliance, Reputation	AG/TS	5x3=15	15 15 15	Patient safety incidents	• All actions on track, some with revised dates • Specification of work on hinge replacements completed
CRR92	Addressing Inequalities	Experience	SL	4x3=12	12 12 12	Staff Experience	• EPUT working with three providers to build comparative EDI training suites for EPUT staff to replace existing sessions, followed by funding and implementation by end of year • Additional element on Datix to improve reporting of racial discrimination/ abuse • EDI plan in place aligning with EPUT strategy. The plan sets EDI strategy until November 2024 with a key focus being the support of staff affected by discriminatory behaviour, abuse and bullying • Review of equality impact assessments and quality impact assessments to take place • Strategy from WRES and WDES presentation to Executive Team
CRR93	Continuous Learning	Safety, Compliance	NH	5x3=15	15 15 15	HSE and CQC findings highlighting learning not fully embedded across all Trust services	• Safety dashboard completed and live • Governance structure in place for Learning Lessons • Consistent approach to team meeting agendas across specialist services inpatient wards • Eight actions n track for completion
CRR95	Delivery of new vaccination programme	Service Delivery, Financial	NL	4x2=8	15 12 8	Vaccination focus has changed	• Risk score reduced and risk closed as the programme is complete and all sessions ceased. The Lodge open for 'evergreen' offer • New risk may arise from any spring programme (April 2023)
CRR96	Loggists	Compliance	NL	4x4=16	16 16 16	Major incident cover	• Proposal in progress for presentation to ET in April to increase pool of loggists
CRR99	Safeguarding Referrals	Safety	NH	4x4=16	16 16 16	Escalation from operations and high increase in referrals	• A review of this risk is in progress to ensure this is a trust wide risk that encompasses all safeguarding functions • Safeguarding team at full establishment and are taking on additional caseloads through bank working • Safeguarding policies and procedures in progress for approval at May Policy Oversight and Ratification Group • Action 8 on track for completion May 23 • Action 9 job description in place for the role of safeguarding practitioners and discussions ongoing with Care Unit Directors for funding

03 - New Risks for Approval - None

March 2023

EPUT

04 - Risks closed by ET

March 2023

EPUT

CRR95: Delivery of new vaccination programme

Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT is uncertain of its role and available budget to deliver the autumn vaccination programme then then there may be significant cost and workforce shortfalls resulting in a challenge to delivering future programmes and potential reputational damage

Initial risk score	Current risk score	Target risk score
C5 x L3 = 15	C4 x L2 = 8	C4 x L2 = 8 Met and closed from CRR

Consequence – reduced as EPUT provision has reduced
Likelihood based on possibility challenges in delivering programmes

Progress since last report:

- Reduced score to threshold (4 x 2 = 8) and closed risk CRR95 Delivery of new vaccination programme. Rationale for closure is that the programme is completed.
- The Lodge remains open for 'evergreen' offer.
- Any new risk from future programmes (April 2023 onwards) will be managed through the Directorate Risk Register. Approved by Executive Team to de-escalated from the Corporate Risk Register.

Key Gaps: None

Executive Responsible Officer:
Executive Director of Major Projects

Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

Action	By When	By Who	Gap: Control or Assurance
Work with each system to develop system plans and joint vaccination programme	September 2022 Complete	Nigel Leonard	Roadmap
Review delivery models and associated costs	September 2022 Complete	Nigel Leonard	Delivery model and costings

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Mass Vaccination Team		Project Board	Delivered all targets
Internal plan to reduce direct and in-direct costs	Reviewed all delivery models and associated costs		
Block contract (with marginal rate tolerances) for activity between September and December 2022. Contract proposal £3m to perform 255,000 vaccinations	Worked with each system to develop system plans and joint vaccination programme	Delivered all contractual targets	
Transformation Board for Integrated Immunisation and vaccination service for Essex and Suffolk	Wellbeing outreach service for refugees and individuals on the margins	Workforce bureau and digitalized patient strategy	
Stepping down programme		Director of SAIS service	Reached target of 158,000 vaccinations

05 – Strategic Risks

March 2023

EPUT

SR1: Safety

NHS
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At a Glance:

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 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 sanctions

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	C5 x L2 = 10

Progress since last report:

- Note action 1 and 4 have been completed, with the culture of learning programme progressing well within the organisation. Completed actions will move to controls assurance in future reports and updated on an assurance basis.
- Action 2: delivery of patient safety incident response plan on track
- Action 3: Annual report for Safety Strategy to be presented to the Board of Directors (March '23) reflecting progress made over the two year period and setting out plans for the final year of the strategy.
- At a glance policy/ pictographic restricted items list for inpatients being developed with support of operations and estates

Key Gaps/ delayed actions

- Intensive Support Group supporting adult inpatients with CQC actions.

Executive Responsible Officer: Natalie Hammond, Executive Nurse
Executive Committee: Executive Safety Oversight Group
Board Committee: Board Safety Oversight Group, Quality Committee

Actions (there are also a number of detailed actions beneath these – available on request)

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Refresh Patient Safety Incident Response Plan	Completed Jan 23	Moriam Adekunle Director of Safety and Patient Safety Specialist	Road Map
2. Deliver the Patient Safety Incident Response Plan	May 2023	Moriam Adekunle Director of Safety and Patient Safety Specialist	Controls
3. Deliver the Patient Safety Strategy (Safety First Safety Always) for year 2	End March 2023	Natalie Hammond Executive Chief Nurse	Road Map / Control
4. Implement Culture of Learning Programme	Completed July 22 and ongoing	Moriam Adekunle	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Patient Safety Incident Management Team and EPUT Lessons Team	Lessons Team fully established	Report Safety First Safety Always – Leadership	PSIRF first year review of early adoption
Learning Collaborative Partnership	Established with TOR	Reporting to LOSC/ Quality	Pan Essex CQRG
Quality & Safety Champion Network	Established through soft launch	Quality Committee	Pan Essex CQRG
PSIRF; Complaints; Claims; Safety First Safety Always Strategy	Policy Register	PSIRF reports/ risk management reports/ complaints reports/ ESOG reporting cycle / Clinical Audits	IA Reviews inc PSIRF May 22 and Medical Devices Feb 22 Fundamental Standards CQC Benchmarking from NRLS
Range of learning platforms in place – thematic analysis/ EPUT Lab/ Quality Academy/ Lunchtime Learning/ Key messages / Quality and Safety Champions Network	Have been running and scheduled for future EPUT Lessons Team and Patient Safety Incident Management Team	Learning collaborative partnership Group; EPUT Lessons Learned Programme; LOSC; Quality and Safety meetings chaired by DDQS Learning from deaths oversight	Pan Essex CQRG
Intensive Support Groups	In place		
Nurse Advocates/ RISE leadership	12 nurses completed advocate training; phase 2 of RISE DDQS for professional nurse advocacy and nursing/ AHP strategy delivery		
PMO Support	Overall portfolio status. Progress on delivery of essential safety improvements and transforming projects. Established and working well	PMO reporting to ESOG and BSOG and TB	
Capital investment in patient safety	Progress on delivery of essential safety improvements	Report on enhancing environments	CQC CAMHS inspection safety improvements
Insight into wellbeing		Reports to ESOG and QC Culture of Learning progress report	

SR2: People

At a Glance:

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 safety/quality of care.

Likelihood based on: Establishment of existing and new roles verses the vacancy factor and shift fill rate Consequence based on: Impact of staffing levels on service objectives; length of unsafe staffing (days) through the sit rep return; staff morale; availability of key staff; attendance at key training.

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	C5 x L2 = 10

Progress since last report:

- Action 1 Vacancy factor reduced from 10.5% (Jan 23) to 9.8% in period (Feb 23) Vacancies running at 20% Feb 23 for registered nursing but reduced from 25% Jan 23 and 20% vacancies as at Feb 23 on AHPs/ pharmacy
- Action 2 Approved business case – 45 RMN newly qualified nurses to arrive by June 23 but will require a preceptorship programme supporting
- Action 3 219 bank/ agency conversions since Nov 21
- Action 5 Developing 14 education specific policy documents that are student centred as a requirement of resubmitting to Register of Apprenticeship Training Providers – all on track
- Action 6 Time to Care Programme continues with a focus on year one priorities including review of complex design of new staffing model for inpatients
- Action 7 completed
- Action 12 Optimisation of electronic staff record – key project from Digital Strategy on track for completion June 23 – key benefits will be manager self-service, improved functionality of OLM, recording of appraisals and pay progression via ESR, utilising applicant dashboard and exit interview functionalities, optimising starter and leaver process, and optimising health roster. Pilot completed of centralised rostering in specialist services
- Finalised workforce plan for 23/24 with ICB colleagues
- Staff survey results for 2022 published and socialised
- Completed actions will move to controls

Key Gaps in Assurance

- Action 1, 3 and 7 Exceeding cap on temporary staffing and Trust is tolerating the breach of cap.

Executive Responsible Officer: Marcus Riddell, Acting Executive Chief People Officer
Executive Committee: Executive Team
Board Committee: People, Equality and Culture Committee

Actions (note there are further detailed actions not included here)

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Rolling recruitment programme	Ongoing rolling programme	Matt Gall, Associate Director Resourcing	Control
2. Deliver International Recruitment Programme	Completed December 2022 (with ongoing recruitment)	Joseph Caldeira, Associate Director of International Recruitment	Control
3. Bank/Agency Conversion Programme	Ongoing rolling programme	Matt Gall, Associate Director Resourcing	Control
4. Student Conversion/ transition to registered staff members	Ongoing rolling programme	Annette Thomas-Gregory Director of Education & Learning	Control
5. Successful re-application to Register of Apprenticeship Training Providers	April 2023	Annette Thomas-Gregory Director of Education & Learning	Control
6. Time to Care Programme	December 2023	Paul Scott, Chief Executive	Control
7. Care Group Staffing Plans	Completed March 2023	Paul Taylor, HR Director, Operations	Road Map / Control
8. Develop People Commitments (strategic plan)	September 2023	Paul Taylor, HR Director, Operations	Road Map
9. Develop, seek approval and implement Education and Learning Development Strategy	September 2023	Annette Thomas-Gregory Director of Education & Learning	Road Map
10.Review long-term strategy for smart working	June 2023	Alesia Waterman, HR Director	Control
11. Review dignity, respect and grievance policy	May 23	Debbie Prentice, Associate Director, ER	Control
12. Optimisation of electronic staff record	June 23	Kelly Gibbs, Associate Director of HR	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
HR Team/ People & Culture Directors	Top team fully established 6 Employee Experience Managers	People and Culture Structure to PECC	
HR Policies	Policy Register	IA Reviews Workforce Reports to PECC	Ofsted inspection on 27th-29th July 2022 scoring good in all domains
Workforce Plans and strategies	Workforce Safeguards Workforce Establishment Reviews	Workforce Safeguards, Establishment Reviews and Reports to PECC; Smart Working Group	CQC inspections; NHSE Workforce Returns; System Workforce Returns / benchmarks
Employee experience road map	Developed		
Rolling recruitment programme	Recruitment team	Workforce Reports to PECC International Recruitment Steering Group	MSE System Oversight Assurance Committee
Retention programme	Recruitment team	Reports to F&PC and PECC Turnover rate in performance report Safer staffing data	MSE System Oversight Assurance Committee
Sit Rep Meetings	Staffing Sit-Rep	Quality and performance reports Emergency planning steering group Flow and capacity leads	CQC inspections
Use of Bank and agency Staff (when needed)	Staffing Sit-Rep	Workforce Reports to PECC	CQC inspection reports Use of Resources Assessment
Recruitment Branding	Marketing team	Direct Hire Numbers within the Workforce reporting to PECC	
Staff wellbeing	Engagement Champions Employee Experience Managers	Workforce reports to PECC EDI Sub Committee	Pulse Survey Here for You Steering Group with ICB membership
Data reporting	Staffing sitrep	Safety huddle report to ESOG	Increase in Pulse responses and key themes identified

SR3: Systems and Processes/ Infrastructure

At a Glance:

If our systems, processes and infrastructure do not continue to adapt to support clinical services then we may not have the right facilities/ resources to deliver safe, high quality care resulting in not attaining our safety, quality/ experience and compliance ambitions

Likelihood based on: the possibility of not having the right facilities and resources to deliver safe, high quality care
Consequence based on: the potential failure to meet our safety, quality/ experience and compliance ambitions

Initial risk score	Current risk score	Target risk score
C5 x 3L = 15	C5 x L3 = 15	C5 x L2 = 10

Progress since last report:

- Action 1: Consultations complete. Restructure entering transition and implementation phase with revised trajectory of mid-year stabilisation.
- Action 2: Complete - EPUT Strategy developed and approved by the Board of Directors in January '23 and established biannual reporting to Board (touch points November and March meetings. The 2023/24 associated draft annual Operational plan and financial plan will be presented to the Board of Directors in March '23.
- Action 3: Commercial and innovation strategy under development with timeline for delivery end of May 2023.
- Action 4: Estates Strategy to include associated development control plan and trajectory set for draft December 2023.
- Action 6: Operational Target Operating Model in place, now moved to a control.
- Action 8: EPR OBC progressing and to be presented to the Board of Directors March '23
- Action 9: Data Strategy being presented to the Board of Directors March 2023.
- Completed actions will move to controls
- Action 9: A Power Bi Operational Group will oversee the shaping and refining of Power Bi Centre of Excellence Model. Patient Safety Dashboard near completion.
- Performance Report in validation phase. Live date Q1 for Operational Power Bi

Key Gaps

- Action 7: Potential delays in technical sending mechanism MESH client, not providing GP MESH addresses to received 24hr e-discharge summaries.

Executive SRO: Trevor Smith, Executive Chief Finance and Resources Director & Zephan Trent, Executive Director Strategy Transformation and Digital
Executive Committee: Executive Team, ESOG
Board Committee: BSOG, Finance and Performance Committee, Audit Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Fully recruit to all finance, resources, strategy, transformation and digital systems teams including agreeing portfolios and jointly funded posts	October 2023	Trevor Smith, Executive Chief Finance and Resources Director& Zephan Trent, Executive Director Strategy Transformation Digital	Control - Full establishment
2. Develop EPUT Strategy	Complete	Zephan Trent, Executive Director Strategy Transformation Digital	Roadmap
3. Develop Commercial Strategy	End of May 2023	Liz Brogan, Director of Contracting & Service Development Lauren Gable, Director of Finance Commercial	Roadmap
4. Develop Estates Strategy & Development Plan	December '23	Linda Martin Senior Director of Estates and Facilities	Roadmap
5. Deliver Interim Digital Strategy	March 2027	Zephan Trent, Executive Director Strategy Transformation Digital	Control
6. Deliver on the Target Operating Model	Complete	All Executives with AG as lead	Control
7. Enable connectivity and sharing of patient data across external partners & NHS Trusts	May 23	Sophie Rossell	Control
8. Undertake options appraisal for future of EPRs and progress to full business case and national funding	Nov 23	Adam Whiting	Control
9. Transform EPUT into data led organisation	Mar 23	Adam Whiting	Control / Roadmap
10. Transform existing ITT service provision into Digital Service provision meeting EPUT needs	Mar 24	Adam Whiting	Control/ Roadmap

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
EPUT Strategy	Signed off by Board Jan '23	*Bi annual reporting to BOD* *Touch point Nov '23*	
Operational Target Operating Model	Care Unit Leadership in place and AF Established	AF Meetings established	
Digital Systems, Estates and Facilities, Contracting and Business Development, Finance Teams	Established Support services	IA Estates & Facilities Performance (Moderate/Moderate Opinion)	
Interim Digital Strategy Range of corporate, finance and IG policies Information Governance Framework	*Policy Register Performance*		
	Interim Digital Strategy in place		
	Information Governance Framework in place	*IA Data Security and Protection Toolkit 2022/23 Pending*	*Data Security and Protection Toolkit Annual Assessment*
Information Governance Training	X% IG Training Compliance		*Data Security and Protection Toolkit Annual Assessment*
ISO in place			

SR4: Demand and Capacity

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NHS Foundation Trust

At a Glance:

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: Length of stay, occupancy, out of are placements etc.
Consequence based on: Mismanagement of patient care and length of the effects.
Links to both inpatient and community.

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	5 x 3 = 15

Progress since last report:

- Action 1 - Care Unit leadership teams have in place 2 regular touch points with the executive team via the AF meetings for assurance and then monthly via ET. Each AF meeting results in a clear set of actions with owners and timeframes. CEO led escalations are in place (as required) if actions/mitigations continue to be challenging to deliver/fall short.
- Action 2 Care Unit Strategies signed off and linked to EPUT five-year strategy, with monitoring through accountability framework.
- Action 3 Time to Care programme focus on year one priorities – presentation to L50 group.
- Action 4 Mental Health Urgent Care Emergency Department opened on 20 March 23. Agreed revenue into contracts for 2023/24 with MSE in line with business case.
- Action 7 Analysis piece on demand vs capacity in progress with bed modelling analysis and on track within timeline.
- Action 8 - Consolidation of action plans relating to out of area elimination and sustainability, NHSE out of area reduction, GIRFT, discharge challenge and purposeful admission. Detailed actions in progress with deadlines and leads.
- Completed actions will move to controls.

Key Gaps:

- Adult bed occupancy 99.11% end January. Performance report does not include closed beds. High level concern. Available capacity. Beds closed due to refurbishment and ability to staff to stated standard.

Executive Responsible Officer: Alex Green, Executive Chief Operating Officer
Executive Committee: SMT
Board Committee: BSOG, Quality Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Embedding of Care Units (Operational and governance structures)	Complete	Alex Green, Executive Chief Operating Officer	Control
2. Deliver UEC and inpatient mental health service strategy	Complete	Lizzy Wells	Control
3. Time to Care Programme	December 2023	Paul Scott, Chief Executive	Control 3.
4. MH ED Project (MSE)	Complete	Dr Milind Karale, Executive Medical Director	Control
5. Development of new safety KPI dashboard	Mar 23	Moriam Adekunle	Assurance
6. Ensure recording of DTOCs on EPRs	Ongoing	Flow and Capacity Leads/ Bibi Hossenbux	Assurance
7. Analysis piece on demand vs capacity	End April 23	Jan Leonard/ Sue Graham	Control
8. Delivery of the UEC/Inpatient MH Flow Action Plan	Dec 23	Detailed actions have individual leads – available on request	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Operational staff	Establishment		
Integrated Director posts covering Mental Health and physical health	Establishment		
Recruitment and Development of the Care Unit leadership structures.	Establishment		
Target operating model/ care unit development, Accountability Framework, Safety First, Safety Always Strategy, Flow and Capacity Policy, MAST roll out	Dedicated discharge coordinator	Accountability meetings	
MH UEC Project, MSE Connect Programme, Partnerships, Time to Care initiative, New ways of working and new digital solutions	Flow and Capacity Project	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 sit reps	Updated OPEL framework DTOC 1.7% in Sep 22	Performance and Quality Report to Accountability Meetings and F&PC	
Skilled temporary workforce via Trust Bank	Bank establishment		
Business Continuity Plans	Emergency Planning		
Purposeful Admission Group	Therapeutic offer on wards	SMT and Accountability meetings Capacity and flow work stream	
Care Unit Strategies	Developed	Published alongside EPUT Strategy One year touch points and monitoring through accountability	

SR5: Independent Inquiry

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At a Glance:

If EPUT is not open, transparent and has the correct governance arrangements in place then it may not embed the learning from past failings resulting in undermining our Safety First, Safety Always Strategy

Likelihood based on: the possibility of not embedding the learning and poor CQC ratings as a result
Consequence based on: National media coverage, parliamentary coverage and a total loss of public confidence

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L3 = 15	C5 x L2 = 10

Progress since last report:

- Essex Mental Health Independent Inquiry still in phase 2, collecting evidence from a range of people
- Documentary evidence continues to be provided by the Trust
- CEO has written to and met with the Chair of Inquiry Risk will be under review following discussion at BOD
- Actions 2, 3 and 4 are continuous for the duration of the Inquiry

Key Gaps:

- Memorandum of Understanding (MOU) and Information Sharing Protocol (ISP) remain a gap. The Trust written to secretary of inquiry EMHII to connect legal teams and progress to sign off.

Executive Responsible Officer: Nigel Leonard, Executive Director, Major Projects
Executive Committee: SMT
Board Committee: BSOG, Audit Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Carry out internal audit on learning	March 23	BDO	Assurance
2. Respond to information requests	Rolling programme	Gill Brice, Project Director	Control
3. Learning log in place	Rolling programme	Gill Brice, Project Director	Assurance
4. Project Plan in place	Rolling programme	Jade Line, Project Manager	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Project Team Independent Director and Independent Medical Consultant Advisor	Establishment Expanded to meet increased ask	EOC and Audit Committee oversight	Independent Director and Independent Clinical Advisor in place
Internal methodology for working with inquiry	In place	In place and used for reporting Project Group overseeing	As above
Inquiry Terms of Reference MOU and Information Sharing Protocol	In draft		
Learning Log	Log in place	In place and used for reporting to ET Audit Committee and BOD	
Exchange portal in place to safely transfer information to the inquiry	Data protection impact assessment	Reporting in place	Independent Director and Clinical Advisor
Deep dive into sample of deaths in scope over 20 year period	Completed		
Deep dive in 13 prevention of future death notices	Completed		

SR6: Cyber Security

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At a Glance:

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 risk score
C5 x L4 = 20	C5 x L3 = 15	C4 x L3 = 12

Progress since last report:

- Action 2 – 5/10 internal audit recommendations have been resolved / mitigated. Remain on track to deliver remaining management actions by end March '23.
- Action 3 – The work to create the single BCDR document for all systems is 70% complete.
- Action 4 - Funding approved for purchase of replacement legacy devices (circa 750 iPhones and 150 iPads).
- Areas identified for upcoming BDO audit.
- Cyber Security Support Resource Structure in place.
- BDO internal Cyber Security focussed audit Dec 22 – overall moderate confidence level – action plans in place.
- Yearly penetration test highlighted no high risk vulnerabilities.
- TOR agreed and first meeting of ICS Cyber Assurance Steering Group took place Feb 23.
- Interim Cyber Security Manager appointed to oversee steering group and associated objectives, actions and deliverables.

Key Gaps:

- Substantive recruitment to Cyber Security Assurance Manager post – April start date for recruitment process to begin. Mitigated with the use of interim post holder.

Executive Responsible Officer:
Zephan Trent, Executive Director Strategy Transformation and Digital
Executive Committee: IG Steering Group, Digital Strategy Group
Board Committee: Finance and Performance Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Appoint to substantive Cyber Governance Manager	Sept 23	BDO	Assurance
2. Complete recommendations from internal audit	March 23	Adam Whiting Deputy Director, ITT and BAR	Controls and Assurance
3. Develop business continuity plan and disaster recovery for each system (using third party)	March 23	Adam Whiting Deputy Director, ITT and Business Analysis and Reporting	Controls and Assurance
4. Take actions to meet gaps identified in Cyber Essentials Accreditation – 1) replacement of desktops and laptops that cannot support latest version of Windows	March 23	Adam Whiting Deputy Director, ITT and Business Analysis and Reporting	Controls and Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place – two appointments to be made	Interim Cyber Assurance Manager in post to act in independent role Existing Cyber Security Manager role	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	IGSSC; BDO internal audit May 22 – overall Moderate Confidence level Medium	As above MSE ICS IG & Cyber Levelling Up Project (annual)
Investment in prioritisation of projects to ensure support for operating systems and licenses			
IG & Cyber risk log	Risk working group 2022 complete – highlighted no risks vulnerabilities	IGSSC and Digital Strategy Group	DSPT Areas identified for upcoming BDO Audit
Business Continuity Plans and National Cyber Team processes		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

SR7: Capital Resource

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At a Glance:

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 risk score
C5 x 4L = 20	C5 x L4 = 20	5 x 3 = 15

Progress since last report:

- Action 1: Prioritised capital plan will be presented to Board of Directors as part of the Operational Plan and Finance Budget in March 2023. Draft provided to F&P February 2023.
- Forecast outturn continues to report full utilisation of 2022/23 capital (i.e. maximised use of resources).
- Refreshed Estates and Digital Strategies will identify overall resourcing requirements.

Key Gaps

- Demand outstrips resource requirements – 2023/24 capital envelope circa £18m against proposals of circa £38m (F&P February 2023).
- System management and accountability for capital resources and competing system strategic initiatives is likely to cause further excess demand over sources of funding.

Executive Responsible Officer: Trevor Smith, Executive Chief Finance and Resources Officer
Executive Committee: Executive Team
Board Committee: Finance & Performance Committee

Actions

Action	By When	By Who	Purpose
1. Develop a prioirtised capital plan to maximize the use of available capital resources.	01 April 2023	Lauren Gable Director of Finance	Road Map
2. Horizon scan to maximise opportunities both regional and national to source capital investment	Ongoing	Lauren Gable	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Finance Team (Response to new resource bids and financial control oversight)	Team in place	Decision making group in place and making recommendations to ET, FPC and BOD	
Purchasing / tendering policies	Policy Register	IA reviews	
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2022/23	Capital Project Group forecasting - £14.3m	Capital Resource reporting to Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£New resource secured	Capital Resource reporting to Finance & Performance Committee	
ICS representation re: financial allocations and MH/Community Services	EPR convergence business case developed with additional capital resources identified	ECFO or Deputy Attendance at ICS Meetings; CEO or Deputy membership of ICB;	

SR8: Use of Resources

At a Glance:

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

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20 increased score to 20	5 x 3 = 15

Progress since last report:

- Action 1: Improved financial maturity is demonstrated by the IA audit report opinions with substantial assurance for Key Financial Systems – Budget Management and also costing.
- Action 2: Identification of efficiency saving will now focus on 2023/24 delivery.
- Action 3: Shortfall in efficiency target 2022/23 incorporated within financial outturn.
- Action 4 – Duplicate action for 2023/34.
- Action 5: Forecast outturn 2022/23 remains on target.
- New actions set for 2023/24 delivery.
- ECFO or Deputy attendance at ICS meetings continues.
- Actions completed will move to controls

Key Gaps:

- Financial outlook for 2023/24 onwards challenging with COVID funding significantly reducing, efficiency targets, cost pressures and additional investment requirements.

Executive Responsible Officer: Trevor Smith, Executive Chief Finance and Resources Officer
Executive Committee: Executive Team
Board Committee: Finance & Performance Committee

Actions

Action	By When	By Who	Purpose
1. Improve financial maturity (Training and development for budget holders and business partners)	Complete for 2022/23	Lauren Gable Finance Director	Control
2. Efficiency workshops to identify remaining efficiency savings	Complete for 2022/23	Simon Covill Director of Operational Finance	Control
3. Deliver Financial Efficiency Target (All Budget Holders)	Superseded by Outturn	Trevor Smith Executive Chief Finance Officer	Control
4. In year forecast outturn (FOT) and risk and opportunities assessments	Complete	Simon Covill	Assurance
5. Deliver Operational Plan 2022/23	Complete	Alex Green / Trevor Smith	Control
2023/24 Actions			
1. Identify remaining efficiency savings	01 July 2023	Simon Covill Director of Operational Finance	Control
2. Deliver Financial Efficiency Target	31 March 2024	Trevor Smith Executive Chief Finance Officer	Control
3. In year forecast outturn (FOT) and associated risk and opportunities assessment	End of Sept '23 and Monthly thereafter	Simon Covill Director of Operational Finance	Assurance
5. Deliver Operational Plan 2023/24	March 2024	Alex Green / Trevor Smith	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Finance Team (Response to new resource bids and financial control oversight)	Team in place		
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place	IA Key Financial Systems – Budget Management (Sep '22) Substantial opinion and Costing (March 2023).	
	Scheme of Delegation in place		
	Accountability Framework in place	Financial Management KPIs	
Estates & Digital Team (Response to new resource bids)	Team in place		
Fully identified efficiency target		Finance Report	
Finance reporting	Finance Reports	EA of Accounts	SOF Rating
	AF Reports		
Budget setting	Completed mid year financial review and continues to forecast breakeven position. 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

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06 – Corporate Risks

March 2023

EPUT

CRR94: Engagement and Supportive Observation

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

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

Likelihood of patients probably not received prescribed levels of observation and engagement

Consequence based on not meeting our Safety First Safety Always ambitions

Initial risk score	Current risk score	Target risk score
C5 x L4 = 20	C5 x L4 = 20	C5 x L2 = 10

Progress since last report:

- An investigation has been completed into all recommendations from incidents resulting in an unexpected death in inpatient services or within three months of discharge from inpatient admission between 2000 and 2022. This review included 1500 unique recommendations that were then analysed and categorised into 31 themes. These have been validated with stakeholders across EPUT and completed a mapping exercise to the work that is going on across the trust to address these historic issues. A paper to ET 3 April is in preparation to provide Executive with these results and provide assurance around addressing these historic issues.
- New action plan developed – actions 3, 6, 8 and 10 (rolling programme) completed
- Action 13 round 1 pilot completed
- Completed actions will move to controls

Key Gaps:

- Consider whether Executive Lead should change from ECOO to EN
- Review action completion dates
- Due to changes in personnel and roles there is no ownership or recognition of the actions. A new action plan can now be seen and continues to be finessed from the work being undertaken by the Engagement and Supportive Observation Workstream

Executive Responsible Officer: Executive Chief Operational Officer
Executive Committee: Executive Operational Committee
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Safe Wards to be implemented	Dec 23	Katy Stafford and Ward Staff	Control
2. Review training for regular and non-regular staff (co-produced and delivered)	May 23	To be advised	Control
3. Engagement certificates for staff in encouragement	Completed	Katy Stafford	Control
4. Evidenced based, easy grab therapy resources to be developed and placed on wards (use 1:1s with no prior training)	June 23	Katy Stafford	Control
5. Increased garden access and garden gyms	August 23	Katy Stafford	Control
6. Engagement prompt cards (created by patients)	Completed	Katy Stafford	Control
7. QI project Linden Centre	July 23	Rachael Poland Katy Stafford	Control
8. Purchase equipment e.g. games, newspapers for groups	Completed	Katy Stafford	Control
9. Patients to be included in any ward improvements planned	June 23	Katy Stafford	Control
10. Discuss with staff in supervision and other 1:1s where they may be lacking in confidence	Rolling programme	All Ward Leaders	Control
11. Roster quality checks – ensuring staff do not book too many shifts in a row	TBA	To be advised	Assurance
12. Carers to support in production of training	June 23	Katy Stafford	Control
13. Patient personalised engagement boards (each patient to display a poster board of things they like to talk about/ do for staff prompts)	Completed Round 1 Pilot	All Ward Leaders	Control
14. Patient led safety huddles – Basildon assessment unit	Completed	Louise Bourton	Control
15. Patients and Carers to co-produce engagement video at same time as releasing updated policy and training	August 23	Katy Stafford	Control

Controls Assurance #

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Engagement and Observation Project	Project Group	Plan Complete/ Group Closed	
Revised Observation/ Engagement Policy		CG&QC / Accountability	
Weekly ward huddles		Tendable Audits	
Electronic observation recording tool	In trial stage		
Comprehensive audits using Tendable	Audit Results via weekly huddles	Jun 22 – 25 wards 100%	
Observation and Engagement E-Learning and Training Videos	8 week programme in place; Schwartz round pop up for inpatient areas; safety huddle week focus on TE&SO priorities; videos shared	Learning lessons report in place; Schwartz round feedback forms; reports from safety huddles	

CRR11: Suicide Prevention

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

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

Likelihood based on possibility of not progressing against the ten key parameters for safety mental health services
Consequence based on not taking the correct action

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L3 = 12	C4 x L2 = 8

Progress since last report:

- Glenn Westrop appointed as DDQS with suicide prevention part of portfolio
- Action 2: Alignment of strategy with Safety First Safety Always completed
- Action 4: Outcome measures implemented
- Action 6: implemented, successful, and evidenced
- Draft Strategy has been shared through system transformation programmes and system wide suicide prevention group
- Action 7 completed
- Action 8 communications carried out around suicide prevention day and planning is in train for national patient safety day. Continuous communications planning in place.
- Completed actions will move to controls in future reports.

Key Gaps:

- Actions 3 and 5 are due for completion by the end of March '23.

Executive Responsible Officer: Executive Medical Director

Executive Committee:
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Implementation of revised strategy, work plan and dashboard	April 2023	Nuruz Zaman	Roadmap
2. Align with Safety First Safety Always Strategy	Completed	Nuruz Zaman	Clear strategic direction
3. Focus groups with patients and families and Research into family involvement in suicide	March 2023	Matt Sisto	Control
4. Implement outcome measures	Completed	Nuruz Zaman	Assurance
5. Review approach to Safer Wards and Ligature risk	March 2023	Angie Butcher	Control
6. Introduce self-harm reduction pilot project	Completed	Diana Luckie	Control
7. Communications and Engagement over Sept/ Oct to mark Suicide Awareness Day and MH Awareness Day	Completed	Nuruz Zaman / Comms	Assurance
8. Develop communications plan as part of SPG TOR	Completed - rolling communications programme	NZ/AB/ Comms	Assurance
9. Work with care groups to develop new governance arrangements around suicide prevention into SPG TOR	April 2023	NZ/SPG/GW	Control
10. Work with care groups to review and amend Suicide Prevention Group Terms of Reference	April 2023	NZ/SPG	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Identified Medical Lead	In place		
Support in place via Human Engine	In place		
Suicide Prevention Strategy 2021-23	Suicide prevention group	Overseen by Mortality Sub-Committee	Feedback from ICS leads
Ongoing communication and engagement with staff	Breaking the Silence Safety Plans		
Local reflective sessions			
Oxehealth digital monitoring			
Suicide prevention training			
Suicide prevention outcome measures	Zero instances of preventable deaths 19.3% downward trend in instances of self-harm	95% patients have Personal Safety Plan	

CRR34: Suicide Prevention - Training

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT does not train and support staff effectively in suicide prevention; then staff may not have the necessary skills or confidence to support suicidal patients; resulting in self-harm or death and a failure to achieve our safety first, safety always strategy

Likelihood based on the possibility of staff not having the necessary skills and confidence
Consequence based on a failure to prevent suicide and achieve our safety ambitions

Initial risk score	Current risk score	Target risk score
C3 x L3 = 9	C5 x L3 = 15	C3 x L2 = 6

Progress since last report:

- Action 1 completed.
- Action 2 is now a rolling programme.
- Action 3 there is difficulty in providing training capacity – wording changed to reflect.
- Action 4 this is not mandatory training and with lack of session. availability this makes the trajectory difficult to produce. The aim is to provide regular reports within three months.
- Action 5 was added when sessions were not being attended, this is now reversed with sessions not being available.
- Action 6 discussions still taking place.
- Completed actions will move to controls.

Key Gaps:

- Risk of Did Not Attends (DNAs) on STORM training courses due to service pressures.

Executive Responsible Officer: Executive Medical Director
Executive Committee: ESOG
Board Committee: .Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Interim refresher course required due to attrition	Completed	Nuruz Zaman	Control
2. Move to STORM training	Rolling programme	Nuruz Zaman Annette Thomas-Gregory	Control
3. Expand the capacity of trainers to deliver STORM training	Sep 23	AT-G	Control
4. Develop improvement trajectory and report on suicide prevention training	Jun 23	Nuruz Zaman AT-G	Assurance
5. Develop a quality improvement project to address the barriers on completing the suicide prevention training	Completed	Nuruz Zaman	Control
6. Conversation with STORM about use of licence with temporary staff	May 23	AT-G	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Trainers	Recruited 8 trainers and 8 more being trained in New Year on STORM. Licenses in place. Facilitators trained.		
Training	7 x 2 day courses held on line; schedule arranged for 2023	Targeting inpatient units offering a blended approach	
Suicide prevention strategy	Sets out training requirements overseen by Suicide Prevention Group	Reporting to Mortality Sub-Group Annual Report	

CRR45: Mandatory Training

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NHS Foundation Trust

At a Glance:

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

Likelihood based on possibility of compromising patient and staff safety
Consequence based on scrutiny by regulators and not meeting statutory requirements

Initial risk score C4 x 3L = 12	Current risk score C4 x L4 = 16	Interim target score 4 x 3 = 12 March 2023 Target risk score C4 x L2 = 8

Progress since last report:

- Action 2 revised date of September 23 set (extension subject to approval by policy oversight group) – time needed for mandatory training working group and concurrent pieces of work to enable full review. Current policies are reflective of current practice.
- Actions 1, 3 and 4 are due for completion this month.
- Action 5 is a rolling programme.
- E-lifesaver resuscitation council programme available for staff to log on.
- Trajectory for TASI training is to reach 700 staff by November 23.
- 13 weeks of additional bookings secured for substantive bank and international recruits
- Overarching review taking place

Key Gaps:

- Outreach support needed on training gaps to mitigate any potential impact of extended training periods (as established during the COVID pandemic response).
- A number of course have lower annual compliance rates then desired as we return to pre-COVID monitoring. Mandatory Training Working Group has been established to address this and will report to the Executive Team in April 2023.

Executive Responsible Officer: Director of People and Culture
Executive Committee: Executive Operational Team.
Board Committee: People and Culture Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Implement recovery plan	March 23	Training Team	Assurance
2. Review mandatory training policy	September 23	Annette Thomas-Gregory	Control
3. Work to give flexible workers equal priority on mandatory training	March 23	Training Team	Control
4. Increase TASI trainers	March 23	AT-G	Control
5. Review training locations as fit for purpose	Ongoing programme	AW/ AT-G	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Training Team	Established – current resource 8.5WTE		12 month TASI accreditation from BILD
Induction and Training Policy	Policy system		
Training Tracker	Managers check and provide oversight.	Reporting of training to PECC	
Training recovery plan		Sept training compliance above target	
Training days created for staff			
Monthly reporting to ET		Accountability. F&PC and PECC, SMT and TB	
Training Venues	Training room identified at The Lodge		

CRR77: Medical Devices

At a Glance:

If EPUT does not track missing/ unregistered medical devices or address the clinical rationale/ pathway; then unsafe, non-serviced, non-calibrated and inappropriate devices may be in use; resulting in a failure to achieve our safety first, safety always strategy.

Likelihood based on probability of inappropriate devices being in use
Consequence based on failure to meet our safety ambitions

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L4 = 16	C4 x L2 = 8

Progress since last report:

- Actions1, 2, 8 & 9: The recommendations will be addressed as part of the deep dive exercise, with a view to implementing viable solutions.
- Action 3: An amnesty is currently underway since June 22, to be reviewed by the Medical Devices Group (MDG) for cleansing of data. Significant administration resource required.
- Action 4: Business case approved by Executive Team as within current Directorate resources in March '23 and recruitment process for Medical Devices Safety Officer (MDSO) and dedicated administration support has commenced.
- Action.5: Monthly review of KPI report and amendments to the reporting process as required.
- Action 6: Continue to be sent by Althea with good response from EPUT teams
- Action7: Policy is currently being reviewed and work is underway with Carradale to develop a Medical Devices SOP to include procurement and decommissioning.
- Action 9:.Conversation underway with MSE and ICB to explore external quality assurance for POCT devices.
- Action 10: The Policy is currently being reviewed and work is underway with Carradale to develop a Medical Devices SOP to include procurement and decommissioning
- A full review of this risk will be undertaken at the end of March '23.

Key Gaps:

- Element of medical devices not maintained by Althea – devices to be added to asset register ensuring visibility and contracts to be reviewed
- Assurance that teams are familiar with equipment they are using – deep dive exercise to develop sustainable approach to training and MDSO will oversee work in collaboration with operational colleagues at Ward/ Unit level.
- Point of care testing (POCT) - conversation underway with MSEFT & ICB to explore external quality assurance for POCT devices.

Executive Responsible Officer: Executive Chief Nursing Officer

Executive Committee: Medical Devices Group
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Complete actions from recommendations in internal audit report	March 2023	Nick Archer	Assurance
2. Options appraisal for Capital replacement programme and Medical device replacement strategy	March 2023	Nick Archer	Control (Resource)
3. Medical Device Asset Register – cleansing project	March 2023	Nick Archer	Control (Asset register)
4. Options appraisal EPUT management of Medical Devices inc resource needed	Completed March 2023	Nick Archer	Control (Clear resource)
5. Review Althea contract reporting	March 2023	Nick Archer	Assurance
6. Trialling process of reminder email to services before Althea visits	March 2023	Nick Archer	Control (Innovation)
7. Review of Policy and Procedure to ensure clear process and monitoring set out	March 2023	Nick Archer	Control (Policy)
8. Medical Device Management training	March 2023	Nick Archer	Control (training)
9. Introduce point of care testing	March 2023	Nick Archer	Control
10. New: Medical Devices Policy Review	July 2023	Nick Archer	Control
11. Appoint Medical Devices Safety Officer Band 6	June 2023	Nick Archer	Control (Resource)
12. Appoint Administration Support Band 3	June 2023	Nick Archer	Control (Resource)
13. Devise a Medical Devices Standard Operating Procedure	June 2023	Carradale/ Nick Archer	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Corporate Nursing Team and Datix Team including Head of Deteriorating Patient and Clinical Governance	Established	MDSO in place (Nick Archer)	
Medical Devices Group	Established and meets regularly	Overseen by Medical Devices Group	
Althea contract for device maintenance	Monthly KPI Report	Overseen by Medical Devices Group	
Procurement process in place Medical Devices Policy	Asset Register	Medical Devices Group oversee	Internal Audit Report Q4 2021/22 (Moderate / Limited Assurance)
Asset Register			
Incident Reporting			
BCPs in place		BCP received from Althea	

CRR81: Ligature

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NHS Foundation Trust

At a Glance:

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

Likelihood based on possibility of serious incidents
Consequence based on failure to meet safety ambitions

Initial risk score	Current risk score	Target risk score
C4 x L3 = 12	C5 x L3 = 15	C4 x L2 = 8

Progress since last report:

- Action 1: All actions completed from Independent Review Action Plan.
- Action 2: KPIs and dashboard to highlight progress on ligature reduction.
- Action 8: New process in place to strengthen mitigation statements for any actions where there is reliance on clinical monitoring.
- Action 9: Local Area Ligature Network well established.
- Robust and systemic processes for disseminating learning related to ligature reduction – linked to EPUT Learning Project.
- Pilot Project for one year on Tidal Training including evaluation.
- Completed actions will move to controls

Key Gaps:

Executive Responsible Officer: Executive Chief Finance Officer / Executive Chief Operating Officer

Executive Committee: Executive Safety Oversight Group
Board Committee: Quality Committee

Actions (further detailed actions are included in the Ligature work plan)

Action	By When	By Who	Gap: Control or Assurance
1. Completion of ELFT Independent review Action Plan	Completed	Head of Compliance and EPRR/ Comfort Sithole	Assurance
2. Identify new system for recording ligature actions (overseen by Project Group)	September 23	Chris Rollinson Project Group Lead	Control
3. Ensure EPUT environments meet environmental standards and Review environmental risk stratification document	April 23	Linda Martin	Control
4. Review standards on outdoor garden furniture	August 23	Linda Martin	Control
5. Specification of work for continued hinge replacement or change activities	Completed end March 23	Linda Martin Fiona Benson	Control
6. Further roll out of DTA to bedroom doors	March 23	Linda Martin Anthony Flaherty	Control
7. Review environmental risk stratification document	March 23	Linda Martin Fiona Benson	Control
8. Increase awareness and ownership of ligature reduction work	March 2023		Control
9. Develop robust and systemic processes for disseminating learning related to ligature reduction. Link to Culture of learning project	April 23	Head of Compliance and EPRR/ Comfort Sithole	Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Ligature / Patient Safety Leads in Estates, H&S and Compliance Team	Established Project Group Plan	Ligature Project Group with revised TOR to improve clinical representation ESOG/ BSOG dashboards Accountability framework	Internal Audit BDO 2021 ELFT independent review 2021
Ligature Policy and Procedure	Ligature wallet audits	Overseen by LRRG ESOG and BSOG top priority	Internal Audit 2021 (all actions complete) ELFT Review (actions open) Awarded Best External Environment
Ligature Training	71 staff trained via TIDAL (as at July 2022)		
Trend analysis		Ligature Incident Rate 45.5 Sep 2022 (consistent trend in line with benchmark)	
Local area ligature network	Network established		
KPIs and dashboard to highlight progress on ligature reduction			
Tidal Training			

CRR92: Addressing Inequalities

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At a Glance:

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

Likelihood based on possibility of not embedding equality and diversity
Consequence based on a failure to meet our people plan ambitions

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C4 x L3 = 12	C3 x L2 = 6

Progress since last report:

- EPUT currently working with three providers to build comparative EDI training suites for EPUT staff, replacing the existing sessions it provides. Once these sessions are compared, one will be agreed for funding and implementation before the end of the financial year.
- Additional element added to Datix to improve reporting of racial discrimination/ abuse.
- EDI plan in place aligning with EPUT strategy, vision and values. Plan sets out EDI strategy until November 2024 with a key focus being the support of staff affected by discriminatory behaviour, abuse and bullying.
- WRES and WDES action plans completed.
- Staff Charter with set of behaviours for staff to follow.
- Micro Incivilities session planned for March followed by feedback.
- Completed actions will move to controls.

Key Gaps:

- Review of equality impact assessments and quality impact assessments.

Executive Responsible Officer: Executive Director of People and Culture

Executive Committee: Equality and Inclusion Sub-Committee
Board Committee: People and Culture Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Establishment of EDI and Employee experience team	Completed Dec 2022	Loraine Hammond	Control
2. Improve EDI learning offer for EPUT	June 2023	Lorraine Hammond	Control
3. Working on staff safety and closer alignment with VAPR	Complete	Lorraine Hammond / Nicola Jones	Control
4. Develop culture which brings EDI into all Trust work streams	Ongoing programme	Lorraine Hammond	Control
5. Complete WDES and WRES Action Plan	June 2023	Lorraine Hammond	Control
6. Provide course on 'Micro Incivilities' as a learning exercise for staff, then consider rolling out	April 2023	Lorraine Hammond	Control
7. Obtain kite mark for EPUT staff charter	April 23	Lorraine Hammond	Control
8. Develop EDI Framework RAG system	March 23	Gary Brisco/ Lorraine Hammond	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Employee Team including Director	Established and 6 Employee Experience Managers in post. Project started with single front door.	Project resource	
Equality and Inclusion Policies	Policy System	Equality and Inclusion Sub-Committee with Exec lead PECC	
Range of equality networks and staff engagement methods	Established	Equality and Inclusion Sub-Committee	WRES and WDES (actions identified)
RISE Programme	In place	3 cohorts completed	Positive staff feedback

CRR93: Continuous Learning

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NHS Foundation Trust

At a Glance:

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 Good ratings

Likelihood based on the possibility of losing vital learning and patient safety incidents recurring
Consequence based on failure to meet safety ambitions and non-compliance with CQC fundamental standards

Initial risk score	Current risk score	Target risk score
C5 x L3 = 15	C5 x L3 = 15	C5 x L2 = 10

Progress since last report:

- Positive outcomes for Lessons team input into staff induction; production of lessons identified newsletter, production of 5 key messages, first lesson briefing live session, and record keeping video using various media channels – KPI for benefit realisation for ECOL presented to ECOL Steering Group 3 March 23
- The functions of the EPUT Lessons Team is now fully embedded in practice in the Trust. Key changes that will support the enhancing of our learning lessons capability include – establishment of the Learning Collaborative Partnership (LCP), introduction of culture of learning awareness in corporate induction, Live briefing and monthly Live Learning events and standing up Safety Alert Learning Calls. Delivery of training to frontline and corporate service teams on use of Systems Engineering Initiative for Patient Safety (SEIPS) and Human Factors training as part of the Trust leadership development programmes. A hard copy of key learning materials are now available across mental health inpatient services. Support visit to services by members of the Lessons Team to provide onsite support and partnership working with frontline staff including attendance in team development days.
- Completed actions will move to controls

Key Gaps/ delayed actions:

- Embedding new processes
- Amended Terms of Reference of each group to take forward work on themes
- Actions 2,3, 6, 8, 9, 10 due for completion end of this month
- Workforce module development delayed and awaiting further update from digital and performance team (related to action 4)
- Action 5 Funding secured for software development. Project cannot commence until contract is signed off and approved, hence delay to start. Escalated to finance team.

Executive Responsible Officer:
Executive Chief Nursing Officer
Executive Committee: Executive Safety Oversight Group.
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Stakeholder communications plan and series of workshops scheduled and developing through ECOL awareness campaign	Completed Sep 22	Moriam Adekunle	Control
2. Review Human Engine process maps to incorporate into patient safety incident team standard operating procedure	March 23	Moriam Adekunle	Control
3. Review and explore learning from other organisations including non-NHS	March 23	Moriam Adekunle	Control
4. Develop new safety dashboard to go live status as a triaging and early warning tool for lessons team	Completed Feb 23	Moriam Adekunle	Control
5. Develop EPUT Safety and Lessons Management System (ESLMS)	Sep 23	Moriam Adekunle	Control/ Assurance
6. Review PSIRF process	March 23	Moriam Adekunle	Control
7. Establish Governance structure for Learning Lessons	Completed Feb 23	Moriam Adekunle	Control
8. Develop and embed Quality and Safety Champions Network to support embedding the culture of learning	Mar 23	Moriam Adekunle	Assurance
9. Link into UCL partnership who are implementing a range of collaboratives as part of MH Safety Programme	Mar 23	Moriam Adekunle	Control
10. Systems – monitoring of new L3 process within Datix, review early adoption and ensure any required improvements are documented and actioned	Mar 23	Moriam Adekunle	Control
11. Develop QI methodology	Jun 23	Moriam Adekunle	Control
12. Improve consistency of team meeting agendas across specialist services inpatient wards	Completed Jan 23	Scott Huckle	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Patient Safety Incident Management Team	Established		
Quality and Safety Champion Network	In place		
Learning Collaborative partnership meeting and Learning Oversight Committee	In place	Reporting to Quality Committee	Pan Essex CQRG
Adverse incident policy inc PSIRF SOP and People and Culture Policies	Policy system	60% reduction in conduct cases 2021/22	
Range of initiatives via culture of learning project			Internal audit completed – awaiting results
Tackling bullying and harassment in the NHS	Pilot launching Nov 22 and integrate into ways of working by March 23. Funding granted		
Staff behaviour framework			
Themes allocation to clinical/ assurance/ transformation groups			
Learning information sharing			

CRR96: Loggists

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At a Glance:

If EPUT is unable to increase number of trained loggists and increase hours of availability 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 occurring

Likelihood based on the probability of insufficient loggists
Consequence based on poor decision making and audit trail

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L4 = 16	C4 x L1 = 4 March 23

Progress since last report:

- All EPRR incidents logged to date
- Some training places now available and allocated to EPRR Team
- Proposal to be taken to the Executive Team on increasing number of loggists

Key Gaps:

- Insufficient loggists to cover significant period and none available out of hours
- Limited training currently available from region
- Some logging has been undertaken by staff who are untrained

Executive Responsible Officer:
Executive Director of Major Projects

Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Train more loggists	As training available from region	Nicola Jones	Control
2. Present proposal to ET to increase number of loggists	April 23	Amanda Webb	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Pool of trained loggists including EPRR team and Executive Director PA's	All EPRR incidents have been logged to date	Command structure	
Training	Training now available from region and EPRR staff prioritised		

CRR98: Pharmacy Resource

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At a Glance:

If EPUT is unable to fill new and pre-existing positions within Pharmacy Services then there will be a protracted period of operating within business continuity leading to a reduced pharmacy service to our care units and potential impact on the wellbeing of our staff.

Consequence of 4 is severe due to the possibility of significant service disruption and significant workforce shortages. Possible increase in Datix reports due to a range of issues (pharmacy as a contributing factor) Complaints increasing from clinicians.
Likelihood of 5 is almost certain as our ability to deliver a comprehensive pharmacy service to EPUT patients falls far short of business as usual

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L5 = 20	4 x 4 = 16

Progress since last report:

- Action 1: - update on recruitment. 25.5 vacancies (improved by 2 WTE) with a further 4 under offer, 4.4 WTE pending shortlisting and interview, and 17 WTE continue to be out to advert. Increased focus has been given to branding on social media, professional journals, adverts and a pharmacy page on LinkedIn.
- Filling posts with trainees who will need to be supported through to qualification (grow our own approach)
- Note new action 3: Exploring use of safety dashboard to assist as a control to monitor incidents
- Key activities continue to be delivered in line with the agreed business continuity plan.

Key Gaps/ delayed actions:

- Additional challenge to existing team from taking on unregistered applicants through lack of experience and needing to develop expertise amongst juniors (resulting in far less experienced team overall)
- changes to pharmacy structure reflects operational care units, collaborative and ICS structures within the resources available (i.e. North Essex and West Essex cannot have their own teams because we don't have adequate resources to do so) but are aligned with those two care units, systems.
- Team not delivering comprehensive service
- 25.5 vacancies
- Some need to use off-framework agencies with grade inflation
- BCP consistently enacted

Executive Responsible Officer:
Executive Nurse
Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Bring pharmacy team up to full establishment	Rolling programme	Hilary Scott/ Recruitment	Control
2. Deep dive into Datix reporting for pharmacy related incidents – requires involvement of Medical Safety Officer	April 23	Hilary Scott/ Nicola Jones/ Gillian Noble	Control
3.Explore use of the safety dashboard to assist as a control to monitor incidents	March 23	DQSS	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Pharmacy team	Current establishment (36)	Report to Executive Team secured additional funding for pharmacy resources	Collaboration with HEE and HEIs to develop a sustainable pipeline of staff
Use of bank and agency staff	Support from ICB secondment of pharmacists part-time (in HR process)		
Support from patient experience team			
Recruitment campaign	£300k substantive staffing agreed – implementation in progress to fill posts 4 posts under offer, 4.4 pending shortlisting and interview, 17 in advert		
Business Continuity Plan	Enacted		

CRR99: Safeguarding Referrals

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At a Glance:

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

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L4 = 16	C4 x L2 = 8 March 23

Risk score is high based on only just being managed at present but is not sustainable. Safeguarding discussing with operational senior managers how to address the risk and resources to mitigate it.

Progress since last report:

- Action 1 Safeguarding team at full establishment and are taking on additional caseloads through bank working (additional hours worked)
- Safeguarding policies and procedures in progress for approval at May 2023 Policy Oversight and Ratification Group
- Action 8 on track for completion May 2023
- Action 9 job description in place for the role of safeguarding practitioners and discussions ongoing with Care Unit Directors for funding
- Completed actions will move to controls

Key Gaps:

- Mental Health Act and Safeguarding Sub-Committee meetings have been irregular.
- Issues for escalation from MHSSC – completion of safeguarding enquiry forms; increase in safeguarding activity and complexity of cases; exploitation and trafficking of young people and vulnerable adults
- Impact of Dispatches programme and organisational safeguarding raised by ECC
- Action 2 – safeguarding Datix entries awaiting handler sign off (documentation issue)

Executive Responsible Officer:
Executive Chief Nurse
Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Continue additional hours	Immediate and ongoing	Team	Control
2. Review issue related to Datix sign-off risk	April 23	Tendayi Musundire/ Datix Team	Control
3. Build supervision structure into new Perinatal Social Worker roles	Mar 23 complete	Caroline Bogle	Control
6. Undertake internal consultation on complex cases	Ongoing programme	Caroline Bogle	Control
7. Develop local system to monitor child safeguarding case involvement	Complete	Tendayi Musundire	Assurance
8. Incorporate safeguarding forms into patient records	May 23	Tendayi Musundire	Control
9. Create roles of Safeguarding Practitioner to assist Care Co-ordinator to facilitate safeguarding (adult patients)	April 23	Tendayi Musundire and Care Unit Directors	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Trust safeguarding team	Full establishment and additional caseloads		
Safeguarding policies and procedures			
Prioritisation for oversight of S17, S47 and MARAC requests in place for perinatal social work team – attendance at appointments and involvement in reports as well as attendance at statutory meetings on behalf of doctors	In place		
Safeguarding training			
Robust caseload management	Team managers monitor safeguarding caseloads		
Monthly safeguarding reports	Reporting in place		
Datix reporting	Datix investigation		
Monitoring – safeguarding supervision improved. Duty team picking up overflow of demand to respond to S17 and S47 requests (perinatal)			
CQC action plan		Sexual safety guidance embedded at clinical sites through review of current practice and improvement plans	

07 – Risk Movement March 2023

EPUT

Risk Movement and Milestones

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Strategic Risk Movement – two year period (April 2021– March 2023)

Risk ID	Initial Score	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Risk ID
SR1 Safety	20							New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR1
SR2 People	20							New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR2
SR3 Infrastructure	15							New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR3
SR4 Demand	20							New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR4
SR5 Inquiry	20	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR5
SR6 Cyber	12	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	15↑	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR6
SR7 Capital	20																New	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR7
SR8 Resources	15																New	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	SR8

Strategic Risk Milestones – two year period (April 2021 – March 2023)

Risk ID	Initial Score	Time on SR/ old BAF	Apr 22	May 21	Jun 21	Jul 21	Aug2 1	Sep2 1	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec2 2	Jan 23	Feb 23	Mar 23	Risk ID
SR1 Safety	20	>1 year							New	20																	SR1
SR2 People	20	>1 year							New	20																	SR2
SR3 Infrastructure	15	>1 year							New	15																	SR3
SR4 Demand	20	>1 year							New	20																	SR4
SR5 Inquiry	20	>2 years		15↓						SR																	SR5
SR6 Cyber	12	>2 years									CRR	15															SR6
SR7 Capital	20	>6 months																New									SR7
SR8 Resources	15	>6 months																New								20	SR8

Risk Movement and Milestones

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Corporate Risk Movement and Milestones – two year period (April 2021 – March 2023)

Risk ID	Initial Score	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May22	Jun 22	Jul 22	Aug 22	Sep22	Oct 22	Nov22	Dec 22	Jan 23	Feb 23	Mar 23	Risk ID
CRR11	16	12↔	12↔	12↔	8↓	12↑	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	CRR11
CRR34	9	9↔	9↔	9↔	9↔	15↑	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR34
CRR45	12	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR45
CRR77	16	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR77
CRR81	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR81
CRR92	20	20↔	16↓	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	CRR92
CRR93	15	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR93
CRR94	16				New	16	16↔	16↔	16↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	CRR94
CRR95	20																15	15↔	15↔	15↔	15↔	12↓	12↔	12↔	8	CRR95
CRR96	16																			New	16↔	16↔	16↔	16↔	16↔	CRR96
CRR98	20																				New	20	20	20	20	CRR98
CRR99	16																			New	16↔	16↔	16↔	16↔	16↔	CRR99
Risk ID	Initial Score	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May22	Jun22	Jul 22	Aug 22	Sep 22	Oct22	Nov 22	Dec 22	Jan 23	Feb 23	Feb 23	Risk ID

Risk ID	Initial Score	Time on CRR or old BAF	Apr 21	May 21	Jun 21	Jul 21	Aug2 1	Sep2 1	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Risk ID
CRR11	16	> 2 years				8	12																				CRR11
CRR34	9	> 2 years					15																				CRR34
CRR45	12	> 2 years																									CRR45
CRR77	16	>1 year		16																							CRR77
CRR81	12	> 2 years																									CRR81
CRR92	20	>2 years		16								12															CRR92
CRR93	15	>1 year	15																								CRR93
CRR94	16	>1 year				New	16				20																CRR94
CRR95	20	>6 months																15					12		Close		CRR95
CRR96	16	New																				16					CRR96
CRR98	20	New																						20			CRR 98
CRR99	16	New																				16					CRR99
Risk ID	Initial Score	Time on CRR or old BAF	Apr 21	May 21	Jun 21	Jul 21	Aug2 1	Sep2 1	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep2 2	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Risk ID

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08 – Useful Information

March 2023

EPUT

Acronyms

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BAF	**Board Assurance Framework**	**SR**	**Strategic Risk**
SO	Strategic Objective	**CRR**	Corporate Risk Register
RR	Risk Register	**DRR**	Directorate Risk Register
ICS	Integrated Care System	**F&PC**	Finance & Performance Committee
QC	Quality Committee	**PECC**	People & Culture Committee
IGDSPT	Information Governance Data Security & Protection Toolkit	**EOSC**	Executive Operational Sub Committee
BOD	Board of Directors	**ESOG**	Executive Safety Oversight Group
EERG	Estates Expert Reference Group	**LRRG**	Ligature Reduction Group
MHA	Mental Health Act	**HSSC**	Health Safety Security Committee
ECC	Essex County Council	**CQC**	Care Quality Commission
CxL	Consequence x Likelihood	**CRS**	Current Risk Score
SMT	Senior Management Team	**HSE**	Health & Safety Executive
CAS	Central Alert System	**NHSE/I**	NHS England/ Improvement
PMO	Project Management Office	**ESR**	Electronic Staff Record
EFIN	Electronic Finance Record	**TBA**	To be advised or agreed
PFI	Private Finance Initiative	**NHSPS**	NHS property services
CMO	Chief Medical Officer	**EDS**	Equality and Diversity Standards
BAU	Business as Usual	**PCREF**	Patient and Carer Race Equality Framework
PLACE	Patient Led Assessments of the Care Environment	**EDI**	Equality Diversity and Inclusion
EDS	Equality Delivery System	**EPRR**	Emergency Preparedness, Resilience and Reporting
VPAR	Violence Prevention and Reduction	**BAU**	Business as usual

NHS
Essex Partnership University
NHS Foundation Trust

Report by:
Susan Barry
Head of Assurance

On behalf of:
Executive Team

For: Board of Directors

EPUT

		Agenda Item No: 8b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 March 2023**

Report Title:	Approval for policies under matters reserved for the Board of Directors					
Executive/ Non-Executive Lead:	Denver Greenhalgh, Senior Director of Governance					
Report Author(s):	Policy Owners: • Fiona Thomas, Head of Patient Safety Incident Management • Sarah Pemberton, Health and Safety and Violence and Abuse Prevention and Reduction Manager • Amanda Webb, Senior Emergency Planning and Compliance Officer					
Report discussed previously at:	See below					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Project reports only:	
If this report is project related please state whether this has been approved through the Transformation Steering Group	N/A

Purpose of the Report		
To present the following policies under 'matters reserved for the Board' for final ratification: • Being Open Policy • Corporate Health & Safety Policy • Major Incident Plan • Emergency Preparedness, Resilience & Response (EPRR) Policy	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Receive the report noting that the documents had been previously circulated.

2 Note the governance process followed for each document.

3 The Policy Oversight and Ratification Group recommends the detailed policies for approval by the Board in line with matters reserved for the Board.

Summary of Key Issues

The polices have previously been circulated to the Board of Directors and have not been attached to this paper. The policies are available on request.

Being Open Policy and Procedure

The policy and procedure has been updated in line with amendments to the Regulation 20 Duty of Candour and aligned with the Patient Safety Incident Response Framework (PSIRF).

The revised policy was consulted with the Learning Oversight Sub-Committee (25 January 2023), Clinical Governance & Quality Committee (7 February 2023) prior to presentation to the Policy Oversight and Ratification Group (1 March 2023).

Corporate Health & Safety Policy and Procedure

The Health and Safety Policy has been reviewed in line with current Health and Safety Legislation (the Health and Safety at Work etc. Act 1974, the Management of Health and Safety at Work Regulations, the Welfare Regulations - there has been no changes to legislation that impacts the Trust.

The Health and Safety Policy sets out the Trust's commitment to managing health and safety. It sets out to provide the Trust's approach to Health and Safety within the workplace and the management of risk within the Trust in a structured and ordered way which allows the Board of Directors to oversee Management and assurance processes. Included within the Policy are practical arrangements, responsibilities aligned to core functions.

Changes reflect amendments to the operational Health and Safety inspection process, procedures and inspection tool in collaboration with Estates & Facilities and the Trust Fire Officer.

The policy and procedure was presented to the Health, Safety & Security Committee on the 27 February 2023 prior to presentation to the Policy Oversight and Ratification Group (1 March 2023).

Major Incident Plan

A review has been undertaken to the Trusts Major Incident Policy to strengthen the current plan following lessons learned from incidents within the last year (COVID-19, Severe wind, Heat Wave Level 4, Power Outages and IT system Cyber Attack) and following collaboration with other Trusts. The revised plan has been restructured to enable a clear process from initial notification through to Debrief and staff support.

RMPG14g Shelter and Evacuation Plan added as an additional appendix meeting the requirement under the NHS EPRR Framework 2022 which assists NHS funded Organisations meet the requirements of the Civil Contingencies Act 2004.

Consultation included the Executive Team, Directors and L50 membership. The policy and procedure was presented to the Health, Safety & Security Committee on the 27 February 2023 prior to presentation at the Policy Oversight and Ratification Group (1 March 2023).

Emergency Preparedness, Response & Resilience (EPRR) Policy

A review has been undertaken to the Trusts Emergency Preparedness, Resilience & Response Policy in line with the Trusts Major Incident Policy to ensure the alignment of relevant sections and ensure the Major Incident Plan continues to be an easy to use plan for anyone during an Incident.

Consultation with the Executive Team, Directors and L50 membership was undertaken. The policy and procedure was presented to the Health, Safety & Security Committee on the 27 February 2023 prior to presentation at the Policy Oversight and Ratification Group (1 March 2023).

The Policy Oversight and Ratification Group recommends the above policies for approval by the Board in line with matters reserved for the Board.

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			
DoC	Duty of Candour	FLO	Family Liaison Officer
PSIRF	Patient Safety Incident Response Framework		

Supporting Reports/ Appendices /or further reading
Being Open Policy & Procedure Corporate Health & Safety Policy & Procedure Major Incident Plan EPRR Policy

Lead

Denver Greenhalgh
Senior Director of Corporate Governance

		Agenda Item No: 9a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**29 March 2023**

Report Title:	**Code of Conduct for the Council of Governors**					
Report Lead:	Denver Greenhalgh, Senior Director of Governance					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Governance Committee 22 November 2022 Council of Governors 15 February 2023					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Project reports only:	
If this report is project related please state whether this has been approved through the Transformation Steering Group	N/A

Purpose of the Report		
This report provides the Code of Conduct for the Council of Governors for approval.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Receive the report.

2 Approve the Code of Conduct for the Council of Governors.

Summary of Key Issues

The Code of Conduct for the Council of Governors (The Code) sets out in broad terms the role and responsibilities of all Governors of Essex Partnership University NHS Foundation Trust (EPUT) and the standards of conduct expected of them. The Code was previously reviewed in November 2019 and is now due for review.

The Code was reviewed by the Trust Secretary's Office and presented to:

- The Council of Governors Governance Committee on the 22 November 2022, and
- The Council of Governors on 15 February 2023 for consultation, with changes supported.

The following amendments have been made to the Code of Conduct:

Current Statement	Amendment	Rationale
Section 1.5 It should be acknowledged that this Code cannot cover every situation. Governors are expected to make judgements about what is expected of them using the information within this Code as a baseline.	Sentence added "If in doubt, advice should be sought from the Trust Secretary's Office."	Sentence added to highlight Governors can contact the Trust Secretary's Office for advice on the Code of Conduct.
Vision Values & Purpose	New Vision, Values and Purpose section added from new Strategic Plan approved by Board in January 2023	
Section 3.4 Governors should discuss and agree with the Board how they will undertake these and any other additional roles, giving due consideration to the circumstances of the Trust and the needs of the local community and emerging best practice. (Referring to exchange of information).	Section removed.	This is a duplication of Section 3.6 which refers to the establishment of a policy for engagement with the Board of Directors.
Appendix 3: Non-Compliance with the Code of Conduct	Section updated to reflect changes to the Trust Constitution.	N/A

The Board of Directors is asked to receive and approve the attached Code of Conduct.

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			
CoG	Council of Governors		

Supporting Documents and/or Further Reading
Code of Conduct for the Council of Governors

Lead
Denver Greenhalgh **Senior Director of Corporate Governance**

ESSEX PARTNERSHIP UNIVERSITY NHS FT

CODE OF CONDUCT
FOR THE COUNCIL OF GOVERNORS

VERSION NUMBER	003
KEY CHANGES FROM PREVIOUS VERSION	Minor amendment to Section 1.5 Update of Vision, Values and Purpose Removal of Section 3.4 Amendment to Appendix 3 to reflect changes to the Constitution.
AUTHOR	Trust Secretary's Office
CONSULTATION GROUPS	Council of Governors
IMPLEMENTATION DATE	June 2017
AMENDMENT DATE(S)	November 2019, March 2023
LAST REVIEW DATE	March 2023
NEXT REVIEW DATE	March 2026
APPROVAL BY BOARD OF DIRECTORS	

SUMMARY
This document sets out in broad terms the role and responsibilities of all Governors of Essex Partnership University NHS Foundation Trust (EPUT) and the standards of conduct expected of them.
The Trust monitors the implementation of and compliance with this clinical guideline in the following ways;
The implementation and compliance with the Code will be monitored by the Trust Secretary's Office

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CODE OF CONDUCT FOR THE COUNCIL OF GOVERNORS

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APPENDICES

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CODE OF CONDUCT FOR THE COUNCIL OF GOVERNORS

Assurance Statement

This document sets out in very broad terms the role and responsibilities of all Governors of Essex Partnership University NHS Foundation Trust (EPUT) and the standards of conduct expected of them in line with Trust policies.

1.0 INTRODUCTION

1.1 The purpose of the Code of Conduct (Code) is to provide clear guidance on the standards of conduct and behaviour expected of all Governors and addresses both the requirements of office and their personal behaviour

1.2 The Code, together with the Code of Conduct for Members of the Board of Directors (Board), and the constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the Trust

1.3 The Code is intended to operate in conjunction with *NHS Foundation Trust Code of Governance*, the Trust's constitution, the Council of Governors (Council) Standing Orders and the *Guide for NHS Foundation Trust Governors*

1.4 Governors will be expected to sign a personal declaration confirming that they will adhere to the Code which includes specific reference to the Nolan principles

1.5 It should be acknowledged that this Code cannot cover every situation. Governors are expected to make judgements about what is expected of them using the information within this Code as a baseline. If in doubt, advice should be sought from the Trust Secretary's Office.

1.6 The Code is built on and demonstrates the Trust's corporate values Demonstrating values will support the achievement of the Trust's strategic priorities.

VISION, VALUES AND PURPOSE

2.0 QUALIFICATIONS FOR OFFICE

2.1 A Governor must continue to comply with the eligibility criteria required to hold elected or appointed office throughout their period of tenure as set out in the constitution. The Trust Secretary must be advised of any changes in circumstance which disqualify a Governor from continuing in office.

3.0 ROLES AND RESPONSIBILITIES OF GOVERNORS

3.1 The role of the Council is set out in detail in the Trust's Constitution, Standing Orders and *NHS Foundation Trust Code of Governance,* and is further addressed in the *Guide for NHS Foundation Trust Governors* and reflects the NHS Act 2006.

3.2 The Council has two main duties as set out in legislation and the Trust's constitution (para 18):

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

- to represent the interests of the members of the Trust as a whole and the

interests of the public

3.3 Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members and the public and the stakeholder organisation that either elected or appointed them

3.4 Governors should discuss and agree with the Board how they will undertake these and any other additional roles, giving due consideration to the circumstances of the Trust and the needs of the local community and emerging best practice

3.5 Governors should use their voting rights to hold the Non-Executive Directors individually and collectively to account and act in the best interests of patients, members and the public. The Council should take care to ensure that reasons are considered, factual and within the spirit of the Nolan principles

3.6 The Council should establish a policy for engagement with the Board for those circumstances when they have concerns about the performance of the Board, compliance with the provider licence or other matters related to the overall wellbeing of the Trust. The Council should input into the Board's appointment of a Senior Independent Director

3.7 The Council of Governors should ensure its interaction and relationship with the Board is appropriate and effective.

3.8 Further provision as to the roles and responsibilities of the Council is set out in annex 6 of the constitution (see appendix 1).

4.0 CONDUCT FOR GOVERNORS

4.1 Nolan Principles

All Governors are required to adhere to the highest standards of conduct in the performance of their duties. They are expected to abide by the seven Nolan principles of public life which are:

(a) **Selflessness**: Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or material benefits for themselves, their family or their friends;

(b) **Integrity:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties;

(c) **Objectivity:** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit;

(d) **Accountability**: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office;

(e) **Openness:** Holders of public office should be as open as possible about all their decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands;

(f) **Honesty:** Holders of public office have a duty to declare any private interest relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest;

(g) **Leadership**: Holders of public office should promote and support this principle by leadership and example.

4.2 Trust Values

All Governors are expected to demonstrate the Trust's values and behaviours:

- We Care
- We Learn
- We Empower

4.3 Confidentiality

All Governors are required not to disclose confidential information received in their role as Governors, as appropriate.

4.4 Meetings

4.4.1 Governors have a responsibility to attend Council of Governors' meetings. When this is not possible, apologies should be submitted to the Trust Secretary Office in advance of the meeting. In accordance with the constitution (para 5 Termination of Office and Removal of Governors), persistent absence from Council of Governor meetings without good reason established to the satisfaction of the Council may be grounds for removal from the role of Governor in line with the Governor Meeting Attendance Monitoring procedure

4.4.2 Governors are expected to also attend members' constituency meetings, development events and other Governors' meetings on a regular basis in order to carry out their role

4.4.3 Governors must adhere to good practice in respect of the conduct of meetings as detailed in Appendix 2 and respect the views of their fellow Governors.

4.5 Personal Conduct and Role

4.5.1 Governors are expected to conduct themselves in a manner that reflects positively on the Trust acting as an ambassador for the Trust. They are not expected to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute. Specifically, Governors must:

(a) Value and respect Governors, colleagues and all other members of staff, not breach the equality enactments and not bully any person

(b) Recognise that the roles and responsibilities of a Governor in no way includes a managerial function

(c) Acknowledge that other than attending meetings and events as a Governor, they have no rights or privileges over any other member of the Trust

(d) Must have regard to advice provided by the Chair and Trust Secretary pursuant to their statutory duties

(e) Abide by the Trust's constitution, policies and procedures as well as the vision and values of the Trust at all times.

4.6 Conflict of Interests

4.6.1 Governors should act with the utmost integrity and objectivity and in the best interests of the Trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment.

4.6.2 Governors must comply with the provision in the constitution (para 22) and standing orders for the Council of Governors (para 6) regarding conflict of interests.

4.6.3 Governors must comply with the Trust's Declarations of Interests, Gift & Hospitality policy and procedure in line with NHS England guidance on *Managing Conflicts of Interest in the NHS.*

4.7 Training and Development

4.7.1 The Trust is committed to providing appropriate development opportunities for Governors to enable them to carry out their role effectively.

4.7.2 Governors are expected to participate in training and development opportunities that have been identified as appropriate for them.

4.7.3 All Governors are expected to attend the Governor induction programme put in place by the Trust.

4.7.3 Governors are expected to participate in any review process and skills audit carried out by the Trust.

4.8 Visits to Trust Premises

4.8.1 Governors may also become involved in many areas not covered by the legislation. However, Governors do not play an operational role within the Trust. Although the Trust may choose to involve Governors in site visits or volunteering, Governors neither have a right to inspect Trust property or services nor a duty to meet patients and conduct quality reviews.

4.8.2 Governors are also expected to respect the privacy of Trust service users/ patients and official visits to patient areas are only permissible with the approval of the CEO or Chair of the Trust or as part of planned quality (or other) visits organised by officers of the Trust.

4.8.3 Any visits to Trust sites or services will be managed through the Trust Secretary Office.

4.9 Media

4.9.1 Governors must refer all media requests for information to the Trust Secretary's Office who will liaise with Executive Directors and/or the Communications Team as appropriate. This is to ensure that any stories and comments can be coordinated and information published on the Trust is accurate and understandable.

4.9.2 It is important that the Governors recognise that any media interest is handled in a way which complies with the Trusts' legal duties to service users, staff and visitors.

4.10 Fit & Proper Person and Duty of Candour

4.10.1 Governors will need to be aware of the statutory duties imposed on the Trust under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the "Regulations") of the Duty of Candour.

4.10.2 The Trust will ensure that no person who is an unfit person may become or continue as a Governor, except with the approval in writing of NHS England. Governors will need to be aware of the Fit & Proper Person requirement (condition G4) in the Trust's Provider Licence and notify the Trust Secretary's Office of any circumstances which leads to a Governor no longer meeting these requirements.

4.10.3 Under condition G4 of the Provider Licence, an unfit person is:

- an individual:

  (i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

  (ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

  (iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or

  (iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

- a body corporate, or a body corporate with a parent body corporate.

4.10.4 Governors must certify on appointment, and each year, that they are/remain a fit and proper person. If circumstances change so that a Governor can no longer be regarded as a fit and proper person or if it comes to light that a Governor is not a fit and proper person, they are suspended from being a Governor with immediate effect pending

confirmation and any appeal. Where it is confirmed that a Governor is no longer a fit and proper person their membership of the Council of Governors is terminated.

4.11 Undertaking and Compliance

4.11.1 Governors are required, at the beginning of their three-year term of office, to give an undertaking that they will comply with the provisions of this Code by signing a personal declaration as at Appendix 4. Failure to comply with the Code may result in disciplinary action in accordance with agreed procedure (section 6)

4.11.2 On completion or termination of term of office Governors undertake:

- To support newly appointed Governors to take on their responsibilities
- To continue to act in accordance with this Code in matters relating to the activities of the Trust.

5.0 CONCERNS AND RAISING ISSUES

5.1 The Trust Secretary's Office provide day to day support to the Council.

5.2 Questions and concerns about the application of the Code should be raised with the Trust Secretary's Office. The Trust Secretary's Office shall in the first instance arbitrate in any dispute concerning the interpretation of or arising out of these procedures. Any unresolved disputes will be dealt with in accordance with the Constitution.

5.3 All issues of concern should be raised in the first instance with the Trust Secretary's Office who will ensure these are forwarded to the appropriate individual/team to respond.

5.4 If the Trust Secretary does not deal with the concern to the Governor's satisfaction, they should contact the Chair.

5.5 If action taken by the Chair or Trust Secretary is deemed to be insufficient, Governors should contact the Senior Independent Director.

5.6 Governors should also refer to the policy and procedure when there is a disagreement between the Council and Board.

6.0 NON-COMPLIANCE WITH THE CODE OF CONDUCT

6.1 An allegation of non-compliance against the Code of Conduct can be brought against a Governor by a fellow Governor, a member of the Trust, a member of the public or a corporate body.

6.2 A Governor may be removed from the Council in accordance with the relevant provisions in the constitution and the Council's standing orders.

6.3 However, where matters of non-compliance and/or misconduct are alleged, in the first instance, a local informal resolution will be sought led by the Chair of the Trus.t

6.4 If matters of alleged non-compliance and/or misconduct are not resolved through a local resolution, the process set out in Council of Governors standing orders will be followed (see Appendix 3).

7.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

7.1 Review of the Code of Conduct will take place on a three-yearly basis.

7.2 Implementation and compliance with the Code will be monitored by the Trust Secretary.

8.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES/DOCUMENTS

- Declarations of Interest, Gifts & Hospitality Policy and Procedure
- Constitution
- Standing Orders for the Council of Governors

END

Appendix 1: ANNEX 6: ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraphs 17.3, 18.1 and 24.1 refer)

1. Roles and Responsibilities of the Council of Governors

The roles and responsibilities of the Council of Governors which are to be carried out in accordance with the constitution, the Trust's licence and Monitor's *NHS Foundation Trust Code of Governance* include:

1.1 General Duties

1.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, including ensuring that the Board of Directors acts so that the Trust does not breach the terms of its licence. "Holding the Non-Executive Directors to account" includes scrutinising how well the Board is working, challenging the Board in respect of its effectiveness, and asking the Board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the Trust, questioning Non-Executive Directors about the performance of the Board and of the Trust and making sure to represent the interests of the Trust's members and of the public in doing so

1.1.2 to represent the interests of the members of the Trust and the interests of the public

2.1 Non-Executive Directors, Chief Executive and Auditor

2.1.1 to approve the policies and procedures for the appointment and removal of the Chair and Non-Executive Directors on the recommendation of the Nomination Committee of the Council of Governors

2.1.2 to appoint the Chair and Non-Executive Directors

2.1.3 to remove the Chair and the Non-Executive Directors. However, the Council should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all means of engagement with the Board

2.1.4 to approve the policies and procedures for the appraisal of the Chair, and Non-Executive Directors on the recommendation of the remuneration committee of the Council of Governors. All Non-Executive Directors should be submitted for re-appointment at regular intervals. The Council of Governors should ensure planned and progressive refreshing of the Non-Executive Directors

2.1.5 to decide the remuneration of Non-Executive Directors and the Chair and to approve changes to the remuneration, allowances and other terms of office for the Chair and the Non-Executive Directors having regard to the recommendations of the Remuneration Committee of the Council of Governors

2.1.6 to approve the appointment of the Chief Executive of the Trust

2.1.7 to approve the criteria for the appointment, removal and reappointment of the auditor

2.1.8 to appoint, remove and reappoint the auditor, having regards to the recommendation of the Audit Committee

3.1 Strategy Planning

3.1.1 to provide feedback to the Board of Directors on the development of the strategic direction of the Trust, as appropriate

3.1.2 to collaborate with the Board of Directors in the development of the forward plan

3.1.3 where the forward plan contains a proposal that the Trust will carry out activities other than the provision of goods and services for the purposes of the NHS in England, to determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions and notify its determination to the Board of Directors

3.1.4 where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the NHS in England, approve such a proposal

3.1.5 to approve the entering into of any significant transaction (as defined in this constitution) in accordance with the 2006 Act and the constitution

3.1.6 to approve proposals from the Board of Directors for merger, acquisition, dissolution or separation in accordance with 2006 Act and the constitution

3.1.7 when appropriate, to make recommendations for the revision of the constitution and approve any amendments to the constitution in accordance with the 2006 Act and the constitution

3.1.8 to receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council of Governors

4.1 Representing Members and the Public

4.1.1 to prepare and from time to time review the Trust's membership engagement strategy and policy

4.1.2 to notify Monitor, via the Lead Governor, if the Council is concerned that the Trust is at risk of breaching the terms of its licence, and if these concerns cannot be resolved at local level

4.1.3 to report to the members annually on the performance of the Council of

Governors

4.1.4 to promote membership of the Trust and contribute to opportunities to recruit members in accordance with the membership strategy

4.1.5 to seek the views of stakeholders and feed back to the Board of Directors.

Appendix 2: ETIQUETTE FOR COUNCIL OF GOVERNORS AND COMMITTEES' MEETINGS

1 The number of decisions required at Council of Governor meetings will be limited and the business will be conducted in a timely and focused manner

2 Papers will be written to an appropriate standard clearly detailing the purpose of the report, issues, risks and recommendations/actions to be taken

3 Agenda items which require no decisions will be noted. Should Governors require additional clarity on any of these items, further discussions should be arranged outside of the meeting by the Trust Secretary's Office.

4 Discussion at meetings should not duplicate the work of the Directors of the Trust

5 The Chair will work to a timed agenda and all questions will go through the Chair

6 If any item on the agenda requires a vote to be taken, the most simple and effective process for implementing this will be adopted

7 In exceptional circumstances, the Chair will invoke standing orders

8 Governors will endeavour to:

(a) Read all papers before the meeting to maximise effectiveness

(b) Arrive on time

(c) Undertake to make a point only once

(d) Respect one another as possessing individual and corporate skills, knowledge and responsibilities

(e) Listen to one another and be tolerant to other points of view; disagree constructively

(f) Be courteous and respect freedom to speak, disagree or remain silent

(g) Speak to each other to resolve matters prior to them becoming an issue

(h) Focus on discussion on material issues and on the resolution of issues

(i) Be honest, open and constructive

(j) Act in a positive manner

(k) Be ready to apologise if offence is taken

(l) Stay open to discussion

(m) Maintain a view of the strategic picture

(n) Treat one another as they would wish to be treated

(o) Show group support and loyalty to each other

(p) Take decisions as a Council and abide by these

Appendix 3: NON COMPLIANCE WITH THE CODE OF CONDUCT

(Constitution para 5: Termination of Office and Removal of Governors)

5.1 People holding office as a Governor shall cease to do so if:

5.1.1. they resign by notice in writing to the Trust Secretary

5.1.2 in the case of elected Governors, they cease to be member of the area of the constituency or class of the constituency by which they were elected

5.1.3. in the case of an appointed or partnership Governor, the appointing organisation terminates the appointment of the individual

5.1.4. they consistently and unjustifiably fail to attend the meetings of the Council of Governors in line with the Governor attendance policy as agreed by the Council of Governors

5.1.5. they have refused without reasonable cause to undertake any training which the Trust requires all Governors to undertake

5.1.6. they have failed to sign and deliver to the Trust Secretary a statement in the form required confirming acceptance of the code of conduct for Governors

5.1.7. they have failed to complete a submission identifying any conflict of interest or they have knowingly provided false or misleading information in this regard.

5.1.8. they have committed a serious breach of the code of conduct for Governors or fails to abide by the Council of Governors standing orders

5.1.9. they have acted in a manner detrimental to the interests of the Trust

5.1.10. they have expressed opinions which are incompatible with the values of the Trust

5.1.11.they are incapable by reason of mental disorder, illness or injury of managing and administering his property and affairs

5.2 Governors who are to be removed under any of the grounds set out in paragraph 5.1 above (with the exception of sub-paragraph 5.1.1 – 5.1.3) above shall be removed from the Council of Governors by a resolution approved by the majority of the remaining Governors present and voting

5.3 There shall be a working group/committee of the Council of Governors whose function shall be to:

5.3.1 receive and consider concerns about the conduct of any governor and/or

5.3.2 consider whether there are grounds to remove a Governor from office and to make recommendations to the Council of Governors. Membership of the working group/committee shall be determined from time to time

5.4 If the Council of Governors receives a complaint in writing about any Governor or is asked to consider whether an individual is eligible to become or remain a Governor, the working group shall investigate the matter and make a recommendation to the Council of Governors, which may include a recommendation that a Governor is removed from office pursuant to paragraph 5.2 above

5.5 The Council of Governors may decide that whilst the working group is carrying out its investigation, the Governor concerned shall be suspended from office. Suspension is a neutral act and any decision to suspend the Governor concerned shall not be seen as an indicator of, or have any bearing on, the eventual recommendation of the working group

5.6 If the Council of Governors decides to terminate a Governor's tenure of office pursuant to paragraph 5.2 above, the Governor may apply in writing to the Council of Governors within seven (7) days of the date of the decision, for the decision to be referred to an independent assessor

5.7 The decision of the Council of Governors to terminate the tenure of office of the Governor concerned shall not take effect until the later of:

5.7.1 seven (7) days after the date of decision; or

5.7.2 where the Governor applies for the decision to be referred to an independent assessor in accordance with paragraph 5.6 above, the date on which the independent assessor determines the matter

5.8 The Governor shall be suspended from office (if they have not already been suspended from office pursuant to paragraph 5.5 above) with effect from the date of the Council of Governors' decision until the later of the two dates set out in paragraph 5.7 above

5.9 On receipt of an application under paragraph 5.6 above the Council of Governors and the applicant Governor will co-operate in good faith to agree on the appointment of the independent assessor. If the parties fail to agree on the identity of the independent assessor within twenty-one (21) days of the date upon which the application is received by the Council of Governors, then the Council of Governors shall request the Chartered Institute of Arbitrators to nominate an independent assessor

5.10 The independent assessor will consider the evidence and conclude whether the decision to remove the Governor was reasonable or otherwise

5.11 The independent assessor's decision will be binding on the parties. If the independent assessor finds that the decision of the Council of Governors

to remove the governor was not reasonable, the decision of the Council of Governors will be rescinded

5.12 The Trust shall bear the independent assessor's costs unless the independent assessor determines that such costs shall be shared between the Trust and the Governor.

Appendix 4: PERSONAL DECLARATION OF COMPLIANCE

I will:

1 Support the Trust, demonstrating the Trust's values and behaviours, and complying with the constitution and standing orders

2 Respect and treat with dignity and fairness, the public, service users and patients, and their relatives and carers, fellow Governors, NHS staff and partners in other agencies

3 Be a good ambassador for the Trust and always work in the best interests of the Trust, its service users/patients and members

4 Seek to ensure that the membership of the constituency or stakeholder group I represent is properly informed and given the opportunity to influence services

5 Always observe confidentiality on matters relating to the work of the Trust and respect the confidentiality of individual service users and patients, complying with the confidentiality policies of the Trust

6 Attend meetings of the Council of Governors and its related committees during which I will observe good meeting practice (appendix 2)

7 Respect and accept the majority decisions of the whole Council of Governors, understanding that this is the sole decision-making body for the Governors. Committees and working groups will advise the Council of their work for agreement and ratification by the full Council

8 Show my commitment to working as a team member by working with all my colleagues on the Council, in the Trust and the wider community

9 Declare if I am a member of any Trade Union, Political Party or other organisation. I will not represent these organisations (or the views of these organisations). I will be representing the members of the Trust and the public or the organisation that appointed me

10 Seek to ensure that the best interests of the public, service users and patients are upheld in decision making and this is not improperly influenced by gifts or inducements

11 Not approach the media except through the Trust Secretary who will liaise with the Communications Team or Executive Directors as appropriate

12 Not use Trust's material such as Trust's logo, identity badges, etc., without the express permission of the Trust

13 Not make, permit or knowingly allow to be made any untrue or misleading statement(s) relating to my own duties or the functions of the Trust

14 Claim no privileges in my role as a Governor

15 Undertake all mandatory and appropriate training provided and required of me to enable me to fulfil my role as a Governor

16 Abide by the Trust's policies and procedures as appropriate including Whistleblowing Information Governance, Equality & Diversity, Declarations of Interest, Gifts & Hospitality, etc.

17 Make effective use of the resources available to me

18 Be honest and act with integrity and probity at all times

19 Oppose any discrimination

20 Act responsibly whilst contributing to the work of the Council of Governors, bringing my strengths to bear and respecting the strengths of other Governors.

Code of Conduct Acceptance			
I confirm that I have read and agree to abide by the Code of Conduct for the Council of Governors of Essex Partnership University NHS Foundation Trust.			
Name		**Signature**	
Date			

Copies of the signed declaration will be kept by the Trust Secretary.

Board of Directors 29 March 2023