Essex Partnership University
NHS Foundation Trust

**Meeting of the Board of Directors held in Public via Microsoft Teams**
**Wednesday 24 November at 10:00**

**Vision: Working to Improve Lives**

**PART ONE: MEETING HELD IN PUBLIC via Microsoft Teams**

**AGENDA**

| | | | | |
|---|---|---|---|---|
| **1** | **APOLOGIES FOR ABSENCE** | SS | Verbal | Noting |
| **2** | **DECLARATIONS OF INTEREST** | SS | Verbal | Noting |
| | **PRESENTATION**<br>Oxevision<br>Stephan Zentgraf, Account Manager Oxehealth | | | |
| **3** | **MINUTES OF THE PREVIOUS MEETING HELD ON:**<br>29 September 2021 | SS | Attached | Approval |
| **4** | **ACTION LOG AND MATTERS ARISING** | SS | Attached | Noting |
| **5** | Chairs Report (including Governance Update) | SS | Attached | Noting |
| **6** | CEO Report | PS | Attached | Noting |
| **7** | **QUALITY AND OPERATIONAL PERFORMANCE** | | | |
| **(a)** | Quality & Performance Scorecard | PS | Attached | Noting |
| **(b)** | End of Life Annual Report 2020-21 | NH (TR) | Attached | Noting |
| **(c)** | A Framework of Quality Assurance for Responsible Officers and Revalidation – Annual Board Report | MK | Attached | Approval |
| **(d)** | Learning from Death – Mortality Review<br>Summary of Quarter 1 2021/22 information | NH | Attached | Noting |
| **(e)** | Safeguarding Annual Report | NH | Attached | Approval |
| **(f)** | Health, Safety and Security Annual Report | PS (NJ) | Attached | Noting |
| **(g)** | Pharmacy and Medicines Optimisation Annual Report 2020-21 | NH (HS) | Attached | Approval |
| **(h)** | Trust Green/Sustainability Plan | TS | Attached | Approval |
| **(i)** | Freedom to Speak Up Report | YM | Attached | Noting |
| **8** | **ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL** | | | |

| | | | | |
|---|---|---|---|---|
| **(a)** | Standing Committees: | | | |
| | (i) Audit Committee | JW | Attached | Noting |
| | (ii) Board Safety Oversight Group | A R-Q | Attached | Noting |
| | (iii) Finance & Performance Committee | LL | Attached | Noting |
| | (iv) Quality Committee | RH | Attached | Noting |
| | (v) People, Equality and Culture Committee including Terms of Reference Approval | ML | Attached | Noting |
| **9** | **RISK ASSURANCE REPORTS** | | | |
| | (i) COVID-19 Assurance Report | PS | Attached | Noting |
| | (ii) Ligature Risk Management Q2 Report | PS | Attached | Noting |
| **10** | **STRATEGIC INITIATIVES** | | | |
| **(a)** | Safe Working of Junior Doctors Quarterly Report (Jul-Sept 2021) | MK | Attached | Noting |
| **11** | **REGULATION AND COMPLIANCE** | | | |
| **(a)** | CQC Compliance Update | PS | Attached | Approval |
| **12** | **OTHER** | | | |
| **(a)** | Use of Corporate Seal | PS | Not Used | Approval |
| **(b)** | Correspondence circulated to Board members since the last meeting. | SS | Verbal | Noting |
| **(c)** | New risks identified that require adding to the Risk Register or any items that need removing | ALL | Verbal | Approval |
| **(d)** | Reflection on equalities as a result of decisions and discussions | ALL | Verbal | Noting |
| **(e)** | Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement) | ALL | Verbal | Noting |
| **13** | **ANY OTHER BUSINESS** | ALL | Verbal | Noting |
| **14** | **QUESTION THE DIRECTORS SESSION**<br>A session for members of the public to ask questions of the Board of Directors | | | |
| **15** | **DATE AND TIME OF NEXT MEETING**<br>Wednesday 26 January 2022 at 10.00am | | | |
| **16** | **DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules**<br>Wednesday 30 March 2022 at 10.00am<br>Wednesday 25 May 2022 at 10.00am<br>Wednesday 27 July 2022 at 10.00am<br>Wednesday 28 September 2022 at 10.00am<br>Wednesday 30 November 2022 at 10.00am | | | |

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

**Minutes of the Board of Directors Meeting held in Public**
**Held on Wednesday 29 September 2021**
**Held Virtually via MS Teams Video Conferencing**

**Director Attendees:**

| | |
|---|---|
| Prof Sheila Salmon (SS) | Chair |
| Paul Scott (PS) | Chief Executive |
| Prof Natalie Hammond (NH) | Executive Nurse |
| Sean Leahy (SL) | Executive Director of People and Culture |
| Dr Milind Karale (MK) | Executive Medical Director |
| Alex Green (AG) | Executive Chief Operating Officer |
| Trevor Smith (TS) | Executive Chief Finance Officer |
| Janet Wood (JW) | Non-Executive Director |
| Alison Rose-Quirie (ARQ) | Non-Executive Director |
| Amanda Sherlock (AS) | Non-Executive Director |
| Manny Lewis (ML) | Non-Executive Director |
| Loy Lobo (LL) | Non-Executive Director |

**In Attendance:**

| | |
|---|---|
| James Day (JD) | Interim Trust Secretary |
| Chris Jennings | Assistant Trust Secretary |
| Gina Trimble | Trust Secretary Co-ordinator |
| Clare Sumner | Trust Secretary Administrator |
| Mark Dale | Public Governor |
| Jared Davis | Public Governor |
| David Short | Public Governor |
| Dianne Collins | Public Governor |
| Keith Bobbin | Public Governor |
| Pippa Ecclestone | Public Governor |
| Stuart Scrivener | Public Governor |
| Cllr Mark Durham | Local Authority Governor |
| Moriam Adekunle | Director of Safety and Patient Safety Specialist |
| Gill Brice (GB) | Project Director, EPUT, for Nigel Leonard |

**In Attendance for Part**

| | |
|---|---|
| Gary Brisco (GBr) | Equality Advisor |
| Lorraine Hammond (LH) | Director of Equality and Inclusion |
| Jo Debenham (JDe) | Director of Inclusion |
| James Wilson (JWn) | Collaborative Transformation Director |
| Graeme Jones (GJ) | External Consultant for EPUT |

The meeting commenced at 10:00

SS welcomed Board members, Governors and members of the public joining this virtual meeting and set out the protocols for the meeting.

GT was introduced as a new member of the TSO team.

**104/21 APOLOGIES FOR ABSENCE**

Apologies had been received from Nigel Leonard, Rufus Helm, Mateen Jiwani, John Jones, Dr Lynne Prendergast and Lyndsay Taylor. The circumstances were noted.

Signed: …… Date: ……

## 105/21 DECLARATIONS OF INTEREST

There were no new declarations of interest.

## 106/21 PRESENTATION: MENTAL HEALTH FAMILY GROUP CONFERENCE SERVICE

Because of unexpected illness, Dr Lynne Prendergast was unable to attend to present this item, and it was agreed that Dr Prendergast would attend with her colleague Lyndsay Taylor at a future Board.

**The Board agreed to defer this joint presentation to a later date.**

## 107/21 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 26 May were considered. In response to a governor request, JD undertook to obtain clarification of minute 079/21where it read “scaling out resource for low lying members”.

NH indicated Minute 84/21 last line Page 4 needed to read “There had been zero incidents of omissions in care in pressure ulcer reporting year to date”.
In the same minute, in the penultimate line on page 5 the word “exiting” needed to be replaced by “exciting”. JD agreed to make the amendments.

**With the indicated amendments, the Board approved the minutes as an accurate record.**

## 108/21 ACTION LOG AND MATTERS ARISING

The action log was reviewed as follows:

033/21 SS recognised there had been slippage on the People Plan but that work was underway and that this was returning to the Board in November 2021. SL indicated that a huge amount of work was being undertaken across the HR function and that by November the new structure would be set up to address this. This was welcomed and noted.

035/21 The new strategic BAF would be returned to the November Board and the planned approval of the Trust Strategic Priorities in the current Board would facilitate this.

040/21 The Engagement Strategy was linked to the HR review above and the related work in progress, and this matter would also be returned to the November 2021 Board.

090/21 SL confirmed that the Disciplinary (Conduct) Policy and Procedure was being re-written. This would also be returning to the November Board.

In response to SS, SL confirmed the suite of HR matters would be returned to the November 2021 Board

**The Board approved the Action Log.**

## 109/21 CHAIRS REPORT INCLUDING GOVERNANCE UPDATE

The Chair presented a written report providing the Board of Directors with a summary of key activities and an update of governance developments within the Trust. This report had been previously circulated and the Chair was open to questions.

AS indicated that she had undertaken the training package referred to, the link for which had been circulated to Directors in response to World Suicide Prevention Day. This training was highly recommended. This was everybody's business, and AS commended the circulation of this package. SS had also undertaken the training and commended it to the Board and Trust.

NH confirmed that this message was being shared with all staff, not just front line staff, so that they were in a position to help relatives and friends.

**The Board received and noted the Chair's Report.**

**110/21 CEO REPORT**

SS introduced this item, indicating a more concise approach would be taken to free time for later agenda items. PS indicated that the report would be taken as read, and questions could be asked, although AG would still update upon the latest operational position. This would effectively combine agenda item 6, CEO Report and 7(a), Quality and Performance Scorecard.

PS reflected that it had been a difficult past eighteen months and that COVID and operational pressures were continuing into a challenging winter. PS thanked all involved in the Trust for their continued work and resilience. There had been welcome progress to modernise and repurpose the Trust including in relation to safety including staffing and ligature. The vaccination service continued to strengthen, and PS was delighted to be moving forward on the Strategic Direction and Accountability framework today. There had been meaningful staff engagement, particularly on the wards, and PS was optimistic that the new approach would reflect in improved patient care, and how the staff felt about working for EPUT. The Veteran, Dementia and Vaccination services had all been either shortlisted for or received national external awards and very recently the staff "Here for You" service had been shortlisted for an HSJ award. The recognition was welcome, as was the positivity.

On page 6 of fifteen there was a typographical error and the report should read "over 90% incurred no harm" and not 9%.

AG confirmed elements of operational performance were included in the written report.
Adult in-patient mental health capacity had been particularly challenged since August, reflected across the system. AG provided detail of the issues with input and prevention pathways, throughput, and discharge.
The home treatment teams were doing great work keeping people out of hospital. Work was underway with the crisis concordat and ECC regarding S.135 and the practice of S.12 doctors to ensure only those who needed to be in hospital were admitted, and the psychology teams had worked out a protocol to help acute staff assist patients in emergency departments and bedded areas. This was being rolled out across all partners.
The red to green "value added" patient care pilot on Cedar ward had ended and the learning was being rolled out to other wards. Purposeful admission work was continuing. The key element was reviewing the psychological and therapeutic interventions on the ward to achieve clarity on the intended pathway. Best practice would be implemented. Daily sitreps were being streamlined to become more action focussed and to encourage earlier interventions from partners. The winter plan was under development for delivery from October.
An accommodation protocol had been developed with the County and Borough Councils to assist with discharge and help prevent admissions.

The out of area action plan continues and the Trust is using 11 beds at The Priory. These are female beds making the dynamics of the mixed wards in the south of the area challenging.

Experience from the north of the area showed length of stay increased when accomdation was mixed, so best practice would be adopted.
The position was complex but was being drawn together into an overall plan.

LL noted that the average length of stay had tracked higher than the target for a while. LL appreciated where there would need to be variations, but what was the plan to establish a target level that was representative and achievable?
AG confirmed that there were national standards which the Trust had not been achieving although there had been some earlier improvement. The stays were longer than desirable, but clearly affected by acuity levels. The solutions and best outcomes lay in effective admissions and planned expected transfer or discharge dates. The accommodation pathway will help, and all the described initiatives had the aim of reducing the stay on the wards. The combination as a whole would help.

SS reflected that given the Trust was an outlier on length of stay, that this needed to be a priority.

PS indicated that the role of doctors in this would be significant. The Trust was unlikely to get through winter without adjustment to the length of stay but there were many variables. The winter plan would cover this but changes were needed as to how the Trust used it doctors outside the ward situation, and how to engage them earlier.

LL suggested that this would be an opportunity to apply for available central funding for technological solutions to length of stay issues before winter if an application was made now. A new approach was required.

MK indicated that the Trust's assessment units regularly and routinely discharged large numbers of patients, meaning that those who did end up on the wards were very ill indeed, which served to extend the comparative length of stay. The national model and comparators did not necessarily reflect that acuity. MK went on to confirm all the doctor-led initiatives in the Trust contributing to reduced stays, including a revised approach to patients with personality disorders.

AR-Q had recently visited and been impressed by The Lakes in Colchester. Whilst there she had learned of a past incident which had been prolonged for both patient and staff because of limits to the extent of restraint able to be deployed. Was that restraint limit determined by the designation and category of the ward, or was this level designated by the assesment and acuity of the patient?
AG confirmed her understanding of the incident specifically and the complexity of restraint generally.
MK indicated that escalation to a more appropriate unit was the expected approach to be taken, but was not without resource challenges.
NH indicated that the National TASI guidance determined the level of restraint and number of staff allowed to be involved. The Trust was doing well in limiting certain types of restraint but acuity, environment, response levels and training all played a factor. There was also guidance on working with the Police should they be required.
It was agreed that this discussion would be continued in the Safety Oversight Group.

JW asked if the Trust had yet received the H2 allocation, and also the impact on H2 of the loss of elective catch-up funding.
TS confirmed a delay in the receipt of the H2 numbers although internal preparation and planning work continued. He noted there was a positive focus on capital funding to enhance recovery and work was underway to submitted applications for funds.

AS asked about the sensitivity of the staffing levels indicator. An example was provided of a green overall RAG rating when at a ward level there were red RAG hotspots.
AG indicated that in some areas, including CAMHS, there was a daily sitrep and that the immediate detailed position varied with occupancy and acuity that was at a level greater than the general reporting

NH indicated that for the Unify report the Trust put forward actual against establishment figures and that between the two there was always room for operational disparity based on patient numbers and acuity. Work ready to go to address this included the Safecare module and a further data review. This would give care hours per day per patient, which would be a more accurate indicator of levels of patient care. This would also broaden the base of reporting to include therapeutic input from our AHP's.
SL confirmed 19 new hires across the CAMHS function. A formal staffing review was planned, but a narrative review was already underway across the organisation looking at establishment, numbers and need. This was comprehensive and would provide rich data in about 12 weeks, which would be ahead of an establishment review. Action was being taken.

AS was assured there was additional action beneath the headlines.

ML raised that within the international nurse recruitment section of the report, of nine nurses recruited in August 2021, three had withdrawn because of poor press surrounding EPUT. The subsequent investigation was welcomed, but ML was also interested to know where the Trust had reached with its communications strategy. Providing context and promoting our great work was important. When could this be expected?
SL outlined that the international nurse recruitment levels should be higher and that this was under discussion at exec level. There was significant investment to re-invigorate this programme.
Work was underway to improve the employee offer, but the press relating to the recent CQC report had been a temporary factor causing candidates to withdraw. At the end of the month a significant EPUT and Essex-wide branding exercise was going live after great effort to promote EPUT and Essex as a great place to work. Work was underway to establish a suite of employee benefits as further recruitment incentives. Unfortunately, there was competition for talent within the NHS encouraging staff to move frequently for improved immediate recruitment benefits. This had to stop. The attraction and retention strategy was under development.

The new Comms teams were now working on internal and external comms strategies. In response to SS, SL indicated the bones of these strategies were anticipated in November. This would be a draft and intended to be flexible to be able to move with the Trust as it develops. SS and ML welcomed an outline Comms strategy being available for November.

AR-Q asked that the Board be kept up to date with the length of time suspended staff remained suspended pending investigatory work and any disciplinary proceedings.
Separately AR-Q praised the work of the Ipswich based Refugee and Homeless Service as a great example of true integration. If there could be some recognition for that team, it should be given. They would be welcome invitees to the Board to talk about what they do. Not everyone knew about this work, which was worth celebrating.
SL indicated that safeguarding related suspensions were often dependent upon information from the Police and protocols had now been established, but that the length of suspension remained an important indicator. SS indicated this could be a matter for the new People Committee.

LL offered his assistance to SL in relation to developing a hiring strategy for nurses from India. This was welcomed and would be pursued outside the meeting.

PS thanked all concerned and welcomed AR-Q's observation on the Suffolk service and the exemplar integration. Bringing them to Board was a good idea. The service was under pressure from COVID and a fresh influx of people from Afghanistan.
In relation to engagement and Comms, work was underway on this strategy. Work in lieu of this emerging framework was current. It was hoped that the optimism in the report could be shared through that pathway. PS hoped that the in-depth reporting and responses on safety issued showed the improved traction and that this would reflect in more optimistic staff attitudes as well as the metrics as the Trust approached a difficult winter.

**The Board received and noted the CEO's Report.**

## 111/21 QUALITY AND PERFORMANCE SCORECARD

It was agreed that this had been covered in the previous item.

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

## 112/21 MENTAL HEALTH ACT ANNUAL REPORT

SS welcomed the comprehensive Mental Health Act report for approval, looking back at the previous year.

NH confirmed that there had been extensive prior scrutiny at the Quality Committee. NH expressed her thanks to the MHA Administration team. The pandemic had resulted in new and different ways and times of working and a need to be adaptable to meet MHA requirements and work even more closely with colleagues.

SS confirmed the Board's thanks. Any questions or feedback was welcomed.

LL reflected that for future reports a key-points executive summary would be helpful to distil the key elements, but welcomed and endorsed the work undertaken and reported by the team.

**The Board of Directors received and approved the MHA Annual Report.**

## 113/21 WORKFORCE DISABILITY EQUALITY STANDARD (WDES) REPORT 2021

SL introduced the WDES report, and asked that it be taken as read whilst inviting any questions.
SS again welcomed an extremely comprehensive report whilst recognising that there was still a long way to go

SL recognised some improvement had been made but also that more work was needed.

AR-Q recognised that there was further to go in relation to disability and ethnicity issues but noted that the action plans had an apparent emphasis on review rather than expressly following this up by action, implementation and delivery. There needed to be targets to achieve and deliverables, and an idea of how that would be done.
SL agreed the actions did not address the issue and that more work needed to be done. This would be re focussed.

ML welcomed more relevant and smarter objectives, but recognised that the low relative numbers involved left the reported position vulnerable to comparatively small changes year to year. Narrative data to support the quantitative data would be helpful to set the context of our performance as an employer at a qualitative level.
The WDES and forthcoming WRES plans would be the right items for discussion at the forthcoming People Committee. This was a powerful approach, and whilst approval today was understood, these plans would need to be returned to. SS confirmed this approach and remitted the matter to SL and Lorraine Hammond and her team.

SL indicated that the Trust was seen as a positive disability employer but the context was changing because of home working and the reluctance of people to talk about their disabilities. There was work underway so disability could be recognised and help offered.

LL reflected upon the complexity of the executive summary bullet points and wondered if some of the percentage differences were nothing more than a minor variation around the mean – in which case this would not be a great concern. SL agreed to pick up on bullet point clarity outside the meeting.

**The Board of Directors received and approved the contents of the WDES report for internal and external use, subject to the identified ongoing work and clarity on the action plan, to be monitored through the new People Committee for return to the Board in due course.**

## 114/21 WORKFORCE RACE EQUALITY STANDARD (WRES) REPORT 2021

SL introduced this item and shared his optimism and excitement about the movement and improvements made over the last two years and the positive interaction that was happening and being recognised. The WRES report was still relatively positive, which had been the aim.

AR-Q welcomed the improvement over the last couple of years. Against what yardstick would the Trust know it had been successful with regard to the overall number of BAME staff it had?
SL indicated that the Trust needed to reflect the community it served, but that more data would be needed to set targets. This would come through the new People Committee.

ML agreed with the improved mood surrounding our BAME employees and was pleased to hear that MA was setting up a talent management structure for BAME staff. The Trust had some outstanding BAME clinical leaders. Examples were cited.
Unfortunately there were still some core issues for the BAME staff, particularly around experiencing bullying and harassment and the number involved in disciplinary action compared to white staff. This was a perennial problem, above benchmark and apparently worsening. It was important to recognise and address those challenges.
SL indicated that conversations were continuing to try to reach, support and give a voice to the individuals experiencing day-to-day micro-aggression. Greater understanding of the data was needed, and with LH on board the opportunity was there.

SS indicated that there was much for the new People Committee to consider, with a need to consolidate and understand all the data.
LL commented that it was important to look upstream at the number and proportion of BAME applicants, and the effectiveness of reaching out to the right applicants.
LL also indicated that the current report did not show trends, and that a format to show improvement or worsening would be useful.
LL was enthusiastic about initiating a project to use the Trust date to get deep inside what was happening within the Trust, with workforce being a suitable topic.
SL indicated that data played an obvious part, but that the “feel” of the organisation was key. He had spent two years through the pandemic listening to the Trust, which provided insight not available through data. He felt the Trust was in a good place, drawn from building relationships. Data would have its place in the new committee but it was about employee voice. SL reconfirmed his enthusiastic system-wide response in supporting the BAME leadership suggestion from MA as an example of listening to that voice.
LL indicated that he was happy to accept the conversation as unstructured data.

PS reconfirmed his sense of the change being made and thanked LH for the work underway, reconfirming the support LH had from all concerned. This work was fundamental to the moral obligation to people and underpinning our service delivery. Our BAME staff needed to be confident to deliver their best. The Trust needed to be inclusive to attract and deliver the best. The improvements and constructive challenge on this massive agenda was welcomed.

**The Board of Directors endorsed the report and commended the work thus far. The Board would continue to engage on this issue and the disability issue discussed in the previous item.**

## 115/21 BOARD ASSURANCE FRAMEWORK

PS indicated that the BAF refresh was nearing completion, aligning strategic risk to the new strategic objectives. The new BAF would be received in November with a better differentiation of strategic and operational risks.
An electronic system to modernise the Trust's handling of risk was being scoped.

The existing BAF had been under close exec scrutiny, resulting in the movement described in the report.
The BAF and CRR risk numbers and movement were set out.
Two high level risks remained relating to resource and capacity and CAMHS Tier 4. Work was continuing to mitigate those risks.

AS sought clarity with regard to what was intended in the new process to avoid misalignment between Corporate risk management and Board assurance and strategic risk management. The paper presented today did not make that, or the mitigation clear.
PS indicated that these concerns were the reason for the refresh, with seminars and work being undertaken with a consultancy as well as the risk team. This would achieve separation and clarity of pathways to enable deepening of risk management within the organisation.

SS welcomed the development and confirmed the wiilingness of the Board to engage with its production, including input on risk appetite and tolerance.

PS agreed to bring what had been developed to a Board seminar or workshop ahead of the November Board.
JD confirmed that Board time set aside on 27th and 28th October for Board development would now be repurposed for the seminar.
SS confirmed this could build on the previous work with Amberwing.

In response to AR-Q, PS indicated that whilst it was appropriate to close the EU Brexit risk, the business continuity, staffing and supply chain lessons learned were appropriate to apply to the more recently emerging pressures, and would likely be reflected in the new risk registers in some form.

**The Board of Directors received and noted the contents of the report and in particular**

- **Noted progress on the BAF refresh**
- **Noted progress on procurement of an electronic risk register**
- **Noted assurances to Executive Team and the Audit Committee**
- **Confirmed review of the risks identified in the BAF 2021/22 September summary) and approved the risk scores including recommended changes outlined taking account of actions by the BAF ET Sub-Group at its August meeting**
- **Approved the BAF risk closures and amendments iterated in the key issues and main report**
- **Noted the September (Q2) Key Performance Indicators**
- **Reviewed the risks identified in the CRR 2021/22 |August summary including actions taken by BAF ET Sub-Group at its August meeting**
- **Approved the CRR risk closures and amendments iterated in key issues and main report**

- **Identified any further risks for escalation to the BAF, CRR or Directorate risk registers**
- **Confirmed a separate Risk Seminar session would be held to cover the new BAF ahead of the next Board.**

**116/21 STANDING COMMITTEES**

**(i) Audit Committee**

JW confirmed the circulated written committee report and took the opportunity to welcome the intended pre-Board risk seminar to examine the risk management systems. This had been an Audit Committee concern, and time had been pencilled in to cover Risk Management, the Accountability framework and Governance Review.

From the report, the significant improvement in managing the fire risk was welcomed. This had been a long term concern. The governance and operational grip was now much greater and was likely to be reflected in future BAF editions. The fire report and JW's annual report were available.

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

**(ii) Charitable Funds Committee**

AS highlighted an altered application process for NHS Charities Together charity funding which was being taken forward.

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

**(iii) Finance and Performance Committee**

ML highlighted two matters, one requiring Board approval. £1m of the Trusts annual Capital programme (£14m) remained available for allocation. Priority 1 Estates and Safety schemes have been identified, in total amounting £0.9m in 22/23 with a £1.1m impact in 22/23. The Schemes had been shared with the Capital Group, L30 and Executive Team and had been supported. A request to progress these investments was agreed with the Trust Board to be kept informed as part of the F&P Assurance update.

The second item was an excellent report from Anthea Hockley and discussion on mandatory training. The report explored the curriculum, a post COVID full re-instatement, relative performance against other neighbouring Trusts, and the performance of the ESR system. The minutes recorded the outcomes but praise was owed to Anthea and her team for covering this huge area of work year on year.

**The Board received and noted the report, thanked the Workforce Development team, approved and endorsed the identified capital expenditure request and confirmed acceptance of assurance provided.**

**(iv) Quality Committee**

The Quality Committee report was considered. AS was happy to answer questions in the absence of RH.

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

SS took the opportunity to thank the Governor observers now attending the standing sub-committees for their attendance and diligent feedback.

**117/21 RISK ASSURANCE REPORTS**

**i) Covid 19 Assurance Report**

PS provided background detail in support of the circulated report, confirming a period of relatively stable COVID incidence amongst patients and staff with only occasional flare-ups. PS was grateful to staff and patients adhering to COVID precautions when elsewhere restrictions had been relaxed. It was right for healthcare settings to set the tone.
The Trust was preparing to be able to contribute to the national enquiry into COVID scheduled for Spring 2022.
The Trust was monitoring the position in the approach to winter because the behaviour of the virus was difficult to predict alongside the increase in vaccination.

**The Board of Directors noted the content of the report and confirmed acceptance of assurance given in respect of actions identified to mitigate risks.**

**ii) Ligature Risk Management**

PS presented the previously circulated quarter one Ligature Risk Management Report from the Ligature Reduction Group. This set out the actions underway. In May 2021, external auditors BDO were able to provide the Trust with substantial assurance over the design of the controls in place and moderate assurance on their effectiveness. PS paid tribute to TS and AG who had subsequently supported staff and improved the environment to continue to address this risk. The position was fundamentally different from the position a year earlier and staff knew and were confident when environmental improvements would be made, and were confident that issues raised would be addressed. More work was needed, but the shift was worthy of note. The improved culture of flagging and managing issues helped sustain the new confidence. The ligature issue was not resolved but had moved significantly for the better, with improving outcomes. The future schedule of works was being developed for the coming year.

SS paid tribute to the impressive level of investment and sustainable work undertaken in relation to the environment, culture and learning to address ligature issues at the Basildon unit, and the engagement and enthusiasm of staff. TS had been thanked and NEDs were encouraged to visit.

LL reflected that now this risk was beginning to be brought under control there was an opportunity to commission some research from the universities into national and international best practice on ligature management to incorporate into the Trust's approach. It could be that in addition to learning we may find we are outstanding in some areas.
PS indicated it was important to continue to focus on the basics and related assurance, but that NH was already working with Cambridge University Engineering Department, and this included an

international element. Also, SS was already working with Prof. Hepplewhite on therapeutic environments which encapsulated ligature risk. The journey had been started and would be consolidated.

AG confirmed her thanks to all those engaged with the process of designing out risk, adopting the right technical advances and refining practice.

NH confirmed that on behalf of the Trust that she was part of a national team, along with the CQC and National Patient Safety Agency, which had involved a literature review of world research papers on ligature risk. It was a difficult task to distil best practice because of varying international approaches to mental health provision. NH was presenting the Cambridge work to the Mental Health Safety Improvement Programme in the following week. This was a collaborative working to improve ligature risk nationally. National tools were being developed and EPUT was at the forefront of that work.

NH was thanked

**The Board of Directors received and noted the contents of the report and commended the ongoing work.**

**iii) EPUT Winter Planning 2021-22**

GB was welcomed and introduced the key points of the circulated EPUT Winter plan which addressed the service delivery and COVID plans into the winter period. This involved work with internal and system colleagues and was ongoing and evolving exercise..
Attention was drawn to seven key objectives, four key risks and a schedule of mitigation actions.

ML welcomed the systematic approach adopted but questioned the apparent absence of reference to the COVID and Flu vaccination programme, and the combination of the two. GB agreed to take that back.

NH reflected that the time related COVID booster schedule could act to limit the opportunity for timely flu injections if both were to be together. The flu programme was underway but would be challenging this year because of more remote working.

SS agreed the importance of the vaccination programme being reflected in the winter plan.

**The Board of Directors received and noted the plan and requested that the COVID and flu vaccination programme be included in the future plan.**

**118/21 STRATEGIC INITIATIVES**

**i) Mid & South Essex Community Collaborative - Transition to Decision-Making Form**

JWn was welcomed to the meeting.
PS indicated the importance of the point now reached whereby the Board was in a position and being asked to enable EPUT to play an equal decision making part in the MSE Community Collaborative Board. PS indicated his thanks to ML and JW who had steered the development of the proposals and transit through the Audit Committee to a point where they could now be agreed.

JWn indicated that the proposal and supporting paper provided the EPUT Board of Directors with the

opportunity to review and approve the terms of reference and emerging governance arrangements for the Mid and South Essex Community Collaborative, and thereby enable the Mid and South Essex Community Collaborative Board to immediately transition into a decision-making forum comprising its partners, EPUT, NELFT and Provide. This built upon the decisions and ongoing work since the spring of 2021 to establish a collaborative approach to community health provision in Mid and South Essex amongst the three organisations.
The paper outlined the transition of the existing advisory Board comprising the Chairs and CEOs to a decision making forum with a wider operational footprint and associated emerging governance structures.
This would involve confirming delegated decision making authority on the new Board to CFO in relation to financial matters and CEO up to the limits set out in the paper and on an equal footing to NELFT and Provide. It also sent a clear message to the system and beyond about the intent to work together, and provided a foundation to explore further options and commissioning approaches.
The request was approval of a transition to decision making status and approval of the enabling Terms of Reference for the new Board.

TS confirmed that this had been a positive exercise, with an agreed harmonised approach now reflected in a revised set of SFIs and SoRD which had been approved both informally via ML and JW and formally through the Audit Committee. This enabled alignment with EPUT governance rather than an overriding it. Assurance could be taken from the work done.

JW supported TS. The delegated limits for Executives hadn't changed but there was now a focus on collaboratives. ML endorsed the proposals and commended the transparency and sharing across the NED groups of the three organisations.

As Chair of the Collaborative Board SS commended the open sharing of ideas and purpose that had moved things forward in a cohesive way. SS extended her thanks to all involved and reflected upon the opportunities on the ground to develop services and widen the involvement of local government in the Collaborative.

JWn welcomed future opportunities to update the EPUT Board on developments and confirmed that against recent national guidance the Collaborative had matured well.

**The Board of Directors noted and approved the contents of the report and unanimously**

- **Agreed the transition of the community collaborative board to decision-making status**
- **Approved the Terms of Reference for the Community Collaborative Board in decision making form**

**ii) New Strategic Objectives and Accountability Framework**

PS introduced a previously circulated paper requesting that the Board agree the new vision, purpose, set of strategic objectives and values for the Trust, along with noting and endorsement of the new Accountability Framework.

Presented for agreement in the paper were

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

**Purpose**
We care for people every day. What we do together, matters.

**Strategic objectives**
1. We will deliver safe, high quality integrated care services.
2. We will enable each other to be the best that we can.
3. We will work together with our partners to make our services better.
4. We will help our communities to thrive.

**Values**
1. We care
2. We learn
3. We empower

These values were underpinned by openness and transparency which were the key pillars of the new Accountability Framework, endorsement of which was also sought.

PS confirmed the leadership of TS and AG in the development of the Accountability Framework, and also the leadership of TS in the development of the Strategic Objectives. The Strategic Objectives were distilled in the circulated paper. This had been hard work and not just an exercise in coming up with some Strategic Objectives and a vision, purpose and values. It had been the result of engagement with our colleagues and stakeholders. This is why it had taken some time, but the objectives reflected not just the views of the Executive team and Board but of those important to our service provision and what EPUT needed to achieve.

The theme of engagement would continue and the document would not be sent out to our stakeholders and colleagues as seen now, but would be put together with a new brand and distinguishing new look to separate the future from the past, and which would connect with the feelings of those connected with the process. This would include videos from those involved, and going out to colleagues and stakeholders as a Board to confirm that we have heard from them.

Next, all the work being done today would be connected back to those Strategic Objectives. Gaps would be explored, and enabling strategies would be returned to the Board. Those for IT, HR and Comms would be critical to delivery over the next three to five years. PS wholeheartedly recommended adoption and commended the process led by TS leading to the objectives.

TS additionally thanked GJ for facilitating the development of the Strategic Objectives and Accountability Framework. It had been a team effort and thanks were also extended to the Board and Governors for their engagement and contribution. It had been an extensive exercise.

The Accountability Framework was up and running and would evolve, and would prove productive over time. The Framework was designed for Executive oversight as part of the discharge of their duties and the delivery of the Strategic and Corporate objectives. This was focussed on patients, people, external relations and finance, including positive aspects for promoting achievements and best practice more widely. It supported clinical and operational leadership, integrated discussions and future planning. Thanks went to the Executive team and particularly AG, NH and SL who were all active in those meetings.

NH confirmed the inaugural meetings had been welcomed by the attendees as had the patient focus. The common grounding and voice would be valuable when sharing outcomes within EPUT.

AG had also been heartened by the collective conversations. These drew together the clinical, operational and support functions and focussed accountability on service provision. Our leaders had welcomed the opportunities to share new approaches and the enhanced autonomy. This allowed a different conversation with the Executive, including a sharing of concerns and action. In the future

this would allow a different conversation with commissioners and stakeholders on quality and integration.

SL welcomed the positive influence and anticipated this would change culture. This needed to be embedded and brought to life off the page, which was where SL's teams came in. There was some great video material, a new behaviours toolkit and an appraisal process going through the Trust. The task was to link current personal objectives to the new strategic objectives so there would be a constant flow of which everyone is aware. The Marketing and Comms team had a big role in that and had done amazing work with the branding.

LL thanked the Executive for pulling these objectives and measures together. It would be helpful to paint a picture of how all the measures hung together so that there was cross-Trust understanding of the potential impact of action in one area affecting another. This might not always be obvious in a large organisation but would build cohesion.

SL supported LL and confirmed the new behaviour toolkit supported the cross-functional working to bring the values and behaviours to life. It was important that front line staff were the first, and not the last to know of any changes, and that they were engaged rather than told.

TS confirmed that the Accountability framework was a two-way discussion. The initial metrics presented were developing and would evolve. These would define an informed conversation which would make it clear who was doing what, when and when there would be a return to trajectory. The greater specification and transparency would help resolve some longstanding issues. It would also enable good work to be shared internally to colleagues and externally to system partners.

AR-Q sought clarity as to how Divisions would know how well they were performing and developing. TS agreed to share the developing position on RAG ratings etc with AR-Q and NEDs in the informal sessions, and to involve NEDs in the development so that clarity was achieved. SS indicated her expectation that the F&P Committee would also be involved and would feedback in a dynamic way.

ML welcomed the Accountability Framework and noted its ambitious nature and therefore the value of the scheduled Q4 review.
ML reflected that monthly meetings focussing on RAG ratings might not provide sufficient movement to maintain the required dynamism for the meetings to remain meaningful. Secondly, ML asked if the Accountability Framework provided an opportunity to refine the information scorecards and KPI reporting generally, possibly into one report for the Trust.
TS confirmed this initiative ought to reduce and rationalise the number of meetings held elsewhere because of the opportunity for collective and rounded discussions. The discussions would be data prompted but not dominated, and the structured and unstructured elements would develop over time. The aim was to triangulate a number of key sources of data which were currently separated and to be action focussed.

LL offered his professional expertise in building and reviewing executive dashboards. This was welcomed.

PS reflected that when the Framework was operationally embedded it would usefully inform both the F&P and Quality Committees, potentially improve how they worked and provide enhanced assurance to the Board.
SS reflected from experience the importance of the process being alive and meaningful, and it would not always be comfortable. The need was to learn together and understand the value in driving change.

**The Board of Directors commended the work and engagement undertaken, noted and approved the requests within the supporting report, and particularly the Vision, Purpose,**

**Values and the Strategic objectives along with the supportive framework to bring these to life.**
**The Board also noted and endorsed the Accountability Framework and its core supporting principles and values as the way forward for Executive and management oversight of the work of the Trust.**

**119/21 REGULATION AND COMPLIANCE**

**i) Review of SFIs and Standing Orders**

TS introduced the item and confirmed the suite of Governance documents had been reviewed by the Trust teams and compared with other Trusts. They had been adapted to reflect the needs of wider collaboration. Board approval was given following recommendation by the Audit Committee.

**The Board of Directors noted the contents of the report and approved the**

**Standing Orders for The Board Of Directors**
**Standing Orders for The Council Of Governors**
**Standing Financial Instructions**
**Scheme of Reservation and Delegation**
**Detailed Scheme of Delegation**

**ii) CQC Compliance Update**

PS introduced the update report and specifically flagged the remedial actions and outcomes in relation to the CAMHS service, concerns about which were raised by the CQC and restrictions imposed. Work was continuing within the Trust, and system partners and the CQC to enable imminent re-opening.

Along with the Accountability Framework the Trust was enhancing the internal compliance processes and reporting to help the areas most in need of support, and to assist focussed work with the compliance team.

In response to consultation it was likely that the future CQC regulatory regime would be more flexible and proportionate to risk.

JW thanked PS, TS and all the Executive team for keeping the NEDs informed and updated throughout on the CAMHS difficulties and solutions. Governors could take assurance that NEDs have been fully involved and engaged in the conversations.

SS endorsed the thanks on behalf of the Board. AG indicated that the CQC had been assured by the work undertaken so far to remove the restrictions, and phased and controlled admissions were anticipated in early October.

AR-Q confirmed that additionally the CAMHS issue and re-opening had been closely monitored by the Board Safety Oversight Group. As confirmed by AG, admissions would be clinically led, controlled by the Consultants, and would be measured and cautious.

**The Board of Directors received and noted the contents of the report and verbal updates.**

**iii) Emergency Preparedness, Resilience and Response (EPRR) National Core Standards Return 2021**

PS confirmed that the circulated paper was to provide Board assurance that the Trust was compliant with the core standards in relation to emergency preparedness. The Trust has reported full compliance to NHSI/E and this will be assesed in a "confirm and challenge" meeting shortly, when any shortfalls will be identified for action and reported to the Board if required.

**The Board of Directors received and noted the contents of the report and verbal update.**

**iv) CP15 – Code of Conduct for Members of the Board of Directors**

JD introduced the three yearly review of the Board of Directors Code of Conduct and indicated that whilst some useful additional material from the Good Governance Institute had been introduced to the Code, it was essentially the same as in previous years, with some small additions to reflect virtual working. JD sought re-approval, with permission to include and refer to the new vision, purpose, objectives and values agreed in the meeting as necessary without re-referral .

**The Board of Directors received and noted the contents of the report, and agreed its adoption of the Code of Conduct, inclusive of any amendments required to reflect the new Trust vision, purpose, objectives and values.**

**v) Chair and Chief Executive Officer: Division of Responsibilities**

SS introduced the previously circulated paper on the Chair and Chief Executive Officer division of responsibilities. Board approval was sought for the schedule of responsibilities as shared, which had been produced as an essential element of the regular cycle of document review for governance purposes.

**The Board of Directors received and noted the contents of the report and approved the Division of Responsibilities presented.**

**120/21 USE OF CORPORATE SEAL**

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

**121/21 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING**

There were no items of correspondence circulated to the Board.

**122/21 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING**

There were no new risks identified to be added to the Risk Register, nor any items that should be removed that were not discussed as part of the BAF discussions. It was recognised that in due course a revised BAF format would be presented and that this would need to reflect current supply chain pressures.

**123/21 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS**

SS reflected that the WRES and WDES discussions had been insightful and demonstrated the depth of thinking and ambition to move forward.

SL indicated that equality and equity was embedded in all the Trust thinking, not only in relation to our colleagues, but also the people we serve.
SL also confirmed the discussion on the new values of Caring, Learning and Empowering and gave an assurance that Openness still flowed through all of those. It was about the narrative behind that. The Board had shown openness in its discussions about equality and equity today.

**124/21 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIREMENT)**

It was noted that all Board members had remained present during the meeting and heard all discussions with the exception of ML, SL and NH, each of whom was absent for period of a few minutes only, and insufficient for them to have become detached from the business of the meeting and flow of debate, or to limit their contribution.

**125/21 ANY OTHER BUSINESS**

There was no other business.

**126/21 DATE AND TIME OF NEXT MEETING**

SS thanked all for joining the live broadcast.

The next meeting of the Board of Directors is to be held on Wednesday 24th November 2021, 10:30am, at the Lodge, Lodge Approach, Wickford, Essex, SS11 7XX.

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

The following meeting thereafter would be 26th January 2022.

The AMM would be 1st November 2021, which was positively anticipated.

**127/21 QUESTION THE DIRECTORS SESSION**

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

SS took the opportunity to wish John Jones, Lead Governor, a speedy recovery and return from what would, hopefully, be a short period of illness. He had been missed in the meeting but thanks was extended to Pippa Ecclestone, Deputy Lead Governor, who had stepped up.

SS thanked all who had attended and taken part.

The meeting closed at 12:54.

Signed: …… Date: ……

**Appendix 1: Governors / Public / Members Query Tracker (Item 127/21)**

| Governor / Member / Public | Query | Response provided by the Trust |
|---|---|---|
| Mark Dale | MD welcomed the work reflected in the WRES and WDES reports, and sought assurance that not only would there be interconnectivity between these strands of work but that there would also be work to include other groups including the LGBT+ Community and others. This was so that a combination of characteristics could be positively accommodated. | This observation was welcomed by PS.<br><br>SL enthusiastically reconfirmed the importance to “Be You”.<br><br>SL introduced Lorraine Hammond, Director of Equality and Inclusion and emphasised the thread of interconnectivity that would be developed by her throughout the Trust activities. “Be You” encouraged an approach that encompassed all aspects of each multi-faceted individual. SL encouraged a meeting between MD, LH and himself. |
| Pippa Ecclestone | PE had raised the need for clarity of the previous minute “scaling out resource for low lying members”. | This had been mentioned earlier in the meeting. JD confirmed he would seek and forward an explanatory response. |
| Pippa Ecclestone | PE indicated that the response to her query at the previous meeting arising from the CEO Report and performance scorecards concerning<br>5 areas requiring improvement’ did not reflect the Essex STARs position or give further detail on the issues that required improvement | AG apologised for her previous response concentrating only upon IAPT. STARS was only one of the indicators where there was underperformance. This related to the physical health of patients on a joint pathway. Currently performance was 73.8% against a national benchmark of 95%. This is COVID related and reflected the need to restrict staff and patient numbers in our venues. The physical health checks had been reviewed to establish and introduce what can be achieved remotely. Estates had been working to find venues to smooth pinch points such as at Harlow, but the adoption of the SOS bus for vaccinations had highlighted the competition for resources. AG was confident there would be improvement. |

Signed: …… Date: ……

| | | |
|---|---|---|
| Pippa Ecclestone | Regarding Ligature Risk Management, the ELFT report highlights good practice and provides some recommendations for consideration. Will governors/the public be able to find out about the contents of this report, particularly the recommendations? | NH was happy to have a conversation with PE, but following a national safety alert organisations were asked not to put information into the public arena which could provide information potentially leading to a negative impact.<br>NH was able to report that in a recent external review ELFT considered the EPUT systems policies and assessments to be robust and wanted to adopt some themselves. A highlight was to engage clinicians to take greater ownership. |
| Stuart Scrivener | Regarding Ligature Risk Management, I am really pleased that we are focusing on the staff training around the ligature risk. I can see that this will do its part in reducing risk to our patients. However, can I ask if you are happy that we are addressing the underlying ligature risks in our buildings. What is the status of door top alarms, box windows, door handles etc? What steps are we taking? | SS indicated her hope that the discussion held in the meeting and work undertaken by PS, SS and others on the environment would provide assurance on the grip held on ligature issues by the Board members. This would be ongoing. NH confirmed that there had been strong accounts of the work estates were doing and delivering to improve the environment and clinically there was clear focus. The whole organisation was engaged. EPUT was linking into national work-streams and as an innovation pathfinder. It was something the Trust needed to keep its eyes open upon, and to learn from dynamic developments.<br>TS confirmed the weekly oversight provided by ESOG and monthly by BSOG where ligature risk reduction was a key area. Estates had accelerated programmes of work into 2021. There was more to be done but there was greater clarity on what needed to be done and expedited. |
| Stuart Scrivener | With regard to the CQC concerns regarding CAMHS, was AG satisfied with the work and resource being applied to resolve them, and to avoid potential future issues ? | AG indicated that the current discussions would have addressed this in part. There had been intense focus on the areas raised by the CQC and we had excellent assurance at the service and Executive levels.<br>Sustainability was dependent upon a daily risk assessment to identify areas for escalation and also the engagement of system partners to provide the right alternatives to CAMHS admissions. This involved cross system working, but AG was assured on progress to date. The position was positive and the Trust could move forward with caution.<br>AR-Q endorsed the assurance from AG and re-confirmed the careful oversight provided by ESOG and BSOG. The care that needed to be taken meant that solutions were not always rapid, but were measured in order to stay sustainable. |

Signed: …… Date: ……

In the Chair

| | | |
|---|---|---|
| Paula Grayson | Regarding the F&P assurance document, previously I asked the Finance people who were kindly speaking to us if we had been assigned, and then able to make use of the Mental Health Investment Standards funding. At the time the answer was positive. We appear to have an underspend on it now. Can someone explain please? | TS indicated the underspend was as a result of slippage in scheduled recruitments. Options to use those underspends were being looked at. It would have further Executive discussion and then be placed into the system over the next two weeks in the form of further recruitment initiatives. Innovative methods would be employed and the aim was to spend fully to greatest effect. |
| | | |

Signed: …… Date: ……

**ESSEX PARTNERSHIP UNIVERSITY NHS FT**

**Board of Directors Meeting**
**Action Log (following Part 1 meeting held on 29 September 2021)**

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

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

| Minutes Ref | Action | By Who | By When | Outcome | Status Comp/ Open | RAG rating |
|---|---|---|---|---|---|---|
| **March 033/21** | People Plan to be updated to include:<br>1. Review of the recruitment process to ensure staff can be recruited into post more quickly.<br>2. Details of the plans to introduce the role of Associate Practitioner. | SL | ~~July 2021~~ November 2021 | This action has formed part of the HR review which is due for completion in June 2021.<br><br>**Update 28.07.2021**: there is a lot of work being undertaken following the HR review and therefore the Board agreed the action is deferred to November 2021.<br><br>**Update 18.11.2021**<br>The specific areas identified by the Board were added to | Closed | |

| Minutes Ref | Action | By Who | By When | Outcome | Status Comp/ Open | RAG rating |
|---|---|---|---|---|---|---|
| | | | | the plan and have been taken forward. Further updates will be provided at future meetings. | | |
| **March 035/21** | Refreshed Board Assurance Framework To be presented to the Board of Directors in July 2021 in line with refreshed Strategic Objectives. | PS | ~~July 2021~~ ~~Sept 2021~~ Nov 2021 | **Update 28.07.2021:** BAF refresh unable to take place until Board of Directors have approved strategic objectives. Timescale for strategic objectives is presentation to TB in July 2021. Therefore BAF refresh will aim for September TB. Work is underway on refresh using draft objectives and taking into account learning from Amberwing sessions.<br><br>**Update 29.09.2021**<br>Strategic Priorities to be approved at 29th September Board and to be reflected in new strategic BAF to be presented in November.<br><br>**Update 16.11.2021**<br>BAF refresh paper submitted under part 2 with new proposed strategic risks. Once agreed, this will be reported to Part 1 Board going forward. | Open | |
| **March 040/21** | Engagement Strategy to be reset and presented to the next Board of Directors meeting. | SL | ~~May 2021~~ ~~July 2021~~ ~~November 2021~~ January 2022 | Part of the HR review which will be completed in June 2021.<br><br>**Update 28.07.2021**:<br>There is a lot of work being undertaken following the HR review and therefore this action is deferred to November 2021. | Open | |

| Minutes Ref | Action | By Who | By When | Outcome | Status Comp/ Open | RAG rating |
|---|---|---|---|---|---|---|
| | | | | **Update 18.11.2021**<br>The Engagement Strategy for public involvement has been developed and presented to Executive Team. This will be presented to PECC in December 2021 for formal presentation to the Board for ratification in January 2022.<br><br>The Engagement Strategy for Workforce is delayed by the ongoing work to recruit to the People & Culture structure. The Organisational Development Director once in post will be accountable for taking forward new strategies, including a workforce engagement strategy. Therefore, it is requested this element of the action is.<br><br>The new People & Culture structure is being recruited to. The organisational development director will be accountable and own the people strategies. This will also include a Workforce Engagement Strategy. Request extension until April 2022 to allow this to happen.<br><br>The Engagement Strategy for the Workforce will be taken forward separately and an update will be provided at a later meeting extended until April 2022. | | |

| Minutes Ref | Action | By Who | By When | Outcome | Status Comp/ Open | RAG rating |
|---|---|---|---|---|---|---|
| **July 090/21** | Disciplinary (Conduct) Policy and Procedure – approved in principle however further development and articulation of equalities piece and guidance for managers when it is believed an allegation to be malicious to be included. | SL | ~~September 2021~~ ~~November 2021~~ January 2022 | Deputy Director of HR is currently in the process of liaising with Non-Executive Director to gain further insight into the "further development and articulation of equalities' piece"<br><br>**Update 18.11.2021**<br>The Head of ER is reviewing the Disciplinary (Conduct) Policy and Procedure with the Director of Equality, Diversity and Inclusion to ensure the development and articulation of equalities are included – target date 31 December 2021.<br><br>The disciplinary decision tool has been updated to ensure that any fact finding establishes prima face evidence of misconduct before progressing to a full investigation.<br><br>Making malicious allegations is covered within the Dignity, Respect and Grievance Policy and Procedure (bullying). | Open | |

| | | |
|---|---|---|
| | | **Agenda Item No: 5** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

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

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

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

**Recommendations/Action Required**

The Board of Directors is asked to:

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

**Summary of Key Issues**

The report attached provides information in respect of:

- EPUT Child and Adolescent Mental Health Services (CAMHS)
- Service Visits
- Essex Mental Health Independent Inquiry
- Kelvedon Ward Reopening
- Annual Members Meeting

- Occupational Therapy Degree Apprenticeship Pathway
- Black History Month
- EPUT Service of Remembrance

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

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

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

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| CQC | Care Quality Commission | CAMHS | Child and Adolescent Mental Health Services |
| NED | Non-Executive Director | CEO | Chief Executive Officer |
| TILS | Transition, Intervention and Liaison Service | | |

| Supporting Documents and/or Further Reading |
|---|
| Accompanying Report |

| Lead |
|---|
| **Professor Sheila Salmon**<br>**Chair of the Trust** |

**Agenda Item: 5**
**Board of Directors Part 1**
**24 November 2021**

# CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

## 1.0 PURPOSE OF REPORT

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

## 2.0 CHAIR'S REPORT

### 2.1 EPUT Child and Adolescent Mental Health Inpatient Services

As reported at the last Board of Directors, the CQC has published their full report following their visit to EPUT Inpatient CAMHS services in May 2021 which advised that until improvements had been made we should temporarily stop new admissions to Larkwood Ward, Longview Ward and Poplar Unit. The Trust took immediate actions to improve safety and I am delighted that Poplar Ward is now able to admit new patients and we expect that Longview and Larkwood wards will follow shortly. Patient safety remains our highest priority and we continue to work closely with the CQC and our partners to further improve standards at these units.

### 2.2 Service Visits

As reported previously, the NEDs and I have recommenced in person visits to services across the organisation. We have received a warm welcome from our staff and have witnessed the dedication and commitment they have to caring for our vulnerable patients. Recently visits have taken place to the Health and Wellbeing Service for Vulnerable Adults in Ipswich which services Norfolk, Suffolk and now reaches down into Essex; Kitwood and Roding Wards at St Margaret's Hospital; Bernard and Tower Wards at Clacton Hospital and Robin Pinto Unit in Luton.

### 2.3 Essex Mental Health Independent Inquiry

The Essex Mental Health Independent Inquiry will review inpatient mental health deaths from 01 January 2000 to 31 December 2020 at the former NEP and SEPT, as well as EPUT which took over following the merger in 2017. The Inquiry team have announced its first call for evidence – families, friends and carers of inpatients who died are invited to give evidence to the Inquiry about what happened to their loved one. Members of the public with experience of mental health inpatient services in Essex are also invited to give evidence and over the coming months there will also be the opportunity for staff to take part and give evidence. Patient safety remains our top priority and is at the forefront of everything we do at EPUT and we have already made significant investment to improve patient safety. Support services are in place for colleagues that may have any concerns.

### 2.4 Kelvedon Ward Reopening

Following my recent visit to the newly refurbished Kelvedon Ward, I am delighted that the new ward is now open to new admissions. The opening of this ward completes the final phase of the programme to remove dormitory style accommodation across the Trust. I was hugely impressed by the renovations to create a modern ward that provides the best and safest environment possible for our patients.

### 2.5 Annual Members Meeting

Our Annual Members Meeting was held recently and was attended by more than 60 people from EPUT, partner organisations and the local community. The event, held virtually by

Microsoft Teams, reflected on some of the achievements over the past year and looked ahead to our plans to drive forward improvements to patient safety.

**2.6 Occupational Therapy Degree Apprenticeship Pathway**

Eight of our staff members have begun their exciting journey to train as occupational therapists via an occupational therapy degree apprenticeship pathway. They will join our seven current occupational therapy apprentices. We wish all of our apprentices the very best of luck with their studies.

**2.7 Remembrance Service**

Our CEO Paul Scott opened a Remembrance Day Service led by our Head of Chaplaincy and Spiritual Care, Paul Walker and other colleagues for a time of remembrance. This event provided an opportunity to reflect and remember those that have died in service and included poetry readings and observation of the national two minutes silence. Armed Forces Champion and Regional Lead for our Transition, Intervention and Liaison Service (TILS) joined by video and described how the service supports armed forces personnel approaching discharge, as well as veterans, and aims to reintegrate service users into everyday life by helping them access therapy for anxiety, depression and post-traumatic stress disorder.

**2.8 Black History Month**

I was delighted to hear that many of our services held celebrations for Black History Month including sampling traditional food and drinks, music, dancing, quizzes and cultural awareness sessions, helping colleagues to understand and respect cultural diversity.

## 3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

**3.1 New NHS Flexible Working Rights To Improve Work-Life Balance and Retain Staff:** Please see below a copy of the handbook that came into effect on 13 September 2021 that will make flexible working a more realistic option for staff in all roles. **For Information: Link**

**3.2 Thousands Of Black, Asian And Minority Ethnic Staff In Mental Health Trusts Experience Harassment, Bullying or Abuse At Work, New Analysis Finds:** Please see the first link below for a copy of the report published on 9 September 2021 that outlines that a third of ethnic minority employees have experienced harassment, bully or abuse at work from patients, family members and the public. The second link is a copy of The Royal College of Psychiatrists Equality Plan and the third link is a copy of the Royal College of Psychiatrists Mental Health Watch tool that can be used to view data on individual Trusts. **For Information: Link; Link; Link**

**3.3 Record number of children and young people referred to Mental Health Services As Pandemic Takes Its Toll:** Please see the link below for a copy of the report published on 23 September 2021 that outlines the 134% rise of 0-18 year olds referred to children and young people's mental health services. **For Information: Link**

**3.4 RcPsych Advocates For Further Progress In Perinatal Mental Health Services:** Please see the link below for a copy of the report published on 21 September. The report states that the period during pregnancy and a child's first year of life can be a period when mothers and fathers are vulnerable to mental health issues.

**For Information: Link**

## 4.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

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

Report prepared by

Angela Horley
PA to Chair, Chief Executive and NEDs

On behalf of
**Professor Sheila Salmon**
**Chair of the Trust**

| | | |
|---|---|---|
| | | **Agenda Item No: 6** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

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

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

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

**Recommendations/Action Required**

The Board of Directors is asked to:

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

**Summary of Key Issues**

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

| Relationship to Trust Strategic Objectives | |
|---|---|
| SO1: We will deliver safe, high quality integrated care services | 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:**<br>**Capital £**<br>**Revenue £**<br>**Non Recurrent £** | | | |
| **Governance implications** | | | x |
| **Impact on patient safety/quality** | | | |
| **Impact on equality and diversity** | | | |
| **Equality Impact Assessment (EIA) Completed** | **YES/NO** | **If YES, EIA Score** | |

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| CAMHS | Children and Adolescent Mental Health Services | JCVI | Joint Committee on Vaccination and Immunisation |
| HCA | Health Care Assistant | CCG | Clinical Commissioning Group |
| CEO | Chief Executive Officer | ICB | Integrated Care Board |
| PMO | Project Management Office | YTD | Year To Date |
| MHIS | Mental Health Investment Standard | IR | International Recruitment |
| NBS | National Booking System | NMC | Nursing and Midwifery Council |
| OOA | Out of Area | CQC | Care Quality Commission |

| Supporting Documents and/or Further Reading |
|---|
| Accompanying Report |

| Lead |
|---|
| **Paul Scott**<br>**Chief Executive Officer** |

**Agenda Item: 6**
**Board of Directors Part 1**
**24 November 2021**

# CEO Report – November 2021

## 1.0 Introduction

I write this report as we enter the winter months. This means that the NHS, and EPUT, are entering into the period that is, historically, our busiest time. It is clear that a combination of reopening of society, winter bugs, and the need to catch up on the elective back-log mean colleagues across health and care anticipate this to be one of the most challenging winters on record. The incremental toll of living through a pandemic is affecting many colleagues across health and care, which undoubtedly adds to the challenges this winter.

We will not be complacent – staffing numbers are, and will remain for some months, the presenting issue raised when I speak to colleagues across the organisation. We have ambitious and creative plans in place to alleviate the pressure – both in terms of recruitment, retention and making day to day life easier for our frontline colleagues.

With these pressures in mind I remain in awe of colleagues across EPUT who continue to go the extra mile for our patients. The sense of collective endeavour across the organisation is palpable. With this collective compassion and "team-ness" our staff turnover is relatively low and we continue to be able to attract colleagues to join us. This month we will have welcomed an equivalent number of nurses and HCA's than the last 3 months combined.

The leadership team in the organisation will be making additional effort to support, and recognise, all colleagues over the coming months. I want to take this opportunity to thank all colleagues across the EPUT family for their resilience, compassion and dedication to our patients.

We are not alone in facing these challenges and we are working very closely with acute care, primary care and social care providers, as well as our partners in MH and community care, to support all sectors as best we can. The work we have done to build trust and relationships is a strong platform to face the challenges of this winter and has allowed us to develop a comprehensive winter plan that will see increased capacity in our crisis and primary care services.

Many of our partnerships across Essex, and neighbouring counties, will be formalised by the formation of Integrated Care Boards (ICB) in April when the Health and Care Act is implemented. Recruitment has taken place over the last few months for the role and CEO of these new statutory organisations. I would like to offer my congratulations to Anthony "Mac" McKeever who has been appointed to the role of CEO designate for the Mid and South Essex ICB. Mac has been Accountable Officer for the five CCG's in Mid and South Essex and he has been a great supporter, as well as a critical friend, of the work that EPUT is doing.

I also want to offer my condolences to the family of Sir David Amess MP. Sir David was a deeply respected MP, both nationally and locally, and was a great advocate for the users of EPUT services. I know colleagues and service users across the County of Essex will miss him.

## 2.0 Key Issues

**Strategic Objectives and Accountability Framework**

**Safety**

A detailed update is elsewhere on the agenda. We will be bringing a comprehensive annual review against the first year delivery progress at the January Board.

The Executive Team continue to focus on the four priorities (Staffing, Learning, Observation and Engagement and Ligature risk reduction). On the basis of what colleagues have told us we will be introducing a fifth area of focus based on making sure our bed base is used to the best effect. This is based on staffing pressures we face, the needs of the patients that are presenting to us and increased demand for our inpatient services.

As well as delivering a comprehensive ligature reduction programme our Estates teams have improved a number of wards in North East Essex and have completely refurbished two wards in our Basildon unit. These improvements are making a huge difference to the environment for patients and colleagues.

Our accountability framework meetings are now in place and offering an improved platform for conversation, and action, between the Executive Team and clinical services on matters of safety.

We are implementing a new operational structure to ensure our leadership time is appropriately focussed on safety and we will be investing in clinical leadership to join operational leadership teams.

**Vaccination Programme**
Our vaccination teams continue to be incredibly responsive in this fast moving environment.

Our school age immunisation teams have stepped in to offer Covid-19 vaccinations to the 12-15 year old age group across Essex and Bedfordshire, Luton and Milton Keynes. The speed and flexibility of their response to this ask has been incredible and a huge thank you to everyone involved.

Our adult Covid-19 vaccination services continue to deliver across Mid and South Essex and Suffolk and North East Essex integrated care systems and are now busy delivering booster vaccines as well as first and second vaccines.

By the time the Board meets, our teams would have administered over 1million vaccines. From a standing start this is an incredible achievement and has played a massive role in improving public health during the pandemic. Thank you and well done to all colleagues whether you are a permanent employee, someone who has returned to work or joined us temporarily or one of our incredible volunteers.

**Children's and Adolescents Mental Health Tier 4 Inpatient Services (CAMHS) CQC report**
Our teams have worked incredibly hard to stabilise the service by reducing reliance on agency staff, implementing some rapid estate enhancements and delivering significant improvements in compliance. We have been very successful in recruiting in an incredibly challenging market and I am delighted that we have been able to add 11 health care assistants, eight nurses and one consultant to our fabulous teams.

With these improvements we have been able to reopen to some admissions and will look to increase our capacity incrementally over the coming weeks.

## 3.0 Performance and Operational Issues

**Safety and Quality – Natalie Hammond, Executive Nurse**

**Safety and Quality**

We continue to make significant progress on the opening of our CAMHS wards and delivery of our plan. Poplar Unit successfully re-opened for admissions following the CQC partial lifting of the S31 on the 11 October with an agreed maximum of one admission per week.

Longview Ward will now follow the same process and will re-open pending clinical decision and CQC approval. As a planning assumption we are working towards an end of November opening.

Through a successful recruitment campaign, across our CAMHS wards we have recruited 35 new members of staff in seven different disciplines. This has meant we have been able to decrease our dependency on bank and agency staff. In addition to this, we have only had one member of staff leave during the S31.

In order to ensure focus and Executive engagement, we have agreed a fifth safety priority, Patient Flow which will encompass personality disorders, community flow, flow processes, out of area elimination and inpatient modelling.

The four areas of quality improvement have in place steering groups or sub-committees. All of which have been re-set and reformed with driver diagrams, work plans & agendas and had their metrics for monitoring set for improvement. Currently these groups and committees are all showing good progress against their defined metrics.

For example, the number of prone restraint incidents continues to be the lowest they have for 24 months, the number of inpatient falls are below that of January 2021, and pressure ulcers have declined steadily since January 2021 now at the lowest in at least 24 months.
We have the following priorities for the next period:

- Establishing processes for capturing, measuring and reporting on some of our new and hard-to-measure outcomes
- Establishing a regular reporting rhythm so that we can report more easily on the strategy's outcomes and measures
- Formalising quality improvement activities into a single programme for better co-ordination and use of resources
- Completing quality frameworks and action plans for the four priority areas
- Mapping and streamlining governance to make best use of resources while maintaining oversight and accountability. The Trust's Accountability Framework will address this strategically and we will ensure it is implemented at a local level within teams in Nursing, Medical and Operations.
- The reasons for the spike in physical intervention and seclusion are understood, but a deep dive review into this area is planned to build on the success of the overall direction of travel towards fewer instances of physical intervention and seclusion.

The Transformation PMO have been working with the Executive team to capture our key activities both running and delivering in this financial year. These activities have been mapped to our Strategic Objectives and a set of themes for reporting purpose. These themes include, Safety, Alliances & Communities, Strategies, People & Culture and Key Enablers.

**Finance – Trevor Smith, Executive Chief Finance and Resource Officer**

***H2 Planning:***

- The ICS has submitted its financial plan for the second half of the year (H2). The plan has been supported by the Regional office. The plan is a breakeven plan.
- The Trust's financial H2 plan was a component of the ICS H2 plan and was approved under delegated authority. Following the ICS submission a more detailed organisation plan is required by 25 November. This plan is scheduled for Board approval and subject to approval

will be the basis of H2 internal budgets. The plan includes increased resource to meet H2 liabilities with the Trusts annual turnover rising to £422m. The Trust is further developing its efficiency programmes for 22/23.

***Month 7 Results.***

- YTD actual deficit is £32k remaining consistent with Month 6 (M6) results.
- In month temporary staffing was £5.5m (£6.8m in M6). The decrease in spend is mainly due to the impact of pay award in M6 with some underlying improvements in service areas.
- In month COVID spend was £1.2m (£1.0m in M6) bringing the YTD spend to £9.7m.
- In month Mass Vaccination Program spend remained consistent at £2.1m with YTD spend to £14.5m.
- YTD MHIS spend is £7.1m with the YTD underspend being £1.4m.
- The Trust has delivered £3.5m of efficiency savings.

***Capital and Cash***

- Annual plan £14.4m. YTD spend £4.1m. Cash balances remain sufficient for trading activities.

**Operations – Alex Green, Executive Chief Operating Officer**

During October, there were 28 performance and quality indicators within target and four areas of inadequate performance. This is a positive reduction on inadequate performance indicators due to CPA reviews sustained recovery and target attainment for three months. There were nine performance and quality indicators which require improvement, this is a reduction on last month, and no change in the number of indicators at variance with local targets.

There were no days at OPEL 4 in October however adult mental health occupancy rates, average length of stay, and delayed transfers of care have risen and are outside of national benchmarks, as have the number of our patients placed in inappropriate Out of Area (OoA) beds. There is significant work underway to address our flow and capacity issues, including a review of our operating model, purposeful admission and an OoA elimination plan which has developed in collaboration with system partners and NHSE/I colleagues.

We are pleased to report that the number of ligature incidents continued to be lower for a second month and this improvement has brought us within the national benchmark.

Community health services performance remained stable. Children's wheelchair waiting times (West Essex) improved but with one waiting longer than 18 weeks, which was due to supplier delays for specialist equipment. The Podiatric Surgery Service was paused during the peak of the pandemic, which has affected waiting times for this service. The service are currently working on a recovery plan to address waiting times.

**Major Projects – Nigel Leonard, Executive Director of Major Projects**

**Essex Mental Health Independent Inquiry**

On 10 November 2021 the Inquiry team announced its first call for evidence. Families, friends and carers of inpatients who died are invited to give evidence to the Inquiry about what happened to their loved one. Members of the public with experience of mental health inpatient services in Essex during the 20 year period are also invited to give evidence. More information can be found on the Essex Mental Health Independent Inquiry website. As previously noted we welcome the Inquiry and will continue to work with the Inquiry team. Patient safety remains our top priority and is at the forefront of everything we do at EPUT.

**Covid-19 Vaccination Programme Update**

EPUT has continued to play a major role in the roll out of the COVID-19 vaccination programme across Essex and Suffolk with the large scale vaccination centres operated by EPUT having delivered in excess of 980,000 vaccinations at the time of writing this report. It is anticipated that, by the time the Board meeting is held, we will have reached the 1 million mark. This really is a phenomenal achievement and I cannot express my thanks strongly enough to all those involved in this truly remarkable effort – our staff, volunteers and our partner organisations, all of whom have played a key role in this achievement. Their contribution to the success of the vaccination programme and ultimately saving lives cannot be underestimated. We will be recognising and celebrating this success in the media and with those involved.

Over the past two months we have seen a marked increase in uptake at our vaccination centres – both in terms of booked appointments via the National Booking System (NBS) as well as walk in appointments where it has been possible for us to offer these based on vaccine availability and operational capacity. In fact, we have seen such significant demand in some of our centres that there have been occasions where we have unfortunately not been in a position to be able to vaccinate all those who walk in. We are therefore strongly encouraging people to take up the opportunity to pre-book an appointment to ensure they are not disappointed. The activity in our centres has predominantly been for the booster programme for those in priority group 1 – 9; however we have continued to also offer 1st and 2nd doses throughout the period to those eligible to ensure the evergreen offer of vaccination.

We have strived to ensure throughout this period that vaccinations are available to all those eligible in the most flexible ways possible and have also increased the capacity available across all our centres to respond to the demand. All our centres have now been assured to deliver all the types of vaccine available at the current time to ensure we are in the strongest position to offer the maximum capacity available.

Since my last report, the programme for the vaccination of 12 – 15 year olds has commenced with EPUT being responsible for delivering vaccination sessions in schools across Essex and Bedfordshire, Milton Keynes and Luton. To supplement these in school sessions, in mid-October, vaccination centres across the country were asked to offer vaccinating sessions for this cohort to ensure accessibility of the vaccination for those wishing to take it up. We are now offering such sessions at all our vaccination centres.

On 15th November it was announced that, on the advice of the Joint Committee on Vaccination and Immunisation (JCVI), the booster programme would be extended to those in priority group 10 (ie those aged 40 – 49). The National Booking Service will be opening up to bookings for booster appointments for this new cohort from 22nd November. We understand that the system will be open for individuals to be able to book once they reach 152 days (five months) after their second dose, for an appointment that will be no sooner than 182 days (six months) after their second dose.

On the same date it was also announced, again on the advice of the JCVI, that those aged 16 – 17 years who are not in the at risk group should be offered a second dose which should be given 12 weeks or more following the first vaccine dose. Again it is anticipated that the National Booking Service will be opening up to bookings for this new cohort from 22nd November, with appointments only available for individuals once they have reached the recommended 12 weeks after their first dose.

We continue to increase capacity within our vaccination centres wherever possible in order to ensure opportunities for those in the new cohorts to receive their vaccinations.

In addition, we are now undertaking planning to ensure that all our front line staff will be fully vaccinated by the NHS deadline of 1 April 2022.

EPUT has continued to support both the Mid and South Essex and Suffolk and North East Essex systems in their endeavours to ensure the widespread availability of vaccinations for all those eligible. As part of this, for example, we continue to operate a vaccinating bus enabling us to maximise our ability to reach widespread communities and locations. We urge all those eligible to continue to come forward for their vaccinations.

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

**Staff Engagement and Wellbeing**

Our staff engagement and wellbeing activity is centred on building and driving the strategy to listen, connect and impact our employee's experience and engagement.

The 2021 Annual Staff survey was launched on 21 September 2021 and colleagues have until 26 November 2021 to complete the survey. Currently, our overall response rate is 40%, and the table below provides a full breakdown of response rates by executive director level.

| Executive Director Level | Response Rate |
|---|---|
| Chief Executive Office | 82% |
| Strategy and Transformation | 75% |
| People and Culture | 72% |
| Nursing | 51% |
| Operations | 39% |
| Finance and Resources | 38% |
| Medical | 38% |
| Mass Vaccination Programme | 33% |

To help drive up employee interaction with the survey, we have:

- Developed and distributed pre-survey guidance packs.
- Delivered workshops including a bespoke session on confidentiality.
- Focused on action taken as a result of last year's survey with a 'you said, we did' approach to help build confidence in the survey and highlight that it is a catalyst for change.
- Strengthened our survey campaign with a robust communications plan including: a video campaign, regular messages from our senior leaders, updates during CEO live brief session, creation of a monthly engagement & wellbeing newsletter, monthly engagement champion events with Executive Team presence.
- Targeted response rate updates to our Executive Team, L100 and engagement champions. Weekly trust wide updates through our internal communication channels.

**Other key activity:**

- Planning is underway to review and relaunch our engagement champion network with a clearer purpose, expectations and sponsorship. Importantly, the network will be streamlined with the overall employee experience function and aligned with other internal networks.
- Health and wellbeing support continues: working with Here for You, Long- Covid support, Menopause support group, burn out sessions, mindfulness, wellness plans linked to appraisals, updated work-life balance guidance and bespoke individual and team level support.
- Planning is underway to increase senior leadership visibility and to help build on our employee listening strategy through a 'Holiday Helper' initiative that will see our leaders visit and provide support to colleagues in patient-facing teams across the Trust: on our wards, in our clinics, and out in the community.
- Staff Recognition awards continue to recognise the invaluable efforts and commitment from our staff. 358 nominations received to date. And 15 awards given.
- Launch of a new monthly Engagement and Wellbeing newsletter with tailored communications focused on staff engagement and wellbeing.
- Pulse survey planning underway and due to launch January 2022.

- Planning is underway for service specific culture reviews to understand what is working and what requires improvement.

**Recruitment and Retention Highlights**
**Vacancy rate** – 9.9% against target of <12% for September. October data is not available for this reporting period.
**Turnover rate –** 10.2% against target of <12%. This is a 0.5% increase since last report.

**Starters and Leavers**
There were 103 staff members who joined the organisation in September and 82 in October. 60 staff left the Trust in September and 37 in October. The main reasons for leaving are retirement, to undertake further education and work life balance.

Starters – Top Professions

| | Administrative and Clerical | Additional Clinical Services | Add Prof Scientific and Technic | Nursing and Midwifery Registered |
|---|---|---|---|---|
| August 2021 | 37 | 21 | 9 | / |
| September 2021 | 18 | 42 | / | 19 |
| October 2021 | 10 | 51 | . | 13 |

Leavers – Top Professions

| | Additional Clinical Services | Nursing and Midwifery Registered | Administrative and Clerical |
|---|---|---|---|
| August 2021 | 13 | 10 | 7 |
| September 2021 | 19 | 10 | 16 |
| October 2021 | 8 | 9 | 10 |

**Time to Hire**

| | Total Averages | Unconditional Offer to start date (recruitment checks) |
|---|---|---|
| August 2021 | 91.4 days | 33.6 days |
| September 2021 | 90.5 days | 30.8 days |
| October 2021 | 107.3 days | 39.1 days |

The time to hire has increased from previous months with the largest cause being the pre-employment checks. As a team we are going through a restructure as well as splitting the management of the bank from the permanent recruitment. In addition to this, each area across the trust will have a dedicated recruitment advisor for point of contact and management of their recruitment needs, this will be communicated across the trust. Also, we are bringing on board two team members who will be focused purely on administrative recruitment tasks. All of the above will reflect positively in future time to hire figures.

**Retention Plan**
EPUT Retention Leads have been working closely with NHSE/I and Integrated Care Systems to formulate a plan, which has clear ambition against the targets set by the NHS People plan. It has been created to ensure measured targets are achieved and have been segregated into four primary goals, which will each have a number of short, medium and long term targets to meet. Each goal has been assigned to a lead who will have accountability for its completion. Retention leads will be

arranging task and finish groups to appropriately look at each target and ensure implementation is applied within the suggested timeframe.

**Recruitment Programmes**

- **Student nurse Recruitment –** 82 student nurses of which 50 have commenced in post, 8 have agreed start dates and 9 awaiting pre-employment checks. 8 are still going through recruitment process (e.g. awaiting form completion etc.), 7 withdrawn.
- **International Recruitment (IR) –** IR is a vital component of support for enabling us to meet the needs of our population and services.

We were delighted to receive funding specifically for year 21/22 enabling us to employ 60 international recruits of which 10 have arrived and a 50 further are due to arrive by March 22, all of which will enter on to the Adult NMC register.

In conjunction with this, we have submitted an ambitious bid to the NHS England workforce department for financial year 22/23. This will enable us to bring a further 135 International recruits of which 50% will enter on to the NMC adult register, 40% on to the Mental Health register and 10% on to the Learning Disabilities register. This will be a trail blazing programme of work as IR is relatively new to entry on the MH NMC register and entry for LD will be the first pilot in the UK. We are thrilled to be working in partnership with ARU in order to produce a programme of work for MH and LD specialties. This will allow us to support and guide our fabulous IR's in not only integrating into UK life and work, but also thoroughly understand the requirements of our population in relation to UK Law and legislation such as the mental health act, human rights etc.

This is a new way of approaching IR, which has been recognised, by NHS England and NHS East of England as a comprehensive sustainable and ethical way forward. It is an exciting opportunity for both our international recruits and current staff to learn about new cultures, develop skills and knowledge as well as make a huge difference to the population we serve.

**Sickness Management**

- In September, the sickness absence rate rose slightly to 5.7% (above the Trust target of 5% but below the mental health benchmark of 6%), reasons attributed to this are Covid absence, gastro and cold/cough/flu. Long-term sickness remains consistent at 3.5% and is within the Trust target.
- The principal reason for sickness absence is anxiety, stress and depression (108 staff off sick week commencing 8th November – 58% of which is long-term absence, which is a decreasing trend since the September report). This is closely followed by cold cough and flu, with 105 staff and Covid absence being the third highest reason for sickness absence at 50 staff.
- Covid absence has been gradually increasing week on week for the last two months, however has seen its first decline reported 15th November 2021. As at 15th November, the Trust has 22 staff reporting Covid sickness absence, 13 staff isolating not working and 10 isolating but working.

**Employee Relations Highlights**

- 22 Formal disciplinary cases (11 is in relation to temporary worker)
- 13 Suspensions (8 temporary workers)
- 23 Grievances (7 temporary Workers)
- 4 Appeals
- 4 Whistleblowing (Supported by HR)
- 2 Employment Tribunals

Employee Relations activities within disciplinary, suspensions, grievances and appeals have increased since previous reported. However, the increases are primarily relating to concerns being reported in relation to our temporary workforce, and likely linked to the change in how these processes are managed which has improved on managers reporting concerns. Improvements have been reported in reduction of timescales for temporary worker grievance complaints, however substantive staff grievance conclusion timescale KPI breaches remain high and further information is being collected to understand the reasons for this (initial review has reported this is due to annual leave)

| | | |
|---|---|---|
| | | **Agenda Item No: 7a** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

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

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

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

## Recommendations/Action Required

The Board of Directors is asked to:

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

## Summary of Key Issues

**Performance Reporting**

This report presents the Board of Directors with a summary of performance for month 7 (October 2021).

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

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

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

There is one inadequate indicator which is an Oversight Framework indicator for October 2021.

- Out of Area Placements

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

There are no inadequate indicators within the CQC scorecard. As at the end of October 2021, 49 (81%) individual actions have been reported as complete, 13 (19%) individual actions are in progress and are not yet due for completion and (0%) individual actions are overdue.

Within the Finance scorecard one item has been RAG rated inadequate for October;

- Temporary Staffing

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 £**<br>**Revenue £**<br>**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** |
|---|
| *Add signature*<br>**Paul Scott**<br>**Chief Executive** |

NHS
Essex Partnership University
NHS Foundation Trust

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

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

## Report Guide

### Use of Hyperlinks

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

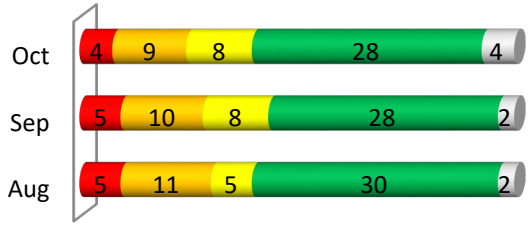
### How is data presented?

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

| Statistical Process Control (Trend Identification) | | | | | |
|---|---|---|---|---|---|
| Variation | | | Assurance | | |
|  |  |  |  |  |  |
| Common Cause – no significant change | Special Cause or Concerning nature or higher pressure due to (H)igher or (L)ower values | Special Cause of improving nature of lower pressure due to (H)igher or (L)ower values | Variation indicates inconsistently hitting and passing and falling short of the target | Variation indicators consistently (P)assing the target | Variation Indicates consistently (F)alling short of the target |
| **Assurance (How are we doing?)** | | | | | |
| Meeting Target<br>EPUT is achieving the standard set and performing above target/benchmark | Requiring Improvement<br>EPUT is performing under target in current month/ Emerging Trend | Inadequate<br>EPUT are consistently or significantly performing below target/benchmark /<br>SCV noted / Target outside of UCL or UCL | Variance<br>Trust local indicators which are at variance as a whole or have single areas at variance / at variance against national position | For Note<br>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

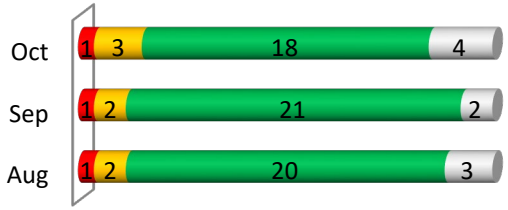



**October Inadequate Performance**

- Inpatient MH Capacity Adult & PICU
- Out of Area Placements
- Patients not seen, inc Patients with No Consultant Review within 12 months
- Psychology

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

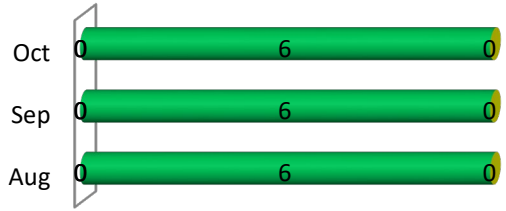
### Summary of Oversight Framework Indicators




**October Inadequate Performance**

- Out of Area Placements

### Summary of Safer Staffing Indicators



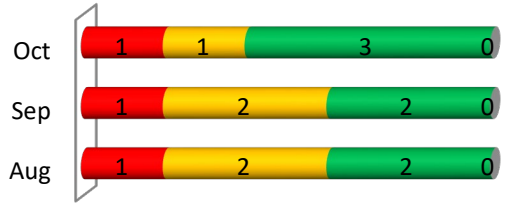

No risks identified within the Safer Staffing section.

### Summary of CQC Indicators

The CQC completed an unannounced inspection of the CAMHS services in May/June 2021.
The CQC has rated our CAMHS service as 'inadequate'. The final report has identified 22 areas for improvement (13 Must Do, 9 Should Do). The Trust has developed an enhanced action plan to address the concerns raised; this will require approval prior to submission to the CQC.

As at the end of October 2021, 49 (81%) individual actions have been reported as complete, 13 (19%) individual actions are in progress and are not yet due for completion and (0%) individual actions are overdue.

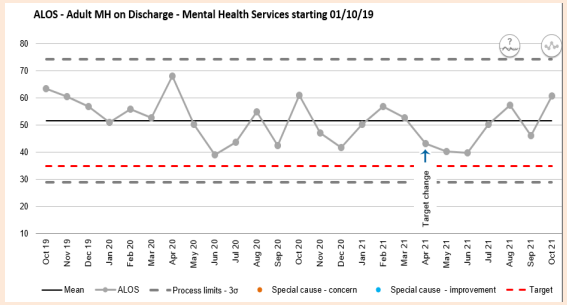
### Finance Summary

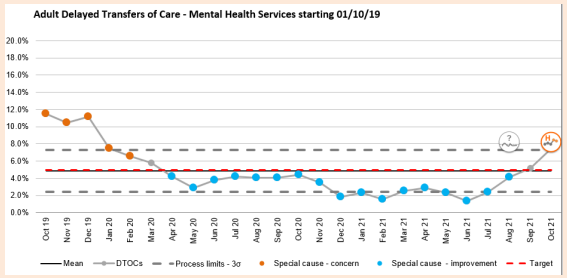
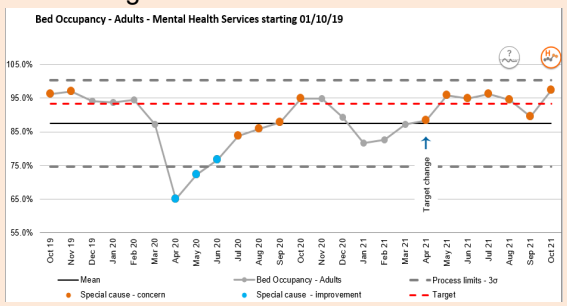
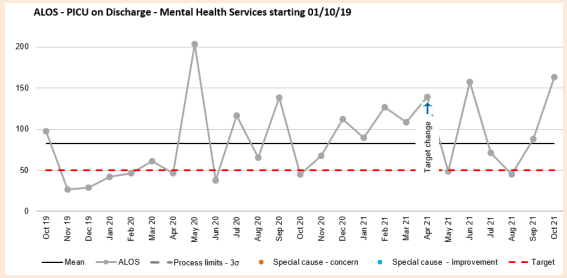


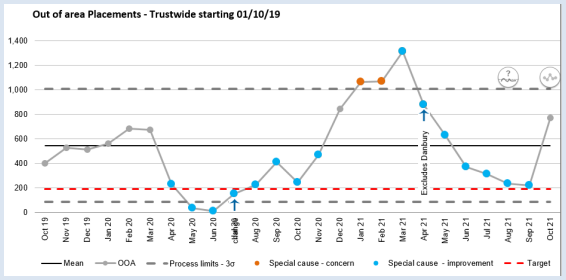
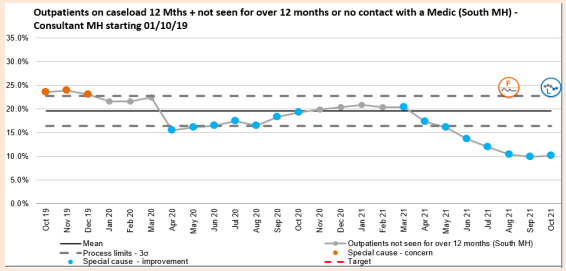

**October Inadequate Performance**

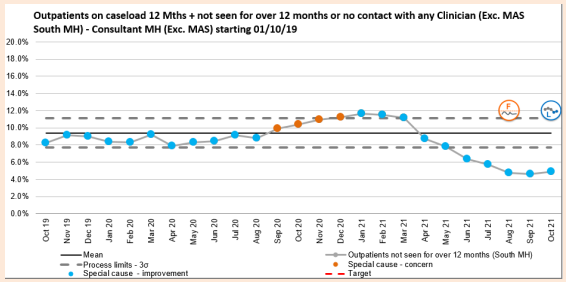
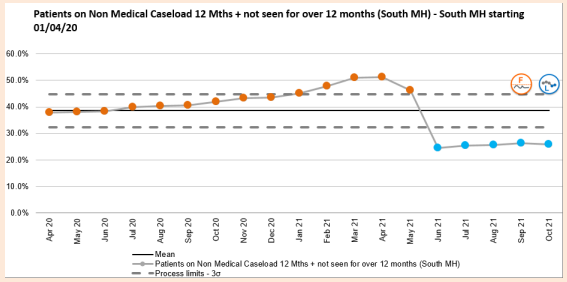
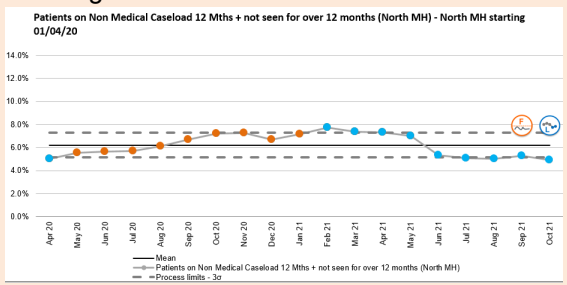
- Temporary Staffing

## SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

<table>
<tr><th colspan="7">Effective Indicators</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position M7<br>Perf</th><th>RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td rowspan="2">2.9 Inpatient Capacity Adult & PICU MH<br><br>Committee: Quality<br>Indicator: Local<br>Data Quality RAG: TBC</td><td colspan="7">Inadequate<br>ALoS; The adult average length of stay on discharge has increased in October, it continues failing to achieve stays that are in-line with or shorter than the NHS benchmark. The Adult rate is currently at 60.7 days against a target of <35 days. There were 90 discharges in October (20 of whom were long stays (60+ days)), with the exclusion of these outliers, performance would have met benchmark. Of the 20 long stays, three were discharged with a length of stay over 300 days, the highest being 949 days.<br>PICU has also risen again and is outside target in October with an average of 163.0 days, against a benchmark of <50. There were three discharged in October (two of whom were long stays (60+ days)). The two long stays were on the ward for 374 days and 70 days, with the exclusion of these outliers, performance would have met benchmark.<br>Meetings are currently taking place to establish the current issues faced that are contributing to higher lengths of stay, and what further actions can be taken to support the improvement of this.<br>Occupancy: Adult bed occupancy has increased further to 97.4% in October and is now outside the 93.4% target. Rates have steadily been increasing since February 2021. PICU bed occupancy remains within target at 70.8% against a benchmark of <88%.<br>Delayed Transfers of Care; has been highlighted as inadequate from October after four consecutive months of increase. Work has been undertaken to increase the reporting of delays on to the patient systems, however there are known factors contributing to delays which in turn increases average length of stay. Of the delays in October, 11 are awaiting supported accommodation, two are awaiting nursing/residential home placements, two are awaiting care packages in their own home, one is awaiting emergency accommodation, and one is delayed due to disputes. The majority of these delays are with NHS and Social Care. All current delays have actions in place to progress them.<br>Using the discharge/seasonal pressures funding, the North discharge team have been able to successfully expand the team with registered clinicians, which has had a positive impact on delays across the North wards. A focus on early identification of potential barriers to discharge, working to support care coordinators with resolution, and system escalation as required has allowed for team to attend to DTOC avoidance rather than just a focus on complex delays.<br>The South team have recently had funding from discharge/seasonal pressures money agreed to replicate the North enhanced discharge team and are beginning the process of recruitment. The current resource in South is focused on the resolution of complex delays.</td></tr>
<tr><td>2.9.2 Adult Mental Health ALOS on discharge less than NHS benchmark<br>Target: <35<br><br>(Adult Acute Benchmark 2020 35)</td><td>60.7 days</td><td></td><td>Below Target = Good<br> 
</td><td></td><td>Consistently failing target<br><br>90 discharges in October (20 of whom were long stays (60+ days)).<br><br>Adult Acute 2020 benchmark EPUT result was 31, against a National mean of 35.</td><td>TBC</td></tr>
</table>

| Effective Indicators | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| | 2.9.3 % Adult Mental Health Delayed Transfers of Care below national benchmark **Target: 5%**<br><br>(Adult Acute 2020 Benchmark 5%) | 7.5% | ● | Below Target = Good<br>  | ● | Four consecutive months of increase.<br><br>Adult Acute 2020 benchmark EPUT result was 8%, against a National mean of 5%. | N/A |
| | 2.9.4 % Adult Mental Health Bed Occupancy below national benchmark **Target: 93.4%**<br><br>(Adult Acute Benchmark 2020 93.4%) | 97.4% | ● | Below Target = Good<br>  | ● | Topaz re-opened as an Adult Ward 29th March 21<br>Cherrydown opened 8th August 21<br>Kelvedon opened 8th September 21<br>Grangewater & Thorpe are transferring patients to Cherrydown & Kelvedon.<br><br>Changes to Bed Numbers effective 1st April 2021.<br>Adult Acute 2020 benchmark EPUT result was 99.7%, against a National mean of 93.4%. | N/A |
| | 2.9.5 PICU Mental Health ALOS on discharge less than NHS benchmark **Target: <50**<br><br>(PICU 2020 Benchmark 50) | 163.0 days | ● | Below Target = Good<br>  | ● | Three discharged in October (two of whom were long stays (60+ days)).<br><br>PICU 2020 benchmark EPUT result was 48, against a National mean of 50. | |

| Responsive Indicators | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7 Perf** | **RAG** | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| **4.5 Out of Area Placements**<br><br>Committee: FPC<br>Indicator: Oversight Framework<br>Data Quality RAG: **Amber** | **Inadequate**<br>October has seen a significant increase in out of area bed days, 773 (excluding Danbury). A target to reduce OOA placements to 0 by the end of September 2021 was in place however has not been achieved. The Trust has worked closely with NHS England on this and they are aware of the challenges that have been presented to the Trust in recent months. An increase in mental health presentations to A&E and further ward closures due to COVID outbreaks has impacted this indicator. Positive steps have been taken with more oversight now available on the placements to the Priory and work remains ongoing to continue to reduce the number of OOA placements. Confirmation was received from NHSE/I that from October, the target will change to 25 per month, with a view to reduce to 0 by March 2022.<br><br>It should be noted that as of December 2020 the Trust purchased 18 beds from the Priory, Danbury ward. These beds were counted in our figures however; the Trust has received confirmation from NHSE who have provisionally agreed these can be reported as appropriate OOA placements. These have been excluded from the OOA data backdated to April 2021; however, we are currently awaiting confirmation that we can reflect this change back to the start of the contract.<br>34 new clients were placed OOA in October, and following the repatriation of 11, there were 34 remaining OOA at the end of the month. | | | | | | |
| | Reduction in Out of Area Placements<br><br>**Target: Reduction to achieve 0 OOA** | 773 Days | | Below Target = Good<br>  | | Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative.<br><br>Data excludes patients placed on Danbury Ward. | Mar 2022 |
| **4.9 Patients Not Seen / no contact for over 12 months**<br><br>Committee: Quality<br>Indicator: Local<br>Data Quality RAG: **Blue** | **Inadequate**<br>Improving trends have been witnessed in recent months across all medical and non-medical indicators. Work remains ongoing to continue this improvement.<br>A final Long Waiters T&F meeting will be taking place on the 16th November to sign off the position statement, following this, performance will be monitored as part of routine reporting.<br>Performance on this indicator continues to be monitored through the Outpatient dashboard, and the Data Quality Task & Finish group. | | | | | | |
| | 4.9.1 Patients with no consultant review within 12 months<br>**Target 0%** | 10.2%<br><br>(420 / 4,127 clients) | | On Target = Good<br>  | N/A | The construct of this indicator has been reviewed and now counts the number of clients who have been on a medic caseload for 12 months + and have not been seen or had contact with a medic for 12 months + as at the end of the reporting period. (inc. telephone contacts / inpatients and contacts with any consultant) | |

| Responsive Indicators | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| | 4.9.2 Patients on Consultant Caseload South Essex not seen / no contact by any clinician for over 12 months **Target 0%** | 4.8%<br><br>(195 / 3,986 clients) | ● | On Target = Good   | N/A | As above but excludes MAS Medic Caseload and includes any contact with another HCP. | |
| | 4.9.3 Patients on non-medical South Essex caseload not seen / no contact by any clinician for over 12 months **Target 0%** | 25.8%<br><br>(1,181 / 4,573 clients) | ● | On Target = Good   | N/A | The constructs for non-medical caseloads have been updated to include telephone contacts (Mobius Only), contact by other clinician and current inpatients effective 1st June 2021.<br><br>Work continues to validate and improve these indicators with breach and monitoring reports being supplied to the Operational Productivity team.<br>These indicators will also continue to be monitored as part of the Data Quality & Performance meeting group. | |
| | 4.9.4 Patients on any North East, West or Mid caseload not seen / no contact by any clinician for over 12 months **Target 0%** | 4.9%<br><br>(234 / 4,773 clients) | ● | On Target = Good   | N/A | | |

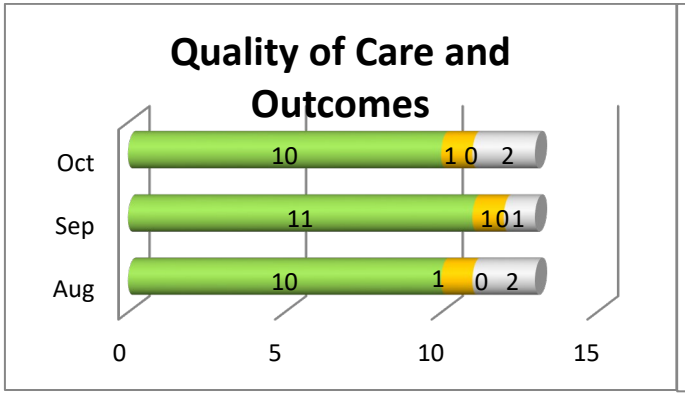
| | | |
|---|---|---|
| **4.10 Psychology**<br><br>  <br><br>Committee: Quality<br>Indicator: Local<br>Data Quality RAG: **Blue** | 4.10 Clients waiting on a Psychology waiting list | Significant work and improvements are being made across the Psychology service and waits are witnessing a reduction in most areas.<br><br>The service prioritises a front end loading of engagement in the form of first provision through a Psychological Awareness Programme. This leads to an accessible formulation focused assessment that can support the development of a clinically informed treatment and safety plan. This results in people accepted initially being seen in a responsive timeframe (longest wait is 4 months, average is 3 months). This set-up also supports wider MDT engagement, a robust risk management response and ensures that people are sitting in a clinical pathway confirmed as being appropriate to meet their needs, and fast-tracks treatment in groups. It also prevents DNA's and provides service users with informed choice regarding treatment. It also assists in ensuring that service users are ready for active psychological intervention.<br>It is also important to note that "longest wait" statistics include service users who have had treatment delayed due to illness (such as COVID), or have declined appointments offered. On average, waiting times for first offer of intervention is half that of the longest wait.<br><br>Within South West; waits are reducing with step 4 being introduced and some patients being stepped across in all localities across the South West. The service is close to being fully recruited to all the additional posts commissioned, which will make a significant difference to how quickly those patients who remain with psychology will be picked up from the wait list. There are 4 Clinical Associates in Psychology (CAP) starting in December who will gradually pick up a case load, as well as other qualified staff starting in the early new year.<br>The service anticipates that the waits will reduce over the next 6-9 months and access to psychology in South West will be much speedier once the wait list is worked through and we are fully resourced, as commissioned.<br>Risk calls are being made to those waiting (not on CPA) and to ensure any additional needs have a care plan and are documented.<br><br>Within South East Essex; the transformation posts are now coming into role. They are picking up additional patients from the wait lists and an incoming trainee is boosting this further. Additional transformation posts commence in January 2022.<br>There has been an investment to run 2 STEPPS groups simultaneously, clearing the STEPPS waiting list. There is also a strategy to target DBT/STEPPS screenings in Southend by increasing screening capacity.<br>A commitment to fund step 4 has now been made and these posts will go out to advert as soon as the letter of intent to fund is in place. Adult community psychology is identifying people to transition to the new provision. This will impact on individual wait times as well as take over ACT and OCD groups.<br>Risk reviews continue to be completed for people waiting, and will be repeated every 3 months.<br><br>Wait times are as follows (November 2021):<br><br>• Basildon: STEPPS/DBT assessment currently has the highest number of clients awaiting intervention with 67 waiting. Across all interventions, the longest waiter is 31 months and this is for specialist individual psychology.<br>• Brentwood: STEPPS/DBT assessment currently has the highest number of clients awaiting intervention with 25 waiting. Across all interventions, the longest waiter is 30 months and this is again for specialist individual psychology.<br>• Thurrock: Individual psychology currently has the highest number of clients awaiting intervention with 26 waiting. Across all interventions, the longest waiter is 31 months and this is for specialist individual psychology. |

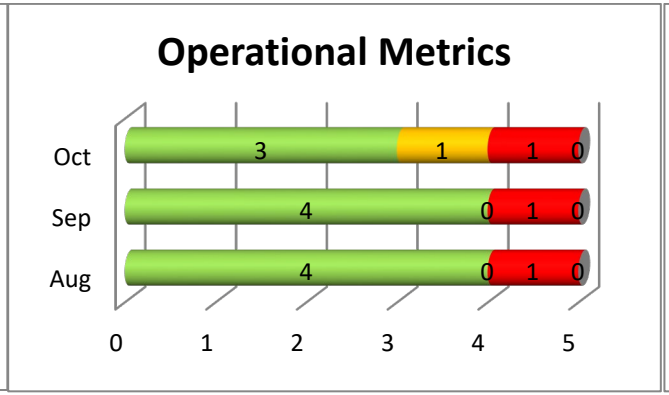
| | | |
|---|---|---|
| | | • Southend: Individual psychology currently has the highest number of clients awaiting intervention with 77 waiting. Across all interventions, the longest waiter is 24 months and this is for individual therapy.<br>• Castle Point: Individual psychology currently has the highest number of clients awaiting intervention with 13 waiting. Across all interventions, the longest waiter is 17 months and this is for individual therapy.<br>• Rochford/Rayleigh: Individual psychology currently has the highest number of clients awaiting intervention with 30 waiting. Across all interventions, the longest waiter is 13 months and this is for individual therapy. |

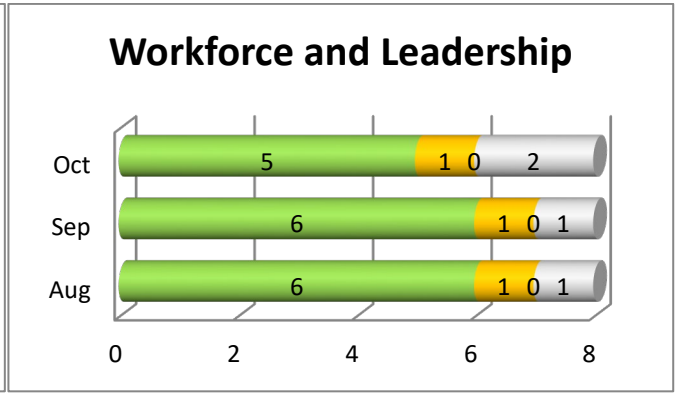
## SECTION 3 – Oversight Framework

Click here to return to Summary

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



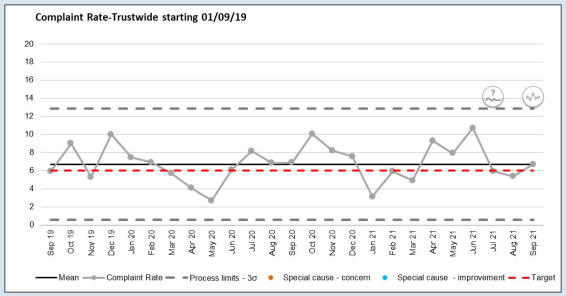




**Inadequate**

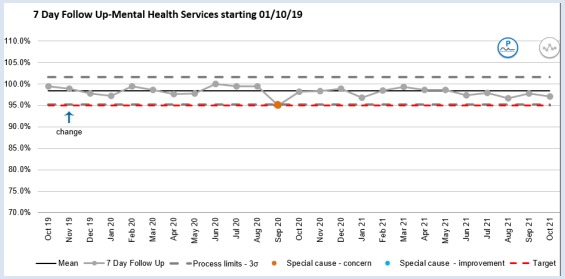
- Out of area placements

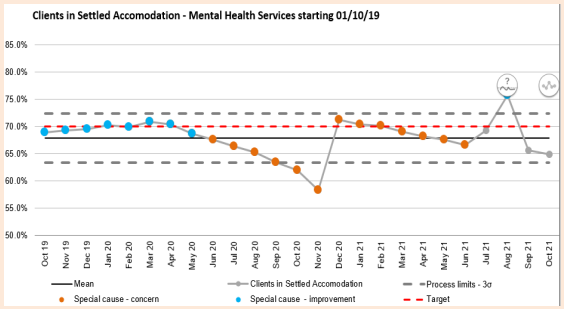
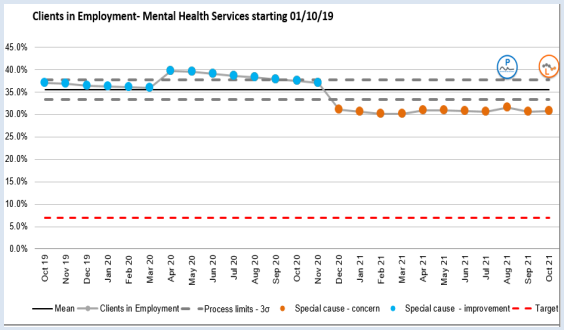
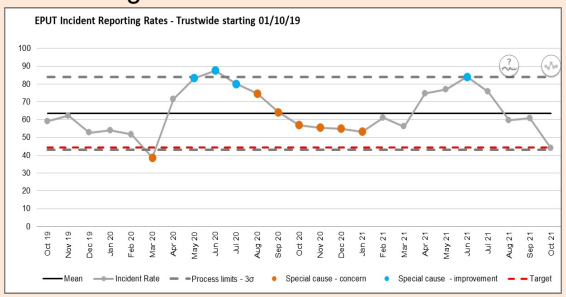
**Requires Improvement**

- Incident Reporting Rates
- Data Quality Maturity Index (DQMI)
- Sickness Absence

| Quality of Care and Outcomes | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| **5.1 CQC Rating**<br><br>Committee: FPC<br>Data Quality RAG: **Green** | Achieve a rating of Good or better | Good | ● | The Trust is fully registered with the CQC.<br><br>A restriction has been imposed onto the registration for the CAMHS service. | | | |
| | No action plans past timescale | | ● | As at the end of October 2021, 49 (81%) individual actions have been reported as complete, 13 (19%) individual actions are in progress and are not yet due for completion and (0%) individual actions are overdue. | | | |
| **4.1 Complaint Rate**<br><br>Committee: FPC<br>Indicator: Oversight Committee | 4.1.1 Complaint Rate<br>**OF Target TBC**<br><br>Locally defined target rate of 6 each month | | ● | Below Target = Good<br>  | ● | Awaiting October update | N/A |
| **5.6 Staff FFT**<br><br>Committee: FPC<br>Data Quality RAG: **Green** | 5.6.1 Staff FFT recommend the Trust as place to work<br><br>**Target 63%** | Indicator is suspended nationally. This is expected to re-launch in January 2022. | | | | | |
| | 5.6.2 Staff FFT recommend the Trust as a place to receive treatment<br><br>**Target 74%** | | | | | | |
| **1.1 Never Event** | 0 Never Events<br><br>**2019/20 Outturn 0** | 0 | ● | Year to Date 0 | ● | | N/A |

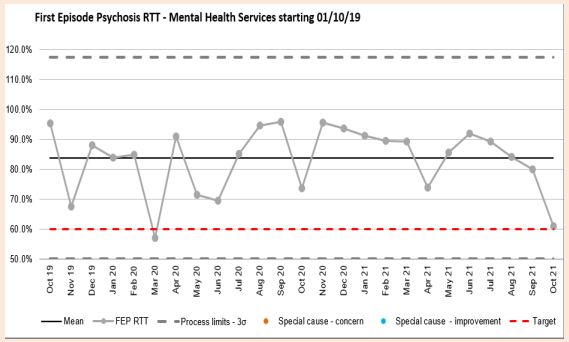
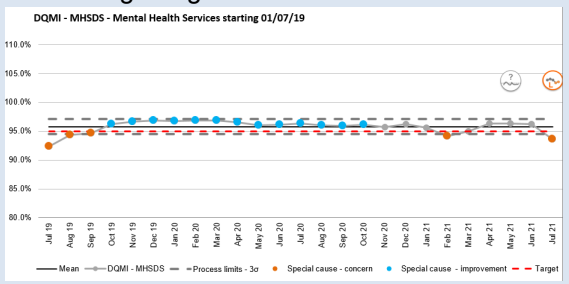
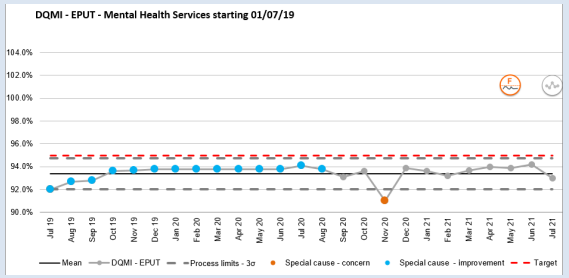
| Quality of Care and Outcomes | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| Committee: Quality<br>Indicator: OF<br>Data Quality RAG: **Blue** | | | | | | | |
| **1.6 Safety Alerts**<br>Committee: Quality<br>Indicator: OF<br>Data Quality RAG: **Green** | There will be 0 Safety Alert breaches<br><br>**2019/20 Outturn 0** | 0 | ● | Year to date there have been no CAS safety alerts incomplete by deadline. | ● | | N/A |
| **3.1 MH Patient Survey**<br>Committee: Quality<br>Indicator: Oversight Framework<br>Data Quality RAG: **Green** | Positive Results from CQC MH Patient Survey | EPUT achieved “about the same” in all 11 domains in the 2020 survey when compared with other Trusts. | | | | | N/A |
| **3.3.1 Patient FFT MH** | 3.3.1 Patient FFT MH response in line with benchmark<br><br>Target = 88% | 96% | ● | | ● | 48 total responses for MH<br>46 Very Good/Good | |

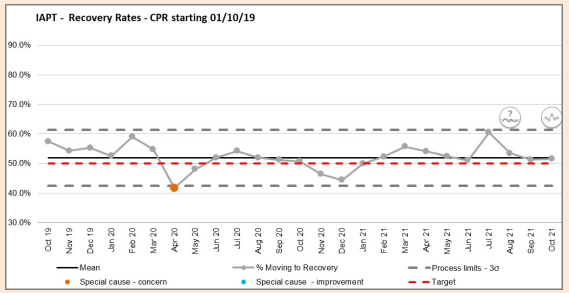
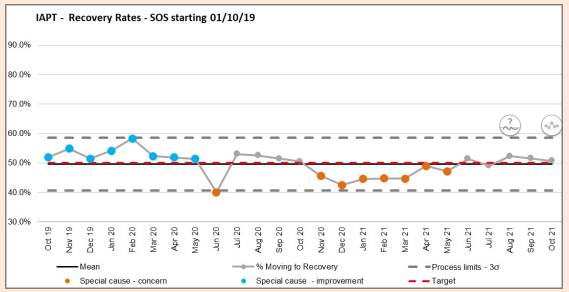
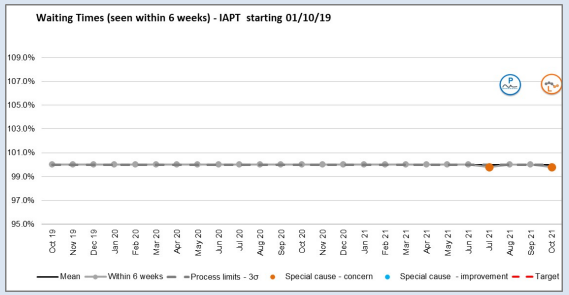
| Quality of Care and Outcomes | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| Committee: Quality<br>Data Quality RAG: **Green** | (Adult Acute 2020 Benchmark 88%) | | | | | Adult Acute 2020 benchmark EPUT result was 88%, against a National mean of 88%. | |
| **3.3.2 Patient FFT CHS**<br>Committee: Quality<br>Data Quality RAG: **Green** | 3.3.2 Patient FFT CHS response in line with benchmark<br>Target = 96% | 97% | | | | 32 total responses for CHS<br>31 Very Good/Good | |
| **2.8 Mental Health Discharge Follow up**<br>Committee: Quality<br>Data Quality RAG: **Blue** | 2.8.1 Mental Health Inpatients will be followed up within 7 days of discharge<br>**Target 95%**<br>**Benchmark 98%**<br>(Adult Acute 2020 Benchmark 98%) | 97.1% | | Above Target = Good<br>  | | Discharge follow ups form part of EPUT's "10 ways to improve safety" initiative.<br>Adult Acute 2020 benchmark EPUT result was 92%, against a National mean of 98%. | |

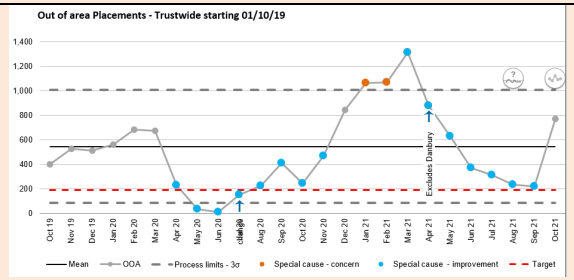
| Quality of Care and Outcomes | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| **2.4 MH Patients in Settled Accommodation**<br><br>Committee: Quality<br>Indicator: Oversight Framework<br>Data Quality RAG<br>**Green** | We will support patients to live in settled accommodation<br><br>**Target 70% (locally set)** | 64.9% | ● | Above Target = Good<br>  | ● | October performance :<br>Paris 59.8%<br>Mobius 80.2%<br><br>Additional operational work continues to help improve performance going forward. | N/A |
| **2.5 MH Patients in Employment**<br><br>Committee: Quality<br>Indicator: Oversight Framework<br>Data Quality RAG:<br>**Green** | We will support patients into employment<br><br>**Target 7% (locally set)** | 30.8% | ● | Above Target = Good<br>  | ● | October performance :<br>Paris 35.5%<br>Mobius 16.7%<br><br>Assurance indicates consistently Passing target. | N/A |
| **1.8 Patient Safety Incidents Reporting**<br><br>Committee: Quality<br>Data Quality RAG:<br>**Amber** | Incident Rates will be in line with national benchmark<br><br>**>44.33**<br>**MH Benchmark** | 43.8 | ● | Above Target = Good<br>  | ● | Below target for October. Performance is refreshed each month and does improve.<br><br>**Fewer incidents have been signed off by managers in time to be included in this report. This is due to the earlier production of performance reporting since November.** | |

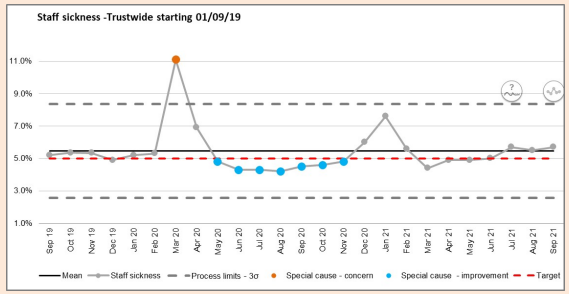
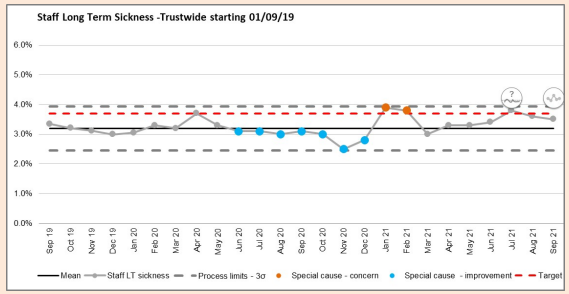
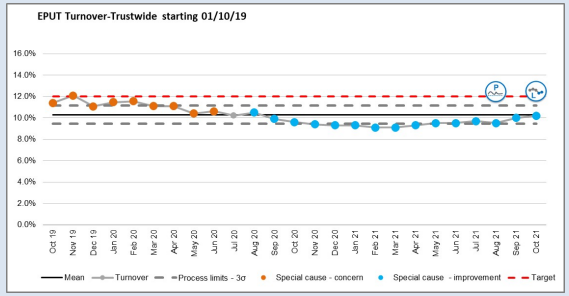
| Quality of Care and Outcomes | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| **1.15 Admissions to Adult Facilities of under 16's**<br><br>Committee: FPC<br>Indicator: Oversight Framework<br>Data Quality RAG: **Green** | 0 admissions to adult facilities of patients under 16 | 0 | ● | Zero admissions in October<br>One year to date. | N/A | | N/A |

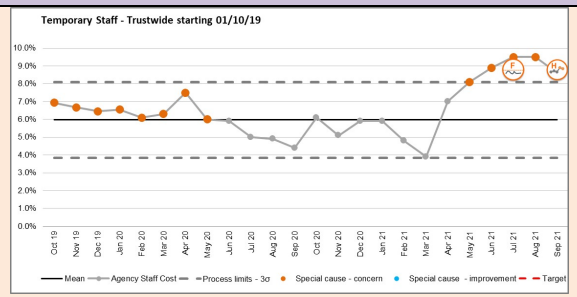
Click here to return to Summary

| Operational Metrics | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| **4.6 First Episode Psychosis**<br><br>Committee: Quality<br>Data Quality RAG: **Green** | All Patients with F.E.P begin treatment with a NICE recommended package of care within 2 weeks of referral<br><br>**Target 60%** | 61.1% | ● | Above Target = Good<br>  | ● | October performance represents:<br>7 / 18 patients.<br>The West Essex breaches are being investigated, staff are not allocating themselves as Care Coordinator when other teams are Care Coordinating. | N/A |
| **2.2 Data Quality Maturity Index**<br><br>Committee: FPC<br>Data Quality RAG: **Green** | The scores have dropped below 95% in July. There appears to have been some technical issues within the Paris extract process with Hospital Bed Type, Consultation Medium used and Estimated Date of Discharge, these have been resolved in the August Submission. Additional checks have been implement to ensure this does not reoccur. | | | | | | |
| | 2.2.1 Data Quality Maturity Index (MHSDS Score – Oversight Framework)<br>**Target 95%** | 93.6% | ● | Above target = good<br>  | ● | Latest published figures are for July 2021 | |
| | 2.2.2 Data Quality Maturity Index (EPUT wide score – Local Indicator)<br>**Target 95%** | 93.0% | ● | Above Target = Good<br>  | ● | Consistently failing target.<br><br>Latest published figures are for July 2021 | |

| Operational Metrics | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| **2.16. IAPT Recovery Rates**<br><br>Committee: FPC<br>Indicator: National<br>Data Quality RAG: **Green** | 2.16.4 IAPT % Moving to Recovery CPR<br>**Target 50%** | 51.6% | ● | Above Target = Good<br>  | ● | Slight increase from September, is still meeting target. | |
| | 2.16.5 IAPT % Moving to Recovery SOS<br>**Target 50%** | 50.7% | ● | Above Target = Good<br>  <br>. | | Slight decrease from the September figure; is still meeting target. | |
| | 2.16.6 IAPT % Moving to Recovery NEE<br>**Target 50%** | 50.8% | ● | Above Target = Good<br>Graphs will be produced once sufficient data is available. | | Slight increase from the September figure; is still meeting target | |
| **2.16. IAPT Waiting Times**<br><br>Committee: FPC<br>Indicator: National<br>Data Quality RAG: **Green** | 2.16.7 % Waiting Time to Begin Treatment – 6 weeks CPR & SOS<br>**Target 75%** | 99.8% | ● | Above Target = Good<br>  | | Consistently above target | N/A |
| | 2.16.8 % Waiting Time to Begin | 93.3% | ● | Above Target = Good | | Consistently above target. | N/A |

| Operational Metrics | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| | Treatment – 6 weeks NEE **Target 75%** | | | Graphs will be produced once sufficient data is available. | | | |
| **4.5 Out of Area Placements** <br><br> Committee: FPC <br> Indicator: Oversight Framework <br> Data Quality RAG: **Amber** | **Inadequate** <br> October has seen a significant increase in out of area bed days, 773 (excluding Danbury). A target to reduce OOA placements to 0 by the end of September 2021 was in place however has not been achieved. The Trust has worked closely with NHS England on this and they are aware of the challenges that have been presented to the Trust in recent months. An increase in mental health presentations to A&E and further ward closures due to COVID outbreaks has impacted this indicator. Positive steps have been taken with more oversight now available on the placements to the Priory and work remains ongoing to continue to reduce the number of OOA placements. Confirmation was received from NHSE/I that from October, the target will change to 25 per month, with a view to reduce to 0 by March 2022. <br><br> It should be noted that as of December 2020 the Trust purchased 18 beds from the Priory, Danbury ward. These beds were counted in our figures however; the Trust has received confirmation from NHSE who have provisionally agreed these can be reported as appropriate OOA placements. These have been excluded from the OOA data backdated to April 2021; however, we are currently awaiting confirmation that we can reflect this change back to the start of the contract. <br><br> 34 new clients were placed OOA in October, and following the repatriation of 11, there were 34 remaining OOA at the end of the month. | | | | | | |
| | Reduction in Out of Area Placements <br><br> **Target: Reduction to achieve 0 OOA** | 773 Days | |   | | Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. <br><br> Data excludes patients placed on Danbury Ward. | Mar 2022 |

| Workforce and Leadership | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| **5.3.1 Staff Sickness**<br><br>Committee: FPC<br>Indicator: Oversight Framework<br>Data Quality RAG: **Blue** | 5.3.1 Sickness Absence consistent with MH Benchmark 6%<br>**EPUT Target <5.0%** | 5.7% | | Below Target = Good<br>  | | In September the sickness absence rate rose slightly to 5.7% and continues the increasing trend. Two directorates are breaching target in September; Finance & Resources, and Operations. Long term sickness remains consistent at 3.5% and is within target. Recent increases have been attributable to COVID absence, Gastrointestinal problems, and Cold/Cough/Flu.<br><br>The sickness figures are reported in arrears to allow for all entries on Health Roster. | |
| | 5.3.2 Long Term Sickness Absence below 3.7%<br><br>**Target 3.7%** | 3.5% | | Below Target = Good<br>  | N/A | | |
| **5.2.2 Turnover**<br><br>Committee: FPC<br>Data Quality RAG: Green | 5.2.2 Staff Turnover<br><br>(Benchmark 2020 MH 12% / 2017/18 CHS 12.1%)<br><br>**OF Target TBC**<br>**Target <12%** | 10.2% | | Below Target = Good<br>  | | Special Cause of improving nature of lower pressure due to (L)ower values.<br><br>Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.<br>Adult Acute 2020 benchmark EPUT result was 9%, against a National mean of 12%. | N/A |
| **5.7.3 Temporary Staff** | 5.7.3 Proportion of temporary Staff (Provider Return)<br>No Oversight Framework Target | | | Below Target = Good | N/A | M7 data is still in the process of being finalised, this has been delayed due to H2 planning. | |

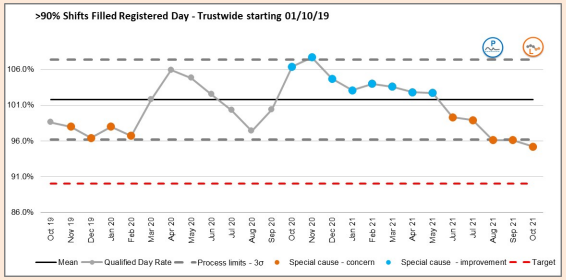
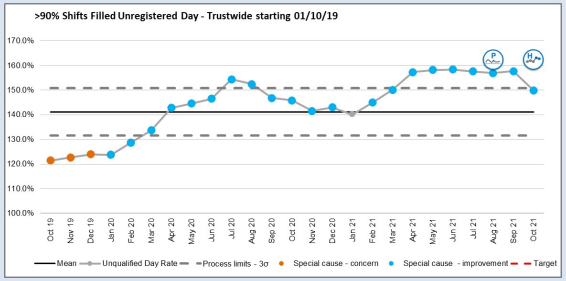
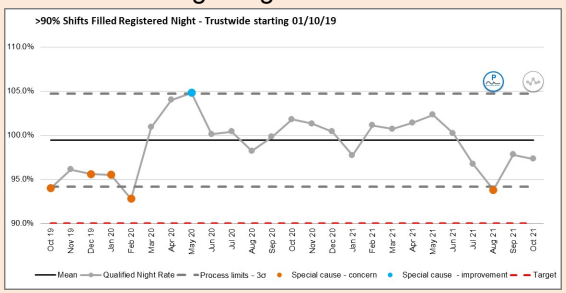
<table>
<tr><th colspan="7">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position M7<br>Perf</th><th>RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td>Committee: FPC<br>Indicator: Oversight Framework Indicator<br>Data Quality RAG: Green</td><td></td><td></td><td></td><td> 
</td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">5.5 Staff Survey<br><br>Committee: FPC<br>Data Quality RAG: Green</td><td>5.5.1 Outcome of CQC NHS staff survey</td><td colspan="5" rowspan="2">The 2021 Staff Survey is currently underway and closes in the 26th November. Results of the survey will be published in March 2022. As at the 5th November; 36% of staff have completed this years survey.<br><br><u>Information from the 2020 Staff Survey</u><br>The Staff Survey ran from September to November 2020.<br>The Trust was measured against 10 themes in the 2020 Survey. EPUT scored above average in one theme, in line with average on six themes, and below average against three themes.<br><br>Support and compassion average rating of:<br>• % experiencing harassment, bullying or abuse from staff in the last 12 months<br>• % not experiencing harassment, bullying or abuse at work from managers in the last 12 months<br>• % not experiencing harassment, bullying or abuse at work from managers in the last 12 months<br><br><table><tr><th>Staff Survey 2020</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr><tr><td>Safe Environment – Bullying & Harassment (high is better)</td><td>8.0%</td><td>8.3%</td><td>Below Average</td><td>●</td></tr><tr><td>Well Being and Safety at Work – Harassment, bullying or abuse at work from managers (low is better)</td><td>11.9%</td><td>10.5%</td><td>Above Average</td><td>●</td></tr><tr><td>Well Being and Safety at Work – Harassment, bullying or abuse at work from other colleagues (low is better)</td><td>17.2%</td><td>15.5%</td><td>Above Average</td><td>●</td></tr></table><br>Teamwork Average of:</td><td></td></tr>
<tr><td>5.5.2 Support & Compassion, Team Work and Inclusion</td><td></td></tr>
</table>

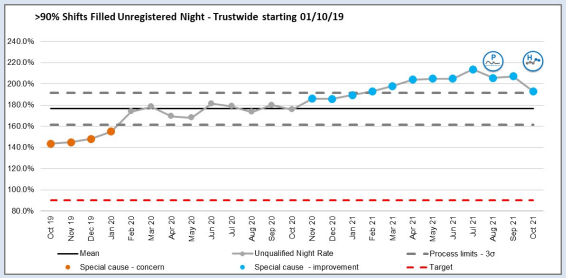
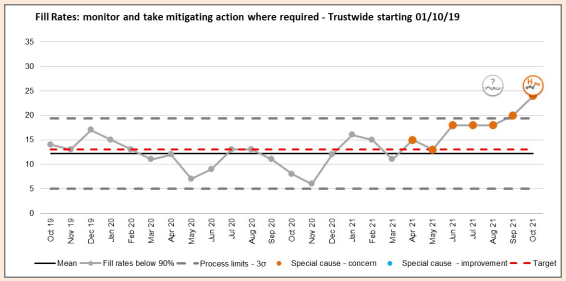
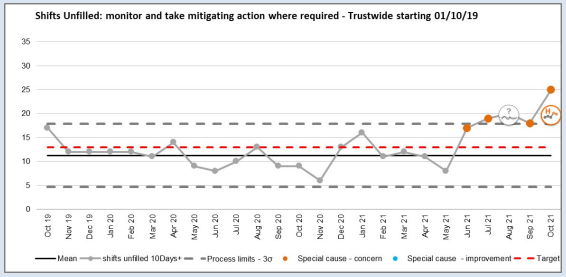
<table>
<tr><th colspan="6">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position M7<br>Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td></td><td></td><td colspan="5">
• % agreeing that their team has a set of shared objectives<br>
• % agreeing that their team often meets to discuss the team's effectiveness
<table>
<tr><th>Staff Survey 2020</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr>
<tr><td>Q4h The Team I work in has a set of shared objectives</td><td>75.4%</td><td>74.6%</td><td>Better than average</td><td>●</td></tr>
<tr><td>Q4i The Team I work in often meets to discuss the team's effectiveness</td><td>68.5%</td><td>69.8%</td><td>Below Average</td><td>●</td></tr>
</table>
Trusts in lowest third across the sector will represent a concern<br><br>
Inclusion (1) Average of<br>
• % staff believing the trust provides equal opportunities for career progression or promotion<br>
• % experiencing discrimination from their manager/team leader or other colleagues in the last 12 months
<table>
<tr><th>Staff Survey 2020</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr>
<tr><td>Q14 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age</td><td>84.7%</td><td>86.6%</td><td>Below Average (Better than last year)</td><td>●</td></tr>
<tr><td>Q15b Discrimination at work from manager / team leader or other colleagues in last 12 months</td><td>8.6%</td><td>7.1%</td><td>Above average</td><td>●</td></tr>
</table>
</td><td></td></tr>
</table>

Click here to return to Summary

## SECTION 4 – Safer Staffing Summary

Click here to return to summary page

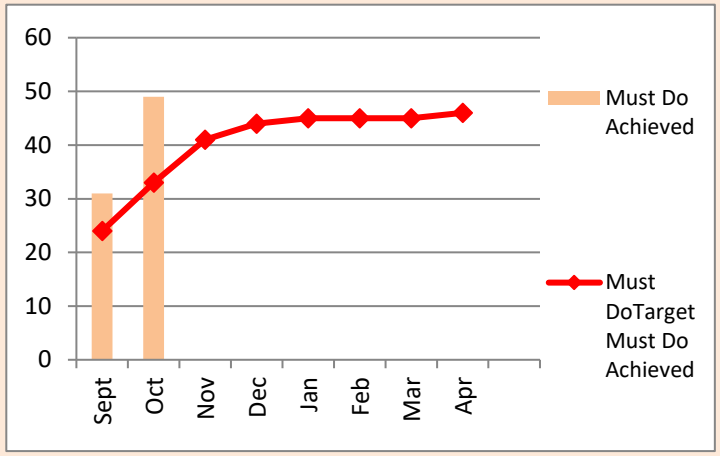
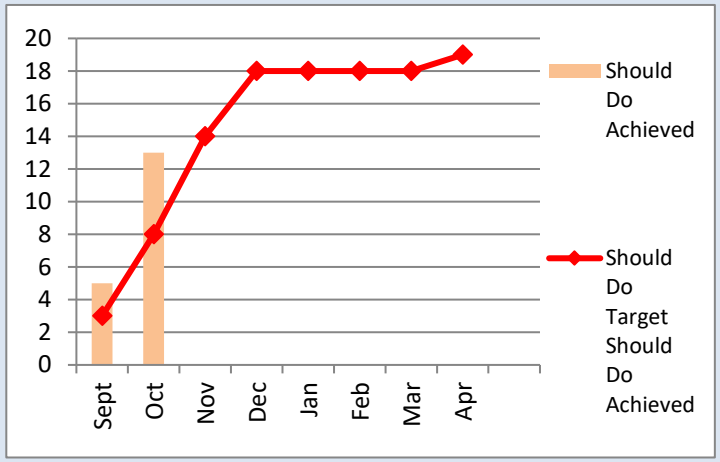
| Safer Staffing | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards. | | | | | | | |
| **Day Qualified Staff** | We will achieve >90% of expected day time shifts filled. | 95.2% | ● | Trend above target = good   | ● | The following wards were below target in October:<br>Older: Henneage, Ruby<br>Nursing Home: Rawreth Lodge<br>Specialist: Fuji, Lagoon, Rainbow<br>Adult: Kelvedon, Gosfield<br>Adult – Assessment: Peter Bruff<br>LD: Heath Close<br>CHS: Mountnessing Ct | N/A |
| **Day Un-Qualified Staff** | We will achieve >90% of expected day time shifts filled. | 149.9% | ● | Trend above target = good   | ● | The following wards were below target in October:<br>Specialist: Causeway, Woodlea Clinic<br>Adult: Kelvedon<br>CHS: Mountnessing Ct | N/A |
| **Night Qualified Staff** | We will achieve >90% of expected night time shifts filled | 97.3% | ● | Trend above target = good   | ● | The following wards were below target in October:<br>Adult: Kelvedon Willow, Kelvedon<br>Adult – Assessment: Peter Bruff<br>CAMHS: Larkwood, Longview<br>Nursing Home: Rawreth<br>Older: Beech – Rochford, Kitwood, Tower<br>Specialist: Dune, Edward House, Causeway | N/A |

| Safer Staffing | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| **Night Un-Qualified Staff** | We will achieve >90% of expected night time shifts | 193.0% | ● | Trend above target = good   | ● | There were no wards below target in October. | N/A |
| **Fill Rate** | We will monitor fill rates and take mitigating action where required | 26 | ● | Below Target = Good   | ● | The following wards had fill rates of <90% in October:<br>Adult: Willow, Gosfield Ardleigh, Cedar, Chelmer<br>Adult-Assessment: Peter Bruff<br>Older Adult: Beech – Rochford, Henneage, Kitwood, Ruby & Tower<br>Nursing Homes: Clifton Lodge & Rawreth Court<br>Specialist: Alpine, Causeway, Dune, Edward House, Forest, Fuji, Lagoon, Rainbow, Woodlea Clinic<br>CAMHS: Larkwood, Longview<br>CHS: Avocet<br>LD: Heath Close | N/A |
| **Shifts Unfilled** | We will monitor fill rates and take mitigating action where required | 25 | ● | Below Target = Good   | ● | The following wards had more than 10 days without shifts filled in October:<br>Adult: Ardleigh, Cedar, Willow, Gosfield<br>Adult-Assessment: Peter Bruff<br>Older Adult: Beech – Rochford, Henneage, Kitwood, Ruby & Tower<br>Nursing Homes: Clifton Lodge & Rawreth Court | N/A |

| Safer Staffing | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RAG** | **Ambition / Indicator** | **Position M7** | | **Trend** | **Nat RAG** | **Narrative** | **Recovery Date** |
| | | **Perf** | **RAG** | | | | |
| | | | | | | Specialist: Alpine, Dune, Edward House, Forest, Fuji, Lagoon, Rainbow & Woodlea Clinic<br>PICU: Hadleigh<br>CAMHS: Larkwood & Longvew<br>LD: Heath Close | |

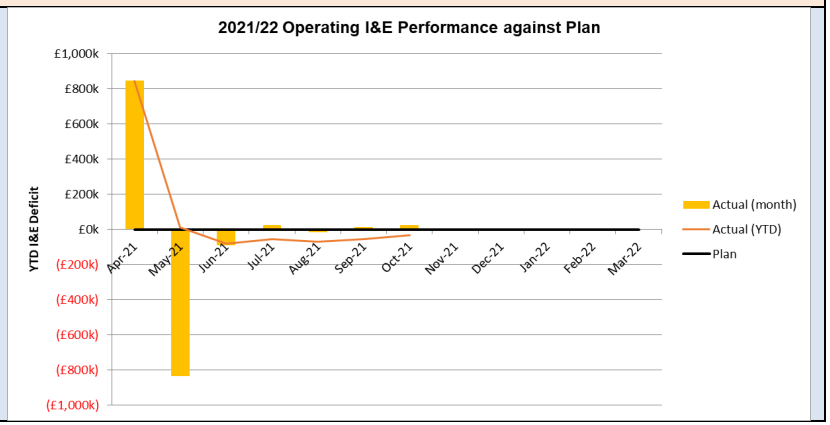
## SECTION 5 – CQC

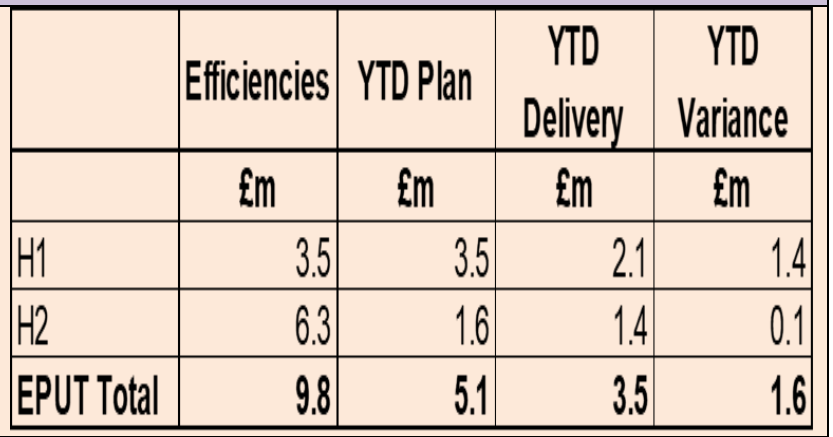
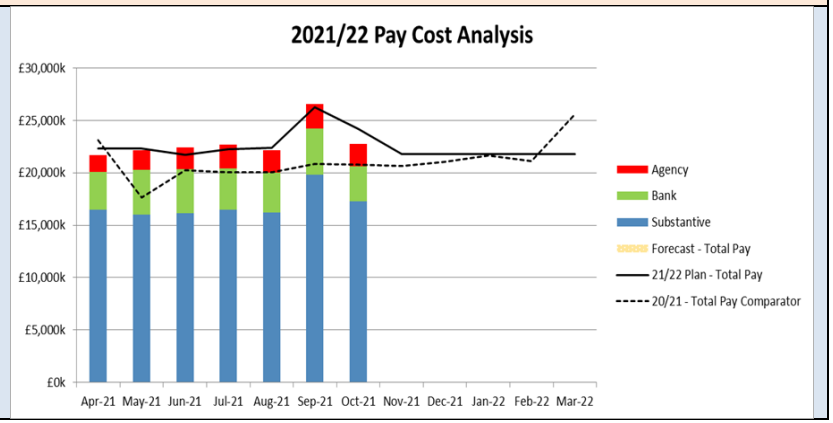
Click here to return to summary page

| RAG | Ambition / Indicator | Position M7 | Trend (above target = good) | Narrative |
|---|---|---|---|---|
| CQC Must do Actions | There will be 0 CQC Must Do actions past timescale | At the end of October 0 actions were past timescale | Achieve target = good performance   | 0 CQC Must Do actions are past timescale at the end of October 2021 |
| CQC Should do Actions | There will be 0 CQC Should Do actions past timescale | At the end of October 0 action were past timescale | Achieve target = good performance   | 0 CQC Should Do actions are past timescale at the end of October 2021 |

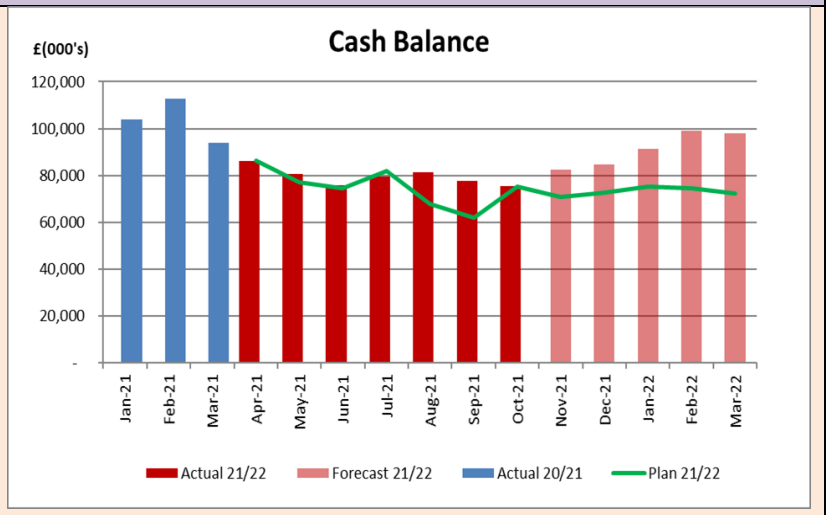
## SECTION 6 - Finance

Click here to return to summary page

<table>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position</th><th>Trend</th></tr>
<tr><td>Capital Expenditure</td><td>Maximising Capital Resources</td><td>The Trust has incurred capital expenditure of £4.1m against the £14.4m programme. At the CPPG held in October, the Committee approved a number of schemes for funding including IT (infrastructure refresh, mobile mast at Broomfield and air conditioning at data centre) and medical equipment bids totalling £0.4m. These bids were funded from within the existing program. Variances mainly relate to timing lags in schemes e.g. eliminating dormitory project with these forecasts to return to plan in future months. Additional working groups and increased frequency of the capital group has been actioned to monitor progress on the capital programme.</td><td>
<table>
<tr><th>Capital</th><th>Annual Plan £000</th><th colspan="3">Year to Date</th></tr>
<tr><th></th><th></th><th>Plan £000</th><th>Actual £000</th><th>Variance £000</th></tr>
<tr><td>ICT (including ePrescribing)</td><td>2,428</td><td>741</td><td>484</td><td>257</td></tr>
<tr><td>MEMS / Other equipment</td><td>200</td><td>47</td><td>26</td><td>21</td></tr>
<tr><td>Safety & Ligature</td><td>1,942</td><td>340</td><td>533</td><td>(193)</td></tr>
<tr><td>Backlog Maintenance</td><td>2,349</td><td>521</td><td>456</td><td>65</td></tr>
<tr><td>Health & Safety</td><td>1,000</td><td>403</td><td>176</td><td>227</td></tr>
<tr><td>Strategic Schemes:</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Dormitory Project</td><td>2,159</td><td>753</td><td>284</td><td>469</td></tr>
<tr><td>Other</td><td>1,085</td><td>666</td><td>344</td><td>322</td></tr>
<tr><td>Charge against Capital Allocation</td><td>11,163</td><td>3,470</td><td>2,303</td><td>1,168</td></tr>
<tr><td>DHSC Dormitory Project</td><td>3,080</td><td>3,080</td><td>1,802</td><td>1,278</td></tr>
<tr><td>PFI Residual Interest</td><td>109</td><td>64</td><td>64</td><td>0</td></tr>
<tr><td>Net CDEL</td><td>14,352</td><td>6,614</td><td>4,168</td><td>2,446</td></tr>
</table>
</td></tr>
<tr><td>Trust I&E 2020/21</td><td>Operating Income and Expenditure</td><td>The year to date position is a £32k deficit. Internal H2 plans have now received approval under delegated authority. These budgets are therefore now used for reporting purposes. The Trust annual budget has now been increased to £422m with an annualised efficiency requirement of £9.8m.</td><td> 
</td></tr>
</table>

| RAG | Ambition / Indicator | Position | Trend |
|---|---|---|---|
| Efficiency Programmes | Planned improvement in productivity and efficiency | In order to deliver annual financial plan which incorporates the H2 impact, the Trust will need to deliver £9.8m of efficiencies during the year. The plan requirement in H1 is £3.5m and H2 target is now £6.3m.<br><br>YTD reported position is £3.5m (of which £1.3m is recurrent). Following meetings with Directorates; further work to review processes and governance arrangements for efficiency schemes is underway and a key focus will be to develop recurrent efficiency programmes before the financial year 22/23. |  |
| Temporary Staffing | Level of Temporary Staffing Costs | The Trust continues to focus efforts in converting bank staff to substantive positions to enable consistency of care. The decrease in cost in M7 is due to M1-M6 pay award back pay incurred in M6. Overall temporary staffing costs for the month of £5.5m including Bank usage £3.4m, Agency usage £2.1m. This remains high at 24% of the total pay bill although is lower than previous months. |  |

| | Efficiencies | YTD Plan | YTD Delivery | YTD Variance |
|---|---|---|---|---|
| | £m | £m | £m | £m |
| H1 | 3.5 | 3.5 | 2.1 | 1.4 |
| H2 | 6.3 | 1.6 | 1.4 | 0.1 |
| **EPUT Total** | **9.8** | **5.1** | **3.5** | **1.6** |

| RAG | Ambition / Indicator | Position | Trend |
|---|---|---|---|
| Cash Balance | Positive Cash Balance | Cash balance as at end of M7 was £75.3m. The H2 planning process required M7 actuals to equal plan, and therefore no variance on cash is reported. The year-end plan for the remainder of the financial year will be updated in M8 once the profiling of the H2 plan has been finalised. |  |



**END**

| | | |
|---|---|---|
| | | **Agenda Item No: 7b** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **End of Life Annual Report 2020-21** | | | | | |
| **Executive/Non-Executive Lead:** | Natalie Hammond, Executive Nurse | | | | | |
| **Report Author(s):** | Ann Nugent, Associate Director Practice Development & Tracy Reed, Clinical Lead End of Life Care | | | | | |
| **Report discussed previously at:** | Quality Committee 9th September, 2021 | | | | | |
| **Level of Assurance:** | **Level 1** | ✓ | **Level 2** | ✓ | **Level 3** | |

| **Risk Assessment of Report** | |
|---|---|
| Summary of Risks highlighted in this report | None |
| State which BAF risk(s) this report relates to | BAF 63, BAF45, BAF 54, BAF61, BAF62. |
| Does this report mitigate the BAF risk(s)? | No |
| Are you recommending a new risk for the EPUT BAF? | No |
| If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register. | |
| Describe what measures will you use to monitor mitigation of the risk | |

| **Purpose of the Report** | | |
|---|---|---|
| This report provides the Board of Directors with an account of the work undertaken across services in End of Life Care. | **Approval** | |
| | **Discussion** | |
| | **Information** | √ |

| **Recommendations/Action Required** |
|---|
| The Board of Directors is asked to:<br>1 Note the contents of the report<br>2 Request any further information or action. |

## Summary of Key Issues

The key issues:

- Good end of life care encompasses recognition of the last dying phase, high quality coordinated care, carer support and advice delivered in a personalised, dignified and respectful manner. Clinical policy and guidelines are in place to provide quality assurances of a standard process for care delivery. During the pandemic a number of policies and guidance have been developed to support changing needs within end of life care services.
- Whatever the cause or condition people with advanced life threatening illnesses and their families should expect good end of life care with services to meet their individual needs. Community teams in South East Essex and West Essex play a key role in ensuring patients at the end of their lives have options regarding care and place of death. Mental health teams also provide care and support to people at end of life. It is essential in providing good end of life care that partnerships with system approaches to care are well established across all organisations and services involved in care delivery.
- Each area is linked with their local hospice and specialist palliative care providers to support complex needs, multi-disciplinary support and bereavement support.
- A person centred approach to choice and wishes is fundamental to outcomes and experience, the end of life care dashboard supports assurance of measurable outcome measures of performance in recording choice in terms of preferred place of care and death. There are other elements of the dashboard that provide assurance of care delivery and this is monitored at the end of life care subcommittee monthly. The end of life care subcommittee is represented by all areas within EPUT.
- Staff competencies and professional development to deliver high quality care delivery, is supported by training and education. These are recorded within local services and part of the supervision and appraisal process for the individual. This supports skill mix and assurances for competencies and service delivery as each member of staff in community services has end of life care competencies they are required to fulfil to deliver elements of care relevant to end of life symptom management and care. During the pandemic there was a need to upskill some of the mental health services and guidance, support and training was put in place to ensure competencies were achieved.
- A patient story has been provided in this report to demonstrate a patient journey and how partnership and integrated working in care delivery is key to high quality outcomes.
- Policy, guidelines, standard operating procedures are in place to support and provide assurances of safe and effective care delivery at end of life.
- The use of clinical audit to support measurable outcomes, evaluate care, support future service development and provide assurances that services are safe and effective. We take part in the National audit for care at end of life – NACEL which is completed yearly for all inpatient deaths in community hospitals. We are part of the advisory body to support the development for Mental Health inpatients and undertook a pilot audit during its development. Other audits include a community end of life care audit, do not attempt cardiopulmonary resuscitation and evaluation review audit of all forms sent to bereaved loved ones for feedback of care.
- Quality and safety meetings are used as a platform to support lessons learned and share information within the community services and cascaded to all team members.
- There are end of life care champions within all the teams, with four times a year meetings. The champions are the links between the clinical lead and service delivery, with information being cascaded and support within services being cascaded in a timely way.
- Collaboration nationally to learn and build stronger networks has resulted in us presenting nationally and sharing good practice. Especially around the upskilling of mental health teams, formularies and standard operating procedures for care delivery during the pandemic from all areas of EPUT.

The Annual report provides a breakdown of the work undertaken by services providing care to those at end of life and during the last days of life for the period 2020 - 2021.

| 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** | |

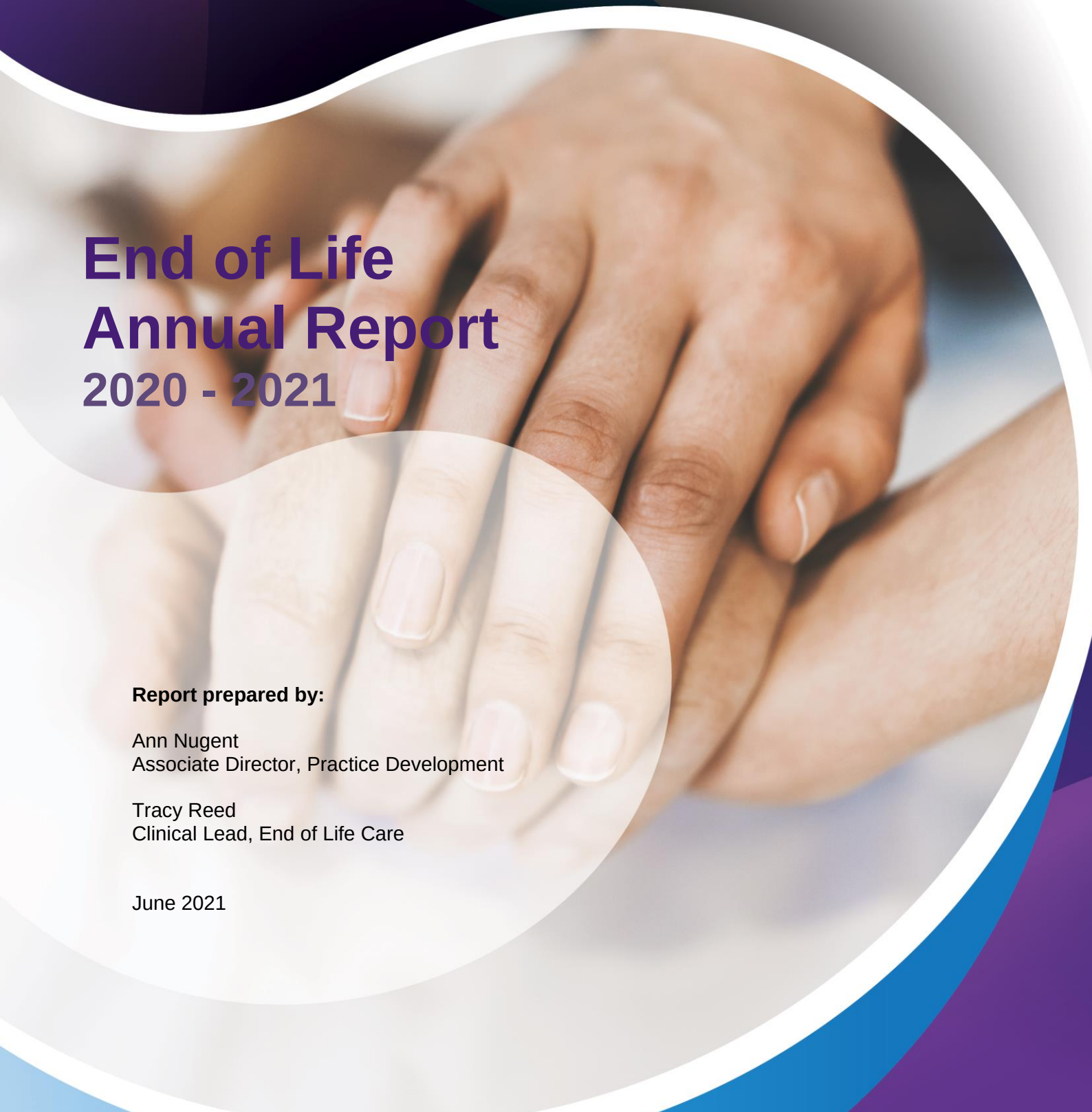
| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| | SEE INDEX page 17 of report | | |
| | | | |
| | | | |

| Supporting Documents and/or Further Reading |
|---|
| |

**Lead**

Natalie Hammond
Executive Nurse

Essex Partnership University
NHS Foundation Trust



# End of Life Annual Report
## 2020 - 2021


**Report prepared by:**

Ann Nugent
Associate Director, Practice Development

Tracy Reed
Clinical Lead, End of Life Care


June 2021

**CONTENTS**

## 1.0 Introduction

End of life care seeks to enhance the quality of life in the face of death by addressing the physical, psychological, social and spiritual needs of patients with advance diseases and their families. Good end of life care encompasses recognition of the dying phase, high quality coordinated care, carer support and advice delivered in a personalised, dignified and respectful manner. Approximately 500,000 people die in England each year. High quality end of life care is an indicator of how we care for sick and vulnerable people across health and social care services.

Whatever the cause or condition people with advanced life threatening illnesses and their families should expect good end of life care with services to meet their individual needs. All those identified as end of life should have the opportunity to discuss, plan and identify their preferences for their care at end of life and their preferred place of death. Therefore all services within the organisation need to recognise end of life care as it encompasses all long term conditions and care delivery to patients as a core element.

There are a number of national documents that support recommendations for high quality end of life care. These include the Ambitions for Palliative and End of Life Care (2021-2026), NICE guidance for end of life care (2017) that built on the Strategy for End of Life Care (2008). They identify six ambitions and the actions required to achieve each one.

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is coordinated
- All staff prepared to care
- Each community is prepared to help

Community health service teams in South East Essex and West Essex play a key role in ensuring patients at the end of their lives have options regarding care and place of death. Mental health teams also provide care and support to people at end of life and the Trust recognises that an integrated approach is essential to provide the very best care for people and their families/carers at end of life, during the last days of life and beyond.

This report provides a breakdown of the work undertaken by services providing care to those at end of life and during the last days of life.

In 2019 End of Life Care received an 'Outstanding' rating by the Care Quality Commission. This was a considerable achievement and boost to services who worked very hard to improve integration and develop services following the rating in May 2018 of 'Requires Improvement'.

During the COVID - 19 pandemic services have adapted to ensure the best outcomes for people at end of life and continue to provide the very highest care irrespective of diagnosis. In the past year community health services have seen an increase in the number of people dying at home as more people were reluctant to go into a care setting because of restricted visiting. The number of people dying in their own home has increased considerably as a result.

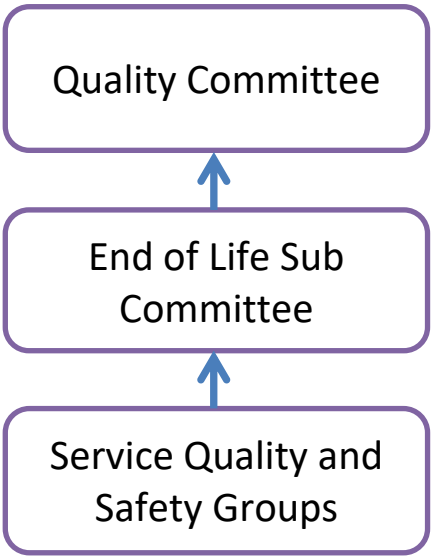
## 2.0 End of Life Subcommittee

The End of Life Subcommittee continues to report into the Quality Committee with Leadership from the Executive Nurse. The subcommittee meets monthly with representation from:

- Clinical Lead, End of Life Care
- Speciality Doctor (consultant psychiatrist)
- End of Life Care Clinical Lead, Frailty and Urgent Care (GP)
- Integrated Services Manager, West Essex Community Health Services
- Head of Inpatient Services, West Essex Community Health Services
- Operational Service Manager, Mental Health Older Adult In-patients
- Associate Director, Dementia and Frailty, West Essex Mental Health Services
- Deputy Director of Integrated Services & Out of Hospital Care, South East Essex Community Health Services
- Associate Director, Practice Development
- Operational Service Manager, Dementia & Older People's Community Mental Health (Mid & South Essex)
- Consultant Clinical Psychologist.

The subcommittee is responsible for overseeing and monitoring implementation of the End of Life Care Framework and making recommendations to the Trust in relation to the planning and provision of end of life and last days of life care. End of life care is a standing agenda item at locality Quality and Safety group meetings to ensure lessons learned are shared at a local level and across the organisation.

Papers for the End of Life Subcommittee can be downloaded in PDF format from the meetings section of InPut.




## 3.0 Clinical Lead for End of Life Care and Speciality Doctor

The Trust appointed a clinical lead and speciality doctor in January 2019. The post-holders are responsible for leading Trust wide initiatives to promote and improve standards of care at end of life and during the last days of life. They work closely with staff in community and mental health services and are responsible for developing education and support packages to ensure staff have the confidence and competence throughout each of the six ambitions.

## 4.0 Competencies

The clinical lead has developed a competency framework for end of life care to support the enhancement of knowledge, development of skills and promotion of positive attitudes and behaviors in care delivery. The objective of the framework is to ensure staff develop professionally through reflection, supervision and through informal and formal training. It aims is to ensure that staff confidently provide the highest quality care by early identification and response to patients who are recognised as end of life both in hospital and the community.

## 5.0 Policies and Procedural Guidelines

### 5.1 Procedural Guideline for the care of the Deceased Patient.

The guideline was revised in 2019 to widen the scope for use to include staff working in a community health service (domiciliary) setting (the previous guideline covered inpatient staff only). It sets the standard for sensitive and compassionate communication with family members/significant others. Providing sensitive care and support after death can be one of the most difficult and challenging aspects for clinical staff but, equally, the most rewarding.

The aim of the guideline is to ensure that there is timely confirmation and notification of death by medical staff and that there is correct preparation of the deceased person's body for viewing by family members/significant others and dignified removal to the appropriate mortuary.

### 5.2 Advance Decisions and Advance Statements

The guideline was introduced to provide clarity to staff in relation to the process for advance decision making and advance statements and choice for adults within the care of EPUT. It supports safeguarding, mental capacity issues and person centred choices though the provision of guidance on the process and legislative requirements.

### 5.3 Verification of Expected Death (VOED)

The existing guideline was reviewed and revised during the COVID - 19 pandemic to include national guidance and provide a framework in relation to training for registered nurses. The training was adapted to support staff competencies through a blended learning approach, including Train the Trainer to ensure that each team have staff available to support the increase in verification of death particularly within the community services. It is accompanied by a competency framework and a register of competent staff is maintained within each locality.

### 5.4 Subcutaneous Drug Administration in Community Health Services by Patients/Carers/Relatives

This was developed to support areas without 24 hour domiciliary services. The operational guidance provides the legal and management information to support patients/carers/relatives to administer subcutaneous medication in the community in a timely way to manage symptoms. It also provided a way of reducing footfall during the COVID - 19 crises for patients who were shielding. The guideline is robust in ensuring safe and effective practice and provides clear information and practical steps to ensure robust risk assessment whilst ensuring a person centred approach to patients/carers/relatives who wish to take on this element of care. This was recently updated as the pandemic continues and is now valid for another year.

## 6.0 End of Life Care Champions

End of Life Care Champions have been identified in areas across the Trust to share learning and continuously develop the approaches to care at end of life. The aim of the champion is to share best practice and ensure that staff, patients and their loved ones have a positive experience of end of life, delivered to the very highest standard. There are currently sixty champions across the Trust. Forums are held quarterly where reflective learning and shared practice are encouraged. The forums also provide the opportunity to update the champions on the latest national and local guidance.

The Clinical Lead for End of Life Care supports this role within the teams and works with each individual to support partnership working with their local specialist palliative care teams ensuring that, irrespective of a patient's environment they receive fair access to palliative and end of life care services. .

## 7.0 End of Life Care Framework

The Trust End of Life Care Framework sets out clear guidance in accordance with the ambitions for palliative and end of life care and the national end of life care strategy. These, together with NICE guidelines and quality standards support end of life care practices. The Framework has been reviewed in accordance with the new guidance issued in 2021; however, there are no significant changes to previous guidance.

The principle aim of our teams is to support people to live well and die well with effective management of all their needs by early identification and effective person centred approaches to individualised care. The actions within the framework are to support the Trust in meeting the requirements as laid out nationally. The ambitions align with the Trusts' vision, values and strategic objectives to continuously improve patient safety, experience and outcomes and are outlined below:

| **1. Each person is seen as an individual** | |
|---|---|
| Key Achievements | The systems in place to capture incidents, compliments and complaints have been strengthened during 2020/21. The clinical lead is copied to any complaints in community health services related to end of life care.<br><br>The Friends and Family Test has been revised to include feedback specific to end of life care and a post bereavement survey is now being used within our inpatient and specialist services. |
| Areas to be progressed | Alignment of community health services clinical systems to comply with national datasets so that the organisation is in a position to interrogate systems.<br><br>Continue to strengthen processes to gain carer feedback within inpatient service and community services.<br><br>The implementation of an Always Event to capture those aspects of the patient and family experience when patients interact with our teams and the health care delivery system. This has been on hold owing to the pandemic. |

| 2. Each person gets fair access to care | |
|---|---|
| Key Achievements | The Clinical lead for EoLC and Speciality Doctor continue to have strong links with partner organisations. These include local acute services, hospices and voluntary services in all locations across EPUT. The formation of the ICS and Alliances across Essex have seen these partnerships continue to develop and service alignment to ensure fair access to care for all EPUT services.<br><br>The dashboard, capturing quality and performance indicators has been further developed to include Treatment Escalation Plans and Proactive Elderly Advance Care Plan (PEACE).<br><br>There have been extensive improvements across the systems in terms of psychological support and a number of business cases to support service redesign.<br><br>A number of resources have been developed and used to support faith and spirituality within all services. |
| Areas to be progressed | Support the development of an EPaCC system in West Essex |

| 3. Maximising comfort and wellbeing | |
|---|---|
| Key Achievements | A formulary to support COVID - 19 was developed at the outset of the pandemic in accordance with national guidance for use in all areas within the organisation. Medication is accessible on all inpatient units.<br><br>Use of the formulary has continued for the past year and has been reviewed, updated and checked against all latest guidance. |
| Areas to be progressed | Continued cascade end of life care competencies to all grades of staff in community services to ensure maximum update.<br><br>Continued working in partnership with external stakeholders. This includes access to external training and development. |

| 4. Care is co-ordinated | |
|---|---|
| Key Achievements | The Clinical Lead for EoLC and Speciality Doctor continue to have strong links with systems partners.<br><br>There is ongoing integration in localities working with primary and secondary care services and hospices.<br><br>Monthly multi-disciplinary meetings with primary and secondary care and hospices have been established to ensure an integrated approach and co-ordination of care.<br><br>A pathway has been developed for people with multiple organ failure who are on the caseload of the STARS Team. |

| | |
|---|---|
| | Work is ongoing with Hertfordshire and Essex Learning Disability Teams to support advanced care planning and a pathway to enhance care. |
| Areas to be progressed | To continue with enhanced partnership working across systems to create best approaches with regard to advanced care planning and individualised care plans. |

| **5. All staff prepared to care** | |
|---|---|
| Key Achievements | End of life care champions are supporting staff at a local level. There are sixty champions across services to support best practices and provide updates on end of life care.<br><br>A dedicated page on the Trust intranet on end of life resources and information.<br><br>A training needs analysis has been undertaken across Mid and South Essex using a Survey Monkey. The greatest number of responses were from EPUT staff who reported that they felt supported and had multiple training opportunities with limited needs against their competencies. |
| Areas to be progressed | Continue the roll out of end of life care competencies for all grades of staff.<br><br>Continue to expand the number of End of Life Care Champions. |

| **6. Each community is prepared to help** | |
|---|---|
| Key Achievements | The Trust participates in Dying Matters events on an annual basis. In 2020 and 2021 this was undertaken via social media and virtually because of the COVID - 19 pandemic. There is continued partnership working with a view to face to face training and possible event later in the year if permitted.<br><br>The end of life Clinical lLead is a member of CCG, ICS and Alliance End of Life Care Groups. |
| Areas to be progressed | Public information relating to end of life care to be posted on the Trust Website and through social media to include blogs and sharing stories with staff and patient experiences.<br>. |

## 8.0 Clinical Audit

### 8.1 National Audit of Care at End of Life (NACEL)

The Trust continues to participate in the NACEL. However, it was suspended in 2020 because of the pandemic. It is now re-commencing with standards focusing on the quality and outcomes of care experienced by those in their last admission in acute and community hospitals throughout England and Wales. The audit monitors progress against the five priorities for care set out in One Chance to Get It Right and

NICE Quality Standard 144, which address last days of life, within the context of NICE Quality Standard 12 (which addresses the last year of life).

There are several components consisting of an organisational level audit for the period 1st April 2021 - 31st August 2021 and a case note review of all deaths within the same period.

The case note review will consider patients who meet the following criteria:

I. Recognition that the patient may die – it has been recognised by the hospital staff that the patient may die imminently (i.e. within hours or days). Life sustaining treatments may still be offered in parallel to end of life care.

II. The patient was not expected to die – imminent death was not recognised or expected by the hospital staff. However, the patient may have had a life limiting condition or, for example, be frail, so that whilst death wasn't recognised as being imminent, hospital staff were "not surprised" that the patient had died.

Deaths that are classed as "sudden deaths" are excluded from the Case Note Review.

### 8.2 Audit of Do Not Resuscitate Cardiopulmonary Arrest Orders.

An audit of DNACPR for those at end of life was completed in November 2020. The purpose of the audit was to ensure the correct processes were in place to ensure a person centred approach to all decision making.

Thirty eight documents across both community health services and mental health were reviewed by the clinical lead and considered the following:

- Number of patients with a DNACPR when identified as end of life
- Number patients with a DNACPR at time of death
- Number of discussions held with patient and relatives/carers
- Number of discussions with a senior member of staff/MDT

#### 8.2.1 Findings

Across community services 96.6% of patients had a valid DNACPR form in place at time of death. For mental health services this was 100%. The audit found that there were extensive records to evidence the conversations with the patient, their loved ones and LPA for health and welfare.

There was evidence documentation to support conversations and evidence of an MDT approach to implementation across all community health services. In mental health this was lower (80%). However, on further investigation, the auditor found that the DNACPR orders had been put in place by the GP practice who provide medical support to the nursing homes. The audit did not seek to demonstrate the quality of

care given to those who are dying or the perception of those receiving it. Rather the results are an indication of those patients/nominated others in EPUT services that had conversations about their condition and the implementation of a DNACPR document which is an indicator that there was recognition of their stage of end of life and inclusion of patient choice.

### 8.1.2 NACEL in Mental Health Services

Mental health services were not included in the national NACEL audit in 2019. However, at the end of 2019 the Clinical Lead and Speciality Doctor were invited to participate in a working group to develop an audit that supported quality outcomes for mental health inpatient service deaths. This resulted in EPUT inpatient mental health services participating in a pilot of care at the end of life which was completed in March 2020.

The findings suggest that the mental health teams are recognising the last days of life but appear to lack the recognition of early identification of end of life care as identified through the low numbers of ACP documents available. At the time of the audit there were no end of life care templates on the Mobius and Paris electronic clinical systems. As such, there was no standard approach to documenting end of life care. Following this templates have now been developed for both systems. This will act as a prompt to support future record keeping of care wishes.

Although the sample size was very small it identified the need for greater awareness and training around some elements of care including religious and spiritual needs in end of life care. Teams are now working with the chaplaincy service that, together with the Clinical Lead are providing awareness sessions and resources. Dementia Teams are rolling out the PEACE treatment escalation plan to support effective care delivery, choice and person centred end of life care.

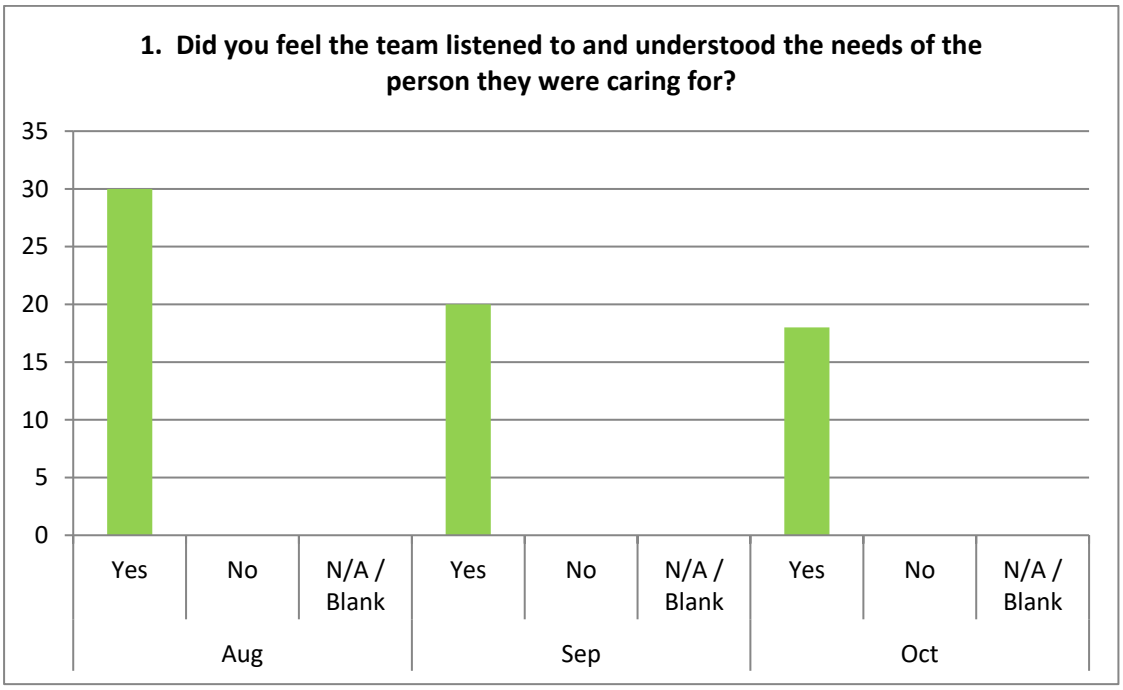
## 8.2 End of Life Care – Community Health Domiciliary Services

In 2020, the impact of the pandemic on services and workforce capacity led to a suspension of the community health domiciliary audit. However, in order to continue to measure quality of services delivering end of life care a service evaluation was undertaken to gather the views and experiences of bereaved relatives.

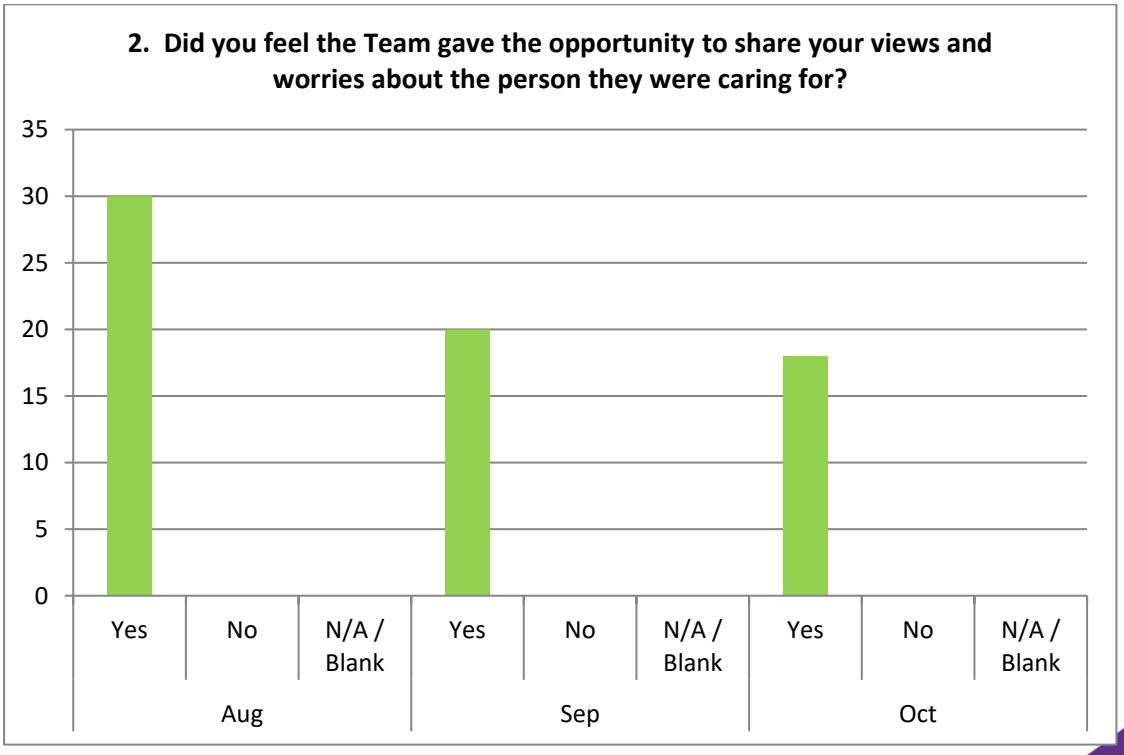
The evaluation form is used by services delivering end of life care across the Trust. The bereaved person is asked if they are happy to participate prior to the forms being sent to them. The form contains a number of questions in relation to whether their loved ones needs were met and whether they were happy with the service delivered. It ran from August 2020 to October 2020. In all 120 evaluation forms, accompanied by a covering letter were sent out. The response rate was 57%.

The results are outlined in the following graphs:

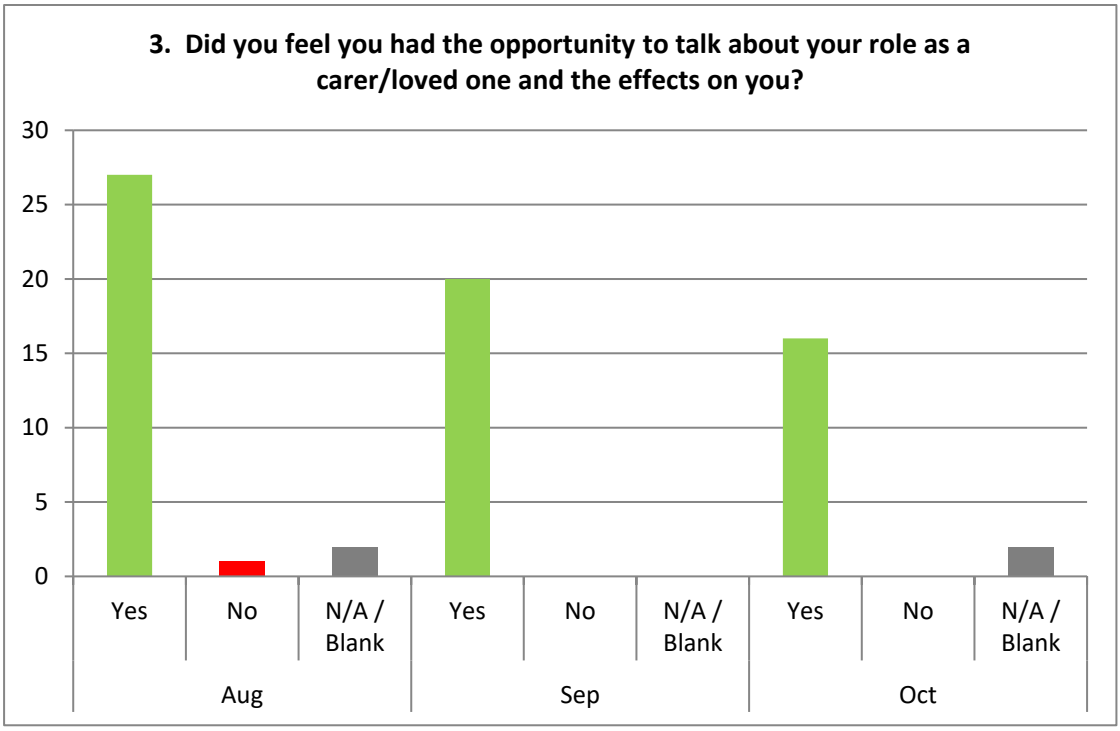
## Question 1



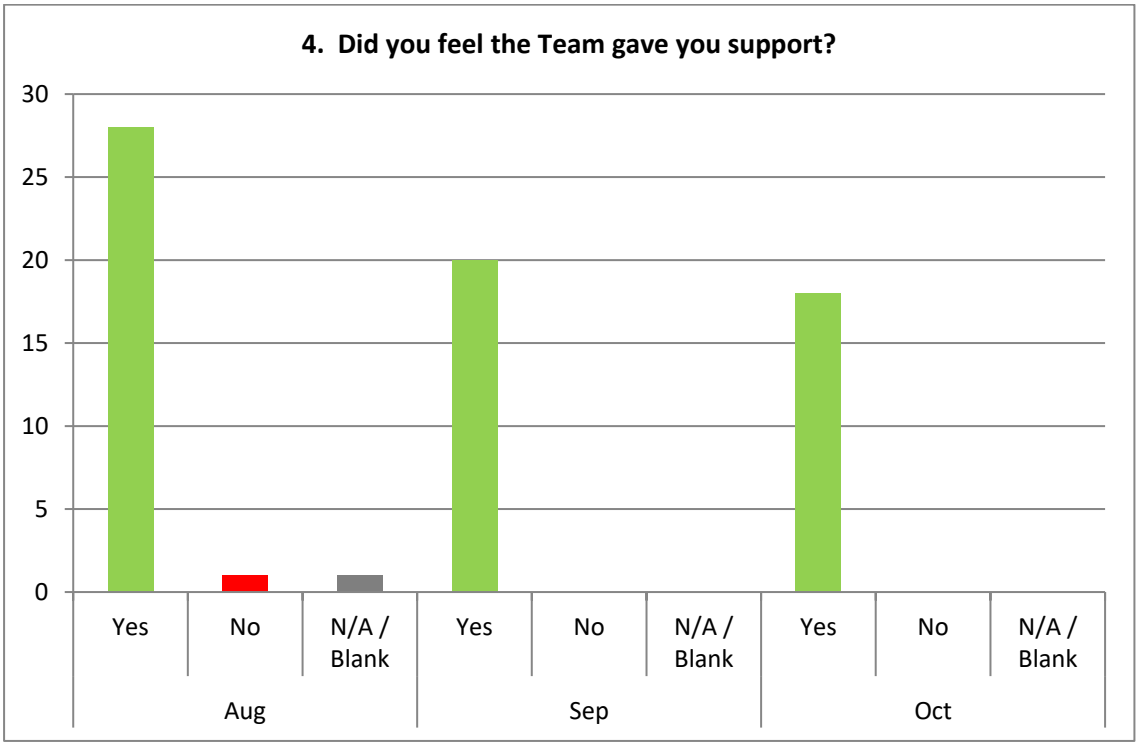

## Question 2



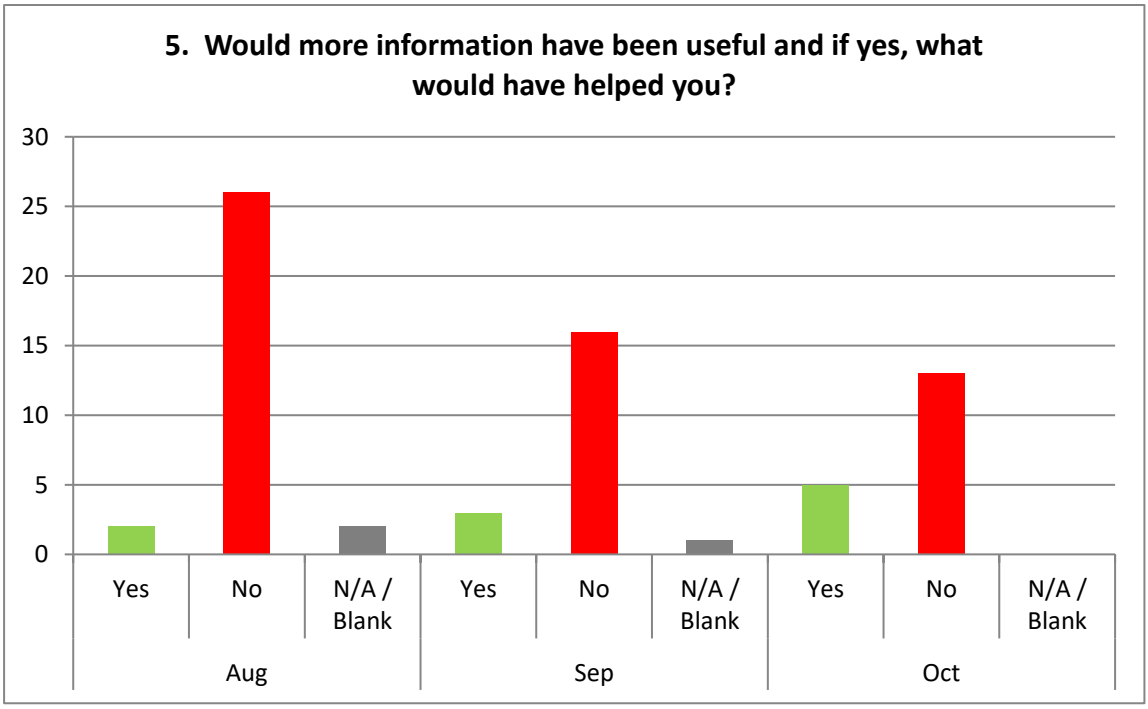
## Question 3



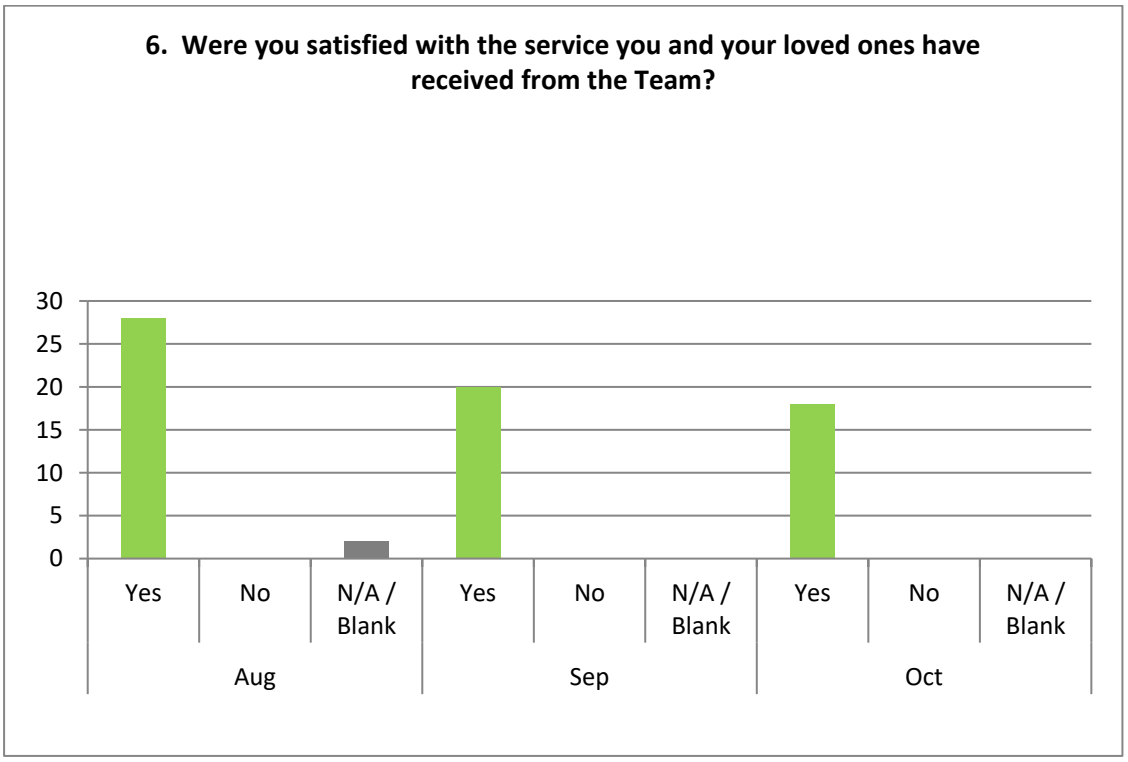

## Question 4



**Question 5**



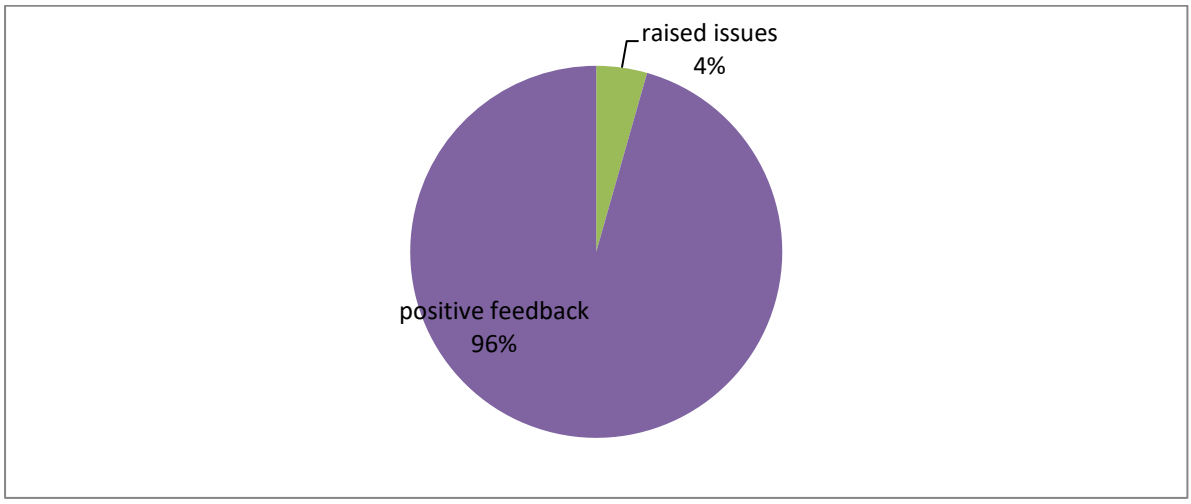

**Question 6**




The feedback has been extremely positive. Where issues were raised these related to other service areas and a lack of a co-ordinated approach to care. The partnership work being

undertaken by the Clinical Lead with primary and secondary care and hospices through regular multi-disciplinary meetings builds on an integrated approach and co-ordination of care.

**Overall Feedback**




## 10.0 NHSE/I End of Life Care Collaborative

The Clinical Lead for End of Life Care is a member of the NHSI/E collaborative which supports shared best practice across a variety of settings. The work undertaken by the Trust in accordance with the Ambitions for End of Life Care has been presented nationally.

## 11.0 Developments in Mental Health

**11.1** Staff on the older adult dementia ward in Clacton have worked collaboratively with St Helena Hospice with a focus on palliative care, implementing a 'My Care Choices' register. The specialist palliative care staff worked with the ward and supported the development and update of a palliative care register with patients and relatives. The Gold Standard Framework process is now well established and the ward is has recently achieved accreditation. There is strong integration with the specialist teams and patients receive person centred approaches to their end of life care. The clinical lead and specialist nurses have supported staff development in gaining enhanced skills during the COVID – 19 pandemic. This included symptom management and the administration of medication via a syringe pump. Feedback from carers and relatives has been extremely positive.

**11.2** Wards and community dementia teams in Chelmsford work closely with the palliative care consultant from Farleigh Hospice who will visit patients on the ward who are palliative and at end of life care. This has enhanced outcomes for symptom management and a greater understanding for the staff in the management of patients requiring palliative care. It has provided confidence in ensuring patient choice and staff are happy to refer for support appropriately.

**11.3** A clinical pathway for patients under the care of STARS (Specialist Treatment and Recovery Service) in the Northeast is shortly to be launched. This was developed jointly with Farleigh Hospice and has been showcased nationally.

## 12.0 Developments within Nursing Homes

**12.1** The two nursing homes continue to have strong links with the specialist palliative care team and primary care within the South East Essex area. Patients are identified using the prognostic indicators and are added to electronic End of Life Care Register. This incorporates all elements of advance care planning and patient choice is recorded. In 2021 a new clinical system was introduced to enable record sharing with both the integrated community services teams and primary care. This has further strengthened joint working and co-ordinated care.

## 13.0 Continued support during the COVID - 19 Pandemic

**13.1** The COVID - 19 pandemic had required a re-focus of all services and the development of staff in 2020 so that they were able to provide the highest quality end of life care across all settings both to patients and carers/relatives. This has continued throughout 2021.

The Clinical Lead and Speciality Doctor have continued to support the development and implementation of a wide range of initiatives including enhanced skills and guidance around early recognition of end of life and symptom management. These include:

- Trust wide COVID - 19 anticipatory symptom management formulary developed in 2020 in accordance with national guidance continues to be reviewed on a weekly basis by the clinical lead and a pharmacist.
- Podcasts produced that are accessible to all staff 24/7 on the new processes.
- Implementation of procedures to stop delays in prescribing for symptom management in the community.
- Person centred approaches to care: implementation of a TEP or PEACE document to record discussions and choices including PPC/PPD/DNACPR/Requesting treatment.
- Continued guidance to staff in supporting difficult conversations developed in partnership with the palliative care consultant in accordance with national guidance. .
- Training relating to a number of aspects of end of life care delivered virtually
- Expert support/advice provided on a daily basis to clinical teams and staff members working outside of their usual area of expertise.

## 13.0 ABBREVIATIONS

| | |
|---|---|
| **EoLC** | End of Life Care |
| **PEACE** | Proactive Elderly Advance Care Plan |
| **TEP** | Treatment Escalation Plan |
| **DNACPR** | Do Not Attempt Cardiopulmonary Resuscitation |
| **CCG** | Clinical Commissioning Group |
| **ICS** | Integrated Care System |
| **CHS** | Community Health Services |
| **NACEL** | National Audit of Care at End of Life |
| **NICE** | National Institute for Health and Care Excellence |
| **MDT** | Multi-disciplinary Team |
| **GSF** | Gold Standards Framework |
| **PPC** | Preferred Priorities for Care |
| **PPD** | Preferred Place of Death |
| **DIPC** | Director of Infection Prevention and Control |
| **LPA** | Lasting Power of Attorney for health and welfare |
| **STARS** | Specialist Treatment and Recovery Service |

| | | |
|---|---|---|
| | | **Agenda Item No: 7c** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24th November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **A Framework of Quality Assurance for Responsible Officers and Revalidation – Annual Board Report** | | | | | |
| **Executive/Non-Executive Lead:** | Dr Milind Karale, Executive Medical Director | | | | | |
| **Report Author(s):** | Nicola Foley – Appraisal and Revalidation Manager | | | | | |
| **Report discussed previously at:** | | | | | | |
| **Level of Assurance:** | **Level 1** | ✓ | **Level 2** | | **Level 3** | |

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

| **Purpose of the Report** | | |
|---|---|---|
| This report provides the Board of Directors information on the implementation of revalidation within the Trust for 2020/21 appraisal year in order to provide annual statement of compliance provided to the higher level Responsible Officer at NHS England | **Approval** | ✓ |
| | **Discussion** | |
| | **Information** | ✓ |

**Recommendations/Action Required**

The Board of Directors is asked to:

1. Note the contents of the report and approve the compliance statement
2. The Designated Body (EPUT) through its Chairman or Chief Executive to submit the compliance statement to the Higher Responsible Officer at NHS England
3. Request any further information or action.

## Summary of Key Issues

The Board of the Essex Partnership University NHS Foundation Trust as a designated body has a responsibility to ensure that it is compliant with the Medical Professional (Responsible Officers) Regulation 2010 (as amended in 2013) Act.

The report is expected in the format stipulated by NHS England and includes details about the quality assurance, clinical governance, Trust's performance on revalidation, actions plans to strengthen the revalidation process, audits on concerns of doctors' practice and audits on the appraisals input and output.

Due to the ongoing COVID-19 pandemic, NHS England suspended the appraisal process for a large proportion of the 2020/21 appraisal year. However, a number of doctors with prescribed connection to EPUT, with support from the revalidation team, decided to complete their appraisal. The appraisal rate for the appraisal year was therefore much lower at 78.4 % compared to the appraisal rate of above 90% in the previous year.

As of 31st March 2021 there were 158 doctors with a prescribed connection to EPUT. Of the 158 doctors, 124 had an annual appraisal (78.4%). 67 doctors had a completed appraisal as per 'Category 1A' and 57 were defined as completed appraisals meeting 'Category 1B' during the appraisal year from 1st April 2020 to 31st March 2021.

Since the appraisals being reinstated, a plan has been put in place for the completion of the appraisals with a view to achieving the target 90% by the end of 2021/22 appraisal year if not sooner.

EPUT has appropriate policies and procedures in place for appraisal and revalidation. EPUT has established good governance arrangements for medical appraisal and revalidation.

There are some areas to be improved upon regarding appraisal rates, namely improving the completion rate to get it back up to the expected 90% and to increase the 1A appraisal rate by reducing the completed 1B, approved missed and incomplete appraisals. This is being monitored by the Responsible Officer through an action plan.

The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act.

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

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

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

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| Supporting Documents and/or Further Reading |
|---|
| |

| Lead |
|---|
| **Dr Milind Karale**<br>**Responsible Officer (Revalidation)** |



Annex D - Annual Board Report and Stat

Classification: Official

Publications approval reference: B0614

# A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

# Contents

# Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.
In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

**Annual Organisational Audit (AOA):**
At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

**Board Report template:**
Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.
A link to the letter is below:
https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:
Section 2a – Effective Appraisal
Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain

internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

**Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

# Designated Body Annual Board Report

## Section 1 – General:

The board of Essex Partnership University NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Action from last year: N/A

   Comments: EPUT has an appropriately trained medical practitioner, Dr Milind Karale, who was appointed as Responsible Officer in 2012.

   Action for next year: N/A

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes

   Action from last year: The Board to continue its support for annual appraisal and revalidation processes.

   Comments: The Designated Body currently provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role. The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act.

   Action for next year: The Board to continue its support for annual appraisal and revalidation processes.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   Action from last year: Continue to carry out process and amend the prescribed connection list as appropriate.

   Comments: There is an established process to ensure the accuracy of the list of doctors with prescribed connections to the Trust. In addition to the information gathered prior to and at the time of a job offer to a doctor, the Workforce Department provides a monthly report of new starters and leavers to the Appraisal and Revalidation Support Manager. Triangulation of this information is carried out with Human Resources – Medical and the clinician

concerned. The Prescribed Connection list with the GMC is amended as appropriate.

Action for next year: Continue to carry out process and amend the prescribed connection list as appropriate.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Update the Medical Appraisal policy and procedure.

Comments: All new national guidance and amendments to existing documentation is read, shared appropriately and implemented where possible. EPUT's Medical Appraisal and Development policy and procedure was last updated in 2018. It is being reviewed again in 2021 to ensure compliance with national guidance.

Action for next year: Continue to monitor and review the policies in place to support medical revalidation.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Action from last year: Continue to Quality Assure our appraisal and revalidation processes and provide the necessary information when requested.

Comments: A peer review has not been undertaken last year and the Trust has relied on internal Quality Assurance processes. The processes have been regularly reviewed by the RO and the Director of Medical Appraisals and Revalidation along with Human Resources. The information relating to appraisal and revalidation has been shared with the CQC as part of their inspection of the organisation.

Action for next year: Organise a peer review of our appraisal and revalidation processes.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Continue to ensure that all doctors are supported in their continuing professional development, appraisal, revalidation and governance.

Comments: All doctors are supported in their continuing professional development, appraisal, revalidation and governance. The Trust has strong medical education and medical management teams, which support the doctors in their continued professional development. This is monitored by

various committees of the Trust. The revalidation office provides regular support for the doctors on appraisal and revalidation, including timely reminders of appraisals, appraisal training and support in developing appraisal portfolios.

Where the doctor does not have a prescribed connection to the Organisation, they are provided with the necessary supporting information to pass on to their Designated Body and include at their appraisal.

Action for next year: Continue to ensure that all doctors are supported in their continuing professional development, appraisal, revalidation and governance.

## Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: Continue to ensure all doctors on our prescribed connection list have a whole practice annual appraisal.

Comments: All doctors with prescribed connection to EPUT are required to have a whole practice annual appraisal, which includes any necessary information on complaints and/or significant events that they have been named in for each appraisal year so that lessons learnt and reflections can be drawn upon. Where the appraiser is not the line manager of the doctor, the line manager provides a medical managers report covering specific issues to be discussed during the appraisal. Where EPUT is not the doctors' sole employer within their appraisal year, the doctor is required to provide a fitness to practice statement from all places where they were employed in a medical capacity.

We have adopted using the Appraisal 2020 model whilst allowing our doctors to choose between this and the standard appraisal template. The majority have opted to use the Appraisal 2020 model and we have received good feedback on this. We will continue to use this approach going forward.

Action for next year: Continue to ensure all doctors on our prescribed connection list have a whole practice annual appraisal.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue to put in place action plans for those who do not have an annual whole practice appraisal and complete the annual audit on missed or incomplete appraisals.

Comments: Where a doctor does not have a whole practice annual appraisal the reasons are understood and a plan put in place for completion. An annual audit of missed or incomplete appraisals is carried out to identify any trends and to improve our processes. The Responsible Officer and the Director of Medical Appraisal and Revalidation review the report on delayed appraisals on a monthly basis.

Action for next year: Continue to put in place action plans for those who do not have an annual whole practice appraisal and complete the annual audit on missed or incomplete appraisals.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Update the Medical Appraisal Policy and Procedure.

Comments: EPUT has a Medical Appraisal policy in place that was updated and ratified in 2018 which is in line with national policy.

Action for next year: Continue to review national policy and update the Medical Appraisal policy and procedure accordingly.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Organise new and appraiser refresher training.

Comments: As of 31st March 2021 there were 35 formally trained and approved medical appraisers across EPUT which is a sufficient number to carry out timely annual medical appraisals for all its licensed medical practitioners.

New appraiser training and appraiser refresher training was held in February 2020 and further training will be organised for 2021/22 year.

Action for next year: Organise new and appraiser refresher training.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal

network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

| |
|---|
| Action from last year: Continue to support the appraisers in their role and ensure that they undergo training when required. Provide them with the necessary information in relation to their appraiser role to include in their appraisal.<br><br>Comments: There is on-going support for the medical appraisers by way of updates and the Appraisal and Revalidation Team is available to address their queries as and when they arise. Training is made available to the appraisers.<br><br>Each appraisee is expected to complete an anonymised feedback of their experience which is summated annually and provided to individual appraisers for their reflection. The individual appraisers include their appraiser role within their own annual appraisal for discussion and reflection.<br><br>Action for next year: Continue to support the appraisers in their role and ensure that they undergo training when required. Provide them with the necessary information in relation to their appraiser role to include in their appraisal. |

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

| |
|---|
| Action from last year: Continue to complete annual audits and submit to Board.<br><br>Comments: Annual audits of our appraisal system are completed and submitted to Board with the Board Report. The report is shared with the Executive Team and discussed at the Quality Committee. Please see attached Appendix A and B for 2020/21 findings.<br><br>Action for next year: Continue to complete annual audits and submit to Board. |

## Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

| **Name of organisation:** | |
|---|---|

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

| | |
|---|---|
| **Total number of doctors with a prescribed connection as at 31 March 2021** | **158** |
| **Total number of appraisals undertaken between 1 April 2020 and 31 March 2021** | **124** |
| **Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021** | **34** |
| **Total number of agreed exceptions** | **23** |

## Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: To ensure timely recommendations are made to the GMC.

Comments: The revalidation process was postponed for the majority of the 2020/21 appraisal year with the GMC allocating new later revalidation dates to those that were due within this period. The changes were communicated to the affected doctors. The revalidation process is now underway again and we will continue to ensure that timely recommendations are submitted.

Action for next year: To ensure that timely recommendations are made to the GMC and that the doctors are ready for revalidation in good time to mitigate against any delays.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Continue to ensure that revalidation recommendations are communicated promptly.

Comments: Revalidation recommendations are communicated to the doctor at the point of the recommendation being made, if not sooner. Where the recommendation of deferral or non-engagement is made, the reasons are discussed with the doctor and a plan is put in place to ensure a subsequent positive recommendation. The GMC communicates the details of revalidation recommendations to the individual doctor directly.

Action for next year: Continue to ensure that revalidation recommendations are communicated promptly.

## Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Continue to create an environment which delivers effective clinical governance for doctors.

Comments: The organisation has effective clinical governance processes for doctors in place which is carried out in a number of ways. For example, relevant information is collected such as complaints and significant events. Lessons Learnt on significant events and audits are also disseminated regularly. The Trust's Clinical Director for Clinical Governance takes the lead on learning lessons within the organisation. The Trust has effective medical management structure to support the clinical governance for the doctors.

Action for next year: Continue to create an environment which delivers effective clinical governance for doctors.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Continue to monitor the conduct and performance of all doctors working in our organisation and provide all relevant information to include at their appraisal.

Comments: Monitoring the performance of all doctors working within the Trust is carried out regularly in a variety of ways. Some examples include monitoring adherence to Trust policies and procedures, recording data on complaints, significant events and service provision, compliance with mandatory training and revalidation requirements and feedback from trainees. The Clinical Directors have a monthly meeting with the doctors under their line management to discuss the performance of doctors.

Corporate data is used and provided to the doctor to include in their annual appraisal. Such data includes information on complaints, significant events, audits and attendance at internal weekly teaching sessions. This information/data is obtained by the individual doctor from the relevant department a couple of months prior to the appraisal.

The doctors include their updated job plan, mandatory training record and declare any probity issues and issues relating to suspensions and investigations that they may be involved in.

Action for next year: Continue to monitor the conduct and performance of all doctors working in our organisation and provide all relevant information to include at their appraisal.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

> Action from last year: Continue with established process and update the policy and procedure as and when required.
>
> Comments: The organisation has a process in place for responding to concerns and has a Maintaining High Professional Standards – Conduct and Capability policy and procedure for Medical and Dental staff which is in line with national guidance and was last updated in 2017. The Trust has an adequate number of trained Case Managers and Case Investigators.
>
> Action for next year: Continue with established process and update the policy and procedure as and when required.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

> Action from last year: Continue to complete annual audit and submit to Board.
>
> Comments: Annual audit of responding to concerns about a doctor in our organisation is completed and submitted to Board with the board Report.
>
> Action for next year: Continue to complete annual audit and submit to Board.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: Continue to transfer information and concerns in a timely manner between responsible officers when necessary.

Comments: Medical Practice Information Transfer forms are used to transfer information and concerns between responsible officers where necessary. This is a nationally approved form.

The doctors are required to declare to the organisation all the places where they are employed in a medical capacity and to provide a fitness to practice statement from them to include in their annual appraisal.

Action for next year: Continue to transfer information and concerns in a timely manner between responsible officers when necessary.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Continue to ensure the appropriate policies and procedures in place are followed and updated and to ensure that those involved in investigations are regularly trained.

Comments: The organisation has a Maintaining High Professional Standards policy and procedure which has been ratified and which is in line with national guidance. Those involved in investigations are trained on the role regularly. There is also an appeal and remediation policy and procedure which are followed when required.

Action for next year: Continue to ensure the appropriate policies and procedures in place are followed and updated and to ensure that those involved in investigations are regularly trained.

## Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Continue with new starter processes

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Comments: EPUT has systems in place to ensure that we are compliant with the Responsible Officer Regulations Act with regards to recruitment and employment checks. Medical HR carries out the necessary pre-employment checks prior to any medical staff joining the Trust and for locum agency doctors. There are also some post-employment checks that are carried out by the Appraisal and Revalidation Team which include name of last Responsible Officer, revalidation due date, copies of previous appraisals, appraisal due date and the MPIT Form.

Action for next year: Continue with new starter processes

## Section 6 – Summary of comments, and overall conclusion

As of 31st March 2021 there were 158 doctors with a prescribed connection to EPUT. Of the 158 doctors, 124 had an annual appraisal (78.4%). 67 doctors had a completed appraisal as per 'Category 1A'[1] and 57 were defined as completed appraisals meeting 'Category 1B'[2] during the appraisal year from 1st April 2020 to 31st March 2021.

Due to the ongoing COVID-19 pandemic NHS England suspended the appraisal process for a large proportion of the 2020/21 appraisal year which is why the appraisal rate for this year dropped below the expected 90%. Since being reinstated a plan has been put in place for the completion of the appraisals with a view to achieving the target 90% by the end of 2021/22 appraisal year if not sooner.

**Overall conclusion:**

EPUT has appropriate policies and procedures in place for appraisal and revalidation. EPUT has established good governance arrangements for medical appraisal and revalidation.

There are some areas to be improved upon regarding appraisal rates, namely improving the completion rate to get it back up to the expected 90% and to increase the 1A appraisal rate by reducing the completed 1B, approved missed and incomplete appraisals. This is being monitored by the Responsible Officer through an action plan.

The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act.

[1] A Category 1a completed annual medical appraisal is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March.

[2] A Category 1b completed annual medical appraisal is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply:

- the appraisal did not take place in the window of three months preceding the appraisal due date;

- the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year;

- the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting.

However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

[3] An Approved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of either a Category 1a or 1b completed annual medical appraisal, but the responsible officer has given approval to the postponement or cancellation of the appraisal.

[4] An Unapproved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of either a Category 1a or 1b completed annual medical appraisal, and the responsible officer has not given approval to the postponement or cancellation of the appraisal.

## Section 7 – Statement of Compliance:

The Board of Essex Partnership University NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Essex Partnership University NHS Foundation Trust

Name: Paul Scott

Signed: 

Role: Chief Executive

Date: 19 October 2021

## Annual Report Template Appendix A – Audit of all missed or incomplete appraisals

| | Totals |
|---|---|
| Number of doctors on GMC Connect as of 31 March 2021 | 158 |
| Number of doctors who were not due for an appraisal by 31 March 2021 (new starters after April 2020) | 7 |
| Number of Completed 1A appraisals for 2020-21 | 67 |
| Number of Completed 1B Appraisals for 2020-21 | 57<br><br>*(these are where the appraisal meetings have been held within the appraisal year but one of the following applied:*<br>• the appraisal did not take place in the window of three months preceding the appraisal due date;<br>• the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year;<br>• the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting) |
| Approved Incomplete/Missed Appraisals for 2020-21 | 23<br>*(7 were new starters and were not due an appraisal by 31st March 2021, 3 were LTS, 1 was on maternity leave, 1 was under continuing investigation and 11 were delayed due to COVID-19)* |
| Unapproved Incomplete/Missed Appraisals for 2020-21 | 11<br>*(11 have been or are in the process of being completed)* |

| **Doctor factors (total)** | **75** |
|---|---|
| Maternity leave during the majority of the 'appraisal due window' | 1 |
| Sickness absence during the majority of the 'appraisal due window' | 3 |
| Prolonged leave during the majority of the 'appraisal due window' | 0 |

| | |
|---|---|
| Suspension during the majority of the ‘appraisal due window’ | 0 |
| New starter within 3 month of appraisal due date | 0 |
| New starter more than 3 months from appraisal due date | 0 |
| Postponed due to incomplete portfolio/insufficient supporting information | 0 |
| Appraisal outputs not signed off by doctor within 28 days | 1 |
| Lack of time of doctor | 0 |
| Lack of engagement of doctor | 0 |
| Other doctor factors | 70 |
| (describe)<br>No appraisal completed in 2020/21 appraisal year<br>No appraisal prior to joining EPUT<br>Appraisal meeting took place after appraisal due date<br>COVID delay<br>Continuing investigation | <br>15<br>6<br>41<br>7<br>1 |
| **Appraiser factors** | **15** |
| Unplanned absence of appraiser | 0 |
| Appraisal outputs not signed off by appraiser within 28 days | 0 |
| Lack of time of appraiser | 15 |
| Other appraiser factors (describe) | 0 |
| **Organisational factors** | **0** |
| Administration or management factors | 0 |
| Failure of electronic information systems | 0 |
| Insufficient numbers of trained appraisers | 0 |
| Other organisational factors (describe) | 0 |

## Annual Report Template Appendix B – Quality assurance of appraisal inputs and outputs

| | | |
|---|---|---|
| Total number of appraisals completed | | 128[1] |
| | Number of appraisal portfolios sampled | Number of the sampled appraisal portfolios deemed to be acceptable against standards |
| Appraisal inputs | 26 | 23 |
| Scope of work: Has a full scope of practice been described? | 26 | 26 |
| Continuing Professional Development (CPD): Is CPD compliant with GMC requirements? | 26 | 19[2] |
| Quality improvement activity: Is quality improvement activity compliant with GMC requirements? | 26 | 20[2] |
| Patient feedback exercise: Has a patient feedback exercise been completed? | 26 | 2[4] |
| Colleague feedback exercise: Has a colleague feedback exercise been completed? | 26 | 7[4] |
| Review of complaints: Have all complaints been included? | 26 | 26[3] |
| Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included? | 26 | 26[3] |
| Is there sufficient supporting information from all the doctor's roles and places of work? | 26 | 26 |
| Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)?<br>For example<br>• Has a patient and colleague feedback exercise been completed by year 3?<br>• Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)?<br>• Have all types of supporting information been included? | 26 | 18 |
| Appraisal Outputs | | |
| Appraisal Summary | 26 | 22 |
| Appraiser Statements | 26 | 26 |
| Personal Development Plan (PDP) | 26 | 18 |

[1] This includes the doctors who had left the Trust prior to 31st March 2021.

[2] We are taking measures to improve individual doctors' reflective notes within their CPD and Quality Improvement Activities. This is ongoing.

[3] Based on evidence submitted within appraisal portfolio.

[4] The patient and colleague feedback is required once every revalidation cycle.

## Annual Report Template Appendix C – Audit of concerns about a doctor's practice

| Concerns about a doctor's practice | High level[5] | Medium level[2] | Low level[2] | Total |
|---|---|---|---|---|
| Number of doctors with concerns about their practice in the last 12 months (Apr 2020 – Mar 2021)<br>Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern | 3 | 2 | 3 | 8 |
| Capability concerns (as the primary category) in the last 12 months | 0 | 0 | 3 | 3 |
| Conduct concerns (as the primary category) in the last 12 months | 3 | 1 | 0 | 4 |
| Health concerns (as the primary category) in the last 12 months | 0 | 1 | 0 | 1 |
| Remediation/Reskilling/Retraining/Rehabilitation | | | | |
| Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2021 who have undergone formal remediation between 1 April 2020 and 31 March 2021.<br>Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice<br>A doctor should be included here if they were undergoing remediation at any point during the year | | | | 1 |
| Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff) | | | | 7 |
| Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff) | | | | 0 |
| General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces) | | | | 0 |
| Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes) | | | | 1 |
| Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade) | | | | 0 |

[5] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

| | |
|---|---|
| Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies | 0 |
| Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies | 0 |
| TOTALS | 8 |
| Other Actions/Interventions | |
| Local Actions: | |
| Number of doctors who were suspended/excluded from practice between 1 April 2020 and 31 March 2021:<br>Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included | 1 |
| Duration of suspension:<br>Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included<br>Less than 1 week<br>1 week to 1 month<br>1 – 3 months<br>3 - 6 months<br>6 - 12 months | ✓ (1 week to 1 month) |
| Number of doctors who have had local restrictions placed on their practice in the last 12 months? | 1 |
| GMC Actions:<br>Number of doctors who: | |
| Were referred by the designated body to the GMC between 1 April and 31 March | 2 |
| Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March | 3 |
| Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March | 2 |
| Had their registration/licence suspended by the GMC between 1 April and 31 March | 0 |
| Were erased from the GMC register between 1 April and 31 March | 0 |
| National Clinical Assessment Service actions: | |

| | |
|---|---|
| Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment | 9 |
| Number of NCAS assessments performed | 0 |

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH


Publication approval reference: PAR614

| | | |
|---|---|---|
| | | **Agenda Item No: 7d** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | Learning from Deaths – Mortality Review Summary of Quarter 1 2021/22 information | | | | | |
| **Executive/Non-Executive Lead:** | Prof Natalie Hammond, Executive Nurse | | | | | |
| **Report Author(s):** | Michelle Bourner, Mortality Project Co-ordinator | | | | | |
| **Report discussed previously at:** | Mortality Review Sub-Committee<br>Quality Committee | | | | | |
| **Level of Assurance:** | **Level 1** | | **Level 2** | ✓ | **Level 3** | |

| **Risk Assessment of Report** | |
|---|---|
| State which BAF risk(s) this report relates to (risk ID and short form title e.g. BAF63 Learning) | BAF63 |
| Are you recommending a new risk for the EPUT BAF? | No |
| If Yes describe the risk to EPUT's organisational objectives | N/A |
| If Yes, is this an escalation from another EPUT risk register? | N/A |
| If Yes, will this risk have an action plan? | N/A |
| If No describe what measures will you use to monitor mitigation of the risk in lieu of an action plan? | N/A |
| Does this report mitigate the BAF risk(s)? | Yes |

| **Purpose of the Report** | | |
|---|---|---|
| This report presents to the Board of Directors:<br>• Information relating to deaths in scope for mortality review for Q1 2021/22 (1st April – 30th June 2021) together with updated information for 2020/21, 2019/20 and 2018/19; and<br>• Learning that has been identified within the Trust as a result of mortality review undertaken since the last report to the Board of Directors. | **Approval** | |
| | **Discussion** | |
| | **Information** | ✓ |

**Recommendations/Action Required**

The Board of Directors is asked to:

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

**Summary of Key Issues**

1. This report presents information that the Trust is nationally mandated to report to public Board meetings on a quarterly basis – ie the number of deaths in scope, the number reviewed and the assessment of problems in care scores; as well as the learning realised from mortality review. Additional information has routinely been included within quarterly reports in the past to provide the Quality Committee with additional assurance / information on inpatient / nursing home deaths and on the timeliness of mortality review processes within the Trust.

2. There were **43** deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in Q1. This is in line (marginally lower) than quarters not impacted by COVID-19 in previous years.

3. Of the 43 deaths, 9 were inpatient deaths and 9 were nursing home deaths. 6 of the 9 inpatient deaths and 5 of the 9 nursing homes deaths have been confirmed as due to natural causes. The remaining causes of death, with the exception of one, are currently under determination. There was one inpatient death which was due to unexpected unnatural causes and this is subject to a serious incident investigation.

4. The attached report includes details of the grade of review to which deaths are being subjected and the timeliness of completion of those reviews. It indicates that the improvement in the timeliness of consideration via the Deceased Patient Review Group has continued. It also indicates that the significant majority of deaths continue to either be closed at Grade 1 desktop review by the Deceased Patient Review Group or investigated at Grade 4 serious incident investigation, with limited use of the Grade 2 case note review option. This will be addressed via the current implementation of the national Patient Safety Incident Response Framework (PSIRF). Detailed proposals for new mortality review processes to align with PSIRF are currently being finalised.

5. The attached report also includes details of the profile of problems in care scores assigned to deaths in scope. This indicates that the significant majority of deaths have been assessed as having no problems in care (score 6).

6. The Mortality Review Sub-Committee also oversees a dashboard of information on deaths of substance misuse service users who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death. This information will be considered by the Sub-Committee to ensure an overview of such deaths. There are no issues of concern to report.

7. Details of learning from mortality review since the last report to the Board of Directors are included in the attached report, together with examples of actions taken in response to learning themes.

| **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 £** | N/A |

| | | | |
|---|---|---|---|
| | | **Revenue £**<br>**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** | N/A |

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

**Supporting Documents and/or Further Reading**

***Attached - Report on Mortality Information and Learning from Deaths for Q1 2021/22***
***Annex A – 2021/22 Dashboard (national reporting format)***
***Annex B - 2020/21 Dashboard (national reporting format)***
***Annex C – 2019/20 Dashboard (national reporting format)***
***Annex D – 2018/19 Dashboard (national reporting format)***

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

**Lead**

Natalie Hammond
**Executive Nurse**

**EPUT**

# LEARNING FROM DEATHS – MORTALITY REVIEW PUBLICATION OF MORTALITY DATA AND LEARNING QUARTER 1 2021/22

## 1.0 PURPOSE OF REPORT

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

- Information relating to deaths in scope for mortality review for Q1 2021/22 (1st April – 30th June 2021);
- Updated information relating to deaths in scope for mortality review in 2020/21, 2019/20 and 2018/19; and
- Learning that has been identified within the Trust as a result of mortality review since the last report to the Board of Directors.

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

## 2.0 BACKGROUND AND CONTEXT

2.1 The effective review of mortality is an important element of the Trust's approach to learning and ensuring that the quality of services is continually improved. "National Guidance on Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care" (National Quality Board March 2017) set out extensive guidance for Trusts in terms of approaches to reviewing mortality, learning from deaths and reporting information. The Trust has subsequently implemented a Mortality Review Policy and agreed its approach to reporting mortality data. This is currently under review and detailed proposals to align mortality review processes to the new Patient Safety Incident Response Framework (PSIRF) arrangements are currently being finalised.

2.2 In line with national guidance, quarterly reports of the nationally mandated information are presented to the Trust Board of Directors outlining mortality data and learning from deaths. This report presents data for Q1 2021/22 (and updated data for previous quarters / years) as at the day the report was prepared (ie 7th October 2021).

## 3.0 SCOPE OF DEATHS INCLUDED IN THIS REPORT

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

3.2 The Mortality Review Sub-Committee also monitors the deaths of patients who had had contact with the EPUT element of the substance misuse service in the 6 months

preceding their death. The data for Q1 has been considered by the Mortality Review Sub-Committee and there are no issues of note or concern to report.

## 4.0 TOTAL NUMBER OF DEATHS IN SCOPE FOR REVIEW

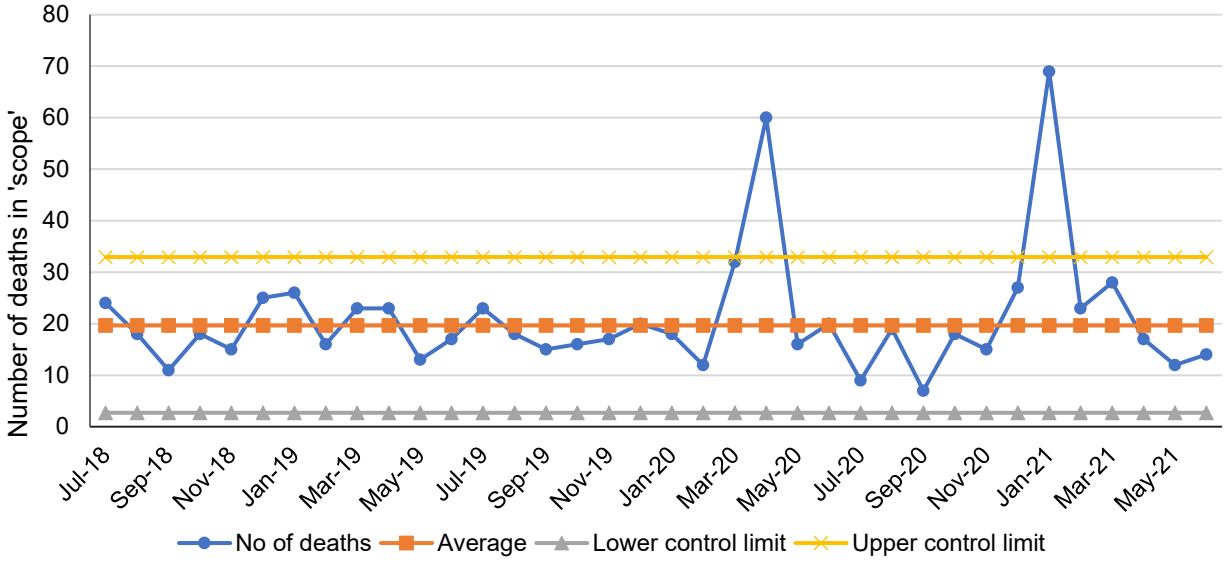
4.1 There were **43 deaths** which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in **Q1 2021/22**. This is in line (marginally lower) than quarters not impacted by COVID-19 in previous years. Data held on the Datix incident management reporting system and electronic clinical record systems is consistent.

***Table 1: Breakdown of total deaths in scope for review***

| Period | Total 2018/19 | 2019/20 Q1 | 2019/20 Q2 | 2019/20 Q3 | 2019/20 Q4 | Total 2019/20 | 2020/21 Q1 | 2020/21 Q2 | 2020/21 Q3 | Jan 2021 | Feb 2021 | Mar 2021 | 2020/21 Q4 | Total 2020/21 | Apr 2021 | May 2021 | June 2021 | 2021/22 Q1 | 2021/22 YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Deaths in scope | 235 | 53 | 56 | 57 | 62 | 228 | 96 | 35 | 60 | 69 | 23 | 28 | 120 | 311 | 17 | 12 | 14 | 43 | 43 |

4.2 Figure 1 below shows the total number of deaths that fell within the scope of the policy each month in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2017 – November 2018). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. Figure 1 below indicates that the number of deaths in scope in Q1 falls within control limits.

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




4.3 The significantly higher levels of deaths in April 2020 and January 2021 were directly impacted by the COVID-19 pandemic. Explanatory information was included in the Q1 and Q4 2020/21 reports to the Board of Directors. The data for Q1 2021/22 indicates a return to levels of deaths consistent with periods pre-pandemic.

4.4 Of the 43 deaths in Q1, 9 were inpatient and 9 were nursing home deaths. Given the nature of the services provided by the Trust, there will be a number of deaths that occur on in-patient wards and in nursing homes which will be expected and which will be due to natural causes. Of the 9 inpatient deaths, 6 have been confirmed as due to natural causes and 5 of the 9 nursing homes deaths have been confirmed as due to natural causes. The remaining causes of death, with the exception of one, are currently under determination. There was one inpatient death which was due to unexpected unnatural causes and this is subject to a serious incident investigation.

## 5.0 GRADE AND PROGRESS OF REVIEWS / INVESTIGATIONS

5.1 The Trust has assurance that all deaths within scope have been or are in the process of being reviewed. The table below outlines the grade of review / investigation to which deaths in scope have been / are being subjected to. Please see paragraphs 5.5 - 5.7 below for information in terms of timeliness of review progress.

***Table 3: Breakdown of grade of reviews / investigations of deaths in scope***

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

| Grade of review / investigation | 2018/19 total | 2019/20 total | 2020/21 total | 2021/22 Q1 total | 2021/22 Total YTD |
|---|---|---|---|---|---|
| **Grade 1** Deceased Patient Review Group | 148 | 144 | 209 | 17 | 17 |
| | 63% | 63% | 67% | 40% | 40% |
| **Grade 2** Case Note Review | 18 | 17 | 5 | 0 | 0 |
| | 8% | 7% | 2% | 0% | 0% |
| **Grade 3** Critical Incident Review | 0 | 1 | 0 | 0 | 0 |
| | 0% | 1% | 0 | 0% | 0% |
| **Grade 4** Serious Incident Investigation | 69 | 65 | 73 | 9 | 9 |
| | 29% | 28% | 23% | 21% | 21% |
| **Final grade under determination** | 0 | 1 | 24 | 17 | 17 |
| | 0% | 1% | 8% | 39% | 39% |
| **TOTAL** | 235 | 228 | 311 | 43 | 43 |

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

- closed at Grade 1 desktop review by the Deceased Patient Review Group (ranging from 63% to 67% in previous years); or
- being investigated as Grade 4 serious incident investigations (ranging from 23% to 29% in previous years).

This trend has continued into Q1 2021/22, with 40% being closed at Grade 1 thus far and 21% being investigated at Grade 4.

5.3 There has been limited use of the Grade 2 clinical case note review option (ranging from 2% to 8% in previous years). This has been kept under review and has been taken into account in development of the national Patient Safety Incident Response Framework (PSIRF) arrangements being put in place across the Trust.

5.4 Positive progress has continued since the last report to the Board of Directors in terms of the timely consideration of deaths via mortality governance processes, with 39% of deaths in Q1, 8% of deaths in 2020/21 and 1% of deaths in 2019/20 requiring the grade of review to be determined. The Deceased Patient Review Group is awaiting further requested information on the 1 death in 2019/20 requiring a grade of review to be finalised.

5.5 There has been good progress with completing Case Note Reviews this quarter as and when capacity has allowed. Since the last report to the Board of Directors, four Case Note reviews have been completed and approved by the Deceased Patient Review Group.

5.6 Case Note Reviews constitute all reviews still in progress for 2018/19 deaths. A total of one Case Note Review is outstanding – this was completed, reviewed and further information requested. This has now been submitted and is going to the next meeting of the Deceased Patient Review Group.

5.7 There are four open Case Note Reviews for 2019/20 deaths. Three of these are completed and awaiting review and the fourth has been reallocated to a new reviewer.

5.8 Reviews / investigations have already been completed for 44% of deaths in Q1 2021/22. The continuation of timeliness of consideration via the Deceased Patient Review Group has been achieved with virtual Group meetings being held on a monthly basis to ensure timely review of deaths within scope of the Mortality Review Policy.

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

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

| **Score** | **2018/19** (Number) | **2018/19** (as a %) | **2019/20** (Number) | **2019/20** (as a %) | **2020/21** (Number) | **2020/21** (as a %) | **2021/22 YTD** (number) | **2021/22 YTD** (as a %) |
|---|---|---|---|---|---|---|---|---|
| **6 - definitely less likely than not** | 191 | 81% | 169 | 74% | 229 | 74% | 17 | 40% |
| **5 - slight evidence** | 22 | 9% | 29 | 12% | 22 | 7% | 1 | 2% |
| **4 - not very likely** | 11 | 5% | 14 | 6% | 8 | 3% | 0 | 0% |
| **3 - probably likely** | 6 | 3% | 4 | 2% | 0 | 0% | 0 | 0% |
| **2 - strong evidence** | 1 | 1% | 0 | 0% | 0 | 0% | 0 | 0% |
| **1 - definitely more likely than not** | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| **Under determination** | 4 | 2% | 12 | 6% | 52 | 16% | 25 | 58% |

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

6.3 Scores for those deaths for which the review has been closed but no score yet allocated are being followed up.

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

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

7.1 Annexes A - C of this report detail the number of deaths that have been referred into the programme. Assurances can be given that all deaths meeting the criteria for referral to the LeDeR programme have been referred. There is one additional death on the EPUT mortality dashboard for Q1, not included in the LeDeR referrals total. This is due to the specific diagnosis and, as yet, whilst this has been reported to the LeDeR Steering Group, there is no reporting facility in place nationally to accommodate this. The reporting abilities are being pursued nationally.

## 8.0 LEARNING FROM MORTALITY REVIEW OF DEATHS

### 8.1 LEARNING FROM INDIVIDUAL MORTALITY REVIEW

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

8.1.2 Example of learning themes from Q1 have related to risk assessment; communication; documentation; clinical; contact during COVID-19; and discharge planning and follow up.

### 8.2 LEARNING FROM THEMATIC MORTALITY REVIEW

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

8.2.2 There are no new thematic reviews to report this quarter.

### 8.3 EXAMPLES OF LEARNING IMPLEMENTED

8.3.1 Since the Trust implemented the Patient Safety Incident Response Framework (PSIRF) the way in which learning is identified and disseminated has adapted. When an incident occurs within the Trust and it meets the nationally or locally defined criteria to be investigated as a Patient Safety Incident Investigation (PSII), the learning from the investigation is collated and reported to the Executive Team, senior managers, the learning oversight committee, bulletins, quality matters leaflet and with the clinical teams involved in the patient's care. When a number of incidents occur of a similar nature, a thematic review is undertaken, with the view that an overarching System Improvement Plan for the Trust is developed and implemented.

8.3.2 For incidents that occur that do not meet the nationally or locally defined criteria, they are discussed at the weekly Clinical Review Group. The appropriate patient safety incident review method is decided and commissioned. How the learning is disseminated is agreed on a case by case basis, and will form part of the thematic review and overarching System Improvement Plan.

8.3.3 The Trust have adopted several methods of review following a patient safety incident:

- After Action Review – a reflective discussion with clinicians involved in the patient's care. This is usually completed within 72 hours to 14 days of the incident. This has been welcomed by clinicians as this method empowers reflective conversations and early learning from the incident, with the view that another method of review can be commissioned thereafter if there is opportunity for further or wider learning.
- A Clinical Review – a desk-top review of the patient's notes and conversation with clinicians involved in the patient's care in order to specifically review areas of the patient's care pathway, such as initial assessment, community care, crisis intervention, transfer and discharge. This review method is completed within 30 working days of the incident, which allows for the learning to be collated, acknowledged and cascaded in a timely manner.
- A Patient Safety Incident Review – this method uses the same methodology as the Patient Safety Incident Investigation and is completed within 30 working days, which encourages acknowledgement of early learning.

8.3.4 Within the review templates, there are specific areas of keys areas of care and service delivery strengths, which encourages the investigators/reviewer to consider these areas of practice in the same way they would consider the weaknesses. The outcomes of this are shared in the same way the future learning points are.

8.3.5 A thematic review is underway at present and this involves patient falls which resulted in head injury requiring treatment in hospital. This is due to be finalised in January 2022.

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

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

For each of these incidents, the quality reviewer (Nurse Consultant for Patient Safety or Patient Safety Incident Management Clinical Lead) will carry out a detailed review of the completed investigation action plan, in conjunction with the service, to identify evidence that the learning has been embedded. This is completed in collaboration with the operational services. The quality review will be conducted three to six months after the action plan has been completed and signed off. Following completion of the quality review, the reviewer presents their findings to the Patient Safety Incident Executive Assurance Group who will identify any further actions required. The Trust also uses these quality reviews to demonstrate a culture of reflection and learning within EPUT. They have been shared with HM Coroner and Commissioning bodies and have received positive feedback.

8.3.7 The Trust continues to ensure that identified learning from investigations and reviews lead to improvements in practice. Examples of actions taken in response to learning include:

- **Review of the Active Engagement Guidance including Did Not Attend** – specific guidance has been included about the role and engagement of family

members/friends/carers who have concerns about a patient who is not engaging with services

- **CPA Policy and Procedure** – From incident investigations/reviews, it was highlighted that the identification of a patient's care coordinator was clear within the patient records. Staff are reminded to ensure that the CPA policy and procedure is followed and aligned with MDT meetings to determine who would be best placed to be allocated as a patient's care coordinator.
- **Updated Handover guidance** – This included within the clinical notes and also team safety huddles

## 9.0 CONCLUSIONS AND FUTURE ACTIONS

9.1 This report provides assurances that all deaths in Q1 which were within scope for mortality review have been reviewed / investigated or are in the process of being reviewed / investigated. The report also provides assurances that the overarching aim of mortality review – ie learning from deaths - is being achieved with examples of the learning themes being acted upon.

## 10.0 ACTION REQUIRED

10.1 The Board of Directors is asked to:

- Note the information contained within the report; and
- Seek clarity where required.

*Report prepared by:*
*Michelle Bourner, Project Co-ordinator*

*On behalf of:*
*Prof Natalie Hammond, Executive Nurse*

*October 2021*

## ANNEX A – MORTALITY DATA DASHBOARD 2021/22

# 2021/22 Learning from Deaths Dashboard - Breakdown for deaths in scope (excluding learning disability deaths)

| | |
|---|---|
| **Trust** | EPUT |
| **Month** | Oct-21 |
| **Year** | 2021-22 |

**Total Deaths in Scope:**

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

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

| Financial Year | Quarter | Total number of deaths in scope | Number of Learning Disability deaths (breakdown detailed on separate sheet) | Number of Other Deaths in Scope (exc LD) | Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust | | | | | | | | | Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Grade 1 (DPRG) | | Grade 2 (CRP) | | Grade 3 (CIR) | | Grade 4 (SI) | | Under determination | 1 - Definitely more likely than not | 2 - Strong evidence (significantly more than 50:50) | 3 - Probably likely (more than 50:50) | 4 - Not very likely (less than 50:50) | 5 - Slight evidence (significantly less than 50:50) | 6 - Definitely less likely than not | Under determination |
| | | | | | Complete | In progress | Complete | In progress | Complete | In progress | Complete | In progress | | | | | | | | |
| 2021-22 | Q1 | 43 | 10 | 33 | 10 | 0 | 0 | 0 | 0 | 0 | 2 | 7 | 14 | 0 | 0 | 0 | 0 | 1 | 10 | 22 |
| **YTD** | | **43** | **10** | **33** | **10** | **0** | **0** | **0** | **0** | **0** | **2** | **7** | **14** | **0** | **0** | **0** | **0** | **1** | **10** | **22** |
| 2021-22 | Q2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **YTD** | | **43** | **10** | **33** | **10** | **0** | **0** | **0** | **0** | **0** | **2** | **7** | **14** | **0** | **0** | **0** | **0** | **1** | **10** | **22** |
| 2021-22 | Q3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **YTD** | | **43** | **10** | **33** | **10** | **0** | **0** | **0** | **0** | **0** | **2** | **7** | **14** | **0** | **0** | **0** | **0** | **1** | **10** | **22** |
| 2021-22 | Q4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total 2021-22** | | **43** | **10** | **33** | **10** | **0** | **0** | **0** | **0** | **0** | **2** | **7** | **14** | **0** | **0** | **0** | **0** | **1** | **10** | **22** |

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

# 2021/22 Learning from Deaths Dashboard - Breakdown for learning disability deaths

| | |
|---|---|
| **Trust** | EPUT |
| **Month** | Oct-21 |
| **Year** | 2021-22 |

**Learning Disability Deaths**

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

| Financial Year | Quarter | Total Number of Learning Disability Deaths (inc inpatient and community) | Total number of these LD Deaths subjected to national LeDeR programme | Number of these LD deaths subjected to review by the Trust | | | | | | | | | Extent that these LD deaths deemed likely to be due to "problems in care" (categorised according to National Guidance) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Grade 1 (DPRG) | | Grade 2 (CRP) | | Grade 3 (CI) | | Grade 4 (SI) | | Under determination | 1 - Definitely more likely than not | 2 - Strong evidence (significantly more than 50:50) | 3 - Probably likely (more than 50:50) | 4 - Not very likely (less than 50:50) | 5 - Slight evidence (significantly less than 50:50) | 6 - Definitely less likely than not | Under determination |
| | | | | Complete | In progress | Complete | In progress | Complete | In progress | Complete | In progress | | | | | | | | |
| 2021-22 | Q1 | 10 | 9 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 7 | 3 |
| **YTD** | | 10 | 9 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 7 | 3 |
| 2021-22 | Q2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **YTD** | | 10 | 9 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 7 | 3 |
| 2021-22 | Q3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **YTD** | | 10 | 9 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 7 | 3 |
| 2021-22 | Q4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total 2021-22** | | 10 | 9 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 7 | 3 |

***Note: Q1 LeDeR referred figure impacted by current functionality of national system - all deaths that can be referred have been, detail included in covering report. This data dashboard is subject to the data limitations outlined in detail in previous reports to the Board of Directors***

## ANNEX B – MORTALITY DATA DASHBOARD 2020/21

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

| | | |
|---|---|---|
| **Trust** | EPUT | **Total Deaths in Scope:**<br>• All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services)<br>• All community Learning Disability deaths (detailed on sheet 2)<br>• All community deaths meeting Serious Incident criteria<br>* Deaths subject to a complaint / claim<br>* Deaths subject to a serious staff concern<br>* Severe Mental Illness as defined in Policy (not already included in above categories) |
| **Month** | Oct-21 | |
| **Year** | 2020-21 | |

| Financial Year | Quarter | Total number of deaths in scope | Number of Learning Disability deaths (breakdown detailed on separate sheet) | Number of Other Deaths in Scope (exc LD) | Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust | | | | | | | | | Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Grade 1 (DPRG) | | Grade 2 (CRP) | | Grade 3 (CIR) | | Grade 4 (SI) | | Under determination | 1 - Definitely more likely than not | 2 - Strong evidence (significantly more than 50:50) | 3 - Probably likely (more than 50:50) | 4 - Not very likely (less than 50:50) | 5 - Slight evidence (significantly less than 50:50) | 6 - Definitely less likely than not | Under determination |
| | | | | | Complete | In progress | Complete | In progress | Complete | In progress | Complete | In progress | | | | | | | | |
| 2020-21 | Q1 | 96 | 8 | 88 | 64 | 0 | 2 | 1 | 0 | 0 | 17 | 0 | 4 | 0 | 0 | 0 | 4 | 8 | 68 | 8 |
| **YTD** | | **96** | **8** | **88** | **64** | **0** | **2** | **1** | **0** | **0** | **17** | **0** | **4** | **0** | **0** | **0** | **4** | **8** | **68** | **8** |
| 2020-21 | Q2 | 35 | 6 | 29 | 13 | 0 | 0 | 0 | 0 | 0 | 15 | 2 | 0 | 0 | 0 | 0 | 1 | 2 | 19 | 8 |
| **YTD** | | **131** | **14** | **117** | **77** | **0** | **2** | **1** | **0** | **0** | **32** | **2** | **4** | **0** | **0** | **0** | **5** | **10** | **87** | **16** |
| 2020-21 | Q3 | 60 | 15 | 45 | 22 | 0 | 1 | 1 | 0 | 0 | 17 | 1 | 3 | 0 | 0 | 0 | 3 | 6 | 26 | 10 |
| **YTD** | | **191** | **29** | **162** | **99** | **0** | **3** | **2** | **0** | **0** | **49** | **3** | **7** | **0** | **0** | **0** | **8** | **16** | **113** | **26** |
| 2020-21 | Q4 | 120 | 32 | 88 | 49 | 0 | 0 | 0 | 0 | 0 | 19 | 2 | 18 | 0 | 0 | 0 | 0 | 6 | 55 | 26 |
| **Total 2020-21** | | **311** | **61** | **250** | **148** | **0** | **3** | **2** | **0** | **0** | **68** | **5** | **25** | **0** | **0** | **0** | **8** | **22** | **168** | **52** |

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

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

| | |
|---|---|
| **Trust** | EPUT |
| **Month** | Oct-21 |
| **Year** | 2020-21 |

**Learning Disability Deaths**

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

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

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

## ANNEX C – MORTALITY DATA DASHBOARD 2019/20

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

| | | |
|---|---|---|
| **Trust** | EPUT | **Total Deaths in Scope:**<br>• All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services)<br>• All community Learning Disability deaths (detailed on sheet 2)<br>• All community deaths meeting Serious Incident criteria<br>* Deaths subject to a complaint / claim<br>* Deaths subject to a serious staff concern<br>* Severe Mental Illness as defined in Policy (not already included in above categories) |
| **Month** | Oct-21 | |
| **Year** | 2019-20 | |

| Financial Year | Quarter | Total number of deaths in scope | Number of Learning Disability deaths (breakdown detailed on separate sheet) | Number of Other Deaths in Scope (exc LD) | Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust | | | | | | | | | Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Grade 1 (DPRG) | | Grade 2 (CRP) | | Grade 3 (CIR) | | Grade 4 (SI) | | Under determination | 1 - Definitely more likely than not | 2 - Strong evidence (significantly more than 50:50) | 3 - Probably likely (more than 50:50) | 4 - Not very likely (less than 50:50) | 5 - Slight evidence (significantly less than 50:50) | 6 - Definitely less likely than not | Under determination |
| | | | | | Complete | In progress | Complete | In progress | Complete | In progress | Complete | In progress | | | | | | | | |
| 2019-20 | Q1 | 53 | 8 | 45 | 24 | 0 | 4 | 0 | 0 | 0 | 15 | 0 | 0 | 0 | 0 | 0 | 2 | 6 | 34 | 3 |
| **YTD** | | 53 | **8** | 45 | 24 | 0 | 4 | 0 | 0 | 0 | 15 | 0 | 0 | 0 | 0 | 0 | 2 | 6 | 34 | 3 |
| 2019-20 | Q2 | 56 | 3 | 53 | 24 | 0 | 4 | 1 | 0 | 0 | 26 | 0 | 0 | 0 | 0 | 3 | 4 | 12 | 34 | 0 |
| **YTD** | | 109 | 11 | 98 | 48 | 0 | 8 | 1 | 0 | 0 | 41 | 0 | 0 | 0 | 0 | 3 | 6 | 18 | 68 | 3 |
| 2019-20 | Q3 | 57 | 11 | 46 | 27 | 0 | 3 | 1 | 1 | 0 | 14 | 0 | 0 | 0 | 0 | 1 | 5 | 7 | 29 | 4 |
| **YTD** | | 166 | **22** | 144 | 75 | 0 | 11 | 2 | 1 | 0 | 55 | 0 | 0 | 0 | 0 | 4 | 11 | 25 | 97 | 7 |
| 2019-20 | Q4 | 62 | 8 | 54 | 39 | 0 | 2 | 2 | 0 | 0 | 10 | 0 | 1 | 0 | 0 | 0 | 3 | 4 | 42 | 5 |
| **Total 2019-20** | | 228 | 30 | 198 | 114 | 0 | 13 | 4 | 1 | 0 | 65 | 0 | 1 | 0 | 0 | 4 | 14 | 29 | 139 | 12 |

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

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

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

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

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

## ANNEX D – MORTALITY DATA DASHBOARD 2018/19

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

| | | |
|---|---|---|
| **Trust** | EPUT | **Total Deaths in Scope:** |
| **Month** | Oct-21 | • All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services)<br>• All community Learning Disability deaths (detailed on sheet 2)<br>• All community deaths meeting Serious Incident criteria |
| **Year** | 2018-19 | * Deaths subject to a complaint / claim<br>* Deaths subject to a serious staff concern<br>* Severe Mental Illness as defined in Policy (not already included in above categories) |

| Financial Year | Quarter | Total number of deaths in scope | Number of Learning Disability deaths (breakdown detailed on separate sheet) | Number of Other Deaths in Scope (exc LD) | Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust | | | | | | | | | Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Grade 1 (DPRG) | | Grade 2 (CRP) | | Grade 3 (CIR) | | Grade 4 (SI) | | Under determination | 1 - Definitely more likely than not | 2 - Strong evidence (significantly more than 50:50) | 3 - Probably likely (more than 50:50) | 4 - Not very likely (less than 50:50) | 5 - Slight evidence (significantly less than 50:50) | 6 - Definitely less likely than not | Under determination |
| | | | | | Complete | In progress | Complete | In progress | Complete | In progress | Complete | In progress | | | | | | | | |
| 2018-19 | Q1 | 59 | 7 | 52 | 35 | 0 | 5 | 0 | 0 | 0 | 12 | 0 | 0 | 0 | 0 | 2 | 0 | 3 | 45 | 2 |
| **YTD** | | 59 | **7** | 52 | 35 | 0 | 5 | 0 | 0 | 0 | 12 | 0 | 0 | 0 | 0 | 2 | 0 | 3 | 45 | 2 |
| 2018-19 | Q2 | 53 | 11 | 42 | 19 | 0 | 3 | 1 | 0 | 0 | 19 | 0 | 0 | 0 | 1 | 3 | 3 | 4 | 30 | 1 |
| **YTD** | | 112 | 18 | 94 | 54 | 0 | 8 | 1 | 0 | 0 | 31 | 0 | 0 | 0 | 1 | 5 | 3 | 7 | 75 | 3 |
| 2018-19 | Q3 | 58 | 4 | 54 | 27 | 0 | 5 | 0 | 0 | 0 | 22 | 0 | 0 | 0 | 0 | 0 | 5 | 7 | 42 | 0 |
| **YTD** | | 170 | **22** | 148 | 81 | 0 | 13 | 1 | 0 | 0 | 53 | 0 | 0 | 0 | 1 | 5 | 8 | 14 | 117 | 3 |
| 2018-19 | Q4 | 65 | 10 | 55 | 35 | 0 | 4 | 0 | 0 | 0 | 16 | 0 | 0 | 0 | 0 | 1 | 3 | 8 | 42 | 1 |
| **Total 2018-19** | | 235 | 32 | 203 | 116 | 0 | 17 | 1 | 0 | 0 | 69 | 0 | 0 | 0 | 1 | 6 | 11 | 22 | 159 | 4 |

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

| | |
|---|---|
| **Trust** | EPUT |
| **Month** | Oct-21 |
| **Year** | 2018-19 |

**Learning Disability Deaths**

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

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

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

| | | |
|---|---|---|
| | | **Agenda Item No: 7e** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **Safeguarding Annual Report** | | | | | |
| **Executive/Non-Executive Lead:** | Natalie Hammond, Executive Nurse | | | | | |
| **Report Author(s):** | Tendayi Musundire, Associate Director for Safeguarding | | | | | |
| **Report discussed previously at:** | MHA & Safeguarding Sub-Committee<br>Quality Committee | | | | | |
| **Level of Assurance:** | **Level 1** | | **Level 2** | ✓ | **Level 3** | |

| **Risk Assessment of Report** | |
|---|---|
| Summary of Risks highlighted in this report | None |
| State which BAF risk(s) this report relates to | Not Applicable |
| Does this report mitigate the BAF risk(s)? | No |
| Are you recommending a new risk for the EPUT BAF? | No |
| If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register. | N/A |
| Describe what measures will you use to monitor mitigation of the risk | N/A |

| **Purpose of the Report** | | |
|---|---|---|
| This report provides the Board of Directors:<br>• With an account of the safeguarding activities undertaken across services and with partners during the year 1 April 2020 to 31 March 2021, and priority areas for 2021/22. | **Approval** | ✓ |
| | **Discussion** | ✓ |
| | **Information** | ✓ |

**Recommendations/Action Required**

The Board of Directors are asked to:

1 Note the contents of the report, the improvements made during 2020/21 and the priority areas for implementation during 2021/22
2 Approve the report and publication
3 Request any further information or action.

## Summary of Key Issues

The key issues:

The report gives assurance that safeguarding of children, young people and adults is considered core business and is a shared responsibility with the need for effective joint working between partner agencies and professionals.

- The annual report outlines how the safeguarding service is performing and promoting best practice.
- The Trust's strategic Framework was renewed in 2020 for the new three-year plan.
- The effective partnership working with partner agencies.
- 2020 – 21 has seen a continuation of the strengthening and improvement of the arrangements in place within the Trust to safeguard our most vulnerable patients.
- Recognition that the pandemic has impacted our populations in a variety of ways and consequently can be seen in the impact on safeguarding services.
- Innovative ways of working as a result of Covid-19
- Safeguarding training meets the national standards as identified in the Intercollegiate Guidance 2019 (children) and the RCN Intercollegiate Guidance 2018 (Adults).
- The 2019-2020 work plan was achieved excluding the delayed Covid-19 aspects and delay in the national implementation of LPS
- Training compliance dipped during the first phase of lockdown and then started to recover across all safeguarding training programmes both virtual and e-learning.

.

The Annual report provides a breakdown of the work undertaken by the safeguarding team during the period 2020 - 2021. This includes:

- Safeguarding Champions events
- Safeguarding adults activity
- Safeguarding and Looked After Children activity
- Service development and initiatives
- Local Safeguarding Partnership business priorities
- Learning lessons and safeguarding practice and domestic homicide reviews
- Feedback from partner agencies
- The voice of service users and staff
- Southend Borough Council Children's 0-19 Public Health Service

The report concludes with the 2021-2022 objectives and notes the safeguarding risks of:

- Increased safeguarding demands post pandemic
- Organisational achievement of implementing LPS from statutory guidance
- Aligning the service to the new STP and ICS arrangements organisational wide

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

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| Supporting Documents and/or Further Reading |
|---|
| |

**Lead**

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

NHS
Essex Partnership University
NHS Foundation Trust

# Safeguarding Annual Report 2020 - 2021

# Contents

# Foreword

It gives me great pleasure to introduce the 2020/2021 Safeguarding Annual Report.

As we move into 2021, the Safeguarding Annual Report provides an opportunity to reflect on where we need to focus our efforts in the year ahead and celebrate our achievements in 2020-21. Despite the impact and challenges faced over the last twelve months by Covid-19 we are assured that there has been no disruption to safeguarding provision and service provision across the Trust. We continue to make good progress in relation to our ambitions as set out in our 2019/2020 Annual Report. Essex Partnership University Trust (EPUT) recognises that one of the most important principles of safeguarding is that it is 'everyone's responsibility'.

This report demonstrates the Trust has continued its commitment towards safeguarding. In addition, it gives assurance that safeguarding is fully recognised as one of the Trust's key organisational priorities and is included within our Corporate Objectives.

Safeguarding children and adults is at the heart of the service we provide. Staff within the Safeguarding Team are committed to the safeguarding agenda, they take pride in delivering high quality, safe services and at all times strive to protect the people referred to them and keep them safe from harm. Emphasis is placed on ensuring that staff are able to develop their skills and knowledge in order to provide a service that meets the needs of their patients, whilst taking into account and adapting to changing situations, i.e. the Covid-19 virus. The pandemic has resulted in the Safeguarding Team operating very differently, both within EPUT and with our partner agencies.

Safeguarding is complex and challenging and our plans for the year ahead are ambitious but they are achievable. Driven by our Safeguarding team in association with system partners we will ensure our service is patient-centred, fair, collaborative, accountable and empowering. My vision for the future is to ensure that the Trust continues to maintain the very highest standards of quality and excellence for safeguarding adults and children, that the Safeguarding Team continue to provide in depth, first-rate training to EPUT staff and that people referred to the team can be assured that they will receive a service that is second to none.

Paul Scott
Chief Executive

# Introduction

A joint children and adult approach have been adopted in line with the Trust's shared safeguarding agendas, principals and duties of care. This annual report will provide a declaration of assurance that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of children, young people, adults and their families or carers who come into contact with our services. The arrangements reflect the 'Think Family' model. This annual report has been written to provide assurance that the Trust has robust and effective safeguarding services in place that reflect the Local Authority priorities and National Guidance, including Working Together to Safeguard Children 2018 and The Care Act 2014.

The annual report provides evidence of the Trust's achievements and its continued commitment to the safety, protection and prevention of harm to our service users.

Whilst a number of achievements have been made this year, we continue to challenge others and ourselves so that we develop and improve the quality of service provided. The service adapted the way it delivers its business as a result of the Covid-19 virus. It has offered new ways of working which enhance the service offered.

The report is divided into the following key areas:

- Safeguarding Strategic Direction and Development
- Safeguarding Adults
- Mental Capacity Act and Deprivation of Liberty Standards
- Safeguarding Children
- Looked After Children
- Service Developments and Innovations
- Serious Case Review and Domestic Homicide Reviews
- Forward Plans

# 1.0 Strategic Direction

This year has seen momentum of movement of the structures and integration of mental health and community health services in relation to safeguarding.

## Outcomes of Annual Plan 2020/21

The objectives set in the 2020/21 plan have been achieved or are ongoing and have been carried forward as demonstrated below. Additional detail on the outcomes of each objective is outlined within this report.

**Table 1: Safeguarding Objectives 2020/21**

| | Objectives 2020/21 | Success Criteria | Actions taken for success |
|---|---|---|---|
| 1 | **Think Family.** | Assessments and care plans demonstrate the impact of parental issues on children in the family and promote the Think Family approach.<br><br>Safeguarding referrals demonstrate that risk to all members of the family have been identified and care plans include the actions and changes to mitigate risk.<br><br>Learning lessons demonstrate think family care has been delivered by staff. | The safeguarding team has supported practitioners who work with adults to understand the impact of parental issues on children and encourage appropriate information exchange and joint working across services. This was highlighted in the training, newsletter and safeguarding champions' events.<br>The safeguarding team have assisted some operational teams to establish effective collaborative processes with children facing teams. This is still on going.<br><br>Agree the principles of a Think Family approach with partner agencies and disseminate these to staff through supervision and training initiatives.<br><br>Identify any barriers that prevent the principles being implemented in practice and take steps to mitigate their impact. This has not been achieved and will be on the next year's objectives. |
| 2 | **Integration of the two safeguarding teams** | **Implementation of agreed new model of safeguarding service delivery and team** | There was a restructure of the safeguarding team and a merger of the teams. |
| 3 | **The Trust will implement the new Liberty Protection Safeguards (LPS) effectively with sufficient resourcing to support said implementation.** | Effective implementation of LPS with sufficient resourcing to support | Scoping of the potential assessments has been undertaken.<br><br>Training implementation plan in place.<br>LPS standing agenda item on the MHA and Safeguarding Sub-Committee.<br>Review of Mental Capacity Act Policy.<br>Engage with partner agencies regarding implementation of LPS Review existing Safeguarding Team systems to determine resources required to implement and support LPS |

| | | | |
|---|---|---|---|
| 4 | **Align the Safeguarding service to the new Sustainability and Transformation Plans (STP) and Integrated Care Sytems (ICS) systems and processes** | The safeguarding service is aligned to the new STP and ICS arrangements. | Integrate and merge the safeguarding service to new STP and ICS arrangements. The implementation of LPS was put on hold until April 2022. This will be an objective for 2021/2 |
| 5 | **Review of the Trusts safeguarding Strategic Framework** | Ratification of the Trusts 2020-23 strategic framework.<br>The Annual Report demonstrates delivery of the objectives in the strategic framework. | A new three-year strategic framework has been developed. |
| 6 | **Review and submission of the Children Section 11 audit in 2020** | Ratification of the Children's Section 11 Audit.<br>Submission of the Section 11 Audit to partners to demonstrate the Trust has discharged its statutory responsibilities. | The timetable for submission of the Children's Section 11 audit was delayed by the Local Safeguarding Partnerships. This will be an objective for 2021/2 |
| 7 | **Young person transition to adult services leaving care** | Established new regular meetings with Personal Assistants (PAs) in leaving care team.<br><br>NHS line and GP services and school Nurse ChatHealth line already offered in leaving care packs as well as health information. | To support young people and practitioners with transition by developing an early referral pathway to adult services to ensure continuity of care. |
| 8 | **Creation of Looked After Children (LAC) team EPUT dashboard to enable service analysis of lac population/cohort.** | LAC team have had project meetings with information team.<br>Caseloads changed ready for dashboard.<br><br>Data cleansing of cohort completed. | Currently working with the information analysis team on this project.<br>Caseloads changed on system one ready for dashboard. |

| | | | |
|---|---|---|---|
| 9 | **To increase and promote LAC health service visibility within partner agencies.** | Information and contact details for LAC team and Health Visitors and School Nurses now included in the entry care packs for looked after children.<br>Regular meetings with Virtual School established to better support those not in education or with additional needs.<br><br>Good robust relationships established with Leaving Care team.<br><br>LAC health team established working links with Emotional Well-being and Mental Health Service (EWMHS).<br><br>Working well with Immunisation and Tuberculosis (TB) team.<br>Links established with Specialist Services for Additional needs. | To attend all partner agency meetings relevant to LAC.<br><br>To develop and maintain good working relationships with partner agencies.<br>Attend new date for foster carer training (delayed due to COVID 19). |

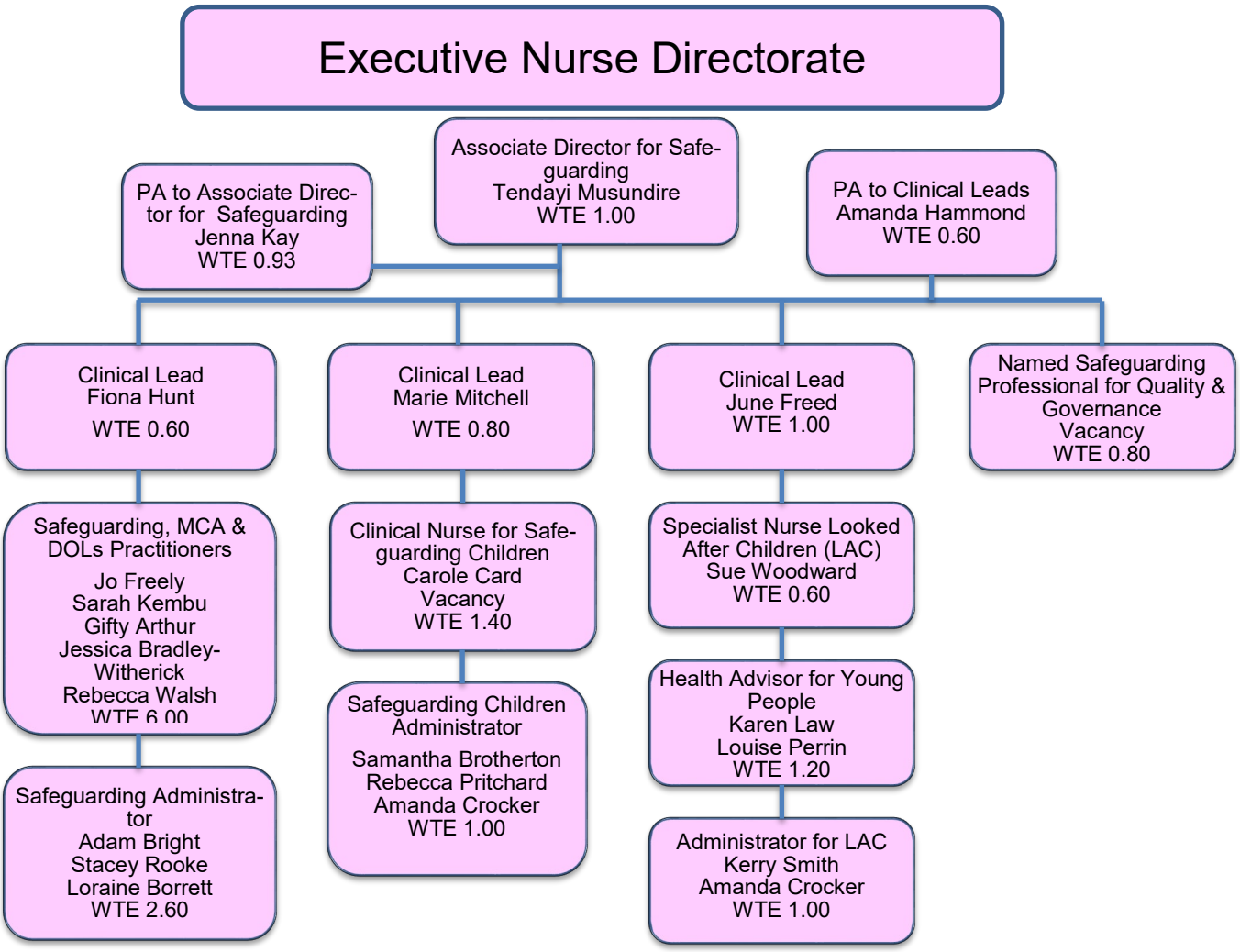
## Safeguarding Structure

Within Essex Partnership University Trust (EPUT), the Executive Nurse is responsible for the delivery of the Safeguarding service which includes the Mental Capacity & Deprivation of Liberty service, Domestic Abuse, PREVENT and the Looked after Children service.

The Safeguarding team is led by the Associate Director for Safeguarding covering Mental Health and Community Health Services. The team additionally provide a Safeguarding Children Service to the 0-19 service in Southend Borough Council (SBC). The team has adopted a "Think Family" philosophy and are providing an integrated approach to safeguarding provision which is facilitated by joint meetings and peer support. The team consists of a variety of professionals such as General and Mental Health Nurses, Social Worker, Midwives and an Occupational Therapist, all of whom bring additional expertise to the service. The safeguarding adult team operate a duty system between the hours of 9-5 Monday to Friday and aim to extend this to the children's provision.

The following diagram shows the existing Safeguarding service structure.

**Diagram 1.1**




## Mental Health Act and Safeguarding Sub-Committee

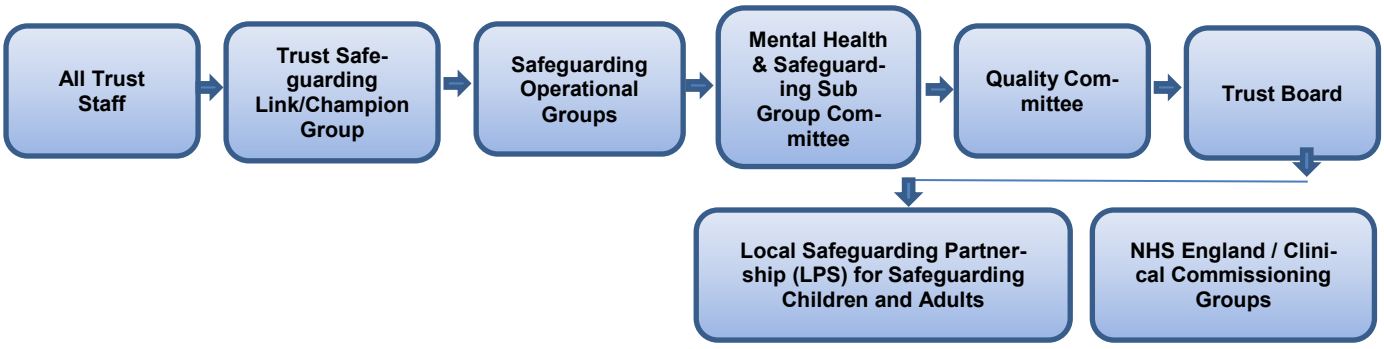
Safeguarding oversight within EPUT is assured via the Trust Mental Health Act and Safeguarding Sub Committee which is chaired by the Executive Nurse and meets bi-monthly. The Sub-Committee reports to the Quality Committee. The membership on the sub-committee also includes a Non-Executive Director. The terms of reference have been agreed by the membership which includes senior managers/clinicians from operational teams, senior members of the teams from the Mental Health Act (MHA) Office and the senior team members from the Safeguarding Team.

All Trust safeguarding and partnership reports, policies and protocols, are agreed at the MHA and Safeguarding sub-committee before being presented to the appropriate Trust Quality Committee, Trust Executive Team or Trust Board. The MHA and Safeguarding sub-committee is supported by operational safeguarding groups within both community and mental health services. The group reviews an action plan of the Trust's strategic safeguarding plans, forward plans its schedule of business and is in alignment with the local area safeguarding partnerships business plans and priorities. Cases where 'lessons learnt' have been identified are presented at the meeting and cascaded to clinical teams.

## Safeguarding Service Reporting Pathway

The diagram below demonstrates the reporting pathway for the Safeguarding service within the Trust. The Trust has robust reporting systems in place which ensures the Trust Board and associated committees are updated regularly on safeguarding performance, trend analysis and quality issues. The Trust Safeguarding Team provides regular reports for the Local Authority, Clinical Commissioning Group (CCG) and NHS England.

**Diagram**




## Strategic Framework 2020-2023

The Framework establishes the vision for the Trust Safeguarding service and builds on existing achievements.

The Framework has been updated every three years to reflect changes in national and local priorities including.

- Structure & Reporting Arrangements
- Clinical Governance
- Partnership Working
- Partnership Learning Reviews and Serious Adult Reviews
- Strengthening Learning
- Equality & Diversity
- Human Resources

The Trust's strategic Framework was renewed in 2020 for the new three-year plan.

## Safeguarding / Serious Incident / Communications Dept. / Complaints.

The safeguarding service is represented by the Associate Director of Safeguarding at the weekly joint meeting (Collaborative Incident Meeting) with the Trust's Serious Incident, Complaints, Legal Department and Communications Teams to ensure the effective interface between the services. The aim is to ensure necessary notifications, (e.g., CCG and CQC) investigations and reports are completed appropriately and to avoid duplication of processes. All appropriate departments are sited on any changes, developments and progress of Serious Incidents, Safeguarding Children Practice Reviews or Serious Adult Reviews and Domestic Homicide Reviews. The Trust Communications team are notified of any case that may result in media interest.

Joint reports between the Safeguarding and Serious Incident services are presented to Local Authority Safeguarding Partnerships on request and the Associate Director of Safeguarding

provide membership when there are joint serious incident and safeguarding reviews to avoid duplicity and support organisational liaison.

All complaints that may or do relate to safeguarding and the care received by service users or concerns regarding staff are sent to the team for consideration. An assessment is made to identify if a safeguarding enquiry or action is required. Ongoing partnership working takes place with the complaints department and Human Resources team when indicated until there is a resolution to the case.

## Partnership Working

The Trust is actively represented on all the Local Authority Safeguarding Children and Adult Partnerships in the areas it provides care for by Executive Directors, Directors and the Associate Director for Safeguarding. This representation is an important part of developing and influencing services for Trust service users and demonstrates the commitment the Trust places on the safeguarding agenda and working relationships with other agencies.

These arrangements give assurance and oversight to the Safeguarding Partners of the work EPUT is involved. The Partners seek help and expertise from the Trust in developing strategies/protocols which include aspects of mental health etc. One of the Local Authorities has co-commissioned with the CCG the EPUT Safeguarding Children team to support their 0-19 services in the authority. Regular reports and audit outcomes are presented to the Local Safeguarding Partnerships. Minutes of these Partnership meetings are routinely placed on the agenda of the Trust's Safeguarding Groups and presented by the EPUT representative.

Each Safeguarding Partnership has a number of sub groups which include the Health Executive Forum, Training sub group, Monitoring Audit and Compliance sub group, Policy Development group etc. These are attended by members of EPUT safeguarding team who actively participate in achieving the aims of the business plans of individual Safeguarding Partnerships.

A Safeguarding service specification for both children and adults has been agreed with Essex CCG's. Monthly and quarterly reports containing updates on the agreed specifications are presented to the respective Clinical Quality Review Group.

The EPUT Safeguarding teams meet regularly with the CCG Designated Nurses and County Wide groups for Safeguarding to review current cases and joint plans with the Local Safeguarding Partnerships. These have included:

- Review of partnership services for Exploitation
- Female Genital Mutilation
- Domestic Abuse
- Looked After Children Health Reviews
- Deprivation of Liberty processes
- Mental Capacity Act
- Safeguarding Adult reviews

## Local Authority Safeguarding Partnerships

**Paul Bedwell, Board Manager, Essex Safeguarding Adults Board:**
*"EPUT have been proactive in their engagement with the Essex Safeguarding Adults Board (ESAB) during 2020/21……. The EPUT Safeguarding team have been particularly engaged with the Board in relation to Safeguarding Adult Reviews and have been very professional in their engagement and responsive to requests for information when needed"*

## Clinical Commissioning Groups (CCG)

**Yvonne Anarfi, Board Manager, Designated Nurse for Safeguarding Children, Basildon, Brentwood and Thurrock CCGs:**
*"The two teams have established a good working supportive relationship, where EPUT has always been prepared (when asked) to offer their support, skills and knowledge. EPUT ADoS and his team safeguarding children team have engaged with the CCGs and supported us in a number of ways, in ensuring that our population receives a good think family approach and the we safeguard together, ensuring our joint arrangements that we have in place are safe, as we work in partnership and collaboratively.*

*EPUT has participated and contributed to our local case and partnerships reviews. They are also been involved in the implementation of the action plan, being led by Thurrock Local Safeguarding Children Partnership. With regards to system working, EPUT safeguarding children team have also attended the organised Southend, Essex and Thurrock Health Female Genital Mutilation meetings and actively participated in the development of the SET Health FGM Flowchart.*

*The ADoS has also attended and presented at various workshops, forums and away days, promoting partnership working, co-production and collaboration. The CCGs and EPUT moving forward looking at how we work in the new landscape in the ICS."*

## Care Quality Commission (CQC)

The Associate Director for Safeguarding has established a relationship with the CQC Inspector (Relationship Owner) appointed to cover EPUT, for the speedy review of concerns or issues raised. The purpose is to review new safeguarding cases reported to CQC and discuss the progress and outcomes of existing cases.

CQC inspectors are invited and have attended Safeguarding cases where appropriate. As a consequence, a good working relationship has been established and processes have been put in place for communicating and reviewing cases that are opened with the CQC. Additional information and achievements are outlined below within the sections relating to children and adults.

## MAPPA – Multi-Agency Public Protection Arrangements

This is the process through which the Police, Probation and Prison Services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public. MAPPA is not a statutory body in itself but is a

mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a coordinated manner. Agencies at all times retain their full statutory responsibilities and obligations.

**Elizabeth Newns, MAPPA Manager, Essex Police:**
*"May I thank you and the EPUT Safeguarding Team for the ongoing support you give to MAPPA. We are truly grateful for all of your help. The support MAPPA receives form EPUT is second to no other. "*

## Essex Police Adult Triage Team

**Karen Hutchings DC, Acting Detective Sergeant, Adult Triage Team, Essex Police:**
*"Everyone said about how extremely professional, helpful and efficient the service we receive to our requests for information is. This enables the team to progress matters quickly, which is incredibly helpful especially in times of high demand or with urgent cases.*

***It is a really good working relationship between agencies…"***

## Safeguarding Training

The Safeguarding Training Strategy, applicable for all Trust staff has been updated to reflect the national requirements in the; Intercollegiate Documents (safeguarding children 2019, adults 2018) the Care Act 2015, the Home Office guidance on Prevent and the Mental Capacity Act 2015 (MCA) which includes the Deprivation of Liberty Safeguards (DoLS) and Intercollegiate Document 2020 (looked after children).

The Strategy outlines the mandatory training programme that EPUT staff will require. This includes different levels of training depending on staff roles, levels of contact with children or adults and levels of responsibility within the Trust, as demonstrated below

**Table: Mandatory Safeguarding training levels**

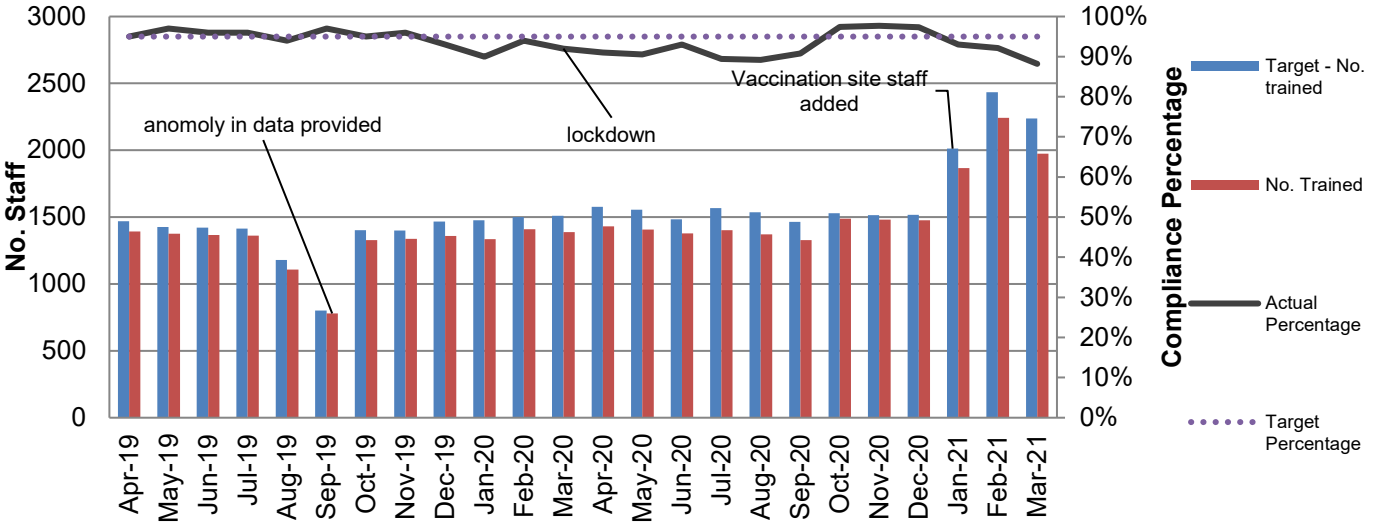
| Statutory Mandatory Training | Staff Category | Delivery Method | Duration | Update Interval | Notes |
|---|---|---|---|---|---|
| Safeguarding Adults and Children Level 1<br><br>CSTF Safeguarding Adults, CSTF Safeguarding Children | All staff | E-learning | E-learning | 3 yearly | Classroom at Corporate Induction |
| Safeguarding Adults and Children Level 2 (inc. MCA, Dols & Prevent)<br><br>CSTF Safeguarding Adults Leve 2, CSTF Safeguarding Children Level 2 | All clinical staff and non-clinical staff that have contact with adults, children, young people and parents/carers<br><br>Update required for level 2 if staff have only completed either level 3 safeguarding children or adults.<br><br>No update required if staff have completed safeguarding level 3 children and safeguarding level 3 adult. | E-learning | 1 day | 3 yearly | Classroom at Corporate Induction |

| Statutory Mandatory Training | Staff Category | Delivery Method | Duration | Update Interval | Notes |
|---|---|---|---|---|---|
| Safeguarding Children Level 3<br><br>CSTF Preventing Radicalisation (Awareness of Prevent)<br><br>CSTF Safeguarding Children Level 3 | All registered staff working within children community and inpatient services bands S 8b<br><br>All registered staff working within community mental health and learning disability services bands S-8b<br><br>All registered staff working with inpatient mental health and learning disability services bands S-8b<br><br>All registered staff working in St Aubyns centre, Poplar ward and Rainbow unit bands S-8b | Classroom | 1 day | 3 yearly | |
| Safeguarding Adults Level 3 (inc. PREVENT WRAP, MCA and DoLS)<br>CSTF Preventing Radicalisation (awareness of Prevent)<br>CSTF Safeguarding Adult Level 3 | All registered staff working within adult mental health and learning disability community inpatient services. Band5-8b | Classroom | 1 day | 3 yearly | |
| Safeguarding Adults/Children Level 4 | All registered staff working within the Safeguarding Team. | Classroom | 1 day | 3 yearly | |

## Mandatory Training Compliance

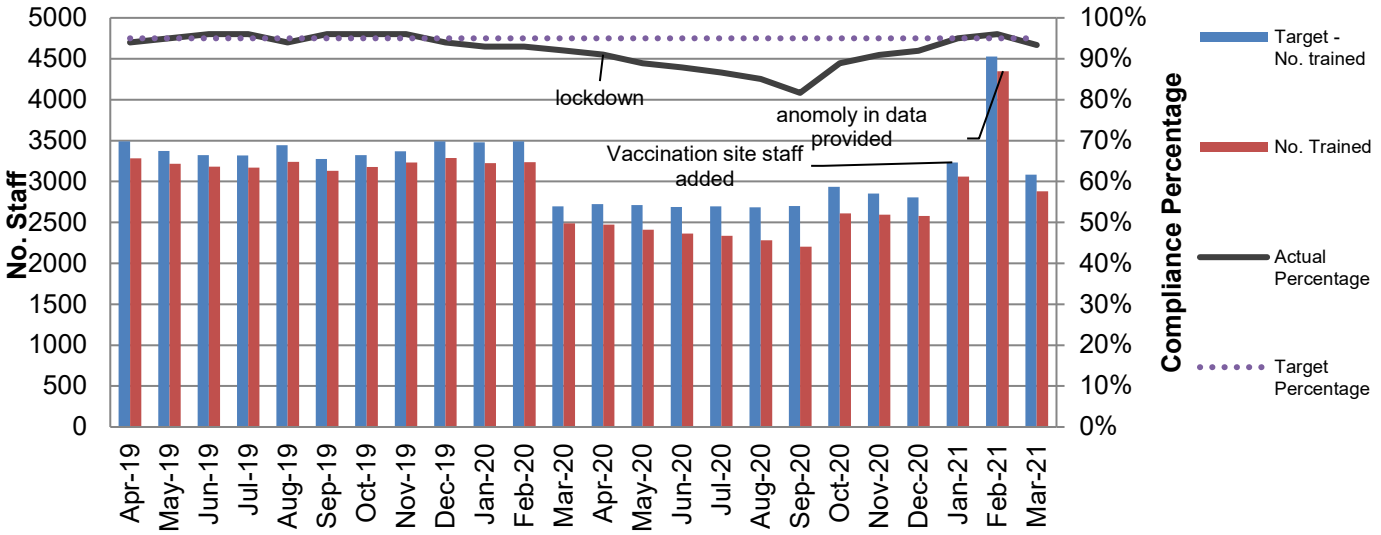
As part of the business continuity plan, face to face training was stopped in February and that had a bearing on our compliance. We resumed Level 3 training in August as virtual and small groups of face-to-face, hence the improvement in compliance.

**Chart: Safeguarding Level 1 Training Uptake**



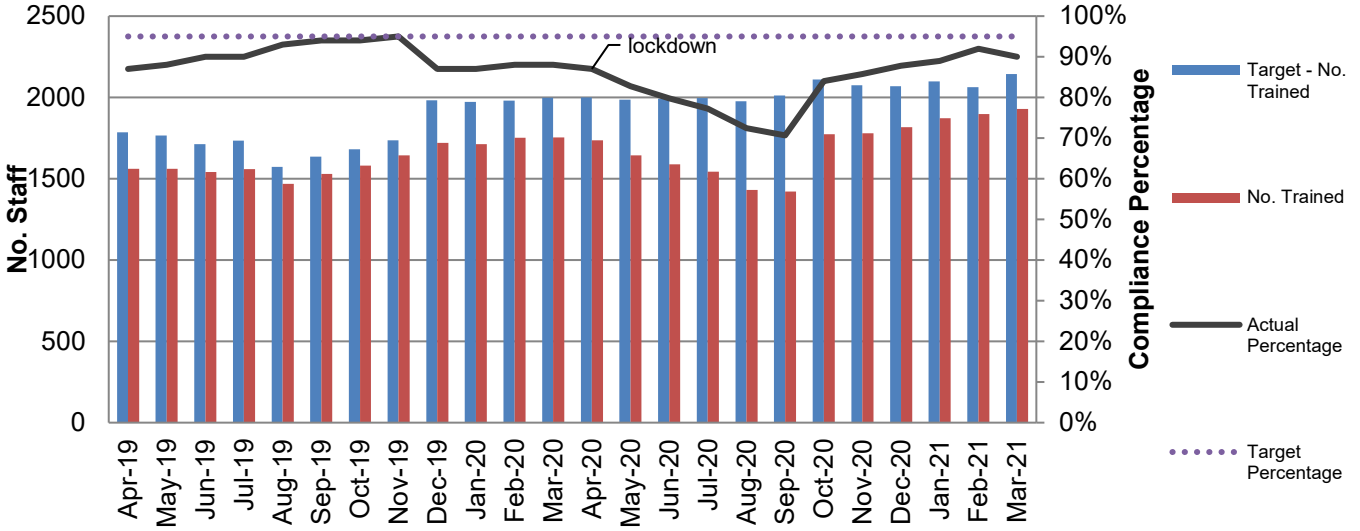

Level 1 training is for all clinical staff (Level 1 is integrated into Level 2 to avoid duplication for staff requiring both competencies). This includes basic awareness of Safeguarding, MCA DoLS, Prevent and Domestic Abuse.

**Chart: Safeguarding Level 2 Training Uptake**



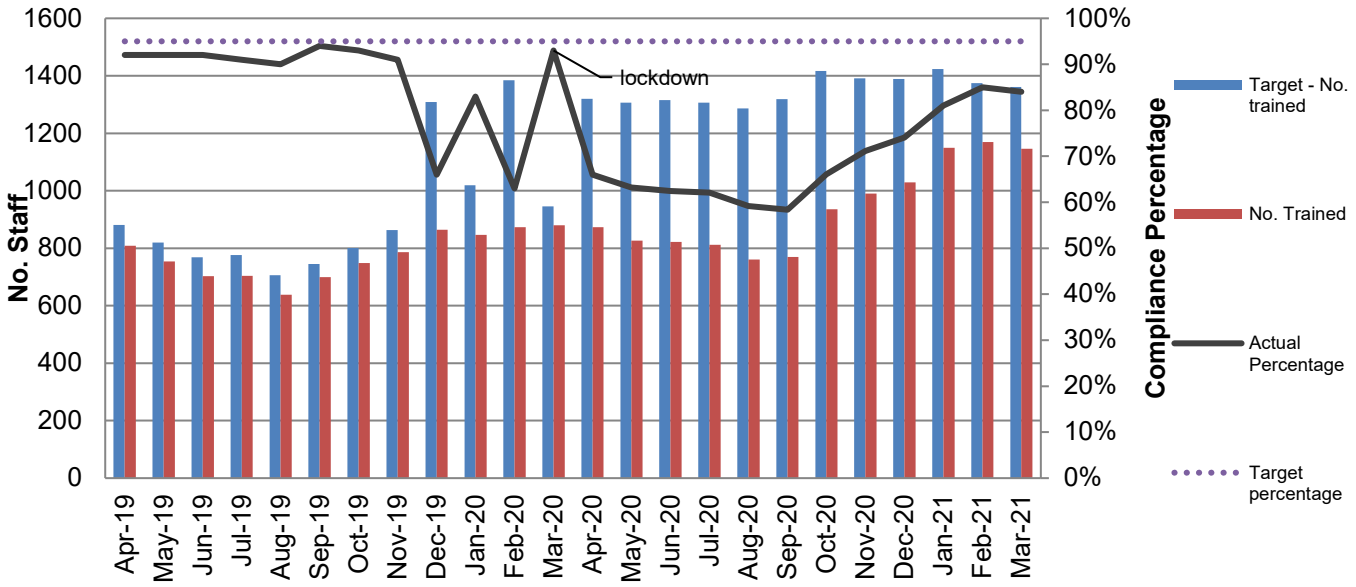

Staff that are required to undertake level 2 training will work with either children or adults and older people and are responsible for assessing planning, intervening and evaluating needs. This additionally includes investigating safeguarding issues, Prevent, MCA & DoLS.

**Chart: Safeguarding Training Uptake - Adults Level 3**



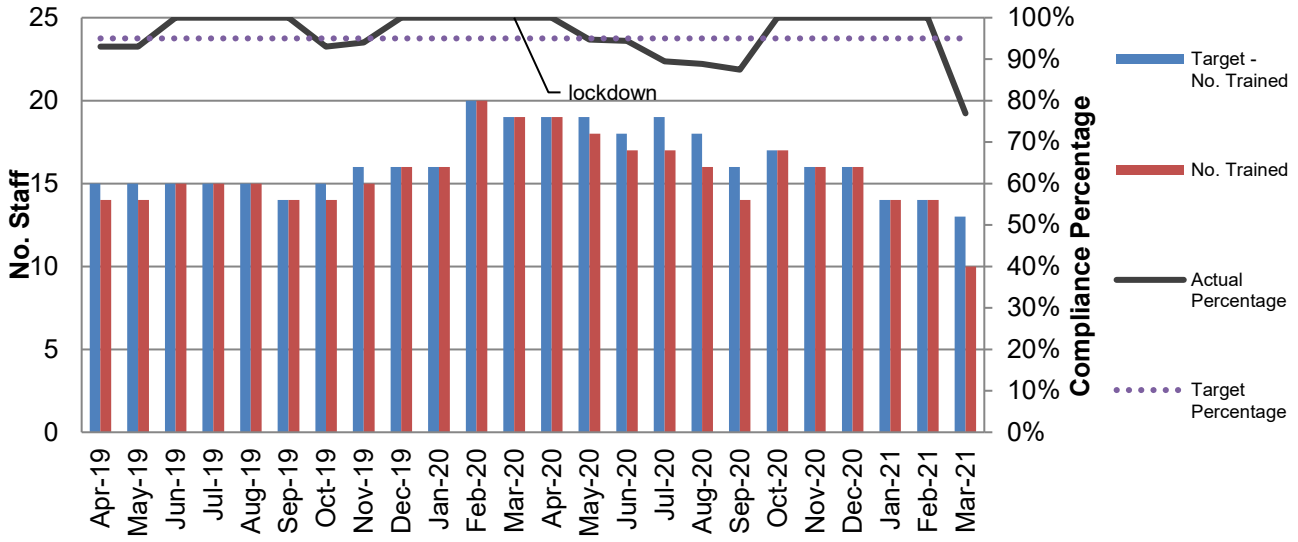

Specific staff working with adults and older people and responsible for assessing planning, intervening and evaluating needs. This includes investigating safeguarding issues, Prevent, MCA & DoLS. The current compliance is not meeting the compliance set by Health Executive Board, 95%.

**Chart: Safeguarding Training Uptake - Children Level 3**




Specific staff working with children or parents and responsible for assessing planning, intervening and evaluating needs. This includes Prevent, CSE, FGM etc. The training compliance is mapped at 95% by the Health Executive Board.

**Chart: Safeguarding Training Uptake - Level 4**




All registered staff working within the safeguarding team. The compliance for the team is generally compliant above the 95% compliance. The team compliance was generally 100% for most of the months.

**Chart: Safeguarding Training Uptake - Prevent Basic Awareness**

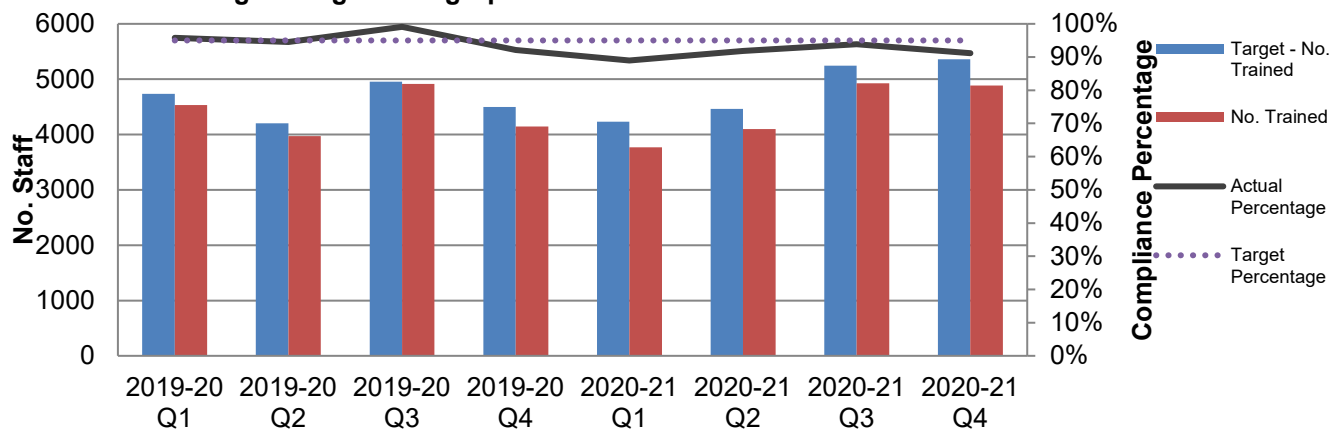
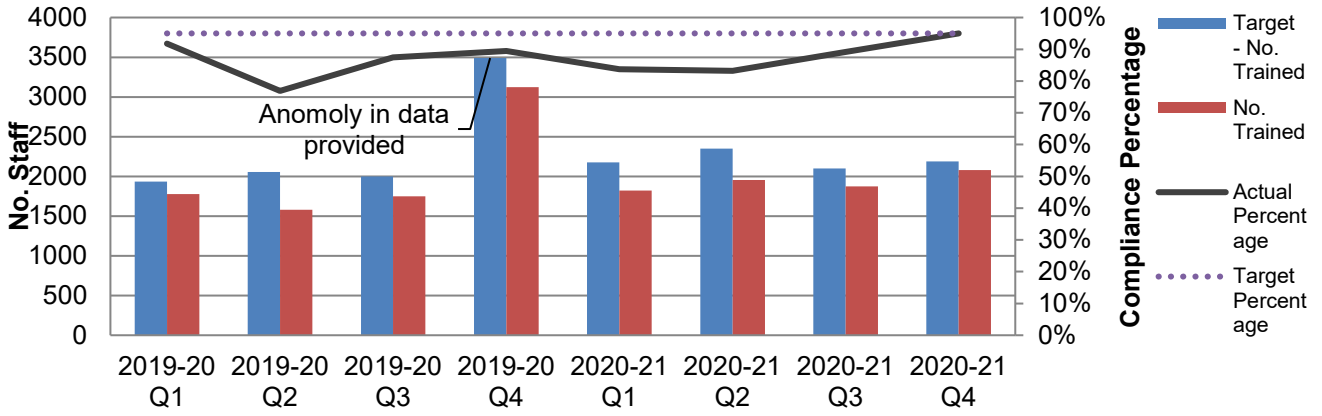



**Chart: Safeguarding Training Uptake - Prevent WRAP**




## Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act (MCA) training programme for all staff working with adults is via E-Learning and is also incorporated into face-to-face Safeguarding adult training. There is an OLM for staff interested in enhancing their knowledge of MCA and specialist MCA DoLS face to face programme for staff working in inpatient units in both mental health and Community Health settings.

This year the team have delivered a range of training and support to staff across the Trust in relation to the Mental Capacity Act. In addition to the MCA component in the Level 3 safeguarding training, we deliver training on understanding the Mental Capacity Act and how we should be using it in our practice, how to support service users to make advanced decisions and advanced directives, and how to complete the MCA form. This training has frequently been bespoke, depending on the needs of the team or locality, in discussion with the team manager or service manager. The feedback from these sessions is positive, with staff saying they can more confidently apply the Mental Capacity Act in their practice following training sessions.

## Looked After Children (LAC) Training

A LAC training programme is delivered to all those involved in providing a direct service to Looked After Children, this includes Health Visitors, School Nurses, Family Nurses etc. This

training outlines the legal framework and raises awareness of the health needs of those children who are Looked After.

### Training Feedback

*"… I have been more aware about children that could be providing a caring role for my patients or children that may at risk if the adult with memory problems is perhaps caring for them. I am now aware of when and how to raise a safeguarding for a child and also how to refer if a child is a carer."*
**Primary Care Nurse**

*"I found it useful being able to do the training from home, reducing travel. The use of the break out rooms was very helpful for small group exercises. The presentation was extremely clear and at a good pace..."*
**Clinical Psychologist**

*"The trainers were engaging, interesting and very informative. Although it was done virtually, it felt very personable and I felt safe to discuss my experiences and knowledge with the group."*
**Immunisation Team**

*"A week after the training I noted some concerns about a family and knew the referral process and who to speak to. I feel more confident about raising safeguarding concerns about children now."*
**Primary Care Network Nurse**

*"The presenter brought a wealth of experience and knowledge to the training, and engaged in the complexity of assessing and holding risk in different healthcare contexts."*
**Parent Infant Therapist**

*"Great discussions and quizzes; good to have break out rooms with fewer people for discussion. Good presentation. Right level of information and use of case histories."*
**Advanced Nurse**

*Good course all round, very helpful and lots of food for thought, very knowledgably presenters and helpful to learn that even for them, they sometimes don't have the answer/ are able to immediately resolve matters as they would like. Learning this made me feel as if we're all the same boat, in trying to help people to the best of our ability and yet sometimes meeting obstacles and having to manage consequent risk.*
**Art Psychotherapist**

## Raising the Profile of Safeguarding

### Safeguarding Champions Events

This year the Safeguarding Team started hosting Safeguarding Champion events. These are presentations delivered by subject specialists over Microsoft Teams, designed to raise awareness of various safeguarding issues. The event is open and advertised to all Trust staff.

- **04/11/2020 – Domestic Abuse, MARAC, DASH – Julie Jones**, "MARAT Manager for over 4 years, dealing with high-risk cases of domestic abuse, action planning for safeguarding by means of a multi-agency conference twice weekly.

- **16/11/2020 – Hoarding – Andrea Williams, "**Social Worker, qualified since 2004. I have been working for Essex County Council for the past 33 years. My particular interest is hoarding, hence the reason why I initiated the Hoarding MDT, which has been running successfully for the past 3 years."

- **18/11/2020 – Child Abuse Linked to Faith and Belief – Gifty Arthur**, "started working for EPUT as a newly qualified staff nurse on Grangewaters Ward (Basildon Mental Health Unit) in January 2011. I joined the Safeguarding Team in July 2015 and have remained in the team to date. My current designation is Clinical Specialist for Safeguarding and I am one of 5. As part of my role, I provide support and advice to Trust staff who are either leading investigations and/or have safeguarding queries. I represent the Safeguarding

Team/Trust at safeguarding adults operational group meetings and occasionally board meetings for the areas I cover. I am the Trust safeguarding representative for Basildon, Southend and Thurrock MAPPA (Multi Agency Public Protection Arrangements), Thurrock MARAC (Multi Agency Risk Assessment Conference) and Thurrock Channel Panel Meetings. **Noree Webb**, is The Salvation Army's Anti Trafficking and Modern Slavery Team Response Coordinator. She is a trained First Responder, interviewing potential victims of modern slavery to refer them into the National Referral Mechanism (NRM) which is the government process to determine whether someone is a potential victim of modern slavery. Norree has presented modern slavery awareness training for local authorities, prison service groups, court witness support volunteers, as well as NGOs and health service groups. Advice is willingly shared with anyone contacting the The Salvation Army who needs a greater understanding of modern slavery and the mechanisms for getting them specialist support.

- **20/11/2020 – Impact of COVID-19 on Safeguarding – Fiona Hunt, "**Named Safeguarding Professional for EPUT I started work in 2013 in SEPT, now part of EPUT, as safeguarding clinical specialist. With a focus on prevention, and building relationships with the teams, safeguarding has gone from strength to strength and is now an even higher priority for the trust. Now as Named safeguarding Professional I take the lead for the adult safeguarding agenda and Mental Capacity. I support a team of clinical experts from a number of different backgrounds with that continued focus of building relationships and supporting investigations and best practice. Mental Capacity Law change is coming in 2022, where DoLS becomes LPS, I am representing the trust at regional meetings, and ensuring we have up to date knowledge and understanding, to ensure we are ready for the change."

- **20/11/2020 – Adverse Childhood Experiences – June Freed**, has worked as a Nurse, Midwife and Health Visitor for several years before moving into the area of Safeguarding Children over 10 years ago after recognising a specific interest in this area. June has had experience working within the voluntary, community and acute health care settings. June has been the author of several Serious Case Reviews and uses the knowledge gained from these to make changes to local practice always striving for a "strong, visible safeguarding leadership".

- **07/12/2020 – Gangs and Exploitation – Alex Bridge**, Service Manager in Southend on sea children's services who works in Child Exploitation, previous to this role he had over 10 years' experience of working with adolescents in the youth justice sector; he is the chair of the Southend Safeguarding Partnership Child Exploitation and Missing subgroup and in 2020 received an Unsung Hero Award for work in Child Exploitation awarded by the National Working Group

- **22/01/2021 – LADO – Mechelle DeKock & Rebecca Scott,** within this role they are accountable for managing highly sensitive information, when managing Allegation Management. They chair and co-ordinating strategy/management planning meetings in respect of allegations made against anyone who works with children/young people. This role of LADO is a broad and challenging with a high level of specialism around risk assessment. The role holds statutory responsibility for coordinating the response across every agency in Essex where there are concerns that an adult who works with children may have caused them or could cause them harm.

- **18/03/2021 – Modern Slavery – Jodi Thompson**, Strategic Lead for Modern Slavery at Southend Borough Council, ensuring the organisation is meeting its statutory duties as set out in the Modern Slavery Act 2015 and mobilising the council to develop a multi-agency response to modern slavery. This includes victim identification and support, co-ordinating case work, awareness raising among statutory and non-statutory agencies and developing a strategic approach to modern slavery in Southend. **Rev. Dr. Dan Pratt,** founder and antislavery co-ordinator for SAMS (Southend Against Modern Slavery) Partnership, bringing community partners together to work towards a slavery-free Southend-on-Sea. He is also founder and antislavery co-ordinator of The Together Free Foundation, a UK based charity working with communities and faith groups to respond to local forms of modern slavery. Dan is a research associate at Regent's Park College, Oxford University.

## Safeguarding Newsletter

- June 2020 – Domestic abuse & safeguarding new starters
- August 2020 – Gangs, Cuckooing, Hidden Harm, Datix, safeguarding staff leaving, Children's Society current projects
- September 2020 - Domestic violence, World Suicide Prevention Day, Safeguarding merger, section 42 processes (inc. Datix)
- November 2020 – EPUT and other organisations Safeguarding Week
- December 2020 – Message from, transfer of care reminder, message from west Essex community mental health service manager, domestic abuse, festive period useful contacts
- January 2021 – Think family, changes to child referrals, SETSAF paperwork
- February 2021 – Children's Mental Health Week, Safer Internet Day, working from home, hints and tips for mental wellbeing, EPUT staff support, domestic abuse support
- March 2021 – LAC team, Eating Disorders Awareness Week, International Women's Day, street prostitution, SI report commendation, NHS England Think Family Week

## Internal Safeguarding Website

The internal Safeguarding website is a key resource for EPUT staff and the Safeguarding team, administration team continuously develop and update the content and design. Newsletters, training materials, policies and procedures, contact posters; are just a few examples of the materials updated and made available over the last year.

The Safeguarding Team have contributed toward identifying and presenting cases relating to children and adult services to the Learning Oversight Committee. Below are examples of lessons learnt by safeguarding teams across the Trust this year which were presented to the learning oversight committee.
Tendayi is this still waiting to be put in, as there are no learning lessons here. If you are not doing this now this last sentence needs to be taken out and from contents page.

# 2.0 Safeguarding Adults

The Care Act was introduced in April 2014 and set out a clear legal framework for how local authorities and other agencies e.g., the NHS and Police should protect adults at risk of abuse or neglect. The Care Act 2014 has now been fully embedded into the Trust Safeguarding service including policies, protocols and training programmes.

## Safeguarding Adults Concerns (Section 42)

The responsibility for conducting an enquiry (investigating Safeguarding Adult issues) differs between Mental Health and Community Health Services. The Local Authority delegates the responsibility for investigating safeguarding issues to the Trust for those accessing Mental Health Services. This means that staff regularly conducts safeguarding enquiries for service users. They typically arrange meetings with police, social care and other agencies as required and invite service user family members or advocates to safeguarding meetings. The Trust safeguarding team monitor compliance with time frames and analyse trends.

For service users accessing Community Health Services, the Local Authority is responsible for the enquiry. However, it is essential that Community Health Service staff are fully involved in investigations by representing the health needs of service users.

A reporting framework has been established to report data, trends and concerns to the Trust Senior Management team meetings the Local Authority Safeguarding and the CCG's.

**Chart: Total No. Safeguarding Concerns Received**

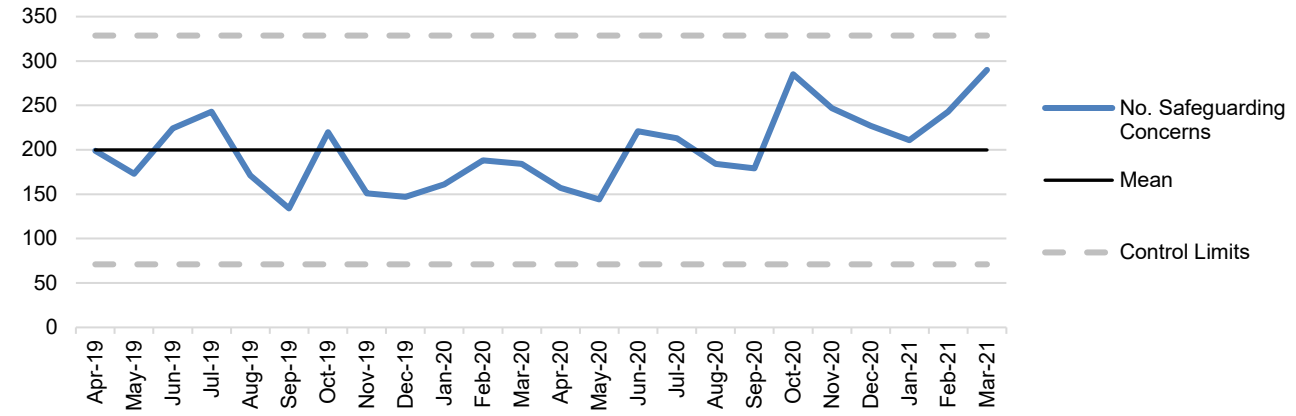



**Chart: No. Concerns Progressed to Enquiry (involving EPUT Services Users)**

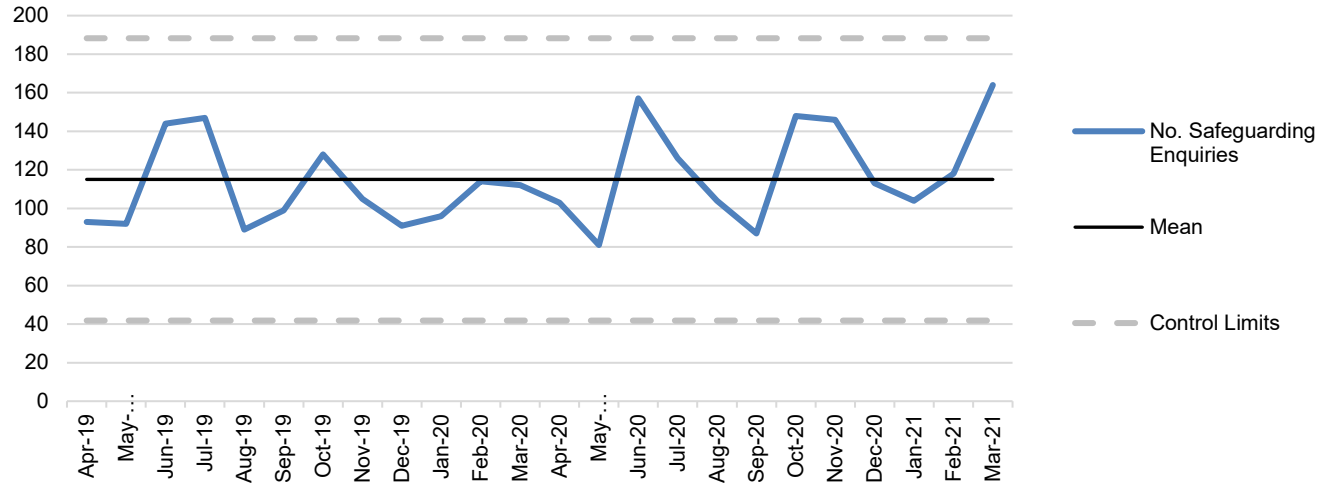


**Chart: No. Safeguarding Enquiries by Referring Agency Type (top 20)**

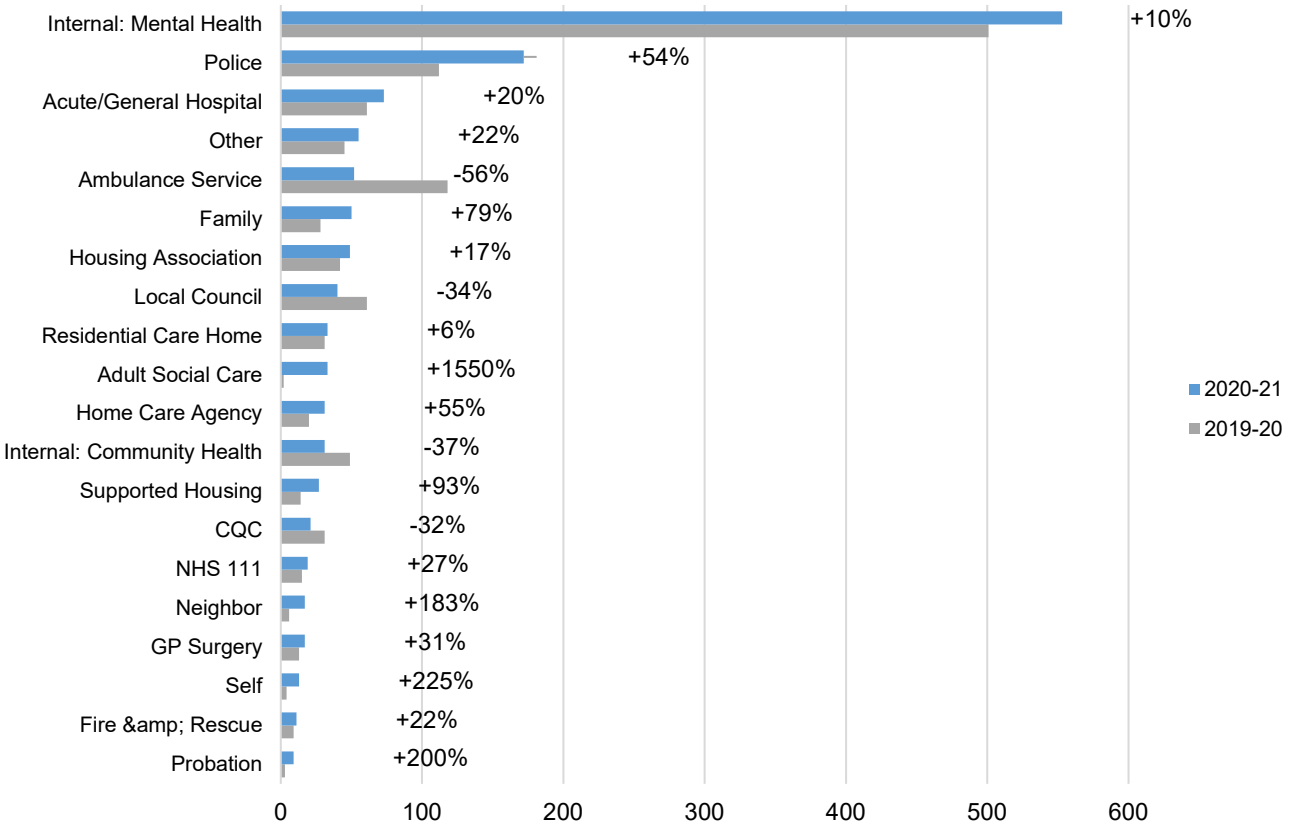



**Chart: Type of Abuse Identified in Safeguarding Enquiries**

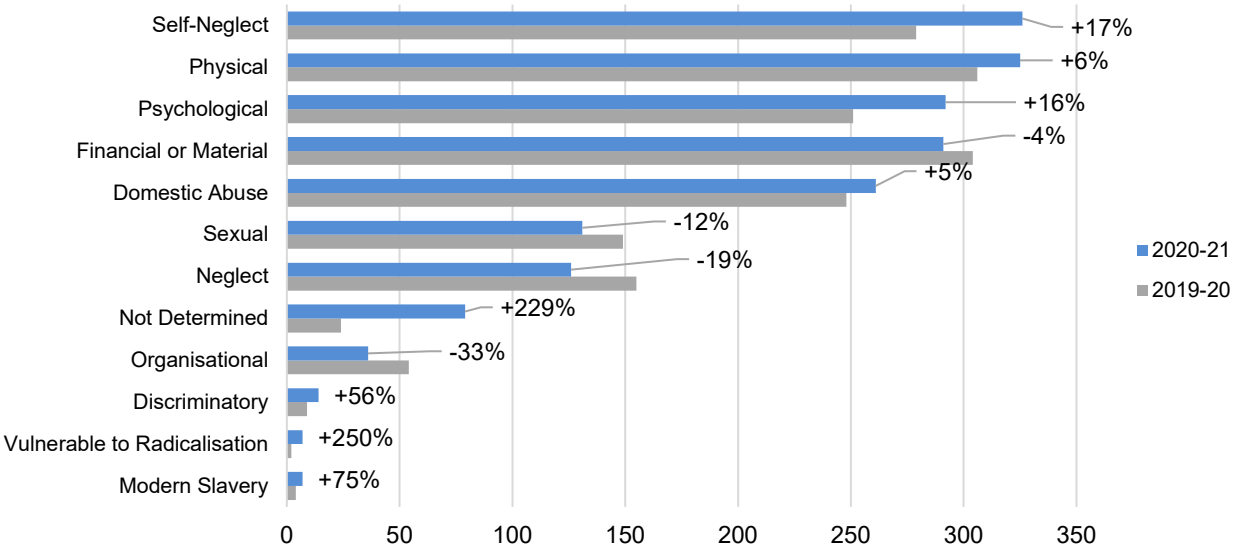


**Chart: Person Alleged to Have Caused Harm, in Safeguarding Enquiries (Top 12)**

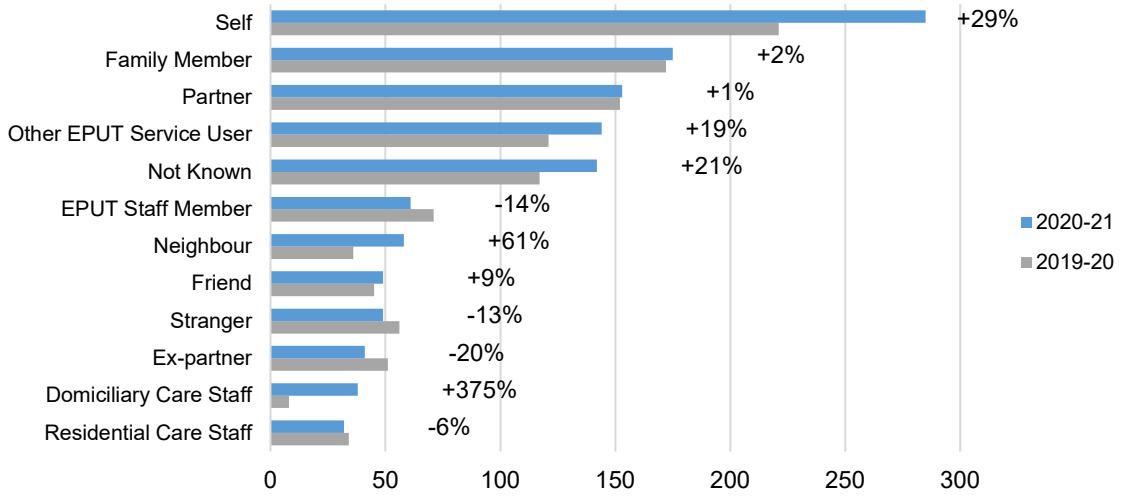



**Table: Conclusion in Safeguarding Enquiries with EPUT Staff Identified as Perpetrator**

| *Conclusion* | *2019-20 %* | *2020-21 %* |
|---|---|---|
| *Substantiated* | 7% | 17% |
| *Partly Substantiated* | 14% | 7% |
| *Unsubstantiated* | 44% | 39% |
| *Inconclusive/Not Determined* | 31% | 28% |
| *Investigation Ceased at Individuals Request* | 4% | 9% |

**Table: Number of Safeguarding Enquiry Closure Forms Received**

| | *2019-20* | *2020-21* | *% Difference* |
|---|---|---|---|
| *No. Safeguarding Closures Received* | 737 | 1254 | +70% |

**Chart: Is the Vulnerable Adult Satisfied with the Outcome, % enquiries closed**

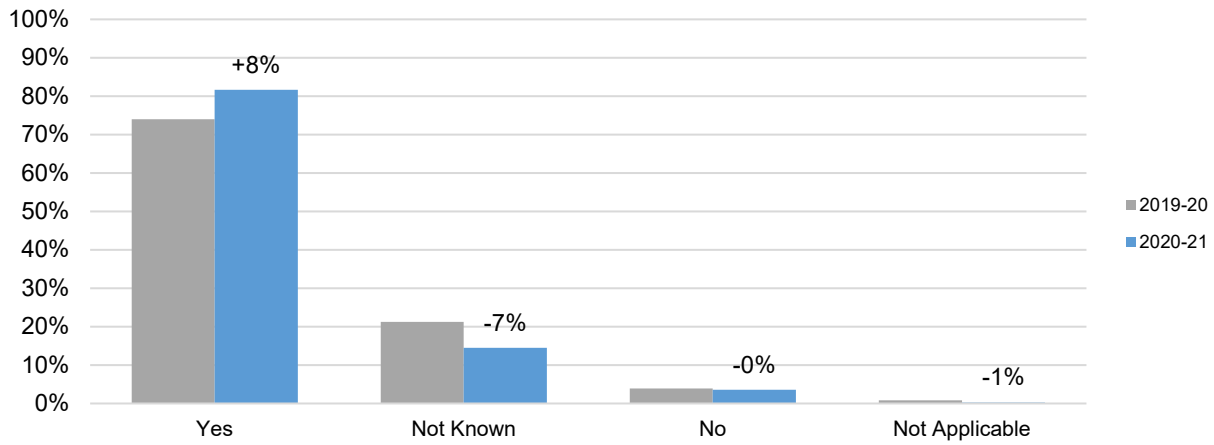


**Chart: Investigation Conclusion, as % of enquiries closed**

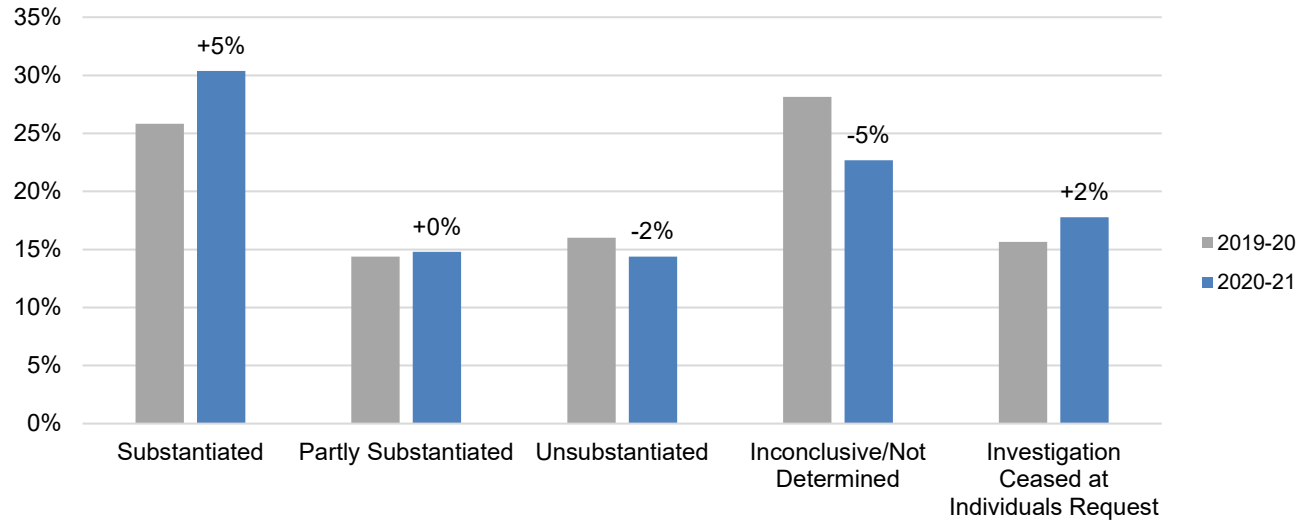



**Chart: Actions Taken in Safeguarding Enquiries (closed)**

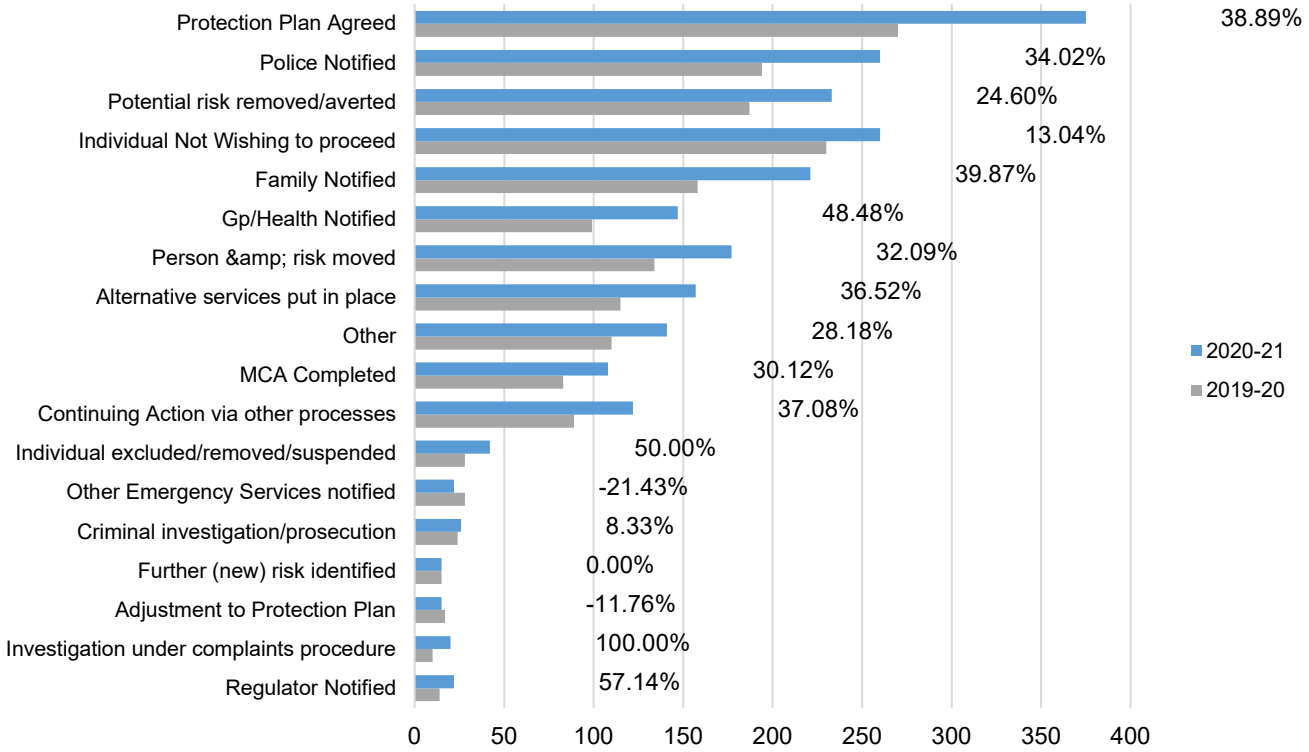
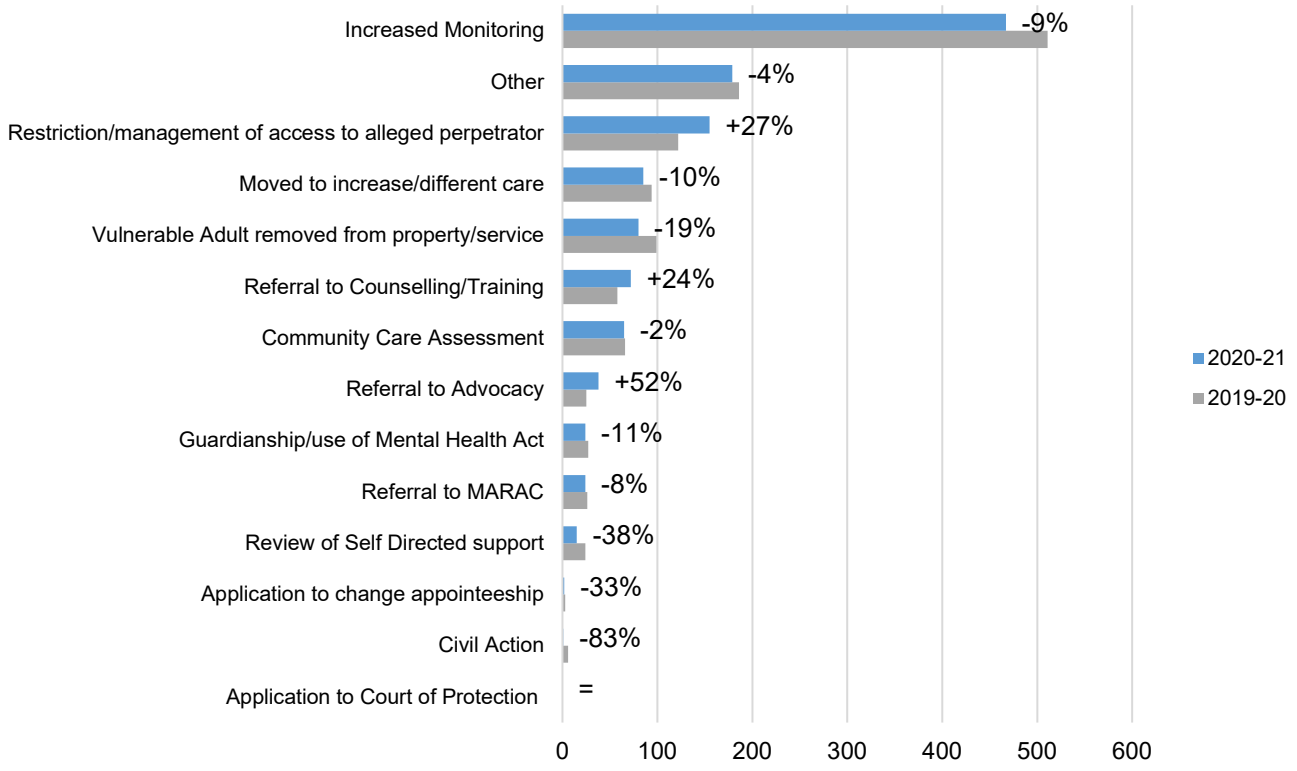


**Chart: Outcomes for Victim in Safeguarding Enquiries**




## Feedback

**Carrie-Louise Hayward, North East Clinical Lead, EPUT Perinatal Mental Health Service**
*"We can say that we have noted that the turn-around is much quicker than previously. The communications from your team are much more efficient. The administration service has much improved and we appreciate all your hard work and the helpfully way you both do it."*

**Sarah Range, Principal Social Worker/Head of Adult Mental Health, Southend Borough Council**
*"We can say that we have noted that the turn-around is much quicker than previously. The communications from your team are much more efficient. The administration service has much improved and we appreciate all your hard work and the helpfully way you both do it."*

## Domestic Abuse

The safeguarding team have a domestic abuse lead who attends multi agency domestic abuse forums as part of the Domestic Abuse Partnership in order to identify the domestic abuse challenges across Essex and participate in service planning across our agencies in relation to domestic abuse. These forums include: MARAC steering group, Domestic Abuse and Older People Task and Finish group, Essex DA Substance misuse group and the DA Health Sub Group. This is currently a very active area of service development because of the new Domestic Abuse Act, and EPUT are an important part of the development of multi-agency strategies via our presence at these forums. The domestic abuse lead also chairs the MARAC twice per month.

This year we have developed a DASH & MARAC database to monitor and report on EPUT mental health service's activity.

**Table: EPUT Mental Health Involvment at MARAC Meetings (2020-21)**

| | 2020 | | | | | | | | 2021 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
| *No. Meetings* | 8 | 21 | 21 | 28 | 23 | 23 | 29 | 34 | 42 | 23 | 30 | 37 | 319 |
| *No. Attended** | 0 | 3 | 3 | 3 | 4 | 4 | 7 | 6 | 10 | 4 | 8 | 3 | 49 |
| *% Attended* | 0% | 14% | 14% | 11% | 17% | 17% | 24% | 18% | 24% | 17% | 27% | 8% | 15% |
| *No. with Report Sent** | 2 | 8 | 6 | 12 | 8 | 13 | 15 | 17 | 17 | 5 | 15 | 19 | 137 |
| *% Report Sent* | 25% | 38% | 29% | 43% | 35% | 57% | 52% | 50% | 40% | 22% | 50% | 51% | 43% |
| *% With input** | 25% | 48% | 33% | 46% | 48% | 61% | 59% | 59% | 52% | 39% | 67% | 51% | 51% |
| *Service User Victim* | 7 | 13 | 11 | 17 | 12 | 17 | 15 | 20 | 22 | 16 | 21 | 22 | 193 |
| *Service User Perpetrator* | 1 | 8 | 10 | 11 | 11 | 6 | 14 | 14 | 19 | 7 | 9 | 15 | 125 |

*By service user's allocated worker, from inpatient and community mental health teams
**report or attendance

## Prevent

The Prevent Strategy is a cross-Government policy that forms one of the four strands of CONTEST – the Government's counter terrorism strategy. The Trust has a lead Prevent Officer as part of the Safeguarding Team and the Trust is represented at a number of meetings with police and strategic groups including the CHANNEL Panel.

**Table: Prevent Referrals Made by EPUT Staff, Submitted to Channel Coordinator (2020-21)**

| | *Q1 (Apr to Jun)* | *Q2 (Jul to Sep)* | *Q3 (Oct to Dec)* | *Q4 (Jan to Mar)* | *Total* |
|---|---|---|---|---|---|
| *No. Referrals* | 4 | 3 | 0 | 0 | 7 |

There were 5 more Prevent referrals made in this year compared to 2019-20 (2 to 7)

# 3.0 Mental Capacity Act & Deprivation of Liberty Standards (MCA DoLS)

The service for Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DoLS) continues to progress well. Staff knowledge has improved and the MCA DoLS training programme has been enhanced.

## Deprivation of Liberty Safeguards (DoLS)

Deprivation of Liberty Safeguards currently applies to those persons in hospital or Care Home who do not have capacity to consent to their care and treatment and who need limits put on their liberty in order to keep them safe.

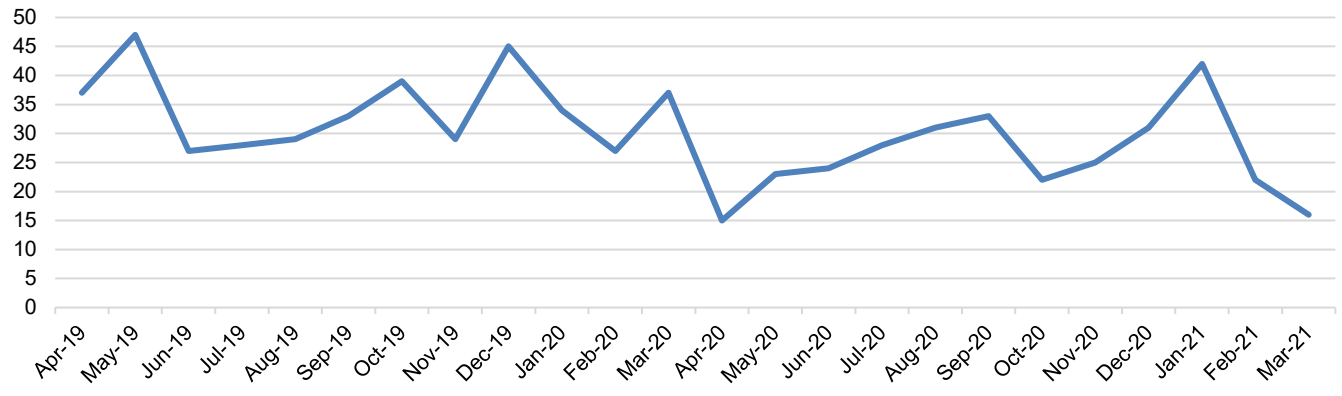
DoLS does not apply to those detained under the Mental Health Act 2083. Therefore, for EPUT, the DoLS service is focussed in Essex, Southend and Thurrock in patient and care home units.

Every other week, the Safeguarding Team provide a report to each service which lists the service users they have on DoLS, whether an MCA assessment has been received and the expiry date (if authorised).

**Table: DoLS Applications by EPUT Services (Inpatient and Nursing Homes)**

| *Year* | *No. Applications* |
|---|---|
| *2019-20* | 412 |
| *2019-20* | 312 |
| *Difference* | -32% |

**Chart: No. DoLS Applications by EPUT Services**




| | *Authorised* | | *Refused* | | *Total No. Assessments* |
|---|---|---|---|---|---|
| *Year* | *No.* | *%* | *No.* | *%* | |
| *2019-20* | 104 | 86% | 17 | 14% | 121 |
| *2020-21* | 53 | 83% | 11 | 17% | 64 |
| *Difference* | -96% | -3% | -18% | +3% | -89% |

## Mental Capacity Act (MCA) Assessments

MCA assessments are recorded and reviewed by the Safeguarding Team.

**Chart: No. MCA Assessments Carried Out by EPUT Staff**

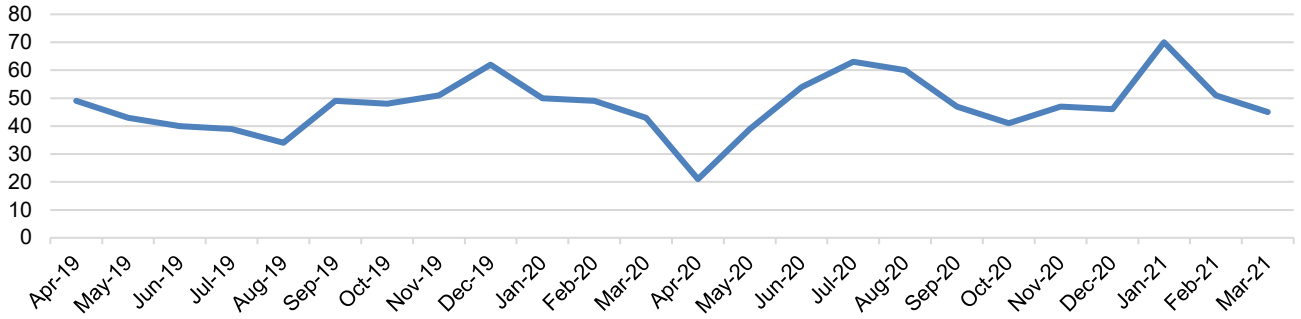
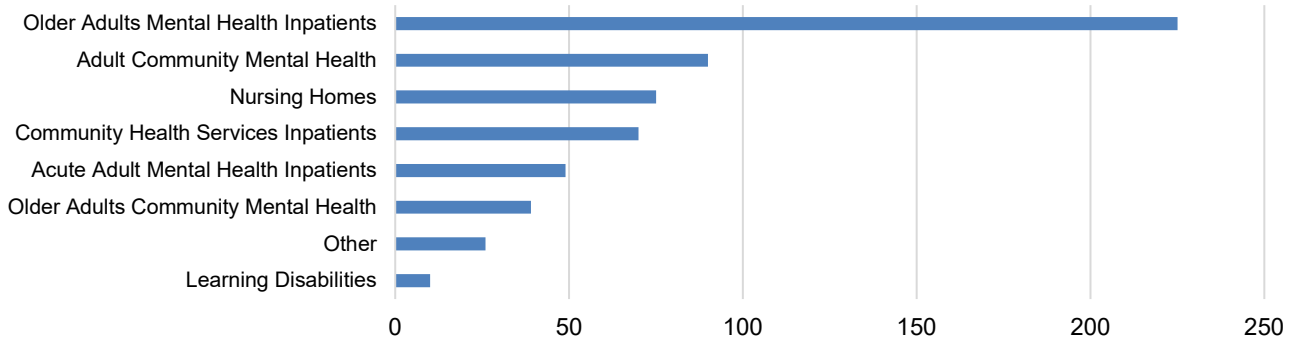



**Table: Mental Capacity Assessments by EPUT Staff**

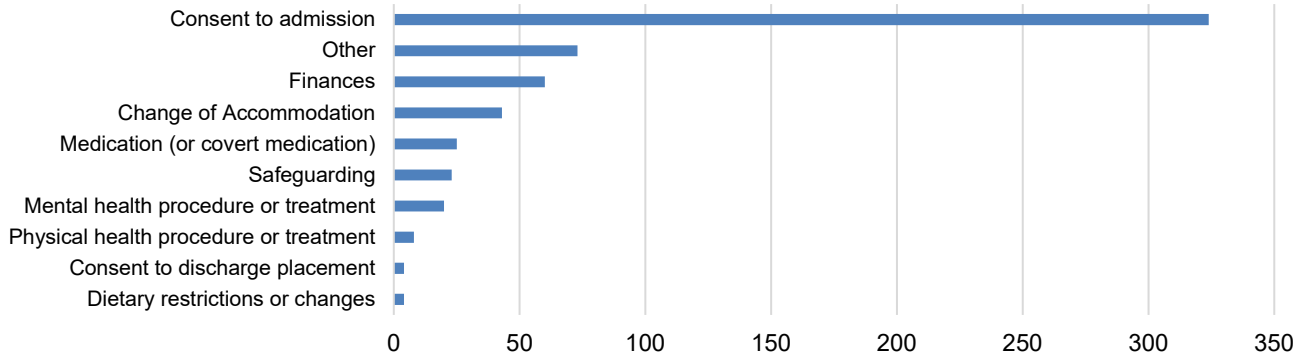
| *Year* | *No. Assessments* |
|---|---|
| *2020-21* | 584 |
| *2019-20* | 557 |
| *Difference* | +5% |

**Chart: No. MCA Assessments by Service Type (2020-21)**




The data identifies that 77% of the assessments by older adults' mental health inpatient services, are for consent to admission (including DoLS and Section 132 rights under the Mental Health Act)

**Chart: No. MCA Assessments by Decision Reason**



# 4.0 Safeguarding Children

The Trust Safeguarding Teams continue to offer expert advice and support to EPUT staff and work in partnership with other agencies and Local Safeguarding Partnerships. The Trusts Safeguarding Children team additionally provide safeguarding support to Southend Local Authority 0-19 service as a commissioned provision.

Working Together to Safeguard Children (2018) provides the clear statutory and legal framework for safeguarding children from harm. The statutory guidance is underpinned by the Children's Act (2004) and is embedded into the Trust Safeguarding systems within its policies and procedures, local protocols, supervision and training programmes.

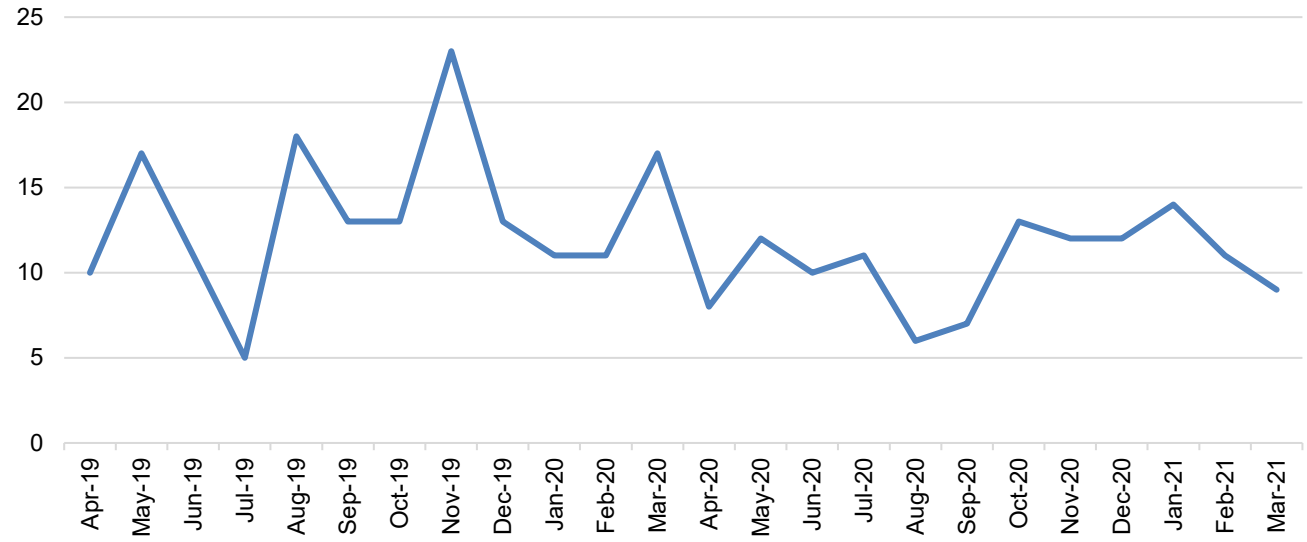
The responsibility for investigating if a child requires safeguarding from harm is the responsibility of the Local Authority through Children's Social Care or the police but EPUT are fully involved with supporting this process by representing the health needs of the clients that are open to the services. Systems and processes are in place for reporting concerns and providing data and assurance within the Trust and external to our partners.

## Safeguarding Children Referrals

EPUT staff make referrals to children's social care for families where there is a concern that a child has been harmed or may be suffering from significant harm and require an immediate response. Safeguarding children's referrals to social care can also be for additional support for a family struggling to cope. Below are some extracts from staff regarding the support they have received.

The chart below shows number of safeguarding children's referrals to social care from EPUT staff, over the previous two years.

**Chart: No. Safeguarding Children Referrals made by EPUT Services**




| *Year* | *No. Referrals* |
|---|---|
| *2020-21* | 125 |
| *2019-20* | 162 |
| *Difference* | -22% |

The data identifies that 28 % of the referrals in 2020-21 were raised by Hospital Liaison teams

**Table: Top 10 Types of Referrals (category of abuse and vulnerability identified) in 2020-21**

| *Type of Referral* | *No.* |
|---|---|
| *Emotional & Parental Mental Ill Health* | **14** |
| *Neglect & Parental Mental Ill Health* | **13** |
| *Neglect & Learning Disabilities* | **8** |
| *Emotional & Drug/Alcohol Misuse* | **8** |
| *Sexual & Child Sexual Exploitation* | **7** |
| *Emotional, Neglect & Parental Mental Ill Health* | **6** |
| *Emotional & Domestic Abuse* | **6** |
| *Physical & Learning Disabilities* | **5** |
| *Physical & Parental Mental Ill Health* | **4** |
| *Emotional & Drug/Alcohol Misuse, Parental Mental Ill Health* | **4** |

**Chart: Vulerability Identified in Child Referrals (2020-21)**

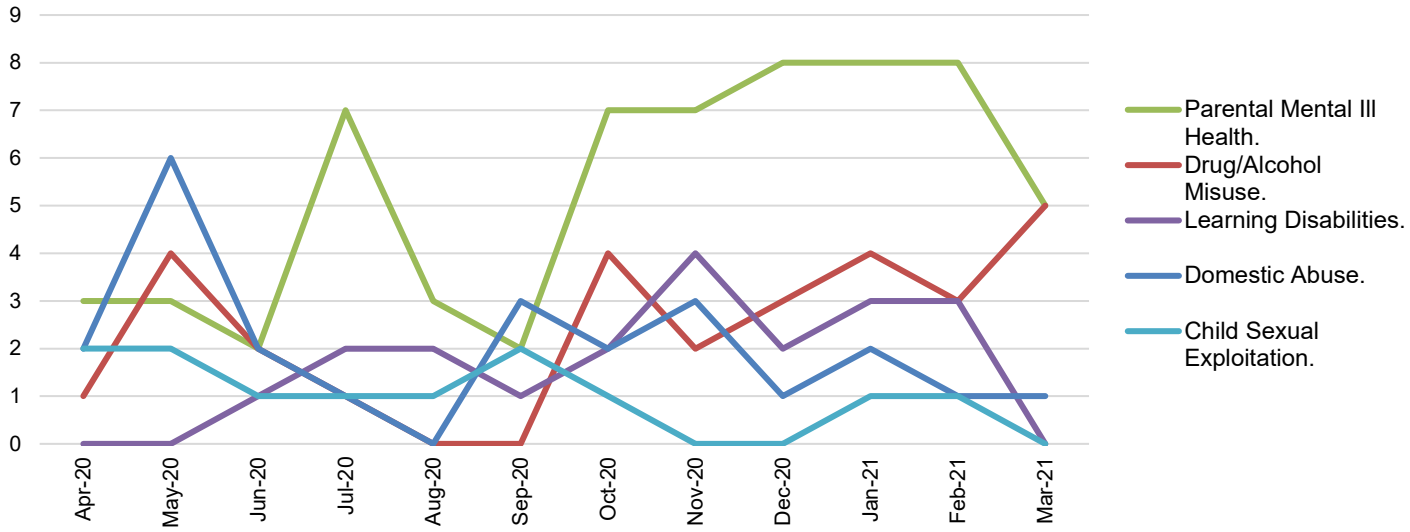
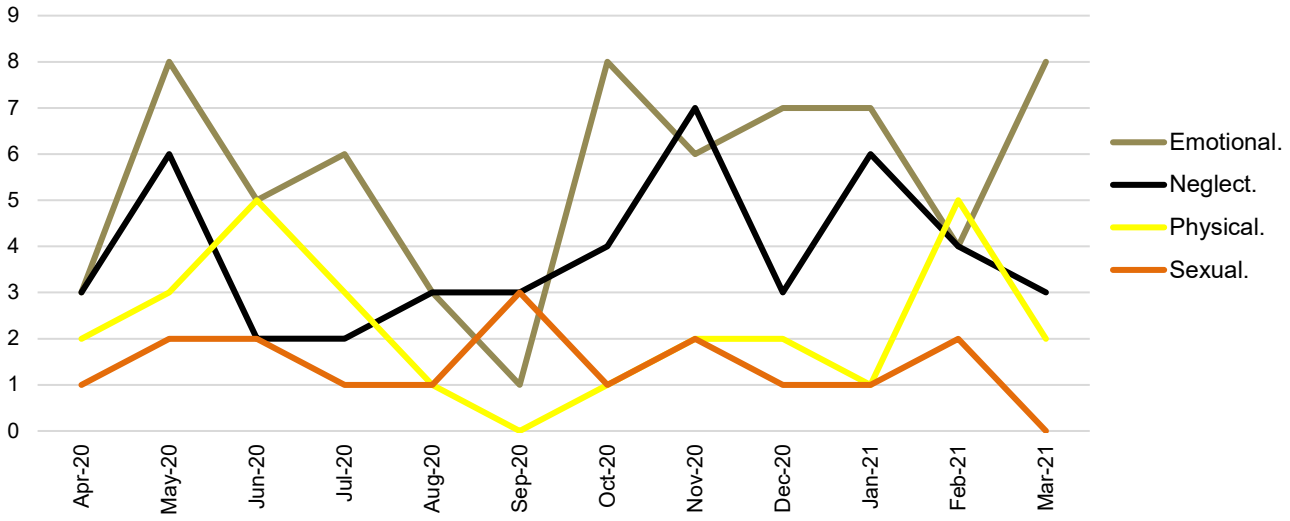


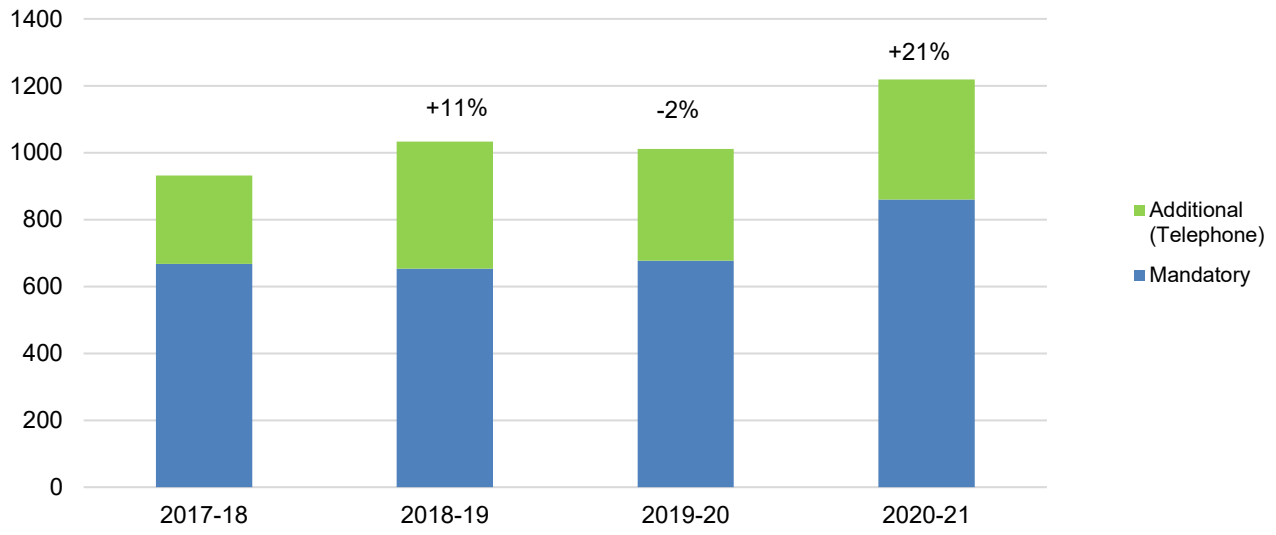

**Chart: Type of Abuse Identified in Child Referrals (2020-21)**



## Safeguarding Children Supervision

Safeguarding children supervision is provided to staff working on the adolescent units, mother and baby units, perinatal mental health and community children services. EPUT staff will phone for telephone advice and consultation when cases are worrying them for reflection and further direction on case management. In a number of cases further intensive work is required in the management oversight and emotional support to the frontline professional.

**Chart: No. Safeguarding Supervision Sessions Delivered**




## Supervision Feedback

**Maura White, Team Leader, Health Visitor, Southend Borough Council**
*"They aren't as readily available for on the spot support. But we do get calls back the same day when message left. And the advice given is very supportive and they give staff praise on the work completed. New member Christina is very good at explaining processes and supporting with advice and actions.*
*We are able to book supervision easily via admin."*

**Sarah Lark, Clinical Lead South East Essex, EPUT Perinatal Mental Health Service**
*"Please can you thank everyone, and especially Marie, for all your wonderful support through the many challenging situations over the past 10 years. The team's support has been invaluable and we are very lucky in this trust to have the level of safeguarding support that we do."*

**Amber Skinner, Health Liaison Nurse, Health Visitor, Southend Borough Council**
*"We have always felt very supported by the safeguarding team in terms of the Health Liaison nurse role; the safeguarding team always show a keen interest in our service and understand the pressures which can be present at times. The team have always been happy to share their opinions and listen to ours with regards to cases which we may come across.*
*Marie Mitchell often emails us relevant documents or studies which she feels we may find useful. Due to the nature of our role, we have at times had to cancel safeguarding supervision sessions and rearrange which the team have always been so understanding about."*

## Partner Feedback

**Yvonne Shaw, Deputy Associate Director for Safeguarding, MSE Hospital Group Mid and South Essex NHS Trust:**
*"I feel that we have an excellent relationship with the EPUT safeguarding children team. Partnership working between the Named Professionals is always productive with a high level of professional collaboration, and this enables us to work together effectively as a health safeguarding system to safeguarding children."*

**Erin Brennan-Douglas, Children's & Public Health Public Health, Southend Borough Council**
*"I think the partnership communication is excellent and timely.*
*As a chair of a subgroup, I depend on it. It is a trusted and valued partnership and admin team and the Manager's memory and detail of the work is commendable.*

## Audit of Infants Age 1 year and under who presented with a non-accidental injury (NAI) within the Children's 0-19 Public Health Service (01/10/19 to 30/09/20)

The aim of the audit was to seek to identify whether the changes in service delivery during the period when restrictions were in place due to the COVID-19 pandemic had an impact on the identification of risk presenting to children by Health Visitors. The audit also focused on looking at whether the communication of risk to and from the service was negatively affected by the pandemic.

The audit reviewed the SystmOne electronic patient records for infants under 1 year of age who suffered an NAI during the period of time along. The mothers and siblings' records were also reviewed to see if historical factors were considered within the risk assessment process.

The notes were scrutinised to see if the level of service delivery was allocated appropriately against the presenting level of risk. The changes to the service in response to the NHSE guidance for the Prioritisation of Community Services (2020) were examined to see if this had an impact on the assessment and care delivery process.

The audit clearly showed that the adapted model of Health Visiting service during the lockdown period did not appear to have altered the effectiveness of the assessment of risk to meet the level of need for the child. It did however highlight that more confidence was needed to fully assess who is involved in the care of the child within the family taking into consideration the 'Think Family' approach. This was particularly relevant during the lockdown period when there was an increased level of stress and anxiety in the home as some families were living in close proximity for weeks coupled with strong feelings of loneliness, separation and isolation.

The audit also highlighted the need for Health Visitors to have an understanding of the cluster factors that might indicate the need for early intervention during a lockdown period.
The findings from the audit were shared at the Health Visitors Educational Forums and the National Assessment Framework (NAF) template was reviewed with the Professional Lead to ensure that the cluster factors were clearly identifiable. A focussed clinical update on the 'Think Family' approach was also delivered by the Named Nurse for Safeguarding Children at the Educational Forum on two occasions.

Overall, the thematic audit highlighted the emerging issues that will inform the delivery of service provision in the event of further lockdowns for the children within the 0-19 Public Health Service in Southend who might be at risk of suffering an NAI.

# 5.0 Looked After Children Service

The current Looked after Children's (LAC) population in the Southeast (EPUT) comprises of a cohort of young people from both Southend and Castle Point and Rochford (CPR) Clinical Commissioning Groups (CCGs). Currently this group consists of 216 children in CPR and 382 children in Southend under 18 years of age. The 18-19 caseload consists of 83 Care Leavers. It is important to note that the overall number of Looked after Children has risen nationally in England over the last year 2020-2021.

In the last five years the population of looked after children in the UK has increased by 10%, from 93,013 to 102,291. NSPCC March 2021(**https://explore-education-statistics.service.gov.uk/find-statistics/children-looked-after-in-england-including-adoptions/2020)** Children looked after on 31 March 2020 increased to 80,080, from 78,140 last year - up 2%. This is a rate of 67 per 10,000 children, up from 65 last year. This national trend is also reflected locally.

Much of the LAC work involves ensuring that the health needs of Looked after Children are assessed, additional needs are identified and appropriate services sought to improve health outcomes for these children and young people.

The EPUT Looked after Children service provides support to frontline staff working with the LAC population as well as direct client care to young people who are over the age of sixteen. This also includes the young people who are not in education and have no universal services practitioners caring for them. This service is provided to children in Southend and CPR Looked after Children.

Another important function of the LAC service is to raise awareness of the needs of Looked after Children by providing up-to-date, accessible, informative and appropriate training which is evidenced based to both EPUT staff and Foster Carers. This is based on health-related topics.

The LAC Team currently has 1 full time Band 7 Clinical Specialist Nurse and 1 part time 0.8 whole time equivalent Band 6 Clinical Health Advisor. The Clinicians are supported by 2 Administrators who equate to 1.0 whole time equivalent.

## Ensuring Quality and Assurance

The LAC Team adapted to new ways of working in accordance with the Government guidance for social distancing issued in March 2020. This meant that at the beginning of lockdown young people were seen virtually and either telephone or video assessments were used to complete health assessments. This was in line with the recommendation from NHSE and PHE.

This was a temporary measure and by the end of July 2020, the LAC Team were back seeing children face to face again. Whilst it is felt that face to face assessments is preferable, some of the older young people did respond favourably to telephone/video assessments and having previously been less willing to engage with assessments have actively responded to virtual assessments during the Covid-19 period.

All members of the LAC Team worked very hard to maintain the service during the Covid-19 period striving to continue to deliver an excellent, safe and clinically effective service for the Looked after Children population. Some of the team members have been working from home, but because of good remote access to IT systems it has been possible to do this without impacting on the service to patients.

The LAC Team have continued to work in partnership with statutory agencies to promote the overall outcomes for Looked after Children under the duty of the corporate parenting responsibilities. This has been possible by being active members of the Corporate Parenting Group and the Multi-Agency Operational Groups. This has been beneficial in striving to improve the outcomes for children who are "looked after" in foster care and residential homes as well reviewing the pathways for transition to adult services for Care Leavers as these young people move to independent living.

The LAC Team have developed a Level 3 Looked after Children's Training. This ensures that the key LAC drivers are able to embed best practice when completing Review Health Assessments (RHAs) in order to be able to provide a holistic review of the health and development of Looked after Children.

Auditing and evaluation of the service and sharing of good practice takes place by quality checking the Review Health Assessments (RHAs). The performance is assessed via the Performance by Return (PBR) audit tool. Good practice is shared via the Designate Doctor for Looked after Children through professional peer meetings. The work that has been completed in relation to the Unaccompanied Asylum Seekers vaccination pathway has received special mention and has been shared with other LAC teams. During the Level 3 LAC training we share good examples of RHAs and this is often gratefully received by the attendees.

The Statutory Frameworks that support the Quality and Assurance within the LAC service include peer reviews, training, attendance at professional meetings, attendance at the East of England LAC Forum, regular Designate Nurse updates as well as quarterly Safeguarding Supervision.

Another component of Quality and Assurance is the administration, monitoring and quality checking of Review Health Assessments (RHAs) and Initial Health Assessments (IHAs), care plans and health passports. These form part of the Statutory Framework in line with key performance indicators set by commissioners and they need to be completed in line with statutory timescales and national guidance.

RHAs are quality assured to ensure that the health needs are being met. In order to ensure the quality of health assessments are of a high standard and maintained within EPUT, a tool has been developed and the information is captured through the Performance by Return (PBR) audit tool.

EPUT LAC Team continue to embed 3 monthly reviews of care plans into practice to help ensure oversight of the journey of the child as well as to ensure health needs are met and there is oversight on the care pathway for those children placed out of area.

## Service Development and progress 2020-2021

The LAC Team has become largely paperless during the recent Covid-19 pandemic and this has vastly improved communication channels and increased the speed of processing health assessments as well as reducing the Trusts carbon foot print.

The LAC Team Clinicians recently attended training on Adverse Childhood Experiences (ACE) which has helped to further inform future practice and training programmes.

With the rising numbers of Unaccompanied Asylum-Seeking Children (UASC) in England, the LAC Team have developed and shared a pathway for this cohort of young people across Southend, Essex and Thurrock (SET). This good practice guidance pays attention to blood screening for TB and Hepatitis and allows the young person to have x-rays on the day of the IHA assessment to avoid unnecessary delay in treatment.

Looked after Children are at increased risk of exploitation and going missing. In response to recognising this risk for the young people, Southend Borough Council have been working in partnership with local agencies including the EPUT LAC team to identify and analyse common risks and patterns through the Multi Agency Sexual Exploitation (MASE) committee. This committee was formed as a direct response to the heightened concerns of missing episodes and exploitation within the Southend population.

The LAC Team are able to recognise young people who may be at risk of Child Sexual Exploitation (CSE) and or Child Criminal Exploitation (CCE). As champions of CSE they have been proactive in seeking to be at the forefront of new initiatives. They are developing links with partner agencies and regularly attend Risk Management Meetings (RMM), Strategy and Professional Meetings enabling a joined up multi-agency approach to improve the outcomes for the Looked after Children.

We have enhanced and shared Health Care Plan templates with our partners who carry out RHA's, we have also developed and shared a risk assessment which was utilised by the school nurses and HV's during the COVID 19 pandemic.

Throughout the pandemic the LAC Team worked closely with their health colleagues in A&E recognising the challenges faced by staff as there was an increase in the number of LAC attending A&E.

More recently, the LAC Team have become involved in contributing to the Education, Health and Care Plan (EHCP) process for the LAC. This has enabled the LAC Team to work closely with partner agencies to support them in this process. This has meant that they have been instrumental in contributing to a clear and early transition pathway for LAC with additional needs into adult services and minimises a possible delay in service provision. Looked after Children with complex needs appears to be another area that has been expanding over the last year.

Working with the Southend Borough Council we continue to be part of "the voice of the child scrum" which shares innovative practice within the Southend area on how to capture the voice of the child.

Working closely with Social Care has raised the profile of health providers for LAC and now the LAC Team contact details are included in the new entry care pack for all LAC children entering care.

The LAC Team are participating regularly in training to inform and support the work of Foster Carers in improving health outcomes for Looked after Children in Southend. This training focuses on raising awareness of the providers to the corporate parenting responsibilities in promoting the health and wellbeing of Looked after Children.

Moving forward, the LAC Team have also been asked to work in partnership with Essex Social Care to co-deliver the training for Foster Carers for the children and young people in Castle Point and Rochford. This training will help to promote the health and mental and emotional well-being of these Looked after Children.

We liaise and escalate to the CCG regularly any Looked after Children that present as a high risk as well as highlighting any system issues or challenges that are faced by our young people.

We continue to work closely with the virtual school and social care and all other partners to provide support for the LAC population.

The aim is to start to attend the team meetings on the Tier 4 Child and Adolescent Inpatient Unit, Poplar Ward to support staff with following the LAC pathways when they have a young person admitted who is a Looked after Child

## The Voice of Young People

Looked after Children need a number of factors to be in place to give them the best possible chance to be happy, healthy and achieve their full potential. The LAC Team recognise that one of these is 'being listened to and involved in their care'. Therefore, a decision was made during the year to change the way that the voice of these young people was being captured within EPUT and a new online survey was developed and introduced in order to promote positive outcomes for the young people. The children complete the online survey following an RHA, this information is captured immediately, and a monthly report is shared with the LAC Team. Engagement with both young people and partner agencies is positive in terms of exploring what they would like from the LAC Team and this has informed the delivery of the service in terms of training, accessibility and enhanced communication.

These are examples below of feedback that young people have given:

| | | |
|---|---|---|
| *"LAC Nurse seemed welcoming so it was comfortable for me to have a conversation "* | *"I feel comfortable to talk as I am familiar with surrounding and people"* | *"Overall amazing recommend it too ppl [sic] "* |
| *"The nurse is very welcoming, kind, down to earth, and extremely supportive.."* | *"[redacted] expressed that he has happy with his RHA It was great."* | *"i felt comfortable... as she was very talkative and helpful"* |

## Partner Agency Feedback:

**Val, Acting Personal Advisor, Leaving Care Team 16 Plus:**
*"I like to share that CM16+ and myself find your team are always accessible and helpful when dealing with our Looked After yp. You provide a sensitive and caring approach towards the yp when dealing with their difficulties which goes a long way in their view and increases their confidence. It has been a valuable asset to have been able to have our monthly meetings and hope that this can continue*

**Laura, Senior Residential Support Worker, Island Lodge, Potton Homes:**
*"I would say that as a service you have been dependable. You have been easy to contact and always been approachable when we have had health concerns with our YP's. You always respond quick time and are there for support all the time. We very much enjoy working with you and your team. I would say we have built a very good working relationship and hope we continue to work together as a team around YP's in our residential homes in the future. Thank you."*

**Chloe, Social Worker, 16 Plus Team:**
*"I strongly believe the LAC nursing team are the bridge between some of our young people and accessing essential health services. I have observed your team to be patient and flexible with some of our yp who have complex needs. It has been excellent practice that there is usually always a member of the LAC nursing team at our strategy meetings to provide information and advice around meeting their physical, mental and emotional needs. When I have needed support or advice a member of the LAC nursing team have always been available to assist and go above and beyond for our young people. The LAC nursing team have also raised concerns in a timely manner that I would not otherwise have been aware of which has helped inform my interventions and support for our yp."*

## Challenges in Looked after Children services

2020-21 has been a busy year for the LAC Team.

The number of Unaccompanied Asylum-Seeking Children (UASC) in England continues to rise and this remains an area of growth within the population of Looked after Children in the local area. The LAC Team are striving to work in partnership and closely with all stakeholders to develop ways of working that take into account the complexity of need and the bespoke nature of care required for this cohort of children.

Another area of growth amongst the Looked after Children population are those who are at risk of Child Sexual Exploitation (CSE) and Child Criminal Exploitation (CCE) as well as those children who go missing from home. The LAC Team attend the operational MACE meetings, which adopts the focus on young people who are at risk of being sexually or criminally exploited, missing or at risk of going missing, or who are displaying significant vulnerabilities or concerning behaviours and they advocate on their behalf.

There is currently a review of the LAC service and the aim of this is to ensure that resources are matched explicitly to the local need focusing on meeting the needs of the Looked after Children and young people. It is important that the LAC service can maximise the resources to pursue the desired outcome of improving health and well-being of all Looked after Children accessing the service.

The EPUT LAC Team have had to carry out additional tasks due to the system issues with the completion of the Initial Health Assessments (IHAs). Working differently in response to the gap in service provision has ensured that the Looked after Children have been registered with a General Practitioner as well as focusing on identifying their health needs when they first enter

the care system. Following this initial contact with the young person the LAC Team follow up on the referrals that have been made and ensure that the Review Health Assessment (RHA) takes place at the appropriate time.

In order to be able to meet the demand to produce complex data regarding the Looked after Children population a request for a Looked after Children's Dashboard has been made. The dashboard will enable the monitoring of national and local indicators so that outcomes can be measured and improvements implemented for the Looked after Children.

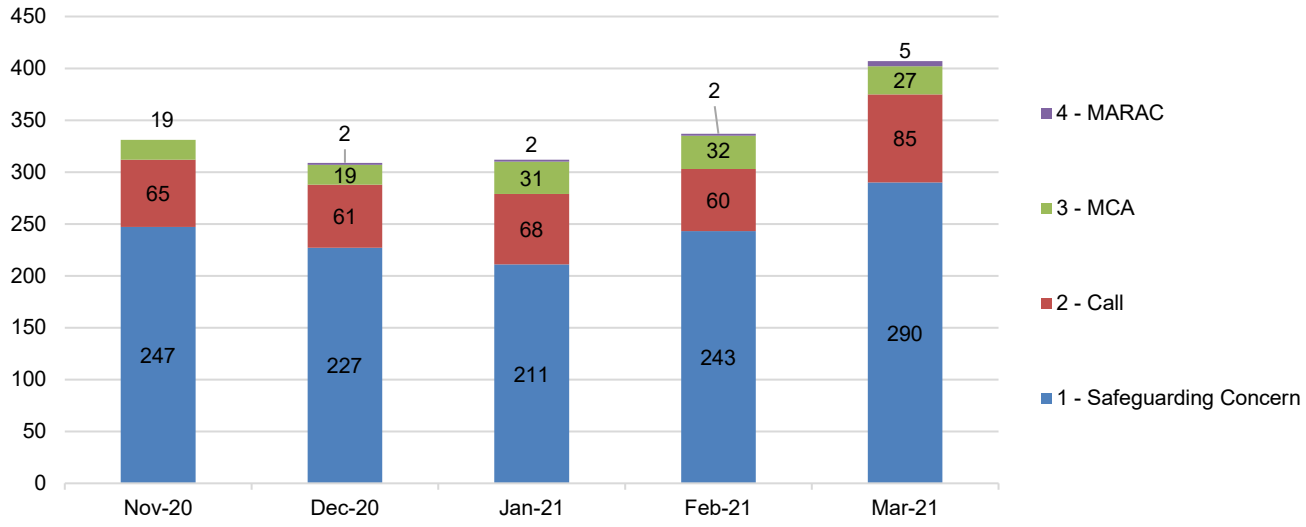
In August 2021, we are currently starting a 3-month pilot evaluating the effectiveness of the virtual platform with our LAC drop-ins that we provide to the residential homes in Southend. This project will also enable us to become aware of the increasing number of unregistered care providers for Looked after Children who are living in semi-independent accommodation and enable a joined-up approach with our partners to work to address the issues that occur.

# 6.0 Developments and Innovative Practice

## Duty System

The safeguarding service have implemented a duty system in which a Clinical Specialist from the Safeguarding Team is designated to be available to deal with certain tasks; including (but not limited to) triaging new safeguarding concerns, reviewing MCA assessments, triaging LADO referrals and providing advice via the duty line. This means that, on Monday to Friday between 9am and 5pm, EPUT staff are always able to get guidance on safeguarding issues.

**Chart: Recorded Activity of the Duty Clinician**




## Safeguarding Activity Reports

New reports have been developed and are provided to various operational team meetings. These give updates on training compliance, safeguarding children referrals, safeguarding adults' activity, MARAC data, MCA, DoLS, themes/hotspots and Safeguarding Champions activity.

## Impact of Covid-19

In March 2020 the safeguarding service implemented its business continuity plans in alignment with operational services as a result of the Covid-19 pandemic. The service revised its service deliverables to the must do's and temporarily ceased delivering service with added value and the level 3 safeguarding training. Level 3 safeguarding training was suspended because the team were unable to gather large groups of staff members in a training room along with the increased demand on our operational staff to care for very sick and vulnerable patients in our care. This resulted in the suspension of 17 training sessions of which there were 10 adult and 2 children's sessions during the period. This would have given capacity for 585 training places equating to 325 adults and 260 children's spaces available to staff.

With the easing of restrictions, the safeguarding service were then able to recover and restore their training service provision back to the pre Covid-19 position whilst retaining some of the innovative and transformational ways that it had delivered business during the restrictions. The team delivered the majority of the training virtually using Microsoft Teams and were able to engage a larger audience using this format. Some direct face-to-face training has been provided to operational teams who have been able to organise solutions for their teams to book a large enough space for their staff to social distance during these sessions.

The team have equally adapted the way they deliver individual and group safeguarding supervision to operational teams, delivered mainly virtually during the period of pandemic. Teams have benefited from this and restoration and recovery has continued with this as an available option along with meeting in person in a COVID-19 secure space. Teams and practitioners choose their preferred method. The safeguarding service operates a duty system between the hours of 9-5 and demand has increased significantly with this service in the last year requiring an increase in resource needed to staff it.

The safeguarding and looked after children service have adapted their attendance at statutory and clinical meetings and now represent the service virtually through corporately approved software platforms. Patient care and safety meetings were prioritised by the safeguarding and looked after children's partners across the system during this time. Equally the team continued to manage partner requests for referrals, enquires, DoLS, MCA, domestic abuse and management of safeguarding and domestic homicide reviews throughout this period through agreed virtual meetings, which have continued since recovery and restoration commenced.

The looked after children team needed to adapt their service delivery model to co-ordinate and monitor the health needs of the looked after children within their care. The service undertook COVID-19 risk assessments for all review health assessments required for looked after children to ascertain if members of the household had symptoms or were self-isolating and offered a virtual or physical contact dependant on the outcome and child's wishes. The team provided the same service to support foster carers on managing the health needs for looked after children placed in their care based on their COVID-19 risk assessment.
The service has developed safeguarding a standard operating procedure for the delivery of the mass vaccination COVID-19 immunisation programme that the organisation has been delivering on so that those immunising have an appropriate safeguarding operational procedure to meet the service needs. The service has worked with other corporate governance teams to assist with the safeguarding aspects of recruitment and training of the staff who have been employed to help deliver the vaccination programme. Like most services the team have

found that the impact of COVID-19 has meant an increase in demand from the team. The key highlights of this are

- The number of referrals during lockdown 1 and 2 went down. But following relaxation number of referrals hit higher levels than ever before

- Number of referrals for self-neglect has increased. This is likely to be as a result of patient with mental illness not being physically visited, but virtual where they can hide the true extent of the conditions, they are living in.

- Domestic abuse high risk case number has increased significantly
- Domestic abuse national call line contact went up 80%
- Domestic homicides have also increased in number

- Every contact count strap line is so important at time of lockdown as every time someone was in contact with a patient it is important to use that as an opportunity to find out if they are safe

- The impact of psychological effect on staff of working in high stress environment will have an effect on home life. People take stress home and are then abusive at home. The increase abuse from staff towards families is likely to have increased and so therefore more staff will have experienced abuse at home during the last year – The team are supporting the development of a new strategy launch for domestic abuse where staff are affected led by HR

- Child deaths have increased during lockdown, and non-accidental injuries of particularly under 5's has increased during lockdown; therefore, the team has seen more referrals and queries for advice regarding child incidents

- Virtual consultations again make it easy to miss bruises, poor clutter environments, lack of body language and not being able to interpret as easily. This could result in missed opportunity to explore where abuse is occurring

- EPUT lead on max vaccination, safeguarding was part of that; new protocols, new systems and supporting front line staff where safeguarding concerns have occurred

- Capacity assessments for people who are being vaccinated, support has been given to challenge where someone has not got capacity to consent

- Duty has increased in volume of work, partly as a result of covid and the impact on services and the level of risk that teams are carrying.

### Southend Borough Council Children's 0-19 Public Health Service - Delivery through COVID Pandemic

The service model in the initial stages of the pandemic was adapted and informed by the COVID 19 Community Prioritisation Guidance from PHE and NHSE and the subsequent restoration guidance to ensure that a risk stratification process was in place to safeguard vulnerable children.

Service delivery followed the business continuity plan with frequent staff briefings, held daily during the early days to ensure that operational leaders and practitioners were confident of the delivery model considering the rapidly changing environment, guidance and risks.

The delivery model incorporated the use of virtual delivery platforms to ensure accessibility of the Healthy Child Programme (HCP) to families, children, and young people. This was supported by the development of an emergency standard operating procedure and risk assessment to ensure that clients requiring initial assessment or who had been identified as on the Universal Partnership Plus Pathway (UPP) where prioritised for face-to-face delivery so that the health needs of children and young people identified as most at risk were identified.

Access to drop-in style clinics was stood down and an appointment-based system instigated via the children centres, to ensure that emerging health needs could be assessed in a timely manner for children and young people, by either a health visitor or school nurse within the community setting.

Increased communication across the system was instigated by the service with operational managers from 0-19 PH, early help, children's social care, maternity, early years commissioning and education to identify themes and risks promptly so that these could be addressed. An example being the increase in clients impacted by mental health who had 'just been managing' pre pandemic and who required additional support to meet their child needs. An urgent referral system was put in place with early years commissioning to support rapid access to early years settings, on the referral of the health visitor which proved vital for many families.

With school environments closed, access to school nurses was via the virtual environment, children centre or client home. Joint visiting was also undertaken with the child or young person's key worker. The CHAT health confidential texting function was reviewed and extended to enable parents to access the offer. The service offer was also communicated to parents and young people who are electively home educated via the EHE newsletter.

Communication letters were sent to key stakeholders - primary care, early years, maternity and head teachers advising them of the service model and how to contact the service. This was also communicated via the organisation's website and service twitter feeds.

In line with restorative guidance, recovery and restoration plans have been put in place. All children on the universal pathway who received a virtual contact in lock down one has been invited to an assessment clinic for a face-to-face review of their growth. The contact model for universal clients during subsequent restrictions was increased to a combined virtual assessment and face to face review within a children centre to increase client contact and support holistic assessment.

The National Child Measurement Programme (NCMP) was stood down at a population-based level, and in line with PHE the service is currently delivering the programme to the prescribed schools as identified for the representative sample. In addition, the school nurses are undertaking weight, height, hearing and vision screening to all children on the Universal Partnership Plus caseload to ensure that any unmet needs during the pandemic are identified.

School nurses are also delivering opt in hearing and vision screening to year Reception entry for 2019-20 and 2020-21 and where there are concerns identified.

Whilst the use of virtual platforms for communicating with parents/carers and young people has its place in some aspects of service delivery, it does impact on the quality and ability to undertake a holistic assessment on children and young people across all the domains, especially family and environmental. The ability to hear the voice of the child is particularly difficult. The impact on vulnerable children is still emerging with greater number of referrals being reported by the health liaison nurses within the multi-agency safeguarding hub at the end of each of the three lock downs.

A service audit was undertaken following concerns identified by health visitors regarding the increase in pre-mobile infants within their caseload who had been identified as suffering NAI, which appeared heightened during the implementation of government restrictions, the learning and recommendations from which have been shared with the partnership. The service has also contributed to the wider 'deep dive' exercise across the local children's system to gain greater insight and learning.

In response to SCR/Child Practice Reviews the following standard operating procedures have been developed to support practitioners in their safeguarding practice over the last year:

- Working with Vulnerable Families for 5-19 Practitioners
- Core health Assessments for 5-19 Practitioners
- Electively Home Educated and Missing from Education 5-19 Practitioners.
- Transfer n and Out of Children's Records

As part of the wider children's system approach to the roll out of the Grade Care profile 2, three practitioners have undertaken the train the trainer programme to support delivery across the partnership.

The service has used appropriate PPE and maintained face to face contacts to children subject to statutory processes and/or identified as vulnerable and continued face to face contacts at new birth and 6 weeks. Staff attendance at management and safeguarding supervision has been maintained as per standards to support risk management/identification and safe practice.

The service except for drop-in clinic activities, which continue to be appointment based in order to remain COVID secure, has now returned to a pre pandemic model from the 12/4/21.

To gain insight into the client experience of the Children's 0-19 Public Health Service a feedback survey has been developed on the Southend Borough Council 'Your Say' website to ensure the user voice informs service development and delivery.

The following exerts are compliments received during COVID from parents:

'*I just want to say a big thank you from the bottom of my heart you have no idea how much you have help me. Before you met me, I was going through stuff with my ex and I thought*

*there was no way out I open up to you and you went extra mile to get me the help that I never knew existed.*'

'*You especially helped me to feel safe and supported when we first moved down here and almost are our constant! I'm incredibly grateful that you are still there at the end of the phone or email so if something suddenly happened then I know that you're still there in case of emergency.*'

## Child and Adolescent Mental Health Services (CAMHS)

The safeguarding team are supporting CAMHS via regular safeguarding supervision sessions which, are 1:1 and group sessions and are available to all CAMHS staff. The team have developed a more concise pathway for all CAMHS services, ensuring there is one safeguarding duty line and one safeguarding duty email to avoid confusion and reduce delays in addressing concerns.

Meetings with matrons for CAMHS units have been initiated so they can share any concerns, via safeguarding team, with CQC, to ensure a more collaborative approach to addressing any concerns.

The team meet with the safeguarding leads for the community teams to review caseloads and advise as to how each enquiry can progress. The future plan is to roll this out to all the teams for consultation and advice.

## LADO

This past year the safeguarding team have reviewed and developed the LADO process, to mirror the safeguarding adult's pathway, with the safeguarding team triaging concerns and reviewing closures. EPUT safeguarding team, meet with the LADO frequently to ensure case progression, mutual understandings and effective partnership working. The service has delivered focussed champions events around the LADO and incorporated this into training sessions, so all staff are aware.

**Mechelle DeKock, Local Authority Designated Officer, Essex County Council**
*"It is positive having a central point of contact to discuss safeguarding matters and work in partnership in progressing both case work and wider safeguarding / practise development. This has given opportunity for monthly partnership meetings with a named LADO .*

*The safeguarding team has been instrumental in challenging information sharing with the LADO Team and promoting the use of the workforce allegations referral form. This has improved the quality of information received at referral stage.*

*Training about Workforce allegations was arranged by the Safeguarding Team, two LADO's presented this to the into the safeguarding leads*

*Ongoing communication between the settings and LADO Team is encouraged, the safeguarding team has developed a workforce allegation workflow chart which staff now have to hand when an allegation is made.*

*The working relationship with the safeguarding team as a whole is positive.*

*Our Team would want to see practical steps in how the voices of the young people are heard ; parental participation is encouraged and with stronger lines of advocacy in particular at St Aubyn Centre where a change in culture is driven forward by the safeguarding team."*

# 7.0 Safeguarding Learning & Domestic Homicide Reviews

## Safeguarding Learning Reviews (SLR) AND Safeguarding Adults Reviews (SAR)

A Safeguarding Learning Review for a child or adult is determined where abuse or neglect is known or suspected and the person has either died or has been seriously harmed and there is cause for concern as to the way in which the Local Authority Safeguarding partners or other relevant persons have worked together to safeguard that person.

Safeguarding Learning Reviews are not inquiries into how a person has died or who is culpable as this would be for the Coroners and Criminal Courts respectively to decide.
They are principally to establish whether there are lessons to be learned from a case about the way in which local professionals and agencies work together to safeguard people.

## Child Safeguarding Practice Reviews

Alison Cutler, Business Manager, Essex Safeguarding Children Board:

"*EPUT has supported the ESCB in attending reviews as panel members and also as a member of the ESCB CSPR review sub-committee with attendance as follows*:

| | |
|---|---|
| Child V | EPUT was part the review team - Attended all meetings thus far |
| Child S | EPUT was part the review team - Attended chronology authors meeting (only one so far) |
| GA - published Nov 20 | Apologies on 04.2.20, Otherwise attended all |

*This support and cooperation have proved to be very helpful in providing information to make decisions on whether or not to carry out a review and also to inform the reviews themselves. EPUT representatives have always provided information requested of them and also been willing to have discussions with the ESCB where there have been issues in order to resolve these. We appreciate the support of EPUT in helping to further improve the safeguarding systems and outcomes for children and young people in Essex*."

## Safeguarding Adults Reviews

There have been 5 reviews where EPUT have been directly involved. This is an increase since the previous year with all of them occurring in Essex County.

**Caroline Venables, Safeguarding Adults Review Officer, Essex Safeguarding Adults Board**

*"Essex Safeguarding Adult Board's Safeguarding Adult Review (SAR) Officer continues to value the positive working relationship they have with EPUT's Head of Safeguarding and members of the Safeguarding Team. This is particularly in light of the increased pressures of all safeguarding partners as a result of the Covid-19 pandemic. EPUT has continued to support ESAB achieve its obligations in respect of SAR's via prompt information sharing and participation, both at the point of initial SAR referral and throughout the Safeguarding Adult Review process.*

*This past year has seen an increase in the number of SAR's that ESAB has commissioned, which the Board recognises has impacted on EPUT and other safeguarding partners.*

*Despite this, the SAR Officer has appreciated the support of EPUT's safeguarding team in the progression of SARs and maximising multi-agency learning. In addition, EPUT's Head of Safeguarding continues to be a valued partner of the ESAB SAR Committee, which met each month in the previous year, via virtual means, to consider 11 SAR referrals (and increase of 2 from the previous year) and progress SARs to conclusion.*

*In the past year, 3 SARs have been published by ESAB, along with some accompanying eLearning materials, which can be found on ESAB's website via https://www.essex-sab.org.uk/safeguarding-adult-reviews"*

## Domestic Homicide Reviews (DHR)

A Domestic Homicide review is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he/she was related or with whom he was or had been in an intimate personal relationship, or member of the same household as him/herself.

An intimate relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality. This may include Honour Based Violence.

Any learning from SCR or DHR are placed on the Safeguarding section of Input and also tabled at the Trust Learning Lesson Group for wider circulation. The safeguarding training (Level 3) has also been reviewed to reflect on any trends, learning or recommendations from the reviews.

There have been 3 DHRs this year.

**Val Billings, SET Domestic Abuse Co-ordinator, SET Domestic Abuse Board**

*""The EPUT team are fully engaged in our Domestic Homicide Review (DHR) process. They are represented at the various stages of the process from the DHR Core multiagency membership group where they give comprehensive agency engagement update to enable us as a working group to establish if the Home Office DHR criteria is met. They provide comprehensive Independent management reports should the process proceed. They add their specialism by attending our DHR panels where their role working in partnership is to look at the case to establish any learning that can be shared across our partnerships. Action plans are evolving to ensure SMART outcomes. Communication with the team is good and has strengthened over the last few year."*

# 8.0 FORWARD PLAN 2021-2022

The Trust Safeguarding service will continue to develop and improve services for clients. The forward plan focuses on key areas for the coming year as demonstrated in the table below;

| | Objectives 2021-2022 | Action Required | Success Criteria |
|---|---|---|---|
| 1 | Think Family. | Identify any barriers that prevent the principles being implemented in practice and take steps to mitigate their impact. | Learning lessons demonstrate think family care has been delivered by staff. |
| 2 | The Trust will implement the new Liberty Protection Safeguards (LPS) effectively with sufficient resourcing to support its implementation. | Review of Mental Capacity Act Policy.<br>Engage with partner agencies regarding implementation of LPS.<br>Review existing Safeguarding Team systems to determine resources required to implement and support LPS | Effective implementation of LPS with sufficient resourcing to support. |
| 3 | Align the Safeguarding service to the new Sustainability and Transformation Plans (STP) and Integrated Care Systems (ICS) systems and processes. | Integrate and merge the safeguarding service to new STP and ICS arrangements which will include the new LPS arrangements. | The safeguarding service is aligned to the new STP and ICS arrangements. |
| 4 | Implementation of the Trusts Safeguarding Strategic Framework. | Years 2020-22 objectives have been delivered or under progression.<br>The Annual Report demonstrates delivery of the objectives in the strategic framework. | . |
| 5 | Review and submission of the Children Section 11 Audit in 2021. | The Children's Section 11 Audit is reviewed and updated. | The Children's Section 11 Audit is submitted to Local Safeguarding Partnerships |
| 6 | Creation of Looked After Children (LAC) team EPUT dashboard to enable service analysis of lac population/cohort. | LAC team have had project meetings with information team.<br>LAC dashboard is developed | EPUT LAC dashboard demonstrates and informs the service profile, activity and performance requirements. |

| | | |
|---|---|---|
| | | **Agenda Item No: 7f** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **Health, Safety and Security Annual Report** | | | | | |
| **Executive/Non-Executive Lead:** | Paul Scott, Chief Executive Officer | | | | | |
| **Report Author(s):** | Nicola Jones, Director of Risk and Compliance | | | | | |
| **Report discussed previously at:** | Health Safety and Security Committee and Quality Committee | | | | | |
| **Level of Assurance:** | **Level 1** | | **Level 2** | ✓ | **Level 3** | |

| **Risk Assessment of Report** | |
|---|---|
| Summary of Risks highlighted in this report | BAF10 - If EPUT does not reduce ligature risks then serious incidents will occur resulting in a failure to deliver our Safety First, Safety Always ambitions |
| State which BAF risk(s) this report relates to | BAF 10 |
| Does this report mitigate the BAF risk(s)? | No |
| Are you recommending a new risk for the EPUT BAF? | No |
| If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register. | N/A |
| Describe what measures will you use to monitor mitigation of the risk | N/A |

| **Purpose of the Report** | | |
|---|---|---|
| This report provides the Trusts Health, Safety & Security annual report to the Board of Directors for noting | **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 as necessary.

**Summary of Key Issues**

This report presents the Trusts Annual Health, Safety & Security Annual Report covering the Health & Safety and LSMS functions.

These were impacted significantly during 2020-2021 due to the Covid pandemic which limited the Trusts H&S and LSMS staff being able to physically access Trust locations. However, over the pandemic the teams prioritised ligature assessments for inpatient units and H&S inspections at community locations. Where possible when access to Trust locations was limited virtual assessments were undertaken and followed up with site visits when safe to do so.

Key achievements during 20/21:
* Collaborative working with Capital projects team for refurbishment projects including (Topaz Ward and Derwent Centre Garden)

* Internal development and implementation of an electronic ligature inspection tool
* Use of new technology to deliver virtual training
* Successful Body Worn Camera pilot
* H&S and LSMS support to Mass Vaccination Project

Key aims for 21/22:
* Enhanced training offer to support Safety First, Safety Always Strategy
* Review of General Workplace Risk Assessment tools and processes
* LSMS on site drop in clinics
* Roll out of Body Worn Cameras

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

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

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

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| BAF | Board Assurance Framework | LRRG | Ligature Risk Reduction Group |
| CQC | Care Quality Commission | ELFT | East London Foundation Trust |
| EERG | Estate Expert Reference Group | LSMS | Local Security Management Specialist |
| HSSC | Health, Safety & Security Committee | H&S | Health & Safety |
| IOSH | Institution of Occupational Safety and Health | NEBOSH | National Examination Board in Occupation Safety and Health |
| DSE | Display Screen Equipment | NRLS | National Reporting and Learning System |
| LWD | Lone Worker Device | BWC/BWV | Body Worn Camera/Body Worn Video |

| Supporting Documents and/or Further Reading |
| --- |
| Health, Safety & Security Annual Report 2020-2021 |

| Lead |
| --- |
| **Paul Scott**<br>**Chief Executive Officer** |

Essex Partnership University
NHS Foundation Trust

# HEALTH, SAFETY & SECURITY

# ANNUAL REPORT 2020 - 2021

## 1.0 Introduction

The annual report for Health, Safety and Security provides assurance that there are satisfactory arrangements in place for managing Health, Safety and Security risks across the organisation.

The organisation is required to fulfil the statutory Health & Safety requirements (Health & Safety at Work Act etc. 1974 and Management of Health & Safety at Work Regulations 1999) and ensure there is the identification of control measures to suitably reduce Health, Safety, security and ligature risks so far as is reasonably practicable.

EPUT recognises the need for the effective management of health and safety and security. Day-to-day management of Health, Safety and Security is undertaken by the Risk Management Department in cooperation with unit and locality managers and all staff according to their level of responsibility.

The Health Safety and Security Committee co-ordinates the implementation and management of health, safety and security and non-clinical risk management across the Organisation, the committee has wide representation from both operational and support services with a representative from each area. It receives assurance on Health Safety and Security at a local level from the Health and Safety/Quality sub-groups and receives action plans on a regular basis for monitoring.

NHS England has not released any new Security Management Standards or Strategies, in line with other NHS Trusts EPUT continues to follow the NHS Protect standards. The LSMS continues to ensure the Trust is compliant against the standards and assurance is provided in regular reports to the HSSC and in the LSMS Annual Report.

## 2.0 Independent Assurance

Due to the Covid-19 pandemic, there has been no external audits in relation to Health and Safety or Estates Management. .

BDO, the Trust's internal independent auditors, carried out an internal audit which focused on Ligature Inspections and also reviewed compliance in accordance with Patient Safety. The audit was carried out to test systems in place with the focus on the following polices which local sites are responsible for adhering to:

- Ligature Risk Assessment and Management Policy
- Engagement and Supportive Observation Policy
- Medical Devices Policy
- Smoking Policy

The audit found moderate assurance advising that generally a sound system of internal control designed to achieve system objectives with some exceptions. There was also evidence of non-compliance with some controls, that may put some of the system objectives at risk. The audit highlighted some good areas of practice and made recommendations which have been taken forward by the Trust.

## 3.0 Leadership

Leadership for ligature management has been invigorated in 2020/21 challenging all staff to move towards the common goals set out in the Trust Safety First, Safety Always Strategy. This year has been a challenging year across the country with the Covid 19 pandemic. Over this time EPUT has continued to maintain a focus on ligature improvement work

The Director of Risk and Compliance was appointed as the new chair for the Health Safety and Security Committee. The new chair challenged the group to ensure ongoing clinical focus at the meetings and responsiveness to actions agreed.

A new Executive Safety Oversight Group has been established, who receive regular updates from the Health Safety and Security Committee and have provide an immediate escalation root when needed from the LRRG.

## 4.0 Governance

### 4.1 H&S and Security Policies and Procedures

The Trust's Corporate Statement and Policy on Health and Safety (RM01) sets out the organisational structure for managing Health and Safety and how the Board of Directors fulfils its statutory obligations as required by the:

- Health and Safety at Work etc., Act 1974;
- Management of Health and Safety at Work Regulations 1992;
- Workplace (Health, Safety, and Welfare) Regulations 1992.

The Health, Safety and Security Committee co-ordinates the implementation and management of health, safety & security as well as non-clinical risk management across the organisation and the Trust has a range of policies and procedures in place to support staff in maintaining compliance with health and safety requirements.

The following polies have been reviewed over this reporting period:

Full reviews

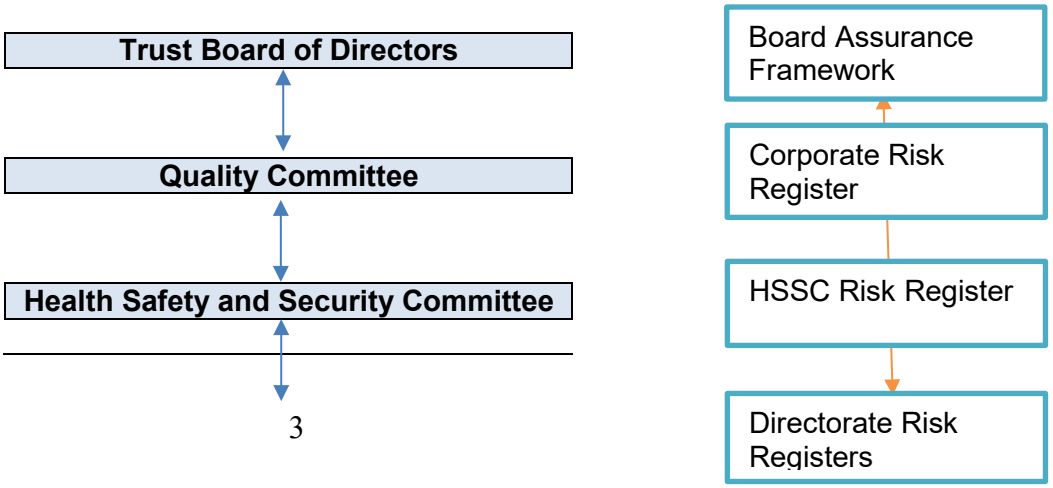
- Corporate Health and Safety Policy
- Fire Safety Policy (by Estates)
- Lone Working Policy
- Ligature Risk Assessment & Management Policy
- Search Policy
- RM10 Safety Alert Bulletins

Minor amendments

- Major Incident Plan
- Criminal Behaviour within a Health Environment (Zero Tolerance) Policy

### 4.2 Ward to Board

The Trust Health Safety and Security reporting has continued through the committee governance structure as outlined in Fig 1 below. The Trust Risk Management Framework is used to escalate risks when appropriate:



### 4.3 Risk Management Team

The Trust Health and Safety Team and Local Security Management Specialists are part of the wider Risk Management Team. The Team provides expert advice and guidance to the organisation and is responsibility for overseeing Health Safety and Security. Throughout the year various members of the team have assisted on special projects with the Ligature Risk Reduction Group, with Estates and Projects teams and with targeted projects and tasks as requested by the HSSC.

- A member of the Health and Safety team passed the IOSH Occupational Health and Wellbeing course in November 2020
- All band 6 and above hold the NEBOSH General Certificate as a minimum requirement.
- A member of the H&S Team holds the LSMS Qualification and has been awarded 'Grad IOSH' Status with IOSH
- All member of the team have completed and successfully passed the IOSH Managing Safely course
- All permanent members of the H&S team have completed and successfully passed the Display Screen Equipment assessors course which enables them to provide a full support service to all staff experiencing pain or discomfort whilst using DSE

The Trust incident management team is also part of the Risk Management Team which provides incident analysis and oversight for all Health and Safety and Security incidents.

EPUT recognises the need for the effective management of health, safety and security. While Day-to-day management of health, safety and security is undertaken by the Risk Management Department this is in cooperation with unit and locality managers and all staff according to their level of responsibility.

## 5.0 Continuous Learning

### 5.1 Datix Risk Management System

The Datix Risk Management system continues to be reviewed and upgraded to enhance its functionality.

The Datix dashboard module has been further developed in 2020/21 and is utilised by both clinical and support staff across the Trust providing real time access to information and reports to assist in the monitoring of specific types of incidents or areas of concern on a self-service basis.

The Trust has a positive reporting culture; EPUT has consistently been above the National Reporting & Learning System (NRLS) cluster benchmark in published reports. The latest NRLS report was issued in September 2020 covering the period October 2019 – March 2020. EPUT reported 60.8 incidents per 1000 Occupied Bed Days (OBD) compared to the national benchmark of 53.2 incidents per OBD. EPUT reporting rate includes incidents from all clinical services provided by the Trust, including the Community Health Services and Nursing Homes.

The tables below detail incidents reported during the financial year. The latest benchmark provided by the NRLS is included for information; this however may change depending on overall cluster reporting.

**Table 1: Mental Health and Specialist MH services**

| Area | Measure | NRLS Bench-mark | 19/20 Outturn | Q1 20/21 | Q2 20/21 | Q3 20/21 | Q4 20/21 | 20/21 YTD |
|---|---|---|---|---|---|---|---|---|
| MH Services | Total Incidents | 53.2 Incidents per 1000 bed days | 8667 | 1922 | 2240 | 2123 | 1719 | 8004 |
| | Incidents per 1000 bed days | | 57 | 74.9 | 68.9 | 66.5 | 61.0 | 67.7 |
| Specialist (inc LD) | Total Incidents | | 3369 | 1259 | 1147 | 1007 | 691 | 4104 |
| | Incidents per 1000 bed days | | 50.5 | 80.0 | 69.9 | 61.7 | 43.4 | 63.7 |
| EPUT (MH/LD & Specialist Services) | Total Incidents | | 12036 | 3181 | 3387 | 3130 | 2410 | 12108 |
| | Incidents per 1000 bed days | | 55 | 76.8 | 69.2 | 64.9 | 54.6 | 66.3 |

**Table 2: Community Health Services**

| Area | Measure | 19/20 Outturn | Q1 20/21 | Q2 20/21 | Q3 20/21 | Q4 20/21 | 20/21 YTD |
|---|---|---|---|---|---|---|---|
| SEECHS | Total Incidents | 2264 | 504 | 499 | 554 | 500 | 2057 |
| | Incidents per 1000 bed days | 150.3 | 1026.5 | N/A* | 365.2 | 299.8 | 559.6 |
| WECHS | Total Incidents | 1356 | 336 | 361 | 334 | 284 | 1315 |
| | Incidents per 1000 bed days | 51.3 | 73.5 | 70.7 | 56.7 | 48.5 | 61.4 |
| Community Health Services | Total Incidents | 3620 | 840 | 860 | 888 | 784 | 3372 |
| | Incidents per 1000 bed days | 87.2 | 166.0 | 168.5 | 119.8 | 104.2 | 134.4 |

*SEECHS recorded no occupied bed days between May – October 2020 due to ward move.

The NRLS cluster group for NHS Community trusts was discontinued as a result of the NHS Transforming Community Services programme. Due to structural changes within these organisations, many no longer have inpatient services and the provision of diverse services between them mean this cluster could not be described as a homogenous group. A comparative reporting rate per 1,000 bed days is not appropriate within this cluster and comparing organisations based on this rate can be misleading. However, the incidents reported below are included in EPUTs patient safety incident reporting and reflected in the overall reporting rate.

**Table 3: Nursing Homes:**

| Area | Measure | 19/20 Outturn | Q1 20/21 | Q2 20/21 | Q3 20/21 | Q4 20/21 | 20/21 YTD |
|---|---|---|---|---|---|---|---|
| Nursing Homes | Total Incidents | 342 | 48 | 56 | 41 | 183 | 342 |
| | Incidents per 1000 bed days | 16.5 | 9.8 | 9.9 | 6.8 | 9.0 | 16.5 |

Incidents reported at the two Nursing Homes are reported separately to the Mental Health & Community Health services. However, the incidents are included in EPUTs patient safety incident reporting and are reflected in the overall reporting of incidents per 1000 bed days.

Claims, Complaints and PALs Department continue to use the Datix system to record, track and report cases on a daily basis.

### 5.2 Safety Alerts

National safety alerts have continued to be used as a key learning source. These are considered through a range of forums across the Trust and are used to influence policy and procedure changes.

### 5.3 H&S and LSMS Incidents

H&S and Security related incidents are reported by all services through the Trust Datix system and overseen by the Trust Health, Safety and Security Committee. Members of the Trust H&S and LSMS Teams review all H&S and security incidents to ensure appropriate actions are taken and identify any lessons learnt.

## 6.0 Enhancing Environments

The team have worked collaboratively with the Capital Projects teams in relation to refurbishment projects, ensuring fixtures and fittings are to Trust standards and that we continue to provide a safe and therapeutic environment to our Service Users. During 2020/21 we have supported on many projects, including:

- Topaz Ward refurbishment, The Crystal Centre
- Derwent Centre Garden Project

## 7.0 Culture - Training

Face to face Datix training was suspended as part of the Trusts response to the Covid 19 pandemic, however this has continued to be facilitated on request via MS Teams. The training includes sessions for reporting staff and managers to highlight the importance of recording patient safety incidents and to improve the quality of Datix incidents. Additionally a section relating specifically relating to Datix is included in the Risk Management presentation, included on the Trusts induction programme.

The Health and Safety team continue to carry out training for Risk Assessments which is included in the ‘core’ element of the Management Development Programme (MDP) and an ‘elective’ Managing Safely course for anyone who wishes to complete the training to aid and support them and their teams with improved health and safety practice and the development of Risk Assessments.

The Risk Team have delivered additional training modules for the Management Development Programme on the Control of Substances Harmful to Health (COSHH) and the General Workplace Risk Assessment module has now been accepted as a core element for attendance by all EPUT managers on the programme.

## 8.0 Innovation

Regular review of the Ligature Risk Assessment tool is undertaken to ensure learning from safety alerts and incidents is considered. In 2020/21 a project was initiated to explore if an electronic risk assessment tool could be used, different options were explored with a number of companies. A member of the H&S Team took a personal interest in this project and designed a bespoke electronic tool this was also considered alongside other options. The in-house designed tool was agreed to be the best fit for EPUT and piloting of this tool has started in April 2021.

A review of the risk assessment process has been undertaken, with a view to simplifying the process in order that it was easier to understand for our staff; this has been completed and is waiting for ratification before roll-out, once this has happened, a new training programme will be undertaken to support this and a communications initial launch and reminder phase to be

implemented. The Risk management team will commence monthly training sessions for this new system from April 2022, and plans to keep these going for the foreseeable future.

## 9.0 Core Activities in 2020-21

### 9.1 Health & Safety

During 2020/21, the Trust 'suspended' all H&S inspections from 19th March 2020 until 20th January 2021 due to the Covid-19 pandemic. Whilst adhering to Government and Trust Covid IPC guidelines it was agreed to recommence the programme in Q4 2020/21.

The focus on completion of health & safety inspections and the frequency for the inspections was not able to be completed in line with the Corporate Health & Safety policy; annual inspections for all inpatient areas, 18 months for community locations where patients visit as out-patient and two years for administration areas. It mitigate the suspension of inspections there has been a focus to complete H&S inspections for all areas in Q4 2021 and throughout 2021/22 to ensure compliance and due diligence.

### 9.2 Lone Working

The safety of EPUTs staff is paramount with a full review of the lone worker process undertaken in 2019. The Trust currently has 1289 devices allocated to staff. All staff have been trained by Lone Worker Solutions or by the LSMS team. There is still currently no face to face training due to the pandemic, however a virtual training email package is sent to all recipients of LWD's

Managers have access to the lone worker device portal to update escalation details and usage. Monthly audits of usage and escalation details by the LSMS have commenced and have not highlighted any concerns to date. The call centre has access to the portal for these details in an emergency.

Shared devices have been issued to inpatient wards for staff to accompany patients on leave. These are for the purposes of Section 17 escorted leave for staff safety. Staff members requiring a device will provide the LSMS with a self-assessment and escalation form to cover the requirement of the staff member's risk.

Lone worker device compliance is monitored via the relevant management structure with a high level summary presented to the HSSC. LWD continue to be requested on an ad hoc basis and allocation is via the agreed process based on assessed levels of risk.

### 9.3 Security Management

Since April 2017 NHS Protect ceased to exist but EPUT has remained compliant with NHS Protect standards. In December 2020, the new Violence Prevention and Reduction Standards were released and work started to consider how these will be implemented into Trust working systems. The LSMS continues to monitor and liaise with peers and the National Association of Healthcare Security for updates and good working practices.

During 2020/2021 the LSMS has continued with the initiative for the robust safe storage of seized illicit substances to protect staff and to enable police to prosecute persons bringing drugs onto our wards.

A pilot of body worn camera (BWC) pilot on 4 adult acute wards commenced the later part of 2019 and is ongoing. An appointed BWV project manager is currently preparing a proposal for the further implementation of cameras across other wards. This is anticipated to either reduce the number of incidents of violence and aggression or the severity of them when they do occur. It also offers

protection to staff and patients against allegations, and provides excellent independent evidence to support investigations.

The LSMS has forged excellent working relationships with the Police which has enabled positive prosecutions from reported crime. Together, although the LSMS team and the Police have not been able to hold physical workshops with staff, they have been able to arrange (scheduled or ad-hoc) virtual meetings, clinics and communications which have been paramount to all staff regarding their safety and how they will be supported if they are a victim of crime. The Police have scheduled visits with Wards whereby, they are able to meet with patients and staff to offer support and guidance. Going forward, the LSMS will continue this joint working with the implementation of Operation Canopus, which is a joint process between the Trust, Police and the Crown Prosecution Service. This Operation is to ensure appropriate action is taken with patients who are responsible for criminal offences, whilst taking into consider patient-capacity unless indicated otherwise. The team's objective and ambition includes this will improve positive improved robust actions against patients (where appropriate) who cause crimes against Staff and the Trust.

The Trust has a process in place for Zero Tolerance which includes sending formal letters perpetrators of violence and aggression. These are signed and approved by Trevor Smith, and there is a continual increase in letters being sent. A Zero Tolerance Policy has been written and is currently awaiting approval.

### 9.4 Ligature Risk Assessment Inspections

The Trust Health and Safety Team holds the responsibility for facilitation of Ligature inspections to be undertaken in all Trust Mental Health inpatient wards. A team of professionals made up of a member of the H&S Team, member of the Estates team and the ward manager or Charge Nurse undertake each Ligature Risk Assessment. This has been further extended to invite the Ward Medical Consultant and a Person with Lived Experience (this is currently on hold due to the Covid-pandemic and this will be reviewed in 2021/2022).

Each assessment is undertaken on the ward over a ½ day period inspecting all un-supervised and supervised areas. Areas on the wards patients cannot access are not included. This ensures robust inspection of the environment and actions identified that require Estates intervention can be taking forward immediately.

A draft inspection outcome report is shared with all parties for agreement and includes action identification. Once all parties agree a final report is issued and actions monitored until completion. Any concerns are escalated to the LRRG. Closing of actions within set timescales has been a challenge in 2020/21 and work is underway between the H&S and Estates Teams to make processes more robust.

Ligature Inspections were previously carried out annually or 6 monthly in line with the Ligature Policy and Procedure requirements. During the Covid-19 Pandemic, many Ligature Inspections were carried out 'remotely/table top' between 19th March 2020 and 31st July 2021; when safely directed to do so, these locations were rebooked for a full onsite inspection.

Throughout 20/21 a total of 20 remote/table top inspections were completed and 48 on site full inspections were completed

The Trust has a Ligature Risk Reduction Group (LRRG) in place which has an overview of the ligature work streams and requirements; the group meets on a monthly basis and is a sub-committee of the HSSC. Membership includes the Executive Director of Mental Health and Deputy CEO (Chair), Director of Mental Health (Deputy Chair), Associate Director of Compliance & Risk, Estates representatives, the Ligature Co-ordinator and Senior Leads from Clinical Services.

The Trust also has an Estates Expert Reference Group (EERG), who the LRRG make recommendations for patient safety work and agreed standards in line with policy. EERG have an agreed risk stratification and prioritisation programme to ensure that projects are achieved.

These groups work collaboratively and have supported the following implementation programs:

- Ligature risk assessment and management policy and procedure (ratified April 2019)
- Ligature awareness eLearning training program
- Risk Stratification
- Related ligature safety alert(s) compliance.

The groups have also commissioned further activity such as

- Commissioned audits of a number of identified hazards
- Site visits following incidents
- Testing of equipment

A separate annual report is available detailed further work around Ligature Management.

### 9.5 General Workplace Risk Assessments

It is a requirement that all areas have a General Workplace Risk Assessment (GWPRA) that identifies the type of unit, the hazards, risks and control measures required to provide assurance that a duty of care is being undertaken by the organisation and the staff. This requirement is included in the Managers Health & Safety training course to increase the knowledge and understanding of risk assessment requirements; it is on the risk register and is part of the H&S inspection checking process.

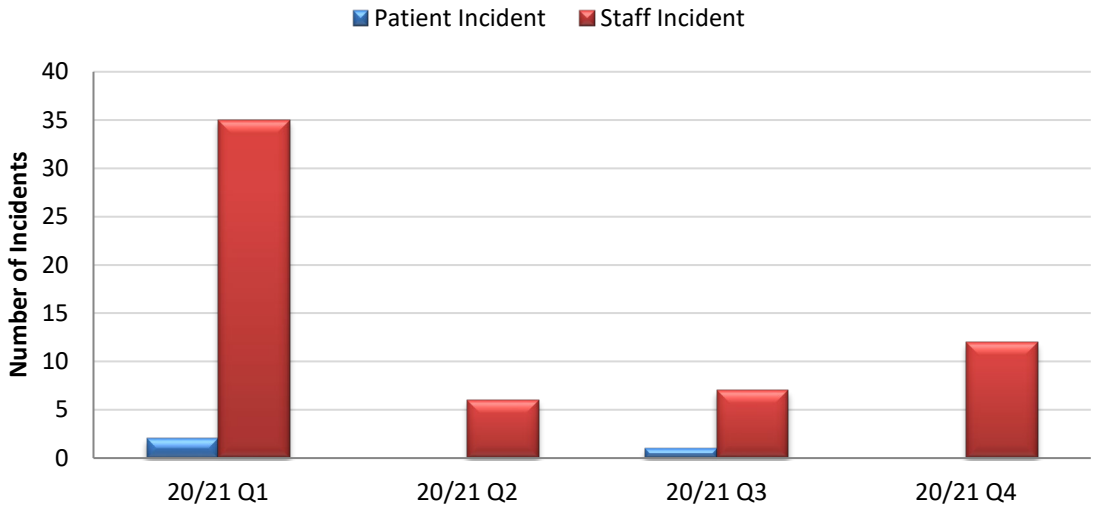
All areas should regularly update their General Workplace Risk Assessments and this has been challenging over the Covid pandemic. The risk team continue to collate the General Workplace Risk Assessments for all areas and have a framework in place to remind staff of the need to review their assessments and are available to provide advice and guidance.

At year end 32% of identified areas had an up to date General Workplace Risk Assessment. This concern has been escalated in the organisation and is monitored on the Trust Corporate Risk Register. As outlined above work is underway to review processes to encourage improvement.

### 9.6 RIDDOR Reporting

Graph 1 below outlines RIDDOR reporting for 2020-21

**Quarterly RIDDOR Reports (Trustwide)**
**Showing Total & Difference in Patient/Staff Incidents**
**April 2020 to March 2021**




There were 63 RIDDOR reports submitted to the Health & Safety Executive (HSE) during the 2020/21 reporting period, 20 were reported in the previous year (2019/20). This increase was due to the HSE requiring all industries to submit cases of staff testing positive for Covid 19 which may have been contracted at work. This process was managed by the Trusts HR department, with a review of each case of staff sickness against set criteria to establish the likelihood of the virus having been contracted at work.

The general reporting process for incidents other than Covid 19, continues to include the Director of Compliance & Assurance, the Associate Director of Risk & Compliance and Operational Directors which has ensured a robust informed decision is made prior to reporting to the HSE.

Incidents of inpatient falls which have resulted in fractures are assessed on a case by case basis and if any omissions in care are identified which contributed to the fall, the incident will be considered under the agreed process for reporting to the HSE.

### 9.7 Central Alerts System (CAS)

The Risk Management Team distributes and monitors Safety Alert information. Compliance is evidenced through the Health Safety and Security Committee and via local Health & Safety Meetings. Additionally, Ward/Team Managers have been requested to include Safety Alerts as a standing item agenda in their Team Meetings.

Alerts assessed as not relevant to the Trust are signed off by the Associate Director of Risk & Compliance (or nominated deputy), in consultation with members of the Trust Medical Devices Committee and identified lead specialists, and the national CAS website updated accordingly.

Alerts assessed as relevant to Trust services are cascaded for action across the organisation via the Datix safety alert module. Remedial work and/or risk assessments are undertaken for areas identified as non-compliant with the safety alert. Once compliance is assured the alert is signed off by the Associate Director of Risk & Compliance or nominated deputy and the national CAS website updated accordingly. Where appropriate alerts are added to the risk register,

The Trust was compliant with external sign off in relation to safety alerts for the period 2020/21. 135 alerts were issued via the CAS system to the Trust, all were assessed for relevance. 9 (6.7%) were assessed as requiring action and a response. 3 were issued as National Patient Safety Alerts, which

were assessed as relevant to Trust services and were monitored via the Clinical Governance and Quality Committee.

### 9.8 Mass Vaccination Project

The team have assisted the Covid-19 Mass Vaccination Project with developing and updating risk assessments for new and existent Vaccination Sites where there has been a change in process or change in the type of approved vaccination used; as the handling and storage of different vaccines can vary quite significantly. Also, the patient care area/environment has been included in the assessment as similarly to the storage and handling of different vaccines; patients may require different post-vaccination care depending of vaccine received.

We have also assisted the Mass Vaccination team with assessing of suitability of proposed new venues along with being invited to express our professional expert opinions in terms of health and safety within new vaccination initiatives i.e. Drive-Thru, Vaccination Buses and Pop-Up Clinics. Through collaboration and building strong relationships; our opinion(s), suggestions and advice are always welcomed, respected and appreciated by the Mass Vaccination Project Team.

## 10.0 Planning 2021/22

The Health and Safety team will be holding Monthly Risk Assessment training courses from April 2021, we will hosting bi-monthly Managing Safely courses for all staff and COSHH training.

The team are developing a Directing Safely to be aimed at senior manager, Associate Directors and above, to enhance and support their understanding and knowledge of health and safety requirements in line with the Safety First, Safety Always Strategy.

The General Workplace Risk Assessment (GWPRA) policy, procedure and process and the Health and Safety inspection policy, procedure and process are planned to be reviewed with a view to simplifying the process and to make it more user friendly for Trust staff. A training program will be developed alongside these reviews to imbed any new processes.

The LSMS team will be visiting all Community and Inpatient areas for staff to familiarise themselves with the team and understand the support and help provided by our dedicated specialist support team, in addition once approved they will be promoting the newly developed Zero Tolerance Policy and Procedures.

The Body Worn Camera Programme and implementation plan will be developed with a view to begin implementation on the wards in Quarter 3/4 2021/2022, the LSMS team will be offering full on-site training, support and guidance to all wards planned to received Body Worn camera's. The Lone Worker Device programme continues with full training and support provided by the LSMS team.

## 9.0 Conclusion

The Quality Committee are asked to discuss:

- the contents of this report
- note the issues identified and any actions required
- agree any further actions in relation to the issues identified

**Report prepared by:**
**Sarah Pemberton, Health, Safety and LSMS Manager**
**Phil Stevens, Datix Risk Manager**
**Date: July 2021**

**On behalf of:**

**Nicola Jones**
**Director of Risk and Compliance (Interim)**

| | | |
|---|---|---|
| | | **Agenda Item No: 7g** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **Pharmacy and Medicines Optimisation Annual Report 2020-21** | | | | | |
| **Executive/Non-Executive Lead:** | Professor Natalie Hammond, Executive Nurse | | | | | |
| **Report Author(s):** | Dr Hilary Scott, Director of Pharmacy<br>Mona Sood, Interim Deputy Chief Pharmacist | | | | | |
| **Report discussed previously at:** | Quality Committee 14th October 2021<br>Clinical Governance & Quality Sub-Committee 27th October 2021 | | | | | |
| **Level of Assurance:** | **Level 1** | ✓ | **Level 2** | | **Level 3** | |

| **Risk Assessment of Report – all reports must relate to a key risk on the Board Assurance Framework (BAF) – *mandatory section*** | |
|---|---|
| Summary of Risks highlighted in this report | None |
| State which BAF risk(s) this report relates to (risk ID and short form title e.g. BAF63 Learning) | BAF45 CQC; BAF 63 Learning and Improving |
| Does this report mitigate the BAF risk(s)? | The annual report provided information on the activities undertaken to support compliance with CQC fundamental standards and key lines of enquiry which relate to medicines management. |
| Are you recommending a new risk for the EPUT BAF? | No |
| If Yes describe the risk to EPUT's organisational objectives | N/A |
| Describe what measures will you use to monitor mitigation of the risk in lieu of an action plan? | N/A |

| **Purpose of the Report** | | |
|---|---|---|
| This report provides the Trust Board with information on activities undertaken during 2020/21 in relation to the safe, secure and effective management of medicines and medicines optimisation. | **Approval** | ✓ |
| | **Discussion** | ✓ |
| | **Information** | ✓ |

**Recommendations/Action Required**

The Trust Board is asked to:

1 Note the contents of the report
2 Approve the Pharmacy and Medicines Optimisation Annual Report for 2020/21
3 Request any further information or action.

## Summary of Key Issues

Medicines play a crucial role in healthcare, and remain the most common therapeutic intervention. However, all have risks associated with their use, and there is an increasing body of evidence that medicines are often used sub-optimally. Expenditure on medicines represents a significant area of financial risk for organisations to plan and manage.

The report continues with the format and content used previously, and provides an overview of the activities of the Trust's two decision-making committees for medicines use during 2019/20. A high level analysis is also included of how the Trust spends resources on drugs for mental health and learning disabilities services. As in previous years, the same level of detail or accuracy is not available for community health services. The report also contains the Accountable Officer for Controlled Drugs report on use of these drugs within the Trust intended to provide assurance that the organisation is fulfilling its responsibilities in relation to CDs.

Key issues include:

- Despite the coronavirus pandemic, in 2020/21 both Medicines Management Groups (MMGs) managed to meet eight of the normal 10 times, with meetings suspended at the start of the financial year and again at the beginning of 2021. Meetings were conducted virtually using Microsoft Teams and average attendance levels were actually higher than in 2019/20 as on-line meetings addressed some of the barriers presented by the geography of Essex. All meetings were quorate (see sections 2 and 3).

- The first quarter of 2020/21, as the pandemic worsened, saw the rapid development of a number pieces of supportive guidance to ensure safe use of medicines in challenging circumstances. These included advice on:

    - use of clozapine, depot antipsychotics and lithium where community based patients were unable to be seen as readily;
    - minimising the infection risk from using patient's own drugs brought into hospital on admission;
    - optimising medication regimens to minimise the contact between patients and staff on inpatient ward;
    - supporting patients / relatives / carers administer medicines by the sub-cutaneous route
    - end of life symptom control to make patients with severe COVID-19 infection comfortable if they were unable to be transferred to an acute trust for care.

  In the absence of MMG meetings these were circulated for comment to MMG members, and then approved by Chair's Action which was ratified at the first reconvened meeting (see sections 2, 3 and 9).

- Throughout 2020/21 work on policies, procedures, clinical audits, updates to sections of the formulary and prescribing guidelines and Patient Group Directions continued, albeit often later than originally scheduled. Some national requirements, such as providing a quarterly Controlled Drug Occurrence Reports were suspended but work dealing with medicines-related incidents continued (see sections 2.3, 3.3 and 8)

- As operational staff were challenged with other priorities a reduction was seen in the rates of reporting medication incidents. This may reflect fewer patient contacts but also less time available to complete the necessary documentation. Medicines incidents as a proportion of overall incident reports was also skewed for 2020/21 as testing of patients

for COVID-19 was reported within the DATIX system. There were no 'severe' incidents reporting and few 'moderate' incidents in 2020/21 (see sections 2.5 and 3.5).

- Like all other operational services the pharmacy team was challenged with staff shortages due to self-isolation requirements and covid-19 infections. Significant changes were made to working practices to allow social distancing with the pharmacy department including separation of ward and dispensary teams. It goes without saying that dispensing and medicines supply, and clinical pharmacy activities cannot be effectively provided from home, and most members of the team continued to work on trust premises. All team leaders experienced challenges at time sustaining an effective service and their stories of the pandemic year are told in section 9 of the annual report (see section 9).

- Medicines expenditure in West Essex Community Health Services increased by 15%, with an increase particularly in relation to dressings and appliances. Community nursing teams took on many of the tasks that general practice ceased to provide as the routine administration of B12 injections which would normally be administered by a practice nurse. Community staff were faced with the care of many severely unwell elderly patients in their own and care homes. Wards at St Margaret's Hospital also acted as overspill COVID-19 wards for PAH meaning that the range and use of medicines differed from normal. Expenditure on medicines in South East Essex Community Health Services decreased by almost half as the inpatient units were closed for the first six months of the year and moved to Brentwood Community Hospital under the auspices of North East London Foundation Trust (see section 4).

- Despite a reduction on the volume of prescribing, expenditure on drugs used in mental health and learning disability services increased by 2.7%. The volume reduction is due to increased quantity per item and changed prescribing patterns in response to different consultations patterns (telephone / virtual consultations) (see section 5).

- Provision of medicines management training had to be rapidly redesigned to accommodate provision virtually using Microsoft Teams as the delivery medium. In addition training, both virtually and on-site was provided during the last quarter of the year to support the roll out of COVID-19 vaccination centres (see section 6).

| **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** | |

| Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against: | | | |
|---|---|---|---|
| **Communication and consultation with stakeholders required** | | | |
| **Service impact/health improvement gains** | | | ✓ |
| **Financial implications:**<br>**Capital £**<br>**Revenue £**<br>**Non Recurrent £** | | | |
| **Governance implications** | | | ✓ |
| **Impact on patient safety/quality** | | | ✓ |
| **Impact on equality and diversity** | | | |
| **Equality Impact Assessment (EIA) Completed** | **NO** | **If YES, EIA Score** | |

## Acronyms/Terms Used in the Report

| | | | |
|---|---|---|---|
| AMR | Antimicrobial Resistance | NP | National Protocol |
| BNF | British National Formulary | NatPSA | National Patient Safety Alerts |
| CAS | Central Alerting System | NELFT | North East London NHS Foundation Trust |
| CCG | Clinical Commissioning Group | NMP | Non-Medical Prescriber |
| CD | Controlled Drug | OST | Opiate Substitution Therapy |
| CDAO | Controlled Drug Accountable Officer | PAH | Princess Alexandra Hospital |
| CDLIN | Controlled Drug Local Intelligence Network | PDG | Patient Group Direction |
| CHS | Community Health Services | PEP | Post Exposure Prophylaxis |
| dm+d | Dictionary of medicines and devices | PSD | Patient Specific Direction |
| ECT | Electroconvulsive Therapy | VTE | Venous Thromboembolism |
| ELFT | East London NHS Foundation Trust | ULT | Ultra Low Temperature |
| ICS | Integrated Care System | WECHS | West Essex Community Health Services |
| MMG | Medicines Management Group | | |

## Supporting Documents and/or Further Reading

Pharmacy and Medicines Optimisation Annual Report 2020-21

## Lead

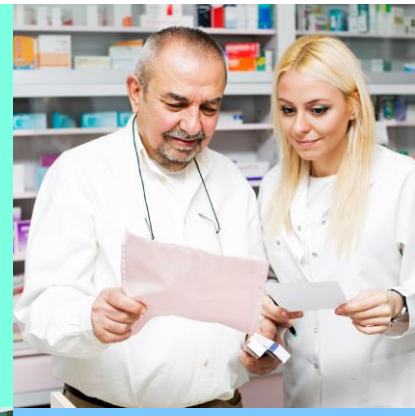
**Natalie Hammond**
**Executive Nurse**

SAB/Meeting Cover Report Template/rev. October 21

Essex Partnership University
NHS Foundation Trust

# Pharmacy and Medicines Optimisation

## Annual Report
## 2020-2021


Report prepared by:

Mona Sood
Interim Deputy Chief Pharmacist

and

Dr. Hilary Scott
Director of Pharmacy and Accountable Officer for Controlled Drugs

Pharmacy

## CONTENTS

## 1.0 INTRODUCTION

***Medicines are a central tool in the delivery of healthcare: our patients depend on medicines to help manage chronic conditions, treat disease and to help them maintain health and prevent illness.***

Medicines continue to be the most common therapeutic intervention that patients receive, and it is estimated that over 2 million doses of medication are scheduled for administration within EPUT every year. That's over 2 million opportunities a year to potentially improve both the quality and length of peoples' lives, but without rigorous mechanisms in place often these could be missed opportunities for benefit. National and international evidence has shown that medicines use is too often sub-optimal for a number of complex reasons (Appendix 1) offers an insight into the stages involved drug treatment). Medicines require expert management to ensure patients benefit optimally; the slightest departure from best practice can compromise patient care significantly and cause unintended harm. It requires specialist skill and knowledge to get this right on each occasion, and the pharmacy team works hard to deliver an effective pharmaceutical service.

Pharmacists graduate at Masters level, having undertaken a general training in all aspects of medicines (much like Core Trainee medics); and following their foundation training are able to manage a wide range of physical health conditions and can practice in any sector. Those that join EPUT specialise in the delivery of either Mental Health, or Community Health Services, which includes complex chronic disease management and immunisation services. The strong but less visible team of skilled pharmacy technicians and support staff who are involved in the dispensing and supply enable our pharmacists to perform to their best in providing clinical pharmacy services.

The team of more than 50 whole time equivalent pharmacists, pharmacy technicians and support workers endeavours to add quality to every stage of the patient's inpatient journey; following the initial basic drug history-taking, a pharmacy-led medicines reconciliation process is undertaken within 24 - 72 hours of admission, in accordance with the relevant NICE Quality Standard. This enables early action to be taken when unintended discrepancies between inpatient medicines and those taken prior to admission are identified, and reduces the risk of any medicines-related safety incident occurring from the outset of the patient's stay. Ward pharmacy teams continue to play an active part in the patient's care, liaising with prescribers to ensure that the patient's treatment is safe, appropriate and clinically effective, communicating with the dispensary teams to secure a timely and consistent supply, and offering one-to-one support to patients in medication taking before they are discharged. Wider ward duties extend to ensuring that medicines handling processes on the wards meet the consistently high standard expected, and supporting ward teams to problem-solve on a day-to-day basis. Much of the work that is done is at the primary care interface, particularly in Community Health Services, which are playing a greater role in allowing patients to stay well and functional within their own homes. Hence the role of the pharmacy department extends way beyond the mechanics of supply and provides a critical safety net to our patients.

With a diverse range of specialities in operation, having effective medicines optimisation processes in place is an essential component of the Trust's programme for determining which drugs will be available, their cost, and how they will be used. This includes the evaluation of the clinical use of drugs, the development of policies and procedures for managing drug use, and administration of the Trust's Formulary and Prescribing Guidelines. This report provides an update on the activity of the two Medicines Management Groups functioning within mental health and learning disability services in Bedfordshire, Essex and Luton, and community health services in West and South East Essex during 2020/21.

Expenditure on medicines continues to be high nationally, with costs in the community exceeding £9.6 billion in 2020/21[1], with a notably sharp rise in the prescribing of antidepressants[2]. The antidepressant sertraline saw the biggest increase in costs – four-fold from £41.2 million in 2019/20, to £168 million in 2020/21 – which reflects not just increased usage, but a global shortage of the Active Pharmaceutical Ingredient (API) which led to price instability until April 2021. Therefore, it is important to organisations, healthcare professionals, and patients that when medicines are used they are evidence based and cost-effective, and that patients are supported to get the best from them. Everyone needs to be assured that the patient will gain benefit from their medicines and not suffer any avoidable harm. To achieve this requires a holistic approach with prescribers, other healthcare professionals and patients working in collaboration to ensure that the right patients get the right choice of medicines, at the right time; improving outcomes, avoiding patients taking unnecessary medicines, reducing wastage, and improving patient safety. This report provides information on the medicines management training programme provided within the Trust, and also a high level analysis of expenditure patterns.

Tackling the increasing issue of antimicrobial resistance (AMR) is a global priority and major government documents were published in 2019 setting out the UK action plan and vision for overcoming AMR. Those involved were not aware how prescient the safe, effective and sustainable use of antimicrobial, antifungal and antiviral medications would become as the world was gripped by a global pandemic in 2020 which is still underway. This report contains information from the 2019 annual audit of antimicrobial stewardship within inpatient wards.

This report provides information on the safe management of controlled drugs and offers some background on EPUT's use of opioids in light of the national trend of growing opioid prescribing and dependence when used on a long-term basis rather than for acute (e.g. post-operative) pain or palliative care purposes.

2020/21 was a year unprecedented in modern history, as the world was gripped by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), with national reliance on acute NHS services as never before. Locally Chief Pharmacists across all sectors, systems and organisations have worked collaboratively to ensure the safe and effective use of medicines, often in unprecedented circumstances, across and beyond Essex. The penultimate section of this report describes the experiences of members of the pharmacy senior management team and their teams in providing agile and responsive services during the first year of the COVID-19 pandemic, and latterly their essential involvement in the mobilisation of the largest mass-immunisation programme in history across health systems in Essex and Suffolk.

[1]NHS Business Services Authority Statistics: https://www.nhsbsa.nhs.uk/statistical-collections/prescription-cost-analysis-england/prescription-cost-analysis-england-202021

[2]Rabeea, S.A., Merchant, H.A., Khan, M.U. *et al.* Surging trends in prescriptions and costs of antidepressants in England amid COVID-19. *DARU J Pharm Sci* **29,** 217–221 (2021). https://doi.org/10.1007/s40199-021-00390-z

The challenges continue into 2021/22, and the final section of the report outlines how we continue to push forward with our quality agenda whilst ramping up operational services once more to meet the high demands of the additional COVID-19 vaccination programme for schools.

As a core clinical function underpinning all operational services, much of what the pharmacy team delivers is unseen yet essential to a safe and effective functioning of EPUT at a macro-level and across the wider care system. Analogous to good health, pharmacy's visibility often gains prominence at times of crisis and in managing the impact of circumstances that arise outside of the department. Whilst this contributes to our deserved reputation as a safety net, there is much more that the modern pharmacy team can add to the quality of a change process when included from the outset; this report unveils some of the less apparent ways in which we did so in the last year. I hope you enjoy reading our report and are inspired to identify opportunities for proactive collaboration with the pharmacy team in times to come.

Dr Hilary Scott, BSc (Hons), MPhil, MBA, PhD, MRPharmS
Director of Pharmacy and Accountable Officer for Controlled Drugs

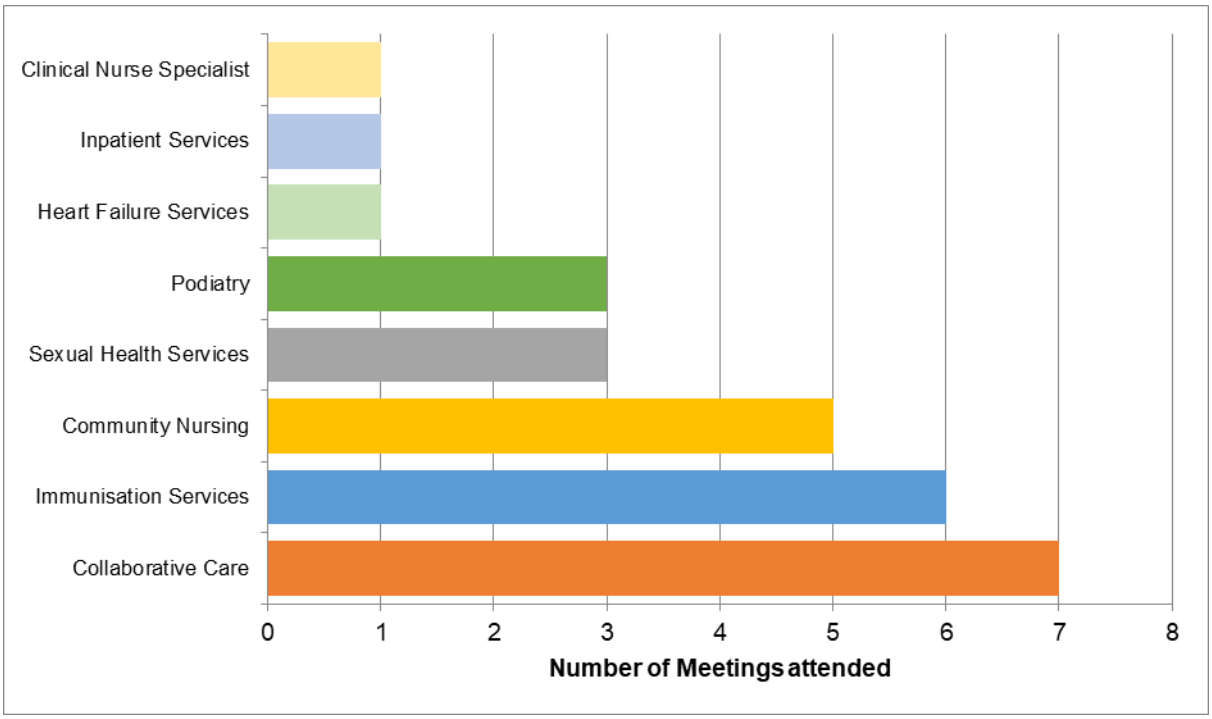
with content contributions from other members of the senior pharmacy team.

## 2.0 MEDICINES MANAGEMENT GROUP – COMMUNITY HEALTH SERVICES

The Medicines Management Group (MMG) for Community Health Services (CHS) is constituted as a standing group of the Clinical Governance & Quality Sub Committee; its role is to develop, implement, and monitor the application of medicines-related practice, and it has responsibility for providing strategic oversight in all aspects of medicines management. Eight meetings took place during 2020/21, with no meetings held in April and May 2020 due to the impact of the COVID-19 pandemic on working practice, and January and February 2021 as the NHS was once more hit with a surge of cases and the demands of the new vaccination programme intensified; an area that had a significant operational input from the CHS team. Throughout 2020/21 meetings were held virtually using Microsoft Teams and all meetings were quorate, with an average of nine participants at each.

Membership of the group is designed to provide input from all major specialities, as well as a geographic spread of participants. Additional staff attend by invitation, depending on the agenda. Membership of the MMG includes nursing, therapy, pharmacy, and clinical support services staff along with representatives of commissioning organisations and primary care. At least two Trust pharmacists attended all meetings; usually the lead pharmacists for SEECHS and WECHS in addition to the Chief Pharmacist, with support from the wider team of pharmacists for designated agenda items.

**Figure 1: Representation at CHS MMG Meetings**




Agendas, papers and draft minutes for MMG meetings can be downloaded in PDF format from the Medicines Management Group Meetings section of the Intranet.

### 2.1 Governance

The Central Alerting System (CAS) is a web-based cascade system used to issue patient safety alerts, important public health messages and other safety critical information. This includes Drug Alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA) which notify of medicines defects. The MMG monitors that the actions required by

these alerts have been implemented by pharmacy departments supplying the Trust. In 2020/21, medicines supply was as follows:

- EPUT supplied medicines to the majority of its inpatient wards;
- East London NHS Foundation Trust (ELFT) supplied medicines to inpatient wards in Luton & Bedfordshire;
- The Princess Alexandra Hospital (PAH) supplied medicines to community services in West Essex.

In 2020/21, 51 alerts where issued: EL(20)A/42 to EL(20)A/61 between April and December 2020, and EL(21)A/01 to EL(21)A/09 between January and March 2021.

In 38 cases no affected stock was held at any pharmacy supplying EPUT, whilst stock was held by the EPUT pharmacy in relation to 3 alerts (2 in common with PAH), and by the pharmacy of another organisation supplying EPUT services for an additional 11. Being a district general hospital with a large range of acute services, the stockholding was broader at PAH and the number of alerts applicable to this provider was unsurprisingly higher than those that applied to specialist mental health/community health services trusts. The majority of alerts required action only at pharmacy level and appropriate action was taken in relation to all alerts where the specified stock was identified to be held.

**Table 1: Summary of actions related to CAS alerts by site, 2020/21**

| Provider site / Action taken | EPUT | ELFT | PAH |
|---|---|---|---|
| Not stocked | 35 | 50 | 24 |
| Affected batch not stocked | 13 | 0 | 14 |
| Action taken for affected batch | 3 | 1 | 13 |
| No held stock affected | 48 | 50 | 38 |
| Totals number of alerts | 51 | 51 | 51 |

It is worth noting that the classification of Drug Alerts was updated by the MHRA in February 2021 to align with the criteria used by the NatPSA.[3] Further details of each alert issued can be found in
Appendix 2.

The MMG also considers quarterly checks on the safe management of controlled drugs and copies of the mandatory occurrence reports submitted to the NHS England Controlled Drug Accountable Officer. For further information see section 8.0 of this report.

## 2.2 Formulary and Prescribing Guidelines

EPUT Community Health Services are predominantly nurse-led, providing a diverse range of support to patients that require tier-2 and domiciliary care. CHS teams are required to work within the relevant Commissioner's formulary and prescribing guidelines which are agreed by applying the latest evidence base to the needs of the local population; where prescriptions are supplied by non-medical prescribers, expenditure is charged to the CCG primary care prescribing budget. The clinical remit of the CHS team is facilitated through the widespread use of Patient Group Directions (PGDs), which enable the legal supply and administration of medicines where prescribers are not available. For example, non-prescribing clinicians working within the Heart Failure Team are able to issue adjunctive

[3] Changes to MHRA Drug alert titles and classification

treatment which means that clinical benefit can be felt immediately by the patient, rather than having to refer back to primary care for the first prescription.

A total of 73 PGDs are used within services across the Trust, and an extensive work programme is necessary to ensure that these remain up to date with the latest evidence base, and work well within to the local population. During 2020/21, the following 26 PGDs were developed or updated and approved by the Group:

**Table 2: Patient Group Directions**

| PGDs | Setting | Approved |
|---|---|---|
| PGD for the Administration of Bacillus Calmette-Guerin (BCG) | Immunisation | June 2020 |
| Post-Exposure Prophylaxis PGDs:<br>- PEP- 5 day Course<br>- PEP-23 day Course | Sexual Health | July 2020 |
| PGD for Inactivated Intramuscular Quadrivalent Influenza Vaccine | Immunisation | August 2020 |
| PGD for Cell-Based Quadrivalent Influenza Vaccine (Flucelvax® Tetra (QIVc) | Immunisation | August 2020 |
| PGD for Intranasal Live Attenuated Influenza Vaccine (LAIV) (Fluenz Tetra®) | Immunisation | August 2020 |
| PGD for Adjuvanted Trivalent Influenza Vaccine (Fluad®) | Immunisation | August 2020 |
| PGD for Egg-Based Inactivated Intramuscular Quadrivalent Influenza Vaccine (QIVe) | Immunisation | August 2020 |
| PGD for Methylprednisolone | Musculoskeletal Services | October 2020 |
| PGD for Methylprednisolone with Lidocaine Injection | Musculoskeletal Services | October 2020 |
| PGD for the supply and administration of intramuscular Medroxyprogesterone acetate (Depo Provera®) injection | Sexual Health | November 2020 |
| PGD for the insertion of Levonorgestrel 13.5 MG progestogen only intrauterine delivery system (Jaydess®) | Sexual Health | November 2020 |
| PGD for the administration of subcutaneous Medroxyprogesterone acetate (Sayana Press®) injection | Sexual Health | November 2020 |
| PGD for the insertion of levonorgestrel 52MG progestogen only intrauterine delivery system (Mirena®) | Sexual Health | November 2020 |
| PGD for the supply and administration of Ceftriaxone | Sexual Health | December 2020 |
| PGD for the supply of Doxycycline | Sexual Health | December 2020 |
| PGD for the supply and administration of intramuscular Medroxyprogesterone acetate (Depo Provera®) injection | Sexual Health | December 2020 |
| PGD for the administration of Metronidazole | Sexual Health | December 2020 |
| PGD for the supply of the combined transdermal patch (Evra®) | Sexual Health | December 2020 |
| PGD for the supply of Bisoprolol | Heart Failure | March 2021 |
| PGD for the supply of Bumetanide | Heart Failure | March 2021 |
| PGD for the supply of Carvedilol | Heart Failure | March 2021 |

| PGDs | Setting | Approved |
|---|---|---|
| PGD for the supply of Furosemide | Heart Failure | March 2021 |
| PGD for the supply of Perindopril | Heart Failure | March 2021 |
| PGD for the supply of Ramipril | Heart Failure | March 2021 |
| PGD for the supply of Spironolactone | Heart Failure | March 2021 |

## 2.3 Policies, Procedures, Protocols and Clinical Guidelines

As part of a process of ongoing review and update in response to changes to national guidance or local requirements, a number of amendments were made to appendices of the procedural guidelines for the Safe and Secure Handling of Medicines in Community Health Services (CLPG13-CHS). The Group also considered a number of clinical guidelines, local operational procedures, or protocols. These included:

**Table 3: Policies, Procedure & Clinical Guidelines**

| Policy / Procedure / Clinical Guideline | | Approved |
|---|---|---|
| CLPG13 | Policy for the Safe and Secure Handling of Medicines in Community Health Services | December 2020 |
| CLPG13-CHS Appendix 13 | Safe and Secure Handling of Medicines in Community Health Services – Administration | September 2020 |
| CLPG13-CHS Appendix 14 | Safe and Secure Handling of Medicines in Community Health Services – Injections | September 2020 |
| CLPG13-CHS Appendix 16 | Safe and Secure Handling of Medicines in Community Health Services – Self Administration of medicines within in-patient units and the community setting | November 2020 |
| COVID-19 Protocol | COVID-19 Guidance on Managing Patients own Drugs | July 2020 |
| COVID-19 Protocol | COVID-19 End of Life Symptom Guide | March 2020 updated September 2020 & November 2020 |
| Formulary | WECHS Woundcare Formulary, including Care Homes Dressings Request Form | August 2020 |
| Formulary | Section 18 – Antimicrobial Prescribing | August 2020 updated November 2020 |
| Protocol | Subcutaneous Drug Administration in Community Health Services by patients/carers/relatives in Essex | July 2020 |
| Protocol | Written instructions for Registered Nurses – Cell-Based Quadrivalent Influenza Vaccine (Flucelvax Tetra) | August 2020 |
| Protocol | Written instructions for Registered Nurses – Egg-Based Quadrivalent Influenza Vaccine | August 2020 |
| Protocol | Written instructions for Registered Nurses – Adjuvanted Trivalent Influenza Vaccine | August 2020 |
| Protocol | Protocol for the administration of Trivalent Influenza Vaccine (Fluad®) under Patient Specific Direction | August 2020 |

| Policy / Procedure / Clinical Guideline | | Approved |
|---|---|---|
| Protocol | Protocol for the administration of Inactivated Quadrivalent – Cell-mediated Influenza Vaccine (Flucelvax Tetra®) under Patient Specific Direction | August 2020 |
| Protocol | Protocol for the administration of Inactivated Quadrivalent Influenza Vaccine – Egg-Based under Patient Specific Direction | August 2020 |
| Resource | Advice on Providing Staff Flu Vaccinations | August 2020 |
| Resource | Good Practice Guidance on using Creams and Ointments | October 2020 |

## 2.4 Patient Safety Issues

A dedicated section on the Group's agenda looks at issues pertaining to patient safety. This includes the MHRA monthly Drug Safety Update. This publication contains advice on the safe use of drugs relevant to many settings. Where appropriate these were highlighted through articles in Trust Today and within the Medicines Management newsletter. Copies of the full Drug Safety Update are published on the Medicines Management folder webpages of the Intranet.

The Group also reviews the contents of Vaccine Update distributed at least monthly by Public Health England and copies are published on the Medicines Management folder webpages of the Intranet. Specific issues discussed are shown in Table 4:

**Table 4: Patient Safety Issues**

| Topic | Month |
|---|---|
| Esmya® (ulipristal acetate): suspension of the licence due to risk of serious liver injury | June 2020 |
| Benzodiazepines and opioids: reminder of risk of potentially fatal respiratory depression | June 2020 |
| Coronavirus (COVID-19): latest guidance for medicines safety (April 2021) | June 2020 |
| Direct-acting oral anticoagulants (DOACs): reminder of bleeding risk, availability of reversal agents | July 2020 |
| Alfentanil important safety information: distinction between different doses | August 2020 |
| Report of the Independent Medicines and Medical Devices Safety Review | August 2020 |
| New Steroid Emergency Card | September 2020 |
| Stimulant laxatives (bisacodyl, senna and sennosides, sodium picosulfate) available over the counter: new measures to support safe use | September 2020 |
| Isotretinoin (Roaccutane®): reminder of important risks and precautions | September 2020 |
| Opioids: risk of dependence and addiction | October 2020 |
| Transdermal fentanyl patches for non-cancer pain | October 2020 |
| Methotrexate once-weekly for autoimmune diseases: new measures to reduce risk of fatal overdose | October 2020 |
| Insulins (all types): risk of cutaneous amyloidosis at injections site | October 2020 |
| Warfarin and other anticoagulants: monitoring of patients during COVID-19 pandemic | November 2020 |
| Ferric carboxymaltose: risk of symptomatic hypophosphataemia leading to osteomalacia and fractures. | December 2020 |

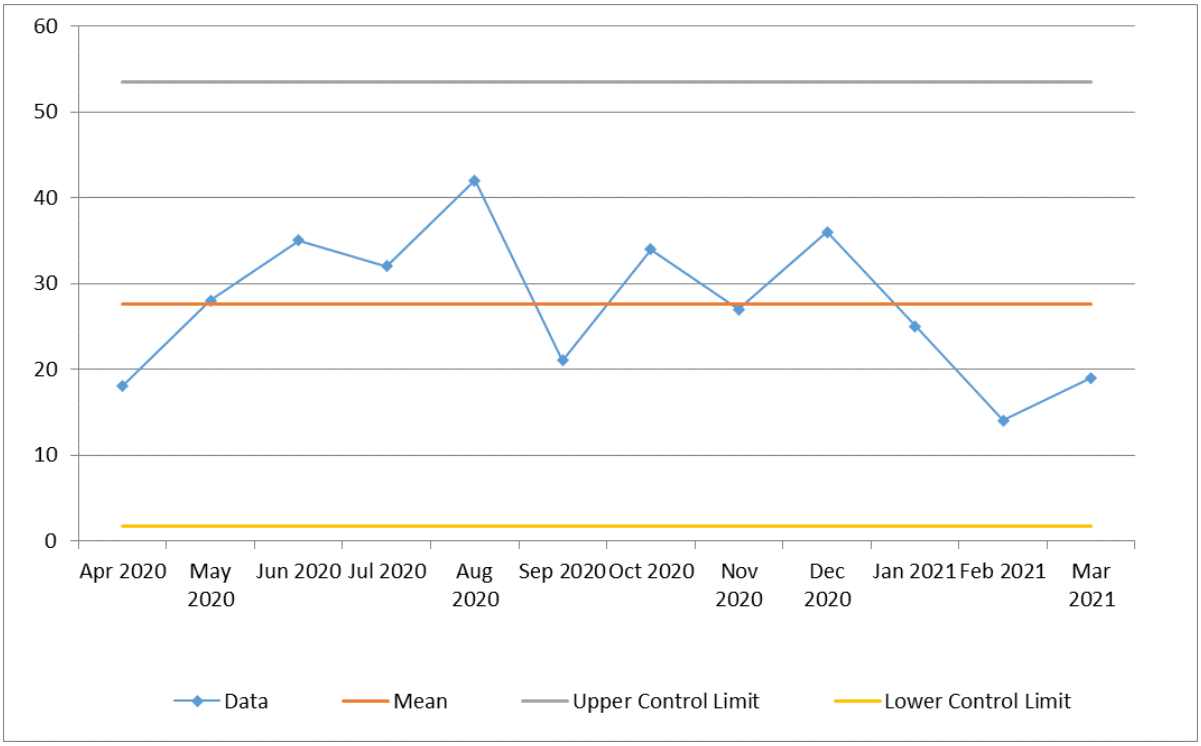
| Topic | Month |
|---|---|
| Small risk of heart valve regurgitation with quinolones and should only be used once risk/benefit ratio has been assessed. | March 2021 |
| Reiteration of prolongation of the QT interval with erythromycin and potentially clarithromycin. Interaction with DOACs leading to increased risk of bleeding and increased risk of infantile hypertrophic pyloric stenosis | March 2021 |
| Cases of severe liver injury with ulipristal have been reported when used for uterine fibroids. The use of EllaOne® for emergency hormonal contraception is not affected. | March 2021 |
| Reports of severe respiratory depression with pregabalin either with or without concomitant opioid use in key patient groups. | March 2021 |

## 2.5 Medicines-Related Incidents

The MMG reviews information about medicines-related incidents on a quarterly basis. During the year, 331 incidents were reported, compared with 388 during 2019/20, a reduction of 14.7% This was unsurprising given the extraordinary circumstances brought about by the COVID-19 pandemic; the pressure of patient-facing community services was magnified by limited accessibility to GP practices which introduced further challenges for community staff (see Section 49).

During the year staff have been actively encouraged to continue to report medicines incidents via DATIX, particularly those relating to omitted doses. The very nature of their work means that CHS staff are in a unique position to detect and mitigate against errors that occur outside of the organisation in patients with higher clinical and social needs, and a sound IT structure means that recommendations to primary care services are actioned in a timely manner.

**Figure 2: Medicines-related incidents reported by quarter in Community Health Services (April 20 - March 21)**



EPUT reports to the NRLS and actively engages with their reporting and learning tools for the purpose of learning lessons and reducing risks. Organisations with high incident reporting rates are usually considered to have a better and more effective safety culture, although rates are affected by a number of factors from the complex - such as organisational culture - to the simply having insufficient time to complete additional paperwork and manage a caseload within working time. Ultimately, learning from incidents cannot take place unless they are reported and reviewed.

Within the NRLS community health services cluster, medication-related incidents represented 8.9% of all reported incidents during the period 1st April 2020 – 31st March 2021[4]; the EPUT reporting rate within Community Health Services was 4.8% for the same period. This is below the benchmark and suggest the need for increased reporting, although the limitations of the data should be noted. Figure 2 shows the number of medication incidents that have been recorded within community health services for 2020/21.

Below are details of the number of incidents reported each quarter during 2020/21. Comparison is made to both the previous quarter and the same quarter of the preceding year, as there can be a seasonal nature to some incidents.

- During 2020/21 quarter one (April 2020 – June 2020), 81 medication incidents were reported accounting for 1.6% of all incidents reported within community health services (a 1.2% decrease compared to quarter four 2019/20; 5.1% decrease compared to quarter one 2019/20).

- During 2020/21 quarter two (July 2020 – September 2020), 95 medication incidents were reported accounting for 1.8% of all incidents reported within community health services (a 17% increase compared to quarter one 2020/21; 35.2% decrease compared to quarter two 2019/20). Many of the additional reports at this time of year original from a small number of clinics and relate to ambient temperatures in medicines storage areas exceeding recommended levels. The numbers are therefore constrained by the ability to regulate environmental factors, as detailed under Figure 5.

- During 2020/21 quarter three (October 2020 - December 2020), 97 medication incidents were reported accounting for 1.6% of all incidents reported within community health services (a 2.1% increase compared to quarter two 2020/21; 1% increase compared to quarter three 2019/20).

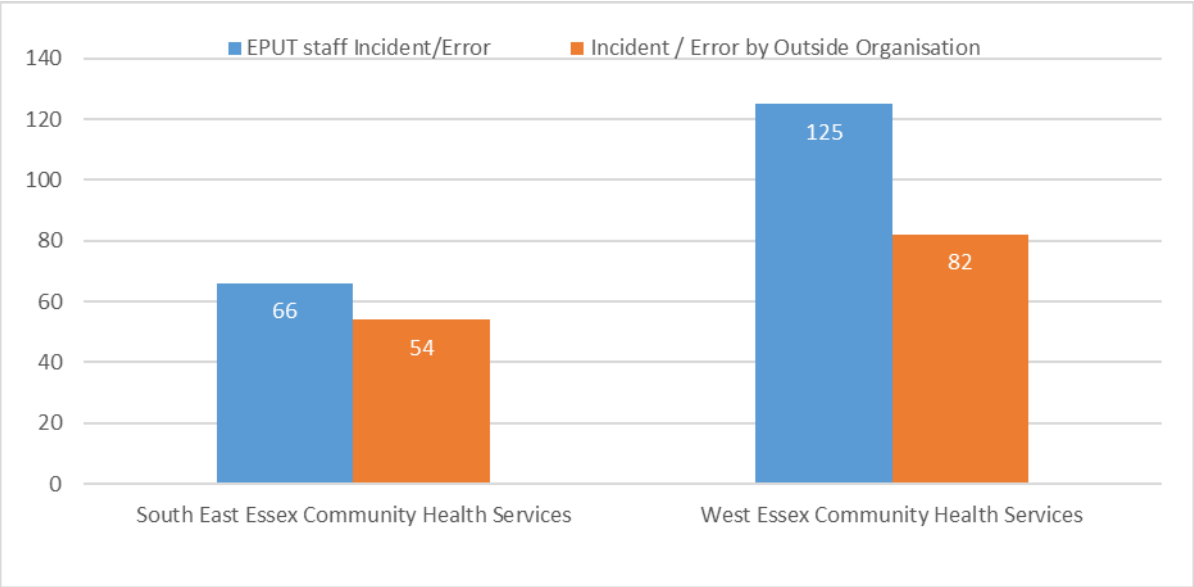
- During 2020/21 quarter four (January 2021 - March 2021), 58 medication incidents were reported accounting for 1.1% of all incidents reported within community health services. (A 40% decrease compared to quarter three 2020/21; a decrease of 29% compared to quarter four 2019/20). The decrease reflected a general reduction in incident reports probably linked to winter pressures compounded by the second wave of COVID-19, the impact of which was greater than quarter one of 2020/21.

Because of the nature of the work undertaken by Community Health Services staff, a proportion of the medication-related incidents arise as a result of the actions of other non-EPUT staff, for example GPs, community pharmacists or local acute hospital staff. 136 (41.6%) incidents reported by CHS originated outside of EPUT, illustrating the critical role of these services to the patient safety network. Such incidents are reported to the relevant local area team of NHS England, relevant Clinical Commissioning Group or the hospital trust

[4] Source: NRLS reference data 2020/21. Although EPUT as an organisation is benchmarked against 52 mental health trusts, the NRLS error rate reported within this section is against 15 community health trusts within England, each delivering a diverse range of services commissioned in response to local need. There is no “one-size fits all” model, although district nursing teams form a significant core of all community health services. The national error reporting rate for mental health trusts in 2020/21 was 6.6%, as detailed in section 3.7.

concerned so that they can be investigated locally and appropriate lessons learned. Incidents relating to the Essex-wide Immunisation Service are included under South East Essex.

**Figure 3: Attribution of incidents**




Medication incidents are rated in accordance with the NRLS ratings of No Harm, Low Harm, Moderate Harm, Severe Harm, and Death. There were no reported Severe or Death rated incidents during 2020/21 and the vast majority were rated as No Harm.

**Table 5: Degree of Harm of Medicines-related Incidents**

| | No Harm | Low | Moderate | Severe | Death |
|---|---|---|---|---|---|
| **2020/21 Q1** | 76 | 3 | 2 | 0 | 0 |
| **2020/21 Q2** | 91 | 3 | 1 | 0 | 0 |
| **2020/21 Q3** | 86 | 11 | 0 | 0 | 0 |
| **2020/21 Q4** | 54 | 4 | 0 | 0 | 0 |
| | 307 (92.8%) | 21 (6.3%) | 3(0.9%) | 0 | 0 |

The vast majority of incidents were recorded as no or low harm; three incidents were reported as resulting in moderate harm during 2020/21, and there were no serious harms or cases of death. An incident is categorised as 'moderate' when further short term treatment or a procedure is required to resolve the situation; all three moderate harms originated outside of EPUT and are briefly described below:

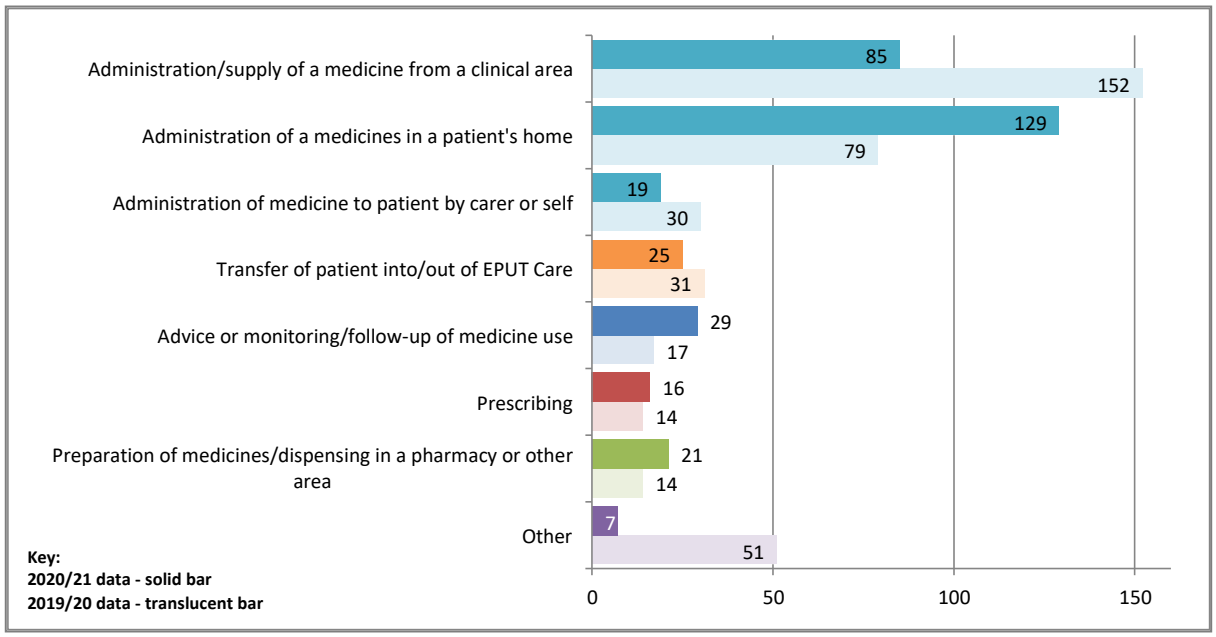
**E154423:** A patient in a care home setting was found by a district nurse to have missed several doses of antibiotics. The member of staff caring for the patient was uncertain as to the indication for administration, did not contact the GP or district nurse for clarification but omitted two days of antibiotic treatment. The given member of staff was updated on the indication on this occasion (possible infected wound) and asked to seek clinical advice if in any doubt about an intervention.

**E158092:** The West Essex Integrated Care team visited a patient out of hours in response to reported sickness (nausea) and agitation. The patient had been prescribed anticipatory medication by their GP, including cyclizine, which was a documented allergy on their notes. Support was sought from NHS111 and a GP visit organised; the member of staff concerned

was unable to administer an alternative anti-emetic pending this face-to-face review although the agitation was managed through midazolam. The patient was referred to Single Point of Access team for follow-up; their GP was contacted regarding the error.

**E165706:** On attending a recently discharged patient, the SEECHS palliative care team discovered that the district nursing team had not been administering the sub-cutaneous dexamethasone, as documented in the discharge summary. On medical examination, it was found that the patient was experiencing a deterioration in their condition with suspected serious acute pathology, which was subsequently relieved by administering the omitted medication as part of a wider therapeutic plan. The district nursing team was advised directly of the revised medication regimen and planned 7-day review by the palliative care consultant. A root cause analysis was undertaken and a gap in communication between the discharging acute trust and EPUT was noted (this information is usually routed through GP services and accessed by EPUT clinical staff via a shared common record). The patient had elected to self-discharge on this occasion.

**Figure 4: Medicines-related Incidents by Stage (April 2020- March 2021)**




## Administration

The majority of reported incidents (n=233) occurred during the stage of administering a medicine either within a patient's home (n=129), within a clinical area (n=85) or by the patient or a carer (n=19). A high number of the errors related to omitted doses and administration of medicines relating to the wrong dose and strength.

## Preparation and dispensing

Twenty-one incidents were reported relating to the preparation and dispensing of medicines. The majority of the errors related to dispensing of the wrong dose/strength, dispensing the incorrect medication and incorrect delivery of medicines.

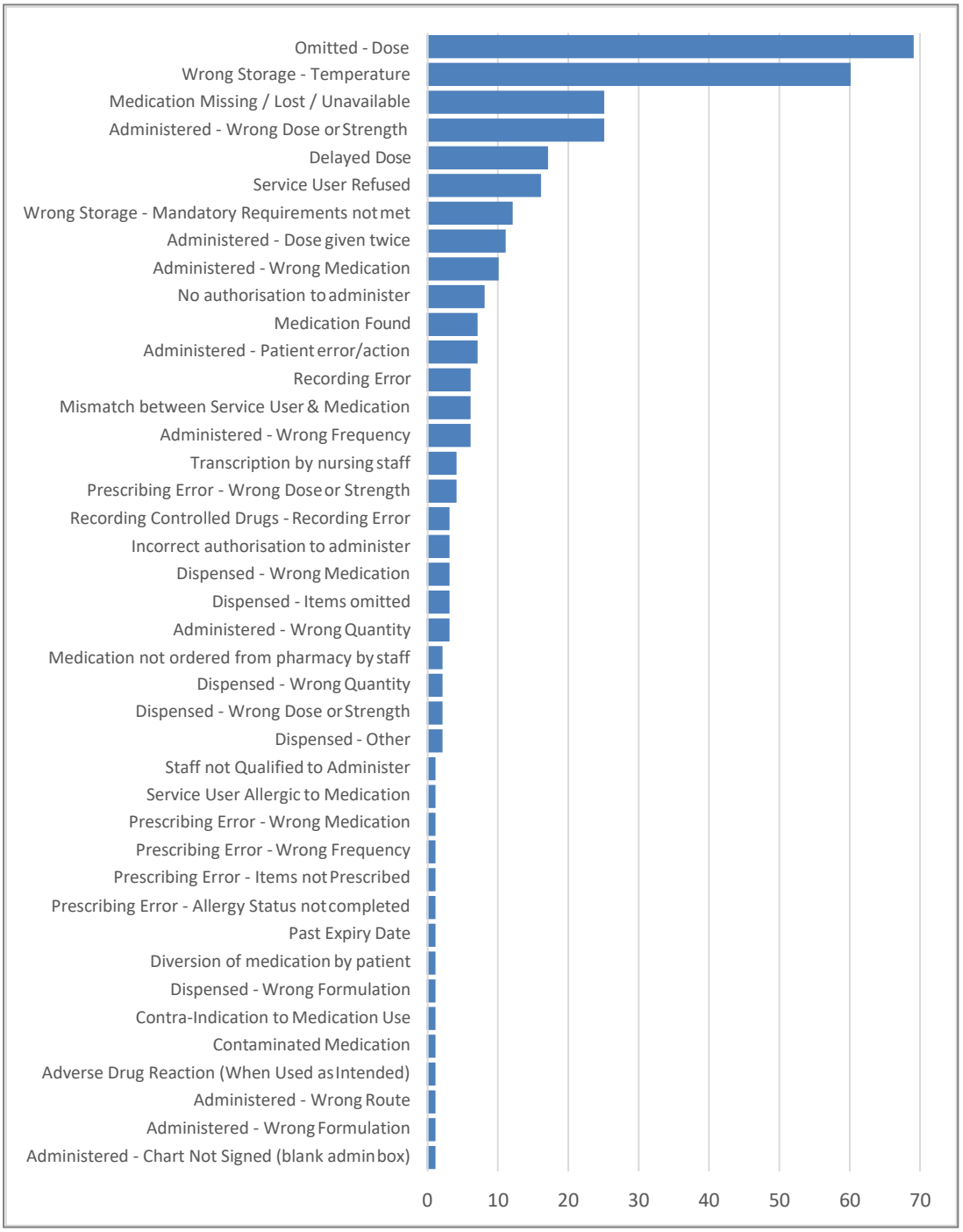
## Prescribing

Sixteen incidents were related to the prescribing process. Themes identified included medicines that were not prescribed on admission, the incorrect frequency or incorrect strength/dose.

**Other**

Seven incidents were reported as 'other'. Work is underway to ensure that fewer incidents are classified as 'Other' by incorporating new reporting categories into DATIX and this was a much lower number than in 2019/20 (51).

**Figure 5: Medicines related Incidents by Subcategory (April 2020- March 2021)**




In common with 2019/20, the two highest categories of medicines incident were omitted doses and storage issues, largely temperature excursions. Whilst CHS staff take every precaution to support patient's in taking their medication, it should be noted that at times doses are omitted based on clinical judgement, in line with agreed protocol. Temperature excursions can be attributed to key events in a limited number of community sites during the summer months, when ambient temperatures exceed 25˚C and CHS staff are asked to seek

specific pharmaceutical advice when this occurs (storing the products in the designated pharmaceutical fridge may appear to be an obvious solution, but this can be counterproductive as moisture can compromise the stock further). The pharmacy team has worked with manufacturers to retain the integrity of pharmaceutical stock where possible, and has in place a standard operating procedure (SOP) relating through which expiry dates can be reduced for medicines exposed to temperature excursions where possible. However, not all stock can be salvaged and this introduces waste to the system, a situation that will not be resolved without intervention. This is particularly challenging where the service is sited within a non-EPUT estate.

### 2.6 Medicines Management Audit Programme

To support compliance with regulation 12 of the Care Quality Commission *Fundamental Standards*[5], and the requirements of national patient safety alerts, the Group regularly reviews issues relating to the management of risks associated with handling medicines.

As part of the rolling three-year Medicines Management audit programme, the Committee considers audits designed to monitor compliance with sections of the Procedural Guidelines for the Safe and Secure Handling of Medicines (CLPG13-CHS). Audits undertaken by other staff may also be considered by the Group. During the year the Group considered the results and action plans for a number of audit reports:

**Table 6: Medicines Management Audits**

| Audit | Audit lead |
|---|---|
| **Antimicrobial stewardship:** a Trust-wide audit of the use of antibiotics, and compliance with the antimicrobial stewardship principles. | Lead Pharmacist, WECHS |
| **Controlled Drugs:** a Trust-wide audit of controlled drug storage and compliance with controlled drug medicines regulations. | Accountable Officer for Controlled Drugs |
| **Safe and secure handling of medicines:** a Trust-wide audit of the security of medicines storage, and compliance with medicines policies and procedures. | Senior Clinical Pharmacist, Education, Training & Governance |
| **Omitted Doses:** a Trust-wide audit of medicines omitted for inpatients, and the reasons for this. | Senior Clinical Pharmacist, Education, Training & Governance |
| **Pharmacy Interventions:** a Trust-wide analysis of the range of interventions made by the pharmacy team in relation to medicines safety, policies and procedures | Senior Clinical Pharmacist, Education, Training & Governance |

[5] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936

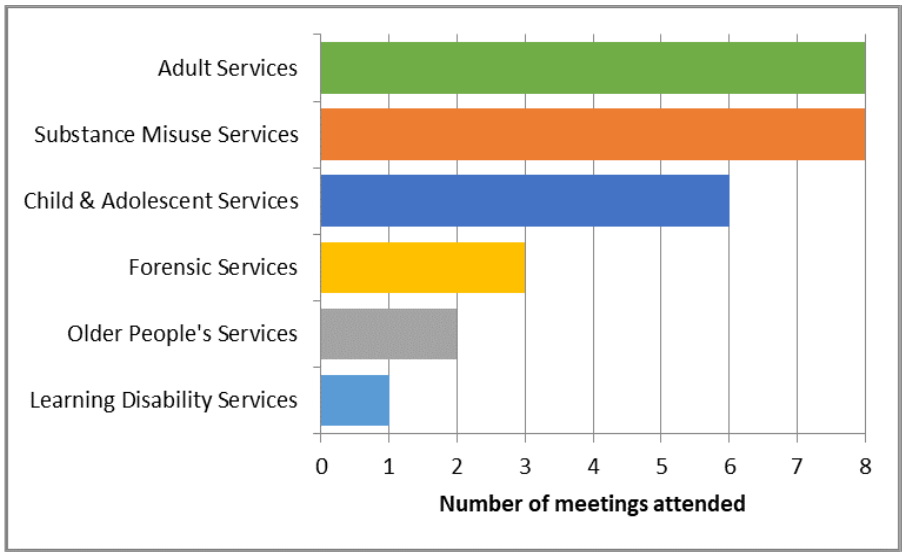
## 3.0 MEDICINES MANAGEMENT GROUP – MENTAL HEALTH AND LEARNING DISABILITIES

Eight meetings of the MMG for Mental Health & Learning Disability services took place during 2020/21, with no meetings held in April and May 2020 due to the impact of the COVID-19 pandemic on working practice, and January and February 2021 as the NHS was once more hit with a surge of cases and the demands of the new vaccination programme intensified. In specifying a minimum of 10 meetings per annum, the Terms of Reference did not anticipate the mass-scale disruption created by a pandemic and the restrictions imposed under lockdown conditions - unprecedented in modern times, and consequently MMG meetings in 2020/21 were held virtually. All meetings were however quorate, meeting the criteria of having at least 6 members are in attendance, including the Chair or Vice Chair and one other consultant, and Chief Pharmacist, Deputy Chief Pharmacist or another pharmacist.

Membership of the group is designed to provide medical and operational input from all sub-specialities, as well as a geographic spread of participants.

Membership of the MMG includes medical, nursing, pharmacy, and clinical support services staff along with representatives of commissioning organisations and primary care. Including those who attended by invitation depending on the agenda, 19 consultants and senior trainees attended at least one meeting, with many attending more regularly. Multidisciplinary support of this meeting remained strong in spite of challenging circumstances, with an average of 14 participants at each and this diversity enabled a broad perspective of thought to be applied to items under consideration. All meetings were attended by the Deputy Chief Pharmacist and nearly all by the Chief Pharmacist and often by specialist pharmacists in attendance to present scheduled items. A cross section of other members attended, with at least one or more staff member from operational services attending, with full attendance by the Clinical Audit (Governance) team and nursing leadership at the majority of meetings.

**Figure 6: Medical and operational representation at MH & LD MMC Meetings**




Representation from senior commissioning pharmacists in Mid, North East and West Essex was strong compared to South Essex; although EPUT is the main MH & LD provider for inpatients in South West Essex, an alternative provider is commissioned for both community health services and community CAMHS. CCG GP Leads receive papers for information and

whilst welcome to attend, in practice route feedback through CCG Medicines Management leads.

Agendas, papers and draft minutes for MMG meetings can be downloaded in PDF format from the Medicines Management Group Meetings section of the Intranet.

### 3.1 Governance

The Central Alerting System (CAS) is a web-based cascade system used to issue patient safety alerts, important public health messages and other safety critical information. This includes Drug Alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA) which notify of medicines defects. The MMG monitors that the actions required by these alerts have been implemented by pharmacy departments supplying the Trust. In 2020/21, medicines supply was as follows:

- EPUT supplied medicines to the majority of its inpatient wards;
- East London NHS Foundation Trust (ELFT) supplied medicines to inpatient wards in Luton & Bedfordshire;
- The Princess Alexandra Hospital (PAH) supplied medicines to community services in West Essex.

In 2020/21, 51 alerts where issued: EL(20)A/42 to A/61 between April and December 2020, and EL(21)A/01 to A/09 between January and March 2021.

In 38 cases no affected stock was held at any pharmacy supplying EPUT, whilst stock was held by the EPUT pharmacy in relation to three alerts (two in common with PAH), and by the pharmacy of another organisation supplying EPUT services for an additional 11. Being a district general hospital with a large range of acute services, the stockholding was broader at PAH and the number of alerts applicable to this provider was unsurprisingly higher than those that applied to specialist mental health trusts. The majority of alerts required action only at pharmacy level and appropriate action was taken in relation to all alerts where the specified stock was identified to be held.

**Table 7: Summary of actions related to CAS alerts by site, 2020/21**

| Provider site / Action taken | EPUT | ELFT | PAH |
|---|---|---|---|
| Not stocked | 35 | 50 | 24 |
| Affected batch not stocked | 13 | 0 | 14 |
| Action taken for affected batch | 3 | 1 | 13 |
| No held stock affected | 48 | 50 | 38 |
| Totals number of alerts | 51 | 51 | 51 |

It is worth noting that the classification of Drug Alerts was updated by the MHRA in February 2021 to align with the criteria used by the NatPSA.[6] Further details of each alert issued can be found in Appendix 2.

The MMG also considers quarterly checks on the safe management of controlled drugs and receives copies of the mandatory occurrence reports submitted to the NHS England Controlled Drug Accountable Officer. For further information see Section 8.0 of this report.

[6] Changes to MHRA Drug alert titles and classification

### 3.2 Formulary and Prescribing Guidelines

Sections of the formulary and prescribing guidelines need to be kept up-to-date to ensure that they reflect National Institute for Health and Clinical Excellence (NICE) and other best practice guidance and clinical evidence. This forms an important element of the work of any decision making committee relating to medicines use.

The senior clinical pharmacist for education, training and governance takes a lead on updating sections of the formulary and prescribing guidelines and shared care protocols. Processes are in place for shared care protocols to consult with stakeholders in the three local ICSs, and the presence of CCG pharmacists at MMG meetings helps to ensure consistency in practice across ICSs.

During 2020/21 updates were made to the following sections in response to updated NICE clinical guidelines, evidence summaries, audit results or the launch of new drugs or new formulations of existing drugs.

**Table 8: Formulary & Prescribing Guideline Sections**

| Section | | Approved |
|---|---|---|
| 1 | Treatment of Depression | updated June 2020 and September 2020 |
| 4 | Treatment of Anxiety | updated June 2020 |
| 8 | Management of Acutely Disturbed Behaviour | updated June 2020 |
| 10 | Management of Alcohol, Opioid & Benzodiazepine Dependence | updated July 2020 and October 2020 |
| 11 | Drug Use in Older Adults | updated June 2020 |
| 12 | Drug Use in Children & Adolescents | updated June 2020 and September 2020 |
| 13 | Drug Use in Learning Disabilities | updated June 2020 |
| 14 | Anticoagulants | Updated October 2020 |
| 17 | Nicotine Replacement | updated June 2020 |
| 18 | Antimicrobial Prescribing | updated June 2020 and September 2020 |
| 21 | High Risk Medicines | updated December 2020 |

The Formulary and Prescribing Guidelines are made available to prescribers on the Pharmacy and Medicines Management web pages of the Intranet. In line with NHS Contract requirements they can also be accessed by healthcare professionals, patients and the public on the EPUT public website.

No Patient Group Directions (PGDs), which are used by drug and alcohol services and community-based staff were updated during 2020/21.

### 3.3 Policies, Procedures and Clinical Guidelines

At the beginning of the pandemic a large number of pieces of clinical advice had to be developed very quickly and distributed to clinicians to support changes in practice. In common with many other meetings the MMG was suspended at this stage and such resources were circulated virtually for comment, amendment and agreement via Chair's action. These were later ratified at the June MMG meeting. As working arrangements

returned to normal in mid-2020/21 the Group considered a number of procedures, protocols and other resources. These included:

**Table 9: Policies, Procedure & Clinical Guidelines**

| Policy / Procedure / Clinical Guideline | | Approved |
|---|---|---|
| COVID-19 Resource | Managing Patients Own Drugs in the context of COVID-19 | June 2020 (confirming previous Chair's Action) Updated July 2020 |
| COVID-19 Resource | Clozapine and COVID-19 | June 2020 (confirming previous Chair's Action) |
| COVID-19 Resource | Temporary FP10 arrangements due to COVID-19 | June 2020 (confirming previous Chair's Action) |
| COVID-19 Resource | Depots and psychotropic medications and COVID-19 | June 2020 (confirming previous Chair's Action) |
| COVID-19 Resource | Lithium and COVID-19 | June 2020 (confirming previous Chair's Action) |
| COVID-19 Resource | Acute disturbance and delirium and COVID-19 | June 2020 (confirming previous Chair's Action) |
| COVID-19 Resource | End of life symptom control guide for use in the COVID-19 crisis | June 2020 (confirming previous Chair's Action) |
| COVID-19 Resource | Rationalising medication on admission and optimising medicine | June 2020 (confirming previous Chair's Action) |
| COVID-19 Resource | Venous thromboembolism (VTE) prophylaxis | June 2020 (confirming previous Chair's Action) |
| COVID-19 Resource | Clozapine, blood dyscrasias ad blood monitoring | June 2020 (confirming previous Chair's Action) |
| CLPG13-MH Appendix 22 | Emergency dispensing by nurses | June 2020 (confirming previous Chair's Action) |
| CG27 | Drug allergies and medical emergencies | December 2020 |
| CG82 | Clinical guideline for the administration of naloxone in known or suspected opioid overdose. | July 2020 |
| Resource | Good practice guide on creams and ointments | October 2020 |

### 3.4 Introduction of New Drugs

One new drug and two new formulations of a drug already included in the formulary were considered by the Group during 2020/21:

- **Esketamine** (Spavato®) for the treatment of resistant major depressive disorder was reviewed. It was agreed that it should not be added to the formulary at this stage due to concerns about the quality of the data available and potential costs.

- **Naloxone** nasal spray (Nyxoid®) for the treatment of opioid overdose was reviewed. It was agreed that this be added to the formulary and the clinical guidelines for the

use of naloxone in known or suspected opioid overdose, subject to clear criteria for when the nasal spray should be used rather than injectable naloxone..

- **Buprenorphine** prolonged release injection (Buvidal®) for the treatment of opioid dependence was reviewed for a second time as progress had been made in addressing the operational issues relating to storage and administration identified during the last review. It was agreed that a limited pilot of use in a small group of substance misuse clients would go ahead.

### 3.5 Non-Formulary Applications

During 2020/21 there were 31 applications to the chair of the MMG for approval to prescribe medicines not included in the formulary, out of which 26 were approved outright or with a request that the MMG be updated with the outcome. One of these approved requests was not actually implemented. Table 10 shows the drugs concerned and the outcome of the applications. It should be noted that although Olanzapine LAI has been requested frequently in 2018/19 and 2019/20, the decision to approve as an alternative to oral treatment is restricted by the complexity and staff capacity (in order to avoid compromising patient safety). Although a useful intervention in specific case, the current clinical infrastructure does not allow this to be prescribed routinely without prior approval by the Chair of the MMG.

**Table 10: Non-Formulary Requests**

| Drug | Number of requests | Number Withdrawn | Number Not Approved | Number of Approvals |
|---|---|---|---|---|
| Agomelatine | 1 | 0 | 0 | 1 |
| Bupropion | 2 | 0 | 1 | 1 |
| Cariprazine | 1 | 0 | 0 | 1 |
| Clozapine (unlicensed use in a patient <18 years) | 1 | 0 | 0 | 1 |
| Clozapine IM | 3 | 0 | 0 | 3 |
| Buprenorphine lyophilisate (Espranor®) | 2 | 1 | 0 | 1 |
| Fluoxetine | 1 | 0 | 0 | 1 |
| Lurasidone | 8 | 2 | 0 | 6 |
| Olanzapine LAI | 9 | 0 | 0 | 9 |
| Orphenadrine | 1 | 0 | 0 | 1 |
| Pimozide | 1 | 0 | 1 | 0 |
| Quetiapine suspension | 1 | 0 | 0 | 1 |
| **Totals** | **31** | **3** | **2** | **26** |

### 3.6 Patient Safety Issues

A dedicated section on the Group's agenda looks at issues pertaining to patient safety. This includes the MHRA monthly Drug Safety Update. This publication contains advice on the safe use of drugs relevant to many settings. Where appropriate these were highlighted through articles in Trust Today and/or within the Medicines Management newsletter. Copies of the full Drug Safety Update are published on the Medicines Management webpages of the Intranet.

Although the Committee reaches a decision that many of these are not relevant within a mental health setting, it raises awareness of safety issues *per se* and provides a process by which a decision is reached about relevance and actions for each issue. Issues considered during the year of particular relevance within mental health included:

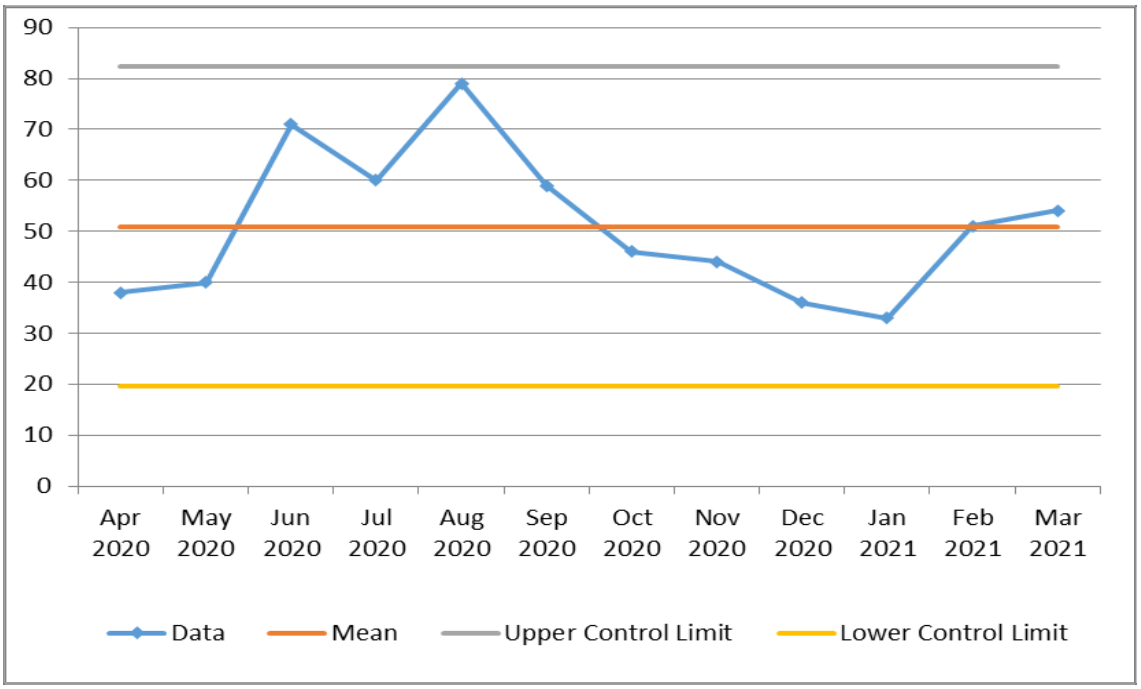
- Benzodiazepines and opioids – risk of potentially fatal respiratory depression
- Valproate Pregnancy Prevention Programme – temporary advice for management due to COVID-19
- Cyproterone acetate – advice to minimise risk of meningioma
- Direct-acting oral anticoagulants (DOACs) – advice on bleeding risk and reversal agents
- Clozapine and other antipsychotics – monitoring blood concentrations for toxicity
- Emollients and risk of severe/fatal burns
- Opioids and risk of dependence and addiction
- Modafinil – risk of congenital malformation
- Bupropion – risk of serotonin syndrome
- Antiepileptic drugs in pregnancy
- SSRI/SNRI – risk of postpartum haemorrhage
- Pregabalin – risk of severe respiratory depression

Other medicines safety related issues discussed included physical health monitoring following rapid tranquilisation, use of anaphylaxis kits by community-based staff, and antimicrobial resistance.

### 3.7 Medicines-Related Incidents

The MMG reviews information about medicines-related incidents on a quarterly basis. During the year, 611 incidents were reported compared with 801 in 2019/20 - a decrease of 23.8%. This was unsurprising given the extraordinary circumstances brought about by the COVID-19 pandemic. Overall, medication incidents reported represented 3.9% of the overall number of incidents reported within mental health and learning disability services.

**Figure 7: Medicines-related incidents reported by Month (April 2020 to March 2021)**



Organisations with a high incident reporting rates are usually considered to have a better and more effective safety culture. Learning from incidents cannot take place unless they are reported and reviewed. Within the National Reporting and Learning System (NRLS), mental health cluster medication-related incidents represented – 6.6% of all reported incidents during the period 1st April 2020 – 31st March 2021[7]; the EPUT reporting rate was 5.2% for the same period. This is below the benchmark and highlights the desirability of increased reporting within mental health and learning disability services. Figure 7 shows the number of medication incidents that have been recorded within mental health and learning disability services for 2020/21.

Below are details of the number of incidents reported each quarter during 2020/21. Comparison is made to both the previous quarter and the same quarter of the preceding year, as there can be a seasonal nature to some incidents.

- During 2020/21 quarter one (April 2020 – June 2021), 149 medication incidents were reported accounting for 3.8% of all incidents reported within mental health services (a 20.7% decrease compared to quarter four 2019/20; 13.4% decrease compared to quarter one 2019/20).

- During 2020/21 quarter two (July 2020 – September 2020), 198 medication incidents were reported accounting for 4.7% of all incidents reported within mental health services (a 32.9% increase compared to quarter one 2020/21; 10% increase compared to quarter two 2019/20).

- During 2020/21 quarter three (October 2020 – December 2020), 126 medication incidents were reported accounting for 3.0% of all incidents reported within mental health services (a 36.4% decrease compared to quarter two 2020/21; a 51.7% reduction compared to quarter three 2019/20).

- During 2020/21 quarter four (January 2021 – March 2021), 138 medication incidents were reported accounting for 4% of all incidents reported within mental health services (a 9.5% increase compared to quarter three 2020/21; 26.6% decrease compared to quarter four 2019/20).

The decrease in reporting seen was significantly greater than the general reduction in overall incident reports. Whilst this is probably linked to the emergence of COVID-19, accompanied by a reduction in service provision, inpatient numbers and staff focus on dealing with the pandemic, the overall larger drop in the reporting rates for all incidents was partially offset by the number of COVID-19 patient cases reported.

Medication incidents are rated in accordance with the NRLS ratings of No Harm, Low Harm, Moderate Harm, Severe Harm, and Death. There have been no reported Severe or Death rated incidents during 2019/20, and the vast majority were rated as No Harm. Details are shown in Table 11.

[7] Source: NRLS reference data 1st April 2020 31st March 2021.The benchmark is against 52 mental health trusts within England, although the overall reporting rates for EPUT may be skewed by the inclusion of data from Mass Vaccination Centres, which technically do not sit within MH & LD provision.

**Table 11: Risk Rating of Medicines-related Incidents**

| | No Harm | Low | Moderate | Severe | Death |
|---|---|---|---|---|---|
| **2020/21 Q1** | 137 | 11 | 1 | 0 | 0 |
| **2020/21 Q2** | 185 | 13 | 0 | 0 | 0 |
| **2020/21 Q3** | 108 | 14 | 3 | 0 | 0 |
| **2020/21 Q4** | 100 | 34 | 4 | 0 | 0 |
| **Total** | 530 (86.7%) | 72 (11.8%) | 8 (1.3%) | 0 | 0 |

*NOTE: four incidents were not categorised for degree of harm.*

Eight incidents were reported as resulting in moderate harm during 2020/21, five of which were attributable to services provided by EPUT. It should be noted that because the mass vaccination programme is categorised as a corporate service within the DATIX system, three of these related to vaccination rather than mental health and learning disability services, but have been captured amongst mental health data.

An incident is categorised as 'moderate' when further short term treatment or procedure is required as a result. These five incidents are briefly described below:

**E160184:** The First Response team made a domiciliary visit to a patient that declared that they had no medication. It was confirmed that the week's supply of quetiapine had in fact been supplied, which was later confirmed by the patient. A joint appointment with the patient and their GP, with a view to organising a joint assessment with the First Response Team and Crisis Resolution Home Team. Moderate Harms group agree that all appropriate actions had been taken at the time.

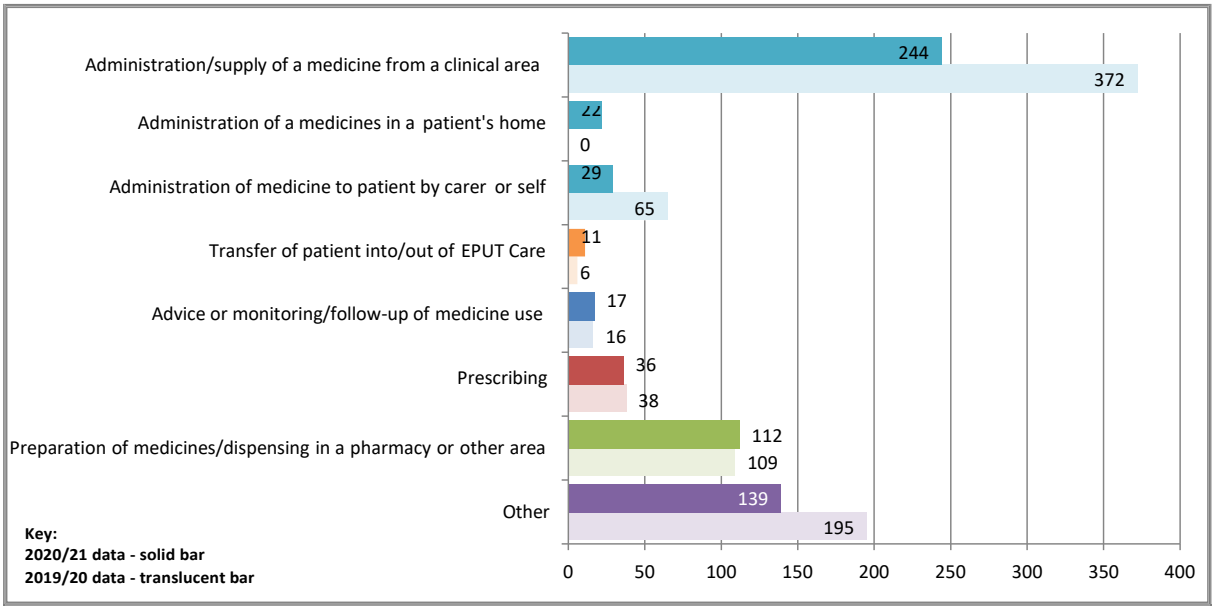
**E178964:** An accompanied patient attended an appointment at a COVID vaccination centre, absence seizures were declared but no clinical reason not to have the vaccination. The patient felt faint and experienced an absence seizure immediately after the vaccine was administered and was transferred to the site emergency room where began to recover, but then complained of central chest pain. An ambulance arrived within 10 minutes of the call for help, undertook a physical assessment and liaised further with A&E. All staff acted in a professional manner throughout the incident, the patient's daughter was kept updated during the incident and the patient was happy with the treatment provided.

**E1799599:** A patient attending a vaccination centre had declared an allergy to seafood during the screening process, and after consenting to the vaccination was consequently asked to remain in the waiting area after the injection, during which time they developed urticaria. An ambulance was called and an injectable antihistamine administered after the patient failed to respond adequately to an initial oral dose. The patient refused to present to hospital and signed a disclaimer accordingly. Appropriate action taken by vaccination centre team.

**E182225:** A patient with a history of penicillin and seafood (neither are contra-indications to the COVID-19 vaccine) at a vaccination centre started to experience an anaphylactic reaction, including an obstructed airway. They were transferred to the resuscitation area and adrenaline administered. The ambulance service arrived within 4 minutes of being called and administered further adrenaline and an antihistamine. The patient was transferred to hospital once stabilised on site.

**E182641:** A patient was taken to A&E by their family member having stopped taking clozapine for two weeks, during which time their mental state deteriorated. A mental health assessment was completed the following day and the patient discharged to stay with their family on a temporary basis and referred to the local Home First Team which visited the day after (2 days after the A&E assessment) and found that the family had re-started treatment at the full dose, rather than being advised to stop treatment or of a re-titration plan. There was no evidence that physical health observations were taken since re-starting (national policy requirement) or that the Lead Clozapine Pharmacist, Clozapine Nurse or CPN had been informed, in breach of local policy.

**Figure 8: Medicines-related Incidents by Stage (April 2020 to March 2021)**




Generally the distribution of incidents by stage in the medication pathway was similar to 2020/21 to 2019/20 (see Figure 8), although overall levels of reporting were lower. Further details are given in Figure 9.

### Administration

The majority of reported incidents (n=244) occurred during the stage of administering a medicine within a clinical area. These included the wrong drug, dose, strength or formulation; administration by the wrong route or at the wrong frequency; and administering a dose where the drug chart had not been signed. Of these incidents 10.7% (n=26) related to situations where the medication charts had not been signed (See Figure 9). Despite this the number of omitted doses/unsigned charts had significantly improved compared with the previous year. In 2019/20, 12% of the administration incidents related to omitted doses, however in 2019/20 this decreased to 4.2%. A further 29 incidents involved the administration of medicines either by the patient or a carer.

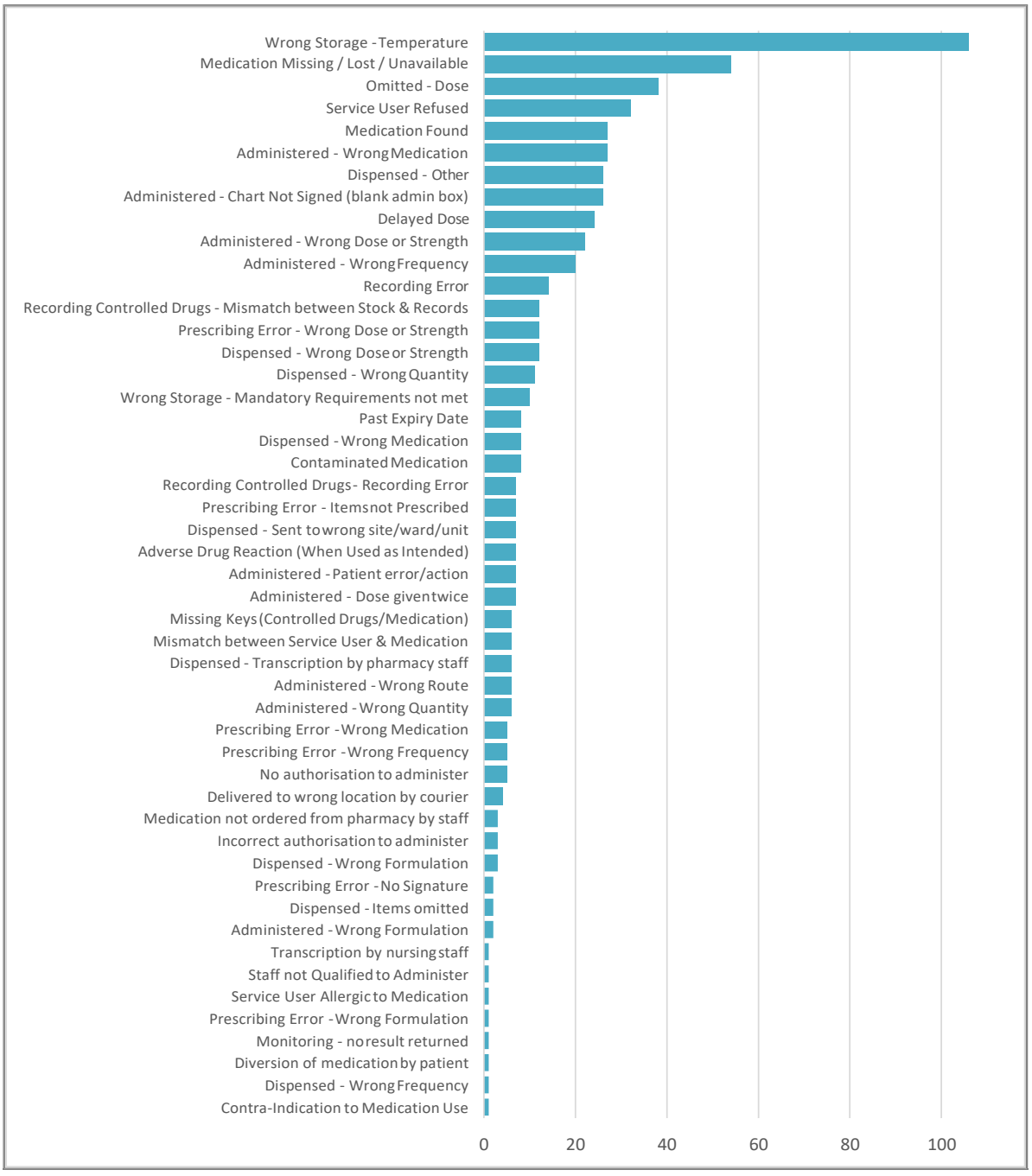
### Dispensing

One hundred and twelve incidents occurred during dispensing medicines in a pharmacy other area. This included items incorrectly dispensed by a community pharmacy, or the pharmacy department of an acute trust. Dispensing errors included supplying the wrong dose, strength, formulation or drug, as well as supply with incorrect details on the label such as quantity, drug or patient name or medicines sent to the wrong ward.

**Prescribing**
Thirty-six incidents were reported relating to the prescribing process. These included prescriptions which had not been signed; medication which had been unintentionally omitted from the prescription, and errors relating to dose, strength, formulation, frequency, route and drug.

**Other**
139 incidents were reported relating to the general handling of medicines. This included incidents that do not fall within the appropriate categories of the medication section of DATIX. Work is underway to ensure that fewer incidents are classified as 'Other' by incorporating new reporting categories into DATIX; however these continues to represent a similar percentage of all incidents.

**Figure 9: Medicines-related Incidents by Subcategory (April 2020 to March 2021)**



### 3.8 POMH-UK and other Medicines-Related Audits

The Prescribing Observatory for Mental Health (POMH-UK) organises national audit-based quality improvement programmes open to all mental health trusts. EPUT is one of approximately 40 trusts providing mental health services which participate in these programmes. The Committee considered the national and Trust results and action plans for two POMH-UK audit reports completed prior to this occurring. In addition, results from six other medicine-related audits undertaken by medical staff were presented to the MMG and two further POMH-UK audits were led by the Clinical Governance team.

**Table 12: Audit Reports**

| Audit | | Presented by |
|---|---|---|
| POMH-UK Topic 17b | Use of Depot/Long-acting antipsychotic injections | Dr Sumanjeet Bose |
| POMH-UK Topic 9d | Antipsychotic prescribing in people with learning disabilities under the care of mental health services | Dr Tom Picton |
| POMH-UK Topic 20a | Prescribing valproate in mental health services | [Cirin Verghese] |
| POMH-UK Topic 18b | The use of clozapine in mental health services | [Cirin Verghese] |
| National | National Clinical Audit of Anxiety and Depression (NCAAD) | Dr Harsha Gopisetty<br>Dr Ratna Ghosh<br>Dr Uma Ranjendran |
| Internal | Rapid Tranquilisation in CAMHS Services | Dr Rana Moharam |
| Internal | Clozapine | Dr Oksana Zinchenko |
| Internal | Clozapine and physical health checks | Dr Shaimaa Aboelenein |
| Internal | Discharge medication prescribed to patients discharge from assessment units | Dr Su Mon Hein |
| Internal | Use of medication cards | Dr Georgios Mousalidis |
| Internal | Use of PRN psychotropic medication on adult inpatient wards | Dr Su Mon Hein |

### 3.9 Medicines Management Audit Programme

To support compliance with regulation 12 of the Care Quality Commission *Fundamental Standards*[8], and the requirements of national patient safety alerts, the Group regularly reviews issues relating to the management of risks associated with handling medicines.

As part of the rolling three-year Medicines Management audit programme, the Committee considers audits designed to monitor compliance with medication safety issues or sections of the Procedural Guidelines for the Safe and Secure Handling of Medicines (CLPG13-CHS). During the year the Group considered the results and action plans for a number of audit reports, although this was fewer than normal:

[8] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936

**Table 13: Medicines Management Audits**

| Audit | Audit lead |
|---|---|
| **Antimicrobial stewardship:** a Trust-wide audit of the use of antibiotics, and compliance with the antimicrobial stewardship principles. | Lead Pharmacist, WECHS |
| **Antimicrobial stewardship:** a Trust-wide audit of the use of antibiotics, and compliance with the antimicrobial stewardship principles. | Lead Pharmacist, WECHS |
| **Controlled Drugs:** a Trust-wide audit of controlled drug storage and compliance with controlled drug medicines regulations. | Accountable Officer for Controlled Drugs |
| **Safe and secure handling of medicines:** a Trust-wide audit of the security of medicines storage, and compliance with medicines policies and procedures. | Senior Clinical Pharmacist, Education, Training & Governance |
| **Omitted Doses:** a Trust-wide audit of medicines omitted for inpatients, and the reasons for this. | Senior Clinical Pharmacist, Education, Training & Governance |
| **Pharmacy Interventions:** a Trust-wide analysis of the range of interventions made by the pharmacy team in relation to medicines safety, policies and procedures | Senior Clinical Pharmacist, Education, Training & Governance |
| **Valproate Annual Risk Acknowledgement Forms**: analysis of the correct completion of the forms required for female patients of child-bearing potential prescribing sodium valproate. | Senior Clinical Pharmacist, Education, Training & Governance |
| **Lithium**: an audit of the processes designed to ensure the safe use of lithium | Pre-Registration Pharmacist |

## 4.0 MEDICINES EXPENDITURE – COMMUNITY HEALTH SERVICES

Dispensing and the supply of medicines for South East Essex community health services occurs in-house, whilst for West Essex this was provided by the local acute trust (the Princess Alexandra Hospital NHS Trust, referred to as PAH later in this report) in 2020/21. Prescriptions written on FP10 forms within community health services are attributed to the relevant commissioning CCG. Therefore, obtaining at least some data on medicines use is dependent on other hospital trusts.

**Table 14: 2020/21 WECHS expenditure by BNF Chapter (wards, clinics and FP10 prescriptions)**
*(Source: REFINE data, Rx-Info Ltd)*

| BNF Chapter - Description | 2020/21 Expenditure | 2019/20 Expenditure | Variance |
|---|---|---|---|
| 1 - Gastro-intestinal system | £9,595 | £10,437 | -8.1% |
| 2 - Cardiovascular system | £59,658 | £55,191 | 8.1% |
| 3 - Respiratory system | £10,332 | £12,137 | -14.9% |
| 4 - Central nervous system | £16,734 | £23,902 | -30.0% |
| 5 - Infections | £21,949 | £22,245 | -1.3% |
| 6 - Endocrine system | £13,547 | £10,104 | 34.1% |
| 7 - Obs, gynae, and urinary-tract disorders | £3,204 | £2,240 | 43..1% |
| 8 - Malignant disease and immunosuppression | £161 | £1,247 | -87..1% |
| 9 - Nutrition and blood | £20,973 | £14,882 | 40.9% |
| 10 - Musculoskeletal and joint diseases | £423 | £796 | -46.8% |
| 11 - Eye | £6,475 | £5,664 | 14.3% |
| 12 - Ear, nose, and oropharynx | £718 | £739 | -2.89% |
| 13 - Skin | £16,224 | £19,824 | -18.2% |
| 14 - Immunological products and vaccines | £144 | £0.00 | n/a |
| 15 - Anaesthesia | £1,463 | £1,402 | 4.4% |
| 18 - Preparations used in Diagnosis | £0.00 | £33 | n/a |
| 19 - Other Drugs and Preparations | £23 | £15 | 52.8% |
| 20 - Drug Tariff Dressings | £209,342 | £174,372 | 20.1% |
| 21 - Drug Tariff Appliances | £41,861 | £27,193 | 53.9% |
| 22 - Incontinence Appliances | £1,961 | £2,002 | -2.0% |
| 23 - Stoma Appliances | £15,554 | £9,054 | 71.8% |
| Miscellaneous | £43,499 | £35,803 | 21.5% |
| | £493,839 | £429,280 | 15.0% |

*These figures vary from the previous year's figures presented in the 2019/20 Annual Report which were correct at the time of publication; it was noted at the time that the data excludes prescriptions written on FP10 and dispensed by community pharmacy. These FP10 charges were reconciled into the account after the report was produced.

Data have been extracted from the national system Refine® into which NHS organisations upload prescribing data on a monthly basis from their pharmacy systems. It is therefore dependent on the upload of data and the correct attribution of cost centres by other organisations where supplies are not provided in-house. In order to be compliant with the Trust's procedural guidelines for the Safe and Secure Handling of Medicines all medicines should be obtained from a supplier approved by the Chief Pharmacist. Although medicines data was regularly provided by the supplying hospital trust, it has proved impossible to

reconcile this with financial data for the medicines budget lines and this has not changed in 2020/21. The lack of robust data on medicines usage makes it difficult to guarantee that other items have not been charged by services to the medicines account code by community health services teams. However, the supply chain for WECHS community services was brought in-house in May 2021 so it is expected an 11-month effect will be seen in the annual report for 2021/22.

During 2020/21, nearly 25,500 items of medication were issued within West Essex Community Health Services, including those prescribed on FP10 and dispensed by a community pharmacy. This represents an overall increase in the number of items of just over 13%. Expenditure on medicines in 2020/21 totalled more than £493,800, a 15% increase compared with expenditure in 2019/20 with cost and activity increases noted for dressings, appliances and stoma appliances, and other drugs and preparations. The continued increase in expenditure on dressings and appliances in 2019/20 reflects that non-medical prescribing (NMP) activity is an acceleration of an existing trend; in 2020/21 as primary care services to patients during the pandemic year underwent a significant reconfiguration but community health services professionals continued to see patients face to face in their own homes. This is consistent with the original aims of non-medical prescribing: to make it easier and quicker for patients to get the medicines they need, thereby improving patient care without compromising patient safety. In addition for much of the year at least some of the wards at St Margaret's Hospital, Epping functioned as overspill COVID-19 wards for PAH meaning that the range and use of medicines was different from previous years. Further detail on the prescribing challenges created by the pandemic are detailed in section 10 of this report.

Notable increases in prescribing trends in specific therapeutic areas include cardiovascular drugs, endocrine and nutritional products. The prescribing of anti-infective agents in 2020/21 appears to be relatively stable; items that fall under "miscellaneous" were largely specific dressing kits that were not mapped to 'dm+d'[9] at the time.

During 2020/21 over 6,000 items of medication were issued within South East Essex community health services, compared with nearly 14,000 the previous financial year, representing a reduction in the number of items dispensed in excess of 56%, with a corresponding decrease in costs of over 45%. The drop in activity and subsequent cost reflects the change in service provision as a result of the pandemic. Beds and staff from Mountnessing Court and the Cumberledge Intermediate Care Centre (CICC) moved to Brentwood Community Hospital in the early weeks of the pandemic as bed–based community health service provision in Mid and South Essex was consolidated. These services were run by North East London NHS Foundation Trust (NELFT).

One area which saw increased costs was prescribing within BNF chapter 13: skin preparations. Prescribing costs here increased due to a change in the choice of preparation used to treat genital warts by Essex sexual health services. Miscellaneous items included Post Exposure Prophylaxis kits (PEP, issued by designated centres including sexual health services where very recent exposure to HIV is suspected).

[9] Dictionary of Medicines and Devices - an 'Interoperability' standard to ensure that diverse clinical systems can effectively 'talk' to each other using a common coded language for the transfer of medicines information.

**Table 15: 2020/21 SEECHS expenditure by BNF Chapter (wards, clinics but excluding most FP10 prescriptions)**

*(Source: REFINE data, Rx-Info Ltd)*

| BNF Chapter - Description | 2020/21 Expenditure | 2019/20 Expenditure | Variance |
|---|---|---|---|
| 1 - Gastro-intestinal system | £752 | £3,122 | -75.9% |
| 2 - Cardiovascular system | £6,182 | £22,097 | -72.0% |
| 3 - Respiratory system | £2,034 | £8,297 | -75.5% |
| 4 - Central nervous system | £6,259 | £12,593 | -50.3% |
| 5 - Infections | £4,577 | £6,663 | -31.3% |
| 6 - Endocrine system | £4,862 | £8,875 | -45.2% |
| 7 - Obstetrics, gynaecology, and urinary-tract disorders | £44,484 | £76,780 | -42.1% |
| 8 - Malignant disease and immunosuppression | £579 | £592 | -2.3% |
| 9 - Nutrition and blood | £2,469 | £6,616 | -62.7% |
| 10 - Musculoskeletal and joint diseases | £469 | £1,521 | -69.2% |
| 11 - Eye | £185 | £876 | -79.0% |
| 12 - Ear, nose, and oropharynx | £113 | £467 | -76.0% |
| 13 - Skin | £23,558 | £16,032 | 46.9% |
| 14 - Immunological products and vaccines | £7,971 | £38,110 | -79.1% |
| 15 - Anaesthesia | £1,736 | £2,332 | -25.6% |
| 20 - Drug Tariff Dressings | £58,544 | £108,356 | -46.0% |
| 21 - Drug Tariff Appliances | £7,174 | £11,037 | -35.0% |
| 22 - Incontinence Appliances | £4,955 | £7,925 | -37.5% |
| 23 - Stoma Appliances | £4,239 | £6,766 | -37.4% |
| Miscellaneous | £8,328 | £9,100 | -8.5% |
| | £189,467 | £348,155 | -45.6% |

*data excludes prescriptions written on FP10 chargeable to primary care in SEECHS.

## 5.0 MEDICINES EXPENDITURE – MENTAL HEALTH AND LEARNING DISABILITIES

### 5.1 Expenditure

During 2020/21, just over 135,000 items of stock, in-patient, out-patient and leave/discharge medication were issued within mental health and learning disability services by the in-house pharmacy service in Essex, and by the pharmacy at ELFT on behalf of the Trust for wards in Bedfordshire, a reduction in volume of 11% compared with the previous financial year. Reduced admissions during the early stages of the pandemic, due to reduced bed numbers to ensure social distancing will have impacted on inpatient expenditure.

A further 24,000 items were dispensed by community pharmacies against FP10 prescription forms. This represents an overall reduction in the number of items of 14.1%. The move of outpatient appointments to video/telephone consultations will have provided less opportunity for the provision of prescriptions resulting in some prescribing being passed to GPs. However it is also likely to have led to prescriptions of longer duration prescriptions where this was safe and appropriate for individual patients reducing the number of overall prescriptions written.

**Table 16: 2020/21 Expenditure by BNF[10] Chapter**

| BNF Chapter | 2020/21 Expenditure | 2019/20 Expenditure | Variance |
|---|---|---|---|
| 1 - Gastro-intestinal system | £31,195 | £35,491 | -12.1% |
| 2 - Cardiovascular system | £33,710 | £34,357 | -1.9% |
| 3 - Respiratory system | £22,194 | £33,481 | -33.7% |
| 4 - Central nervous system | £3,732,272 | £3,572,458 | 4.5% |
| 5 - Infections | £6,289 | £13,984 | -55.0% |
| 6 - Endocrine system | £51,141 | £61,198 | -16.4% |
| 7 - Obs, gynae, and urinary-tract disorders | £3,157 | £6,035 | -47.7% |
| 8 - Malignant disease and immunosuppression | £1,398 | £1,555 | -10.1% |
| 9 - Nutrition and blood | £61,678 | £70,445 | -12.4% |
| 10 - Musculoskeletal and joint diseases | £3,801 | £5,255 | -27.7% |
| 11 - Eye | £4,556 | £5,075 | -10.2% |
| 12 - Ear, nose, and oropharynx | £2,194 | £2,331 | -5.9% |
| 13 - Skin | £10,397 | £16,973 | -38.7% |
| 14 - Immunological products and vaccines | £7,479 | £17,086 | -56.2% |
| 15 - Anaesthesia | £19,395 | £33,253 | -41.7% |
| Others | £53,553 | £29,217 | 83.3% |
| **Total** | £4,044,410 | £3,938,195 | 2.7% |

Data has been extracted from the national system Refine® into which NHS organisations upload prescribing data on a monthly basis from their pharmacy systems. It is therefore dependent on the upload of data and the correct attribution of cost centres by other organisations where supplied are not provided in-house.

[10] British National Formulary

Expenditure on medicines in 2020/21, totalled £4.04 million[11], of which the largest contributor to prescribing costs within mental health and learning disability services were drugs affecting the central nervous system. These accounted for just under 70% of items prescribed, and over 92% of overall expenditure, and include drugs used for the treatment of psychosis, anxiety, depression, dementia, attention deficit hyperactivity disorder (ADHD), epilepsy and substance misuse, as well as analgesics. Costs in this area increased as larger supplies were made per transaction in response to the pandemic (an expedient response to an increasingly volatile supply system, reduced operational capacity and infection control measures amongst other confounding factors); there is no evidence that cost-efficiency was compromised by this.
Nutritional products and prescribing for the treatment of diabetes, gastrointestinal conditions, and cardiovascular disease accounted for the next most expensive areas of prescribing. Between them, these totalled 4.4% of overall expenditure, a reduction on the previous year (5.1%) but nearly 20% of the items supplied. Although expenditure reduced for the majority of areas outside of mental health prescribing, overall prescribing costs for mental health and learning disabilities increased by 4.5%.

Ten sections of the BNF accounted for 95% of total expenditure on drugs, and 70.3% of the volume, more than accounted for by the same ten sections in 2019/20 (cost 91.2%; volume 68.6%), which in turn was an increase on 2018/19 figures. There had been two changes in the top ten sections with expenditure on analgesics and anaesthetic drugs replaced with anticoagulants and drugs used in parkinsonism.

**Table 17: Top 10 BNF Sections (by expenditure)**

| BNF Section | 2020/21 Expenditure | 2019/20 Expenditure | Variance |
|---|---|---|---|
| 4.2 - Drugs used in psychoses and related disorders | £2,895,241 | £2,653,229 | 9.1% |
| 4.10 - Drugs used in substance dependence | £570,668 | £555,258 | 2.8% |
| 4.11 - Drugs for dementia | £67,586 | £90,983 | -25.7% |
| 9.4 - Oral nutrition | £46,270 | £56,096 | -17.5% |
| 4.3 - Antidepressant drugs | £43,172 | £52,587 | -17.9% |
| 6.1 - Drugs used in diabetes | £42,307 | £45,297 | -6.6% |
| 4.1 - Hypnotics and anxiolytics | £39,753 | £41,567 | -4.4% |
| 4.8 - Antiepileptic drugs | £35,439 | £47,228 | -25.0% |
| 4.9 - Drugs used in parkinsonism and related disorders | £30,234 | £23,541 | 28.4% |
| 2.8 - Anticoagulants and protamine | £25,186 | £17,417 | 44.6% |
| | £3,795,855 | £3,583,203[12] | 5.93% |

As in 2019/20, seven relate to the central nervous system, with the remaining three relating to the treatment of diabetes, nutrition and anticoagulants. Over recent years a number of new medicines have become available for the treatment of diabetes, increasing the overall costs for the treatment of this condition - this is significant not only because of the association between first-time psychosis and diabetes, but also the rapidly increasing prevalence after antipsychotics are started through weight gain. This iatrogenic risk must be actively managed as part of a holistic approach to healthcare.

[11] **NOTES:** these figures will not reconcile with those quoted in financial reports as they are based on items dispensed rather than invoiced in the financial year, do not include any end of year accruals, and for FP10s include Net Ingredient Cost rather than the amount invoiced by the NHS BSA to the Trust, which includes discount, dispensing, container and other fees.

[12] **NOTES:** the top 10 comparison cost listed here for 2019/20 differs from that published in the 2019/20 report (£3,636,475) to reflect the new top 10 for 2020/21.

Anticoagulants are prescribed for a number of medical reasons such as atrial fibrillation and the prevention of stroke; there is also a recognised association between the use of antipsychotic drugs and clotting risk; immobility confers a significantly increased risk of blood clots and the confines of a ward setting mean that a reduction in mobility is likely. These are high risk drugs and although generally continued rather than initiated within mental health and learning disability wards, special procedures apply to ensure patient safety; the mental health and learning disabilities MMG approved an update to Section 14 of the Formulary and Prescribing Guidelines in October 2020. Anaesthetic drugs used in ECT have moved out of the top ten with a £13k reduction in expenditure between 2019/20 and 2020/21. This reduction reflects the scaling back of ECT services from three to one centres during the COVID-19 pandemic with the cessation of all but emergency ECT procedures due to the fact that ECT is a potential aerosol generating procedure (AGP).

Amongst these top 10 sections, drugs used for psychosis and related disorders accounted for the greatest proportion at 72.5% of spend (an increase of nearly 5%), and drugs used in the treatment of substance dependence were the next most significant area accounting for 14.3% of spend; both very similar to 2019/20 and 2018/19. The price of buprenorphine (a key treatment used by substance misuse services) increased ten-fold in 2018/19; although the price has reduced from its peak, at the end of 2020/21 it was still over six times the March 2018 price.[13]

**Table 18: Cost comparison of buprenorphine 2018-2021**

| *Source:* Drug Tariff, NHS BSA | Buprenorphine 8mg s/l tablets x 7 |
|---|---|
| March 2018 | £1.81 |
| March 2019 | £18.14 |
| March 2020 | £16.91 |
| March 2021 | £12.11 |

Expenditure on the 'Top 25' medicines accounted for 90.0% of total spend in 2020/21, an increase on the previous year (87.3%). Atypical, (second generation), antipsychotic drugs continued to account for four of the top five drugs by cost. 70.5% of the Trust's overall expenditure was accounted for by the top five drugs, but only 23.0% by volume, an increase on the position in 2019/20 (67.2% cost; 19.6% volume). It is likely that the pandemic lead to increased use of long-acting antipsychotic injections as an alternative to oral therapy in patients who it was not possible to review as regularly.

The single largest elements of expenditure was the atypical antipsychotic risperidone (3), and its metabolite paliperidone (1), on which £1.64m was spent in 2020/21 compared with £1.44m during the previous year. These two drugs together account for more than 41% of expenditure, but just 6.3% of transactions. The atypical antipsychotic aripiprazole accounts for the second highest spend; it is prescribed orally and additionally by long-acting intramuscular injection for the maintenance of patients already stabilised on oral aripiprazole. In 2019/20 it was the third most commonly prescribed treatment, and expenditure has increased by nearly £78,000 in the intervening 12 months.

Within the top 25 drugs there were a number of risers, fallers and new entries (see Table 19).

[13] Drug Tariff price paid for items dispensed by community pharmacies when prescribed on a FP10 prescription form.

**Table 19: Top 25 Drugs (by expenditure)**

| Rank | | Drug | BNF Description | 2020/21 Expenditure | 2019/20 Expenditure | Variance |
|---|---|---|---|---|---|---|
| 1 | ⇔ | Paliperidone | Antipsychotic drugs (atypical) | £1,036,461 | £795,128 | 30.4% |
| 2 | ⇧ | Aripiprazole | Antipsychotic drugs (atypical) | £605,169 | £527,305 | 14.8% |
| 3 | ⇩ | Risperidone | Antipsychotic drugs (atypical) | £600,069 | £651,599 | -7.9% |
| 4 | ⇔ | Clozapine | Antipsychotic drugs (atypical) | £327,782 | £338,662 | -3.2% |
| 5 | ⇔ | Buprenorphine | Drugs used in substance dependence | £283,159 | £334,517 | -15.4% |
| 6 | ⇔ | Methadone | Drugs used in substance dependence | £182,244 | £151,974 | 19.9% |
| 7 | ⇔ | Olanzapine | Antipsychotic drugs (atypical) | £108,963 | £120,144 | -9.3% |
| 8 | ⇧ | Nicotine | Drugs used in substance dependence | £104,017 | £68,214 | 52.5% |
| 9 | ⇩ | Zuclopenthixol | Antipsychotic drugs (typical) | £75,073 | £72,079 | 4.2% |
| 10 | ⇩ | Flupentixol | Antipsychotic drugs (typical) | £57,969 | £69,068 | -16.1% |
| 11 | ⇔ | Quetiapine | Antipsychotic drugs (atypical) | £32,690 | £43,079 | -24.1% |
| 12 | ⇧ | Haloperidol | Antipsychotic drugs (typical) | £27,777 | £19,680 | 41.1% |
| 13 | ⇧ | Memantine | Drugs for dementia | £24,267 | £21,950 | 10.6% |
| 14 | ⇩ | Valproic acid | Antimanic drugs | £22,804 | £33,877 | -32.7% |
| 15 | ⇔ | Rivastigmine | Drugs for dementia | £21,025 | £22,729 | -7.5% |
| 16 | ⇩ | Galantamine | Drugs for dementia | £20,108 | £43,756 | -54.0% |
| 17 | ⇧ | Clonazepam | Hypnotics and anxiolytics | £17,306 | £16,591 | 4.3% |
| 18 | ⇧ | Buprenorphine | Analgesic | £14,319 | £18,476 | -22.5% |
| 19 | ⇧ | Promethazine | Hypnotics and anxiolytics | £13,813 | £14,801 | -6.7% |
| 20 | ⇩ | Pirenzepine | Antisecretory drugs | £12,855 | £15,782 | -18.5% |
| 21 | ⇧ | Sertraline | Antidepressant drugs | £12,154 | £9,801 | 24.0% |
| 22 | ⇔ | Melatonin | Hypnotics and anxiolytics | £11,007 | £10,899 | 1.0% |
| 23 | ⇩ | Naloxone | Drugs used in substance dependence | £10,889 | £23,382 | -53.4% |
| 24 | new | Lorazepam | Hypnotics and anxiolytics | £9,246 | £4,982 | 85.6% |
| 25 | new | Apixaban | Oral Anticoagulants | £8,729 | £9,713 | -10.1% |
| | | | | £3,639,897 | £3,438,189 | 5.9% |

Buprenorphine features in the Top 25 on twice; for both substance dependence (whether alone or in combination with naloxone), and as an analgesic in a much smaller quantity. The reduction in prescribing of buprenorphine for substance dependence has to a degree been compensated for by an increase in the prescribing of methadone. Nicotine prescribing has also increased over the year, suggesting the drive to stop smoking continues, which may have been linked to the worse outcomes of people who contracted COVID-19 seen with smokers providing a fresh impetus to stop. Aside from the known physical health risks associated with smoking, it increases the risk of developing a mental health condition and a clear relationship has been identified between the amount of tobacco smoked and the number of depressive and anxiety symptoms. Maintaining a smoke-free environment in mental health settings is a recognised current challenge.

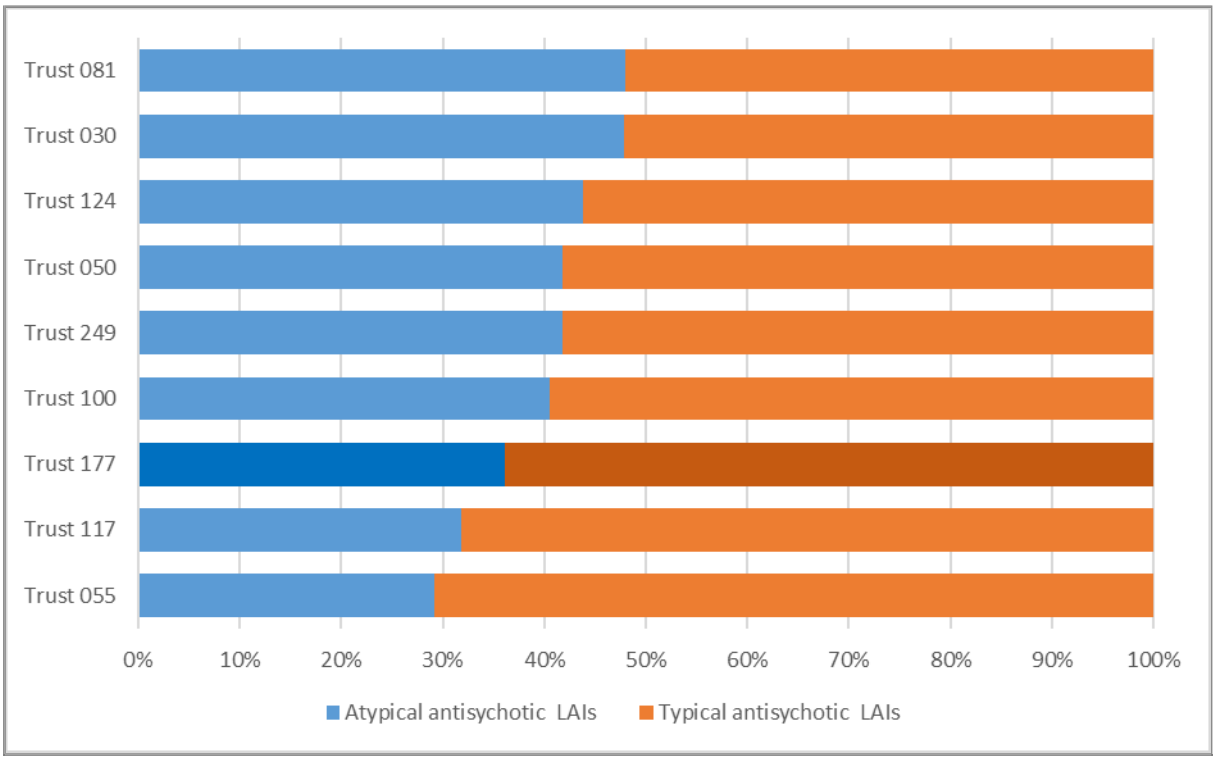
## 5.2 Cost Effective Prescribing

The Trust participates in the benchmarking of prescribing data via the Define® software tool which allows analysis of prescribing practices against those of other (anonymised) trusts. As well as allowing bespoke reports to be run, 32 standard indicators are available. Some areas

of cost effective prescribing are shown below. The prescribing in EPUT (recorded as **Trust 177**) is compared with other mental health trusts in Midlands and East of England[14].

Work has been undertaken in the past, and continues, to encourage the consideration of typical antipsychotic long acting injections (LAIs) before prescribing the more expensive atypical LAIs. Compared to other trusts the proportion of the less expensive typical LAIs (64%) is higher than comparator trusts. The increased use of all LAIs – including atypicals in treatment resistant cases - in general is justified during the pandemic if it prevents relapses, offsets clinical risk to patients and guarantees continuity of supply, and LAIs are also generally being used earlier in the patient pathway than in the past.

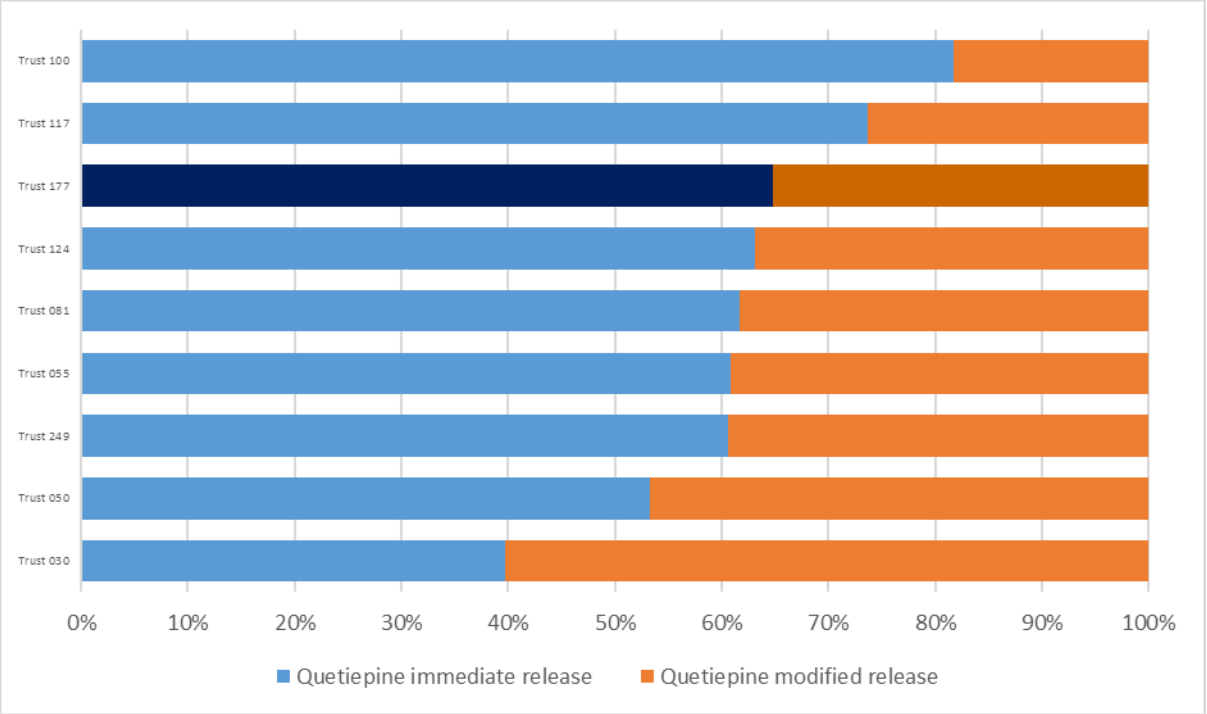
**Figure 10: Prescribing of typical and atypical LAIs (DDDs; April 2020 - March 2021)**




Modified release quetiapine tablets are substantially more expensive than immediate release (IR) tablets with the Drug Tariff[15] price for 300mg IR currently £6.18 per pack and for 300mg XL £170.00 per pack. Wherever possible within the Trust, modified release tablets are reserved for initiation and titration to minimise side effects. Patients are then switched to an immediate release formulation before they are discharged and prescribing continued by the GP. Whilst this has limited savings within the trust, it results in significant cost savings in primary care. 35% of quetiapine doses prescribed within EPUT in 2020/21 were for the more expensive modified release products, an increase on the previous year. This increase reflects efforts to discharge patients from EPUT as quickly and safely as possible, which again is a question of minimising the risk of infection through environmental exposure and ensuring a continuity of supply across the interface.

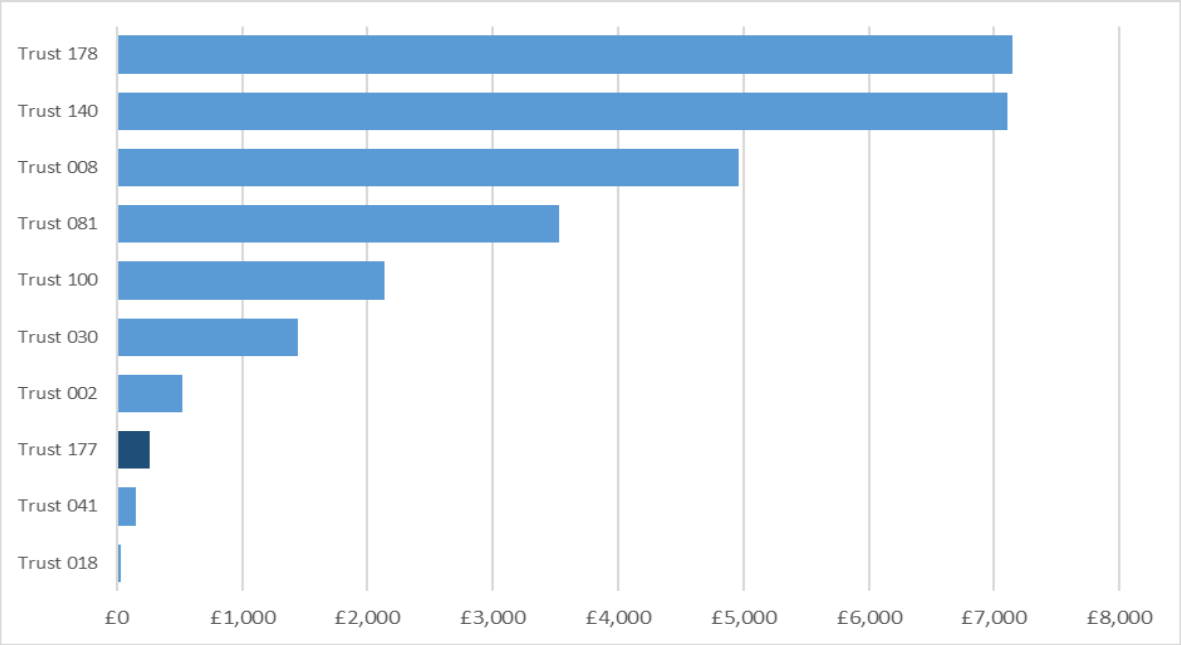
[14] Only trusts with high data quality have been included; where data is missing from one or more sources trusts has been excluded from comparisons.
[15] NHS Electronic Drug Tariff, March 2021

**Figure 11: Prescribing of immediate and modified release quetiapine (DDDs, April 2020 - March 2021)**




The antidepressant agomelatine – available in one strength and pack size only[16] - is not included in the Trust formulary based on a NICE technology appraisal (TA231) which concluded that there is a lack of evidence to support its use. Compared with other trusts EPUT use is very low, usually where a patient is admitted who has previously been prescribed the drug in another organisation. In 2020/21, EPUT spent just £264 on agomelatine, a significant reduction on the previous year.

**Figure 12: Prescribing of agomelatine (Total cost, April 2020 - March 2021)**

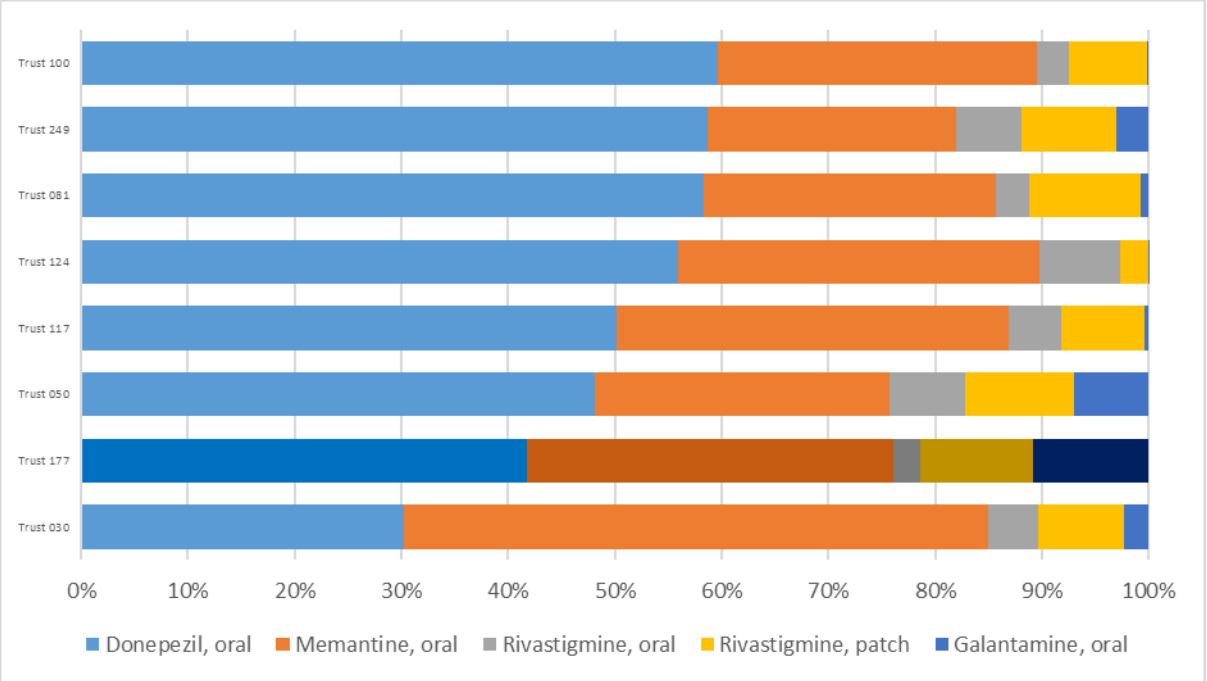



[16] 28 x Agomelatine 25mg tablets cost £30.05. Source: NHS Electronic Drug Tariff, March 2021

Dementia is an umbrella term covering over 200 subtypes of pathology, plus presentations of mixed origin. Dementia presents an ongoing global challenge and although not exclusive to, tends to be more prevalent in aging populations. The aim of treatment in dementia is to promote independence, maintain function, and manage additional symptoms such as agitation. NICE guidance recommends that if prescribing an acetylcholinesterase (AChE) inhibitor for the management of dementia, treatment should normally be started with the drug with the lowest acquisition cost. However, there are no nationally recognised models that offset the cost of drug treatments – which are used for both licensed and unlicensed indications, particularly where there is no single sub-type identified), against the quality of life benefits. The costs to the NHS of even the most expensive AChEi are dwarfed by the other health and social care resources required to meet the needs of this patient cohort and their families.

Donepezil in tablet form has the lowest annual treatment costs, followed by oral memantine and rivastigmine. Rivastigmine patches and oral galantamine are the most expensive products. 76.1% of the doses prescribed within EPUT in 2020/21 are oral donepezil and memantine, a slight improvement on nearly 75% in 2019/2020. More galantamine is used that in most other trusts and this is likely to remain the case whilst it is used as a last-line treatment, as this suggest that other therapeutic options have been explored.

**Figure 13: Prescribing of acetylcholinesterase inhibitors (April 2020 - March 2021)**




Melatonin is a naturally occurring hormone produced by the pineal gland in the brain and involved in coordinating the body's sleep-wake cycle and regulating sleep. Until recently Circadin® (Melatonin 2mg modified release capsules) was the only licensed melatonin product in the UK, licensed for the treatment of older adults, but also widely used in children and adolescents. However, a wide range of other unlicensed, 'special' products and recently additional licensed products are available, but Circadin® remains the recommended product in the Trust formulary and prescribing guidelines. Because EPUT does not provide community CAMHS, 97% of prescribing is for the licensed 2mg modified release product, as shown on Figure 16.

**Figure 14: Prescribing of melatonin formulations (Proportion of DDDs, April 2020 - March 2021)**

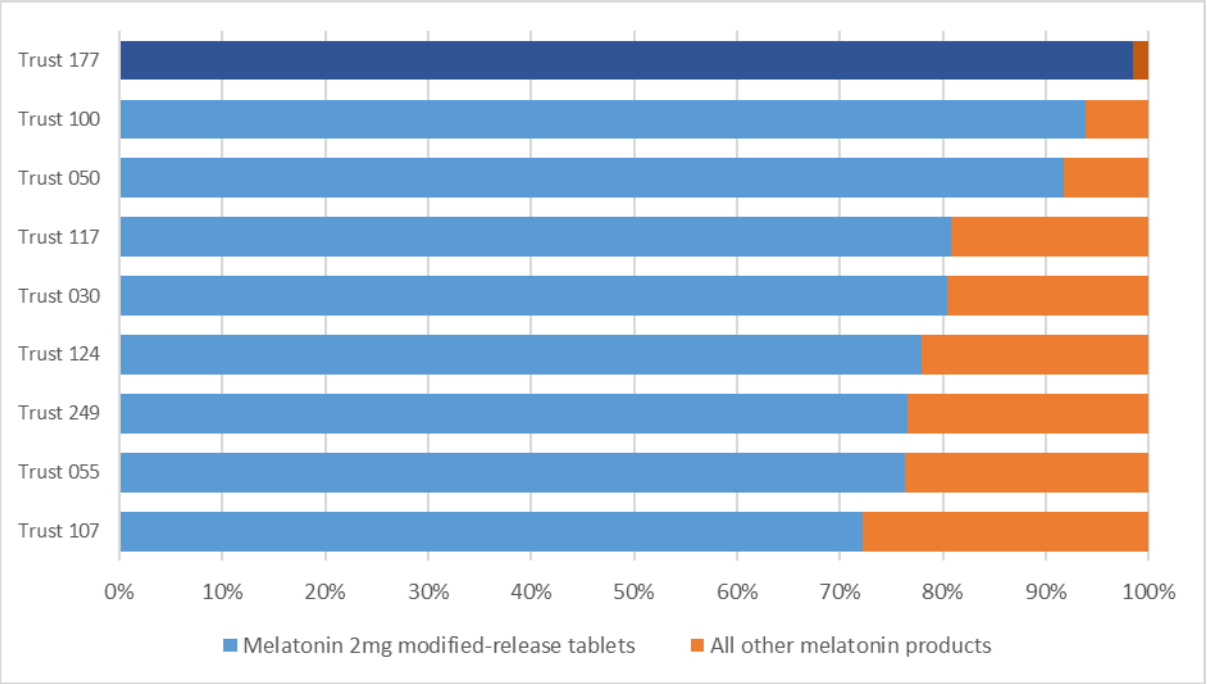
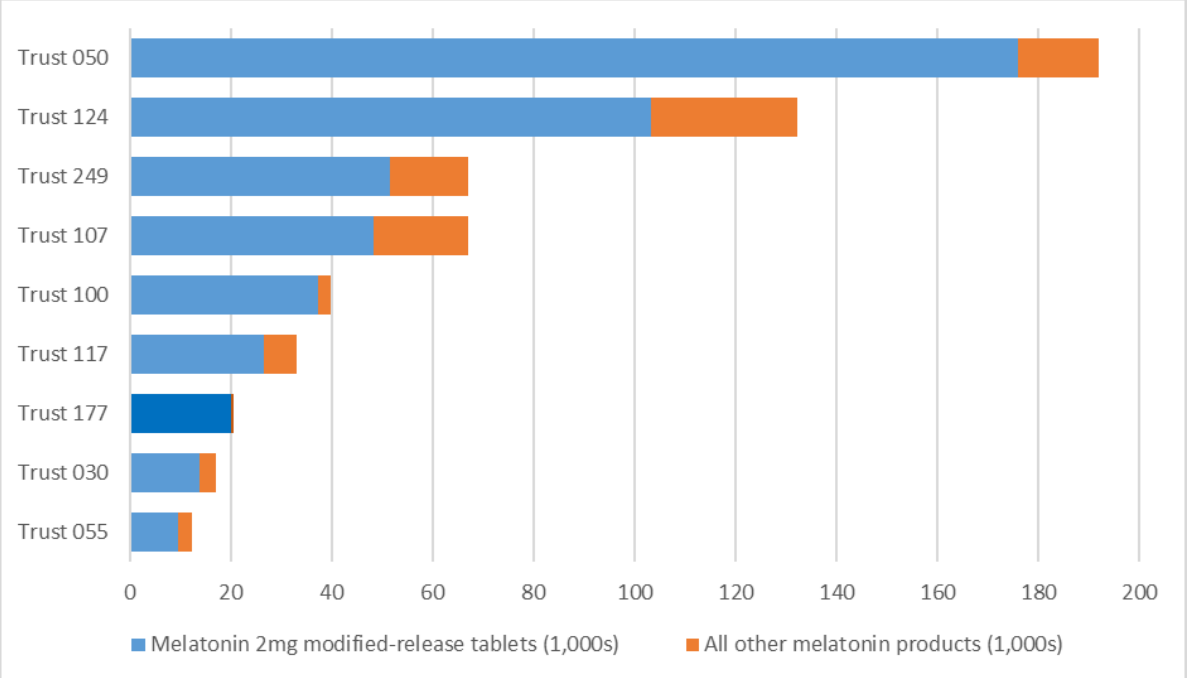



Figure 17 shows that overall prescribing of melatonin in EPUT remains low compared with other trusts, although it should be noted that it has nearly doubled in volume since 2019/20. The pandemic is known to have affected young people particularly hard and this may have contributed to the increase in prescribing. However, it is likely that the full impact has yet to be seen within prescribing figures.

**Figure 15: Prescribing of melatonin formulations (DDDs, April 2020 - March 2021)**



## 6.0 MEDICINES MANAGEMENT TRAINING

### 6.1 Community Health Services

Due to the pandemic the CHS medicines management team provided a mix of virtual and face to face training during 2020/21. Much of the training completed by the team was for staff working in the COVID-19 vaccination centres across Essex and Suffolk.

Specific immunisation training was provided virtually to 88 staff members and included both qualified nurses and healthcare support workers. The team also provided dedicated virtual syringe pump training on the medicines management aspects to 7 members of staff across Essex.

- During the final quarter of 2020/21 approximately **2000 staff** received virtual training in order to work in a COVID-19 vaccination centre. Medicines management training is a core aspect of this training (vaccines are licensed pharmaceutical products).

- Approximately **350 staff** were trained in face-to-face sessions provided on “go live” days at vaccination centres, the nature of which varied according to the grades of staff involved. A senior pharmacist was on site for each go-live to support vaccination teams with the pharmaceutical aspect of the service and ensure that systems ran smoothly from inception, and ongoing training has been delivered by the CHS pharmacy teams when new vaccines were introduced to these centres.

As with any new service, unexpected scenarios emerge and the sheer complexity of the mass vaccination programme and flexibility of the staffing model. The team continues to provide support to staff in vaccination centres and offers advice relating to the frequent changes regarding medicines in this fast moving area of medicine.

### 6.2 Mental Health

The pharmacy and medicines optimisation team provides mandatory training for a number of staff groups in relation to medicines management; in previous years this followed a clear structure that tested the effectiveness of the learning for qualified nursing staff (the initial taught element being face to face, calculations via e-learning follow-up and an observed in practice assessment for inpatient staff). This has been adopted across Essex, creating one Medicines Management training programme for all MH&LD nurses in EPUT across north, south, east and west localities, inpatient and community.

The need for medicines capability was tested as never before in 2020/21: whilst the pandemic heightened the need to deliver medicines treatment in community settings in particular, it also necessitated the rapid establishment of a virtual classroom model via Microsoft Teams. Services had to respond to rapid operational reconfiguration on 2021, and good quality training in medicines was one of the key enabling factors that contributed to this transition without compromising patient safety.

New resources created in 2020/21:

- **Medicines Management Refresher e-learning course:** for new and returning nurses joining the workforce at the start of the pandemic.

- **Emergency Dispensing by Nursing Staff procedure:** intended as a business continuity contingency (in case of pharmacy being unable to deliver a dispensing service).

- **Higher National Diploma in Healthcare Practice:** a completely new training programme on medicines was created for the Trust's trainee Associate Practitioners, as part of EPUT's in-house offer. Once again, MS Teams classrooms enabled the training to be delivered in response to the urgency of service demands.

...as a result of which:

- **100 qualified MH & LD nurses** were trained in Medicines Management over 14 virtual classroom sessions that aimed to replicate face-to-face teaching where possible. Separate classrooms were delivered for community and inpatient MH&LD nurses, covering the same core topics with a further specific focus on aspects of medicines pertinent to that field of nursing, e.g. depot injections such as long-acting olanzapine in community, and controlled drugs in inpatient wards.

- **every CMHT** was able to access the training necessary to allow their nurses to supply medication via Patient Group Direction.

- **100 qualified MH & LD nurses:** were trained in Patient Group Directions, for use by Crisis teams, Home treatment teams, Mental Health Liaison Teams, and other community teams such as Early Intervention in psychosis. This training permits nurses to supply essential medicines to patients at home in a crisis, in the absence of a prescriber, to avert hospital admission. Pharmacy delivered this training entirely on-line via Microsoft Teams, at the peak of the pandemic across 14 community teams (a total of 14 classes), across Southend, Basildon, Chelmsford, Colchester and Harlow. Of note is that every community crisis team was able to access the necessary training, so no patient was left vulnerable to a gap in skills.

The following activities continued:

- **face-to-face clinical pharmacy services:** to inpatient wards and home treatment teams were maintained throughout 2020. This became especially important for the Southend crisis and home treatment team, which was treating home patients throughout the pandemic. When inpatient beds were reduced in numbers, the pharmacy service to the home treatment team was essential to help avoid patient deterioration and to avoid inpatient admission.

- **speciality and core trainee medics** continued to be trained in medicines as part of the induction process.

- **newly qualified and pre-registration pharmacists:** the whole pharmacy team contributed to their education, training and ongoing development as they undertook their foundation years training.

- **trainee pharmacy technicians:** the pharmacy department also continued to take on trainee pharmacists and trainee pharmacy technicians.

- **occasional adhoc medicines management training** continued to be provided to other healthcare professionals and carers, as part of the continuing professional development for those groups, e.g. charities and carers groups.

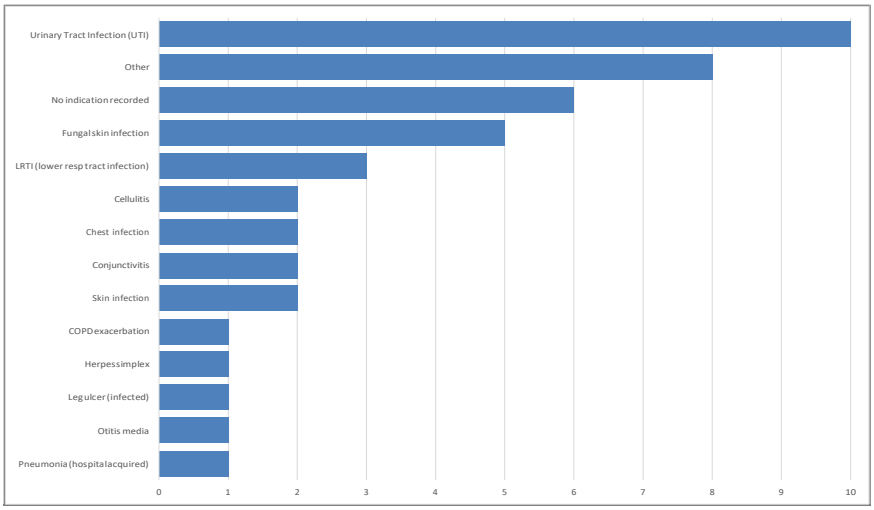
## 7.0 ANTIMICROBIAL STEWARDSHIP

Resistance to antimicrobials is a major global threat to public health[17,18] and has risen alarmingly over the last 40 years. Very few novel antimicrobials have been developed meaning that existing antibiotics are under extreme pressure and inappropriate use of these antibiotics has increased the risk to patients of colonisation with resistant organisms which can subsequently be transmitted to other patients. Antibiotics selected for prescribing should therefore be the narrowest spectrum for the identified condition and broad spectrum antibiotics such as co-amoxiclav, fluoroquinolones and cephalosporins should be avoided unless indicated,[19] choice is dependent on local formularies, which reflect local sensitivity patterns. Public perceptions of antibiotics as means of treating all infections – including minor, self-limiting and viral - are being challenged[20]:

- Being a closed setting, EPUT inpatient clinicians can to a large degree resist patient pressure to prescribe and instead take a systematic approach based on presenting symptoms followed by antimicrobial culture to establish the infection type and causative organism.

- The patient caseload managed by EPUT community health services is becoming increasingly more complex; patients with multiple co-morbidities, at advanced stages of the disease combined with age have a heightened risk of serious morbidity and mortality from infections. In such cases early intervention can lead to much better clinical outcomes for the patient, including avoiding hospital admissions. EPUT CHS clinicians work closely with GPs to ensure that patients stay as well as possible in their home environment, or are referred into the appropriate specialist services where necessary without delay. This ability to work safely, effectively and within clinically appropriate timeframes is in no small part enhanced by the use of SystmOne, which allows real-time access to the patient's primary care record and rapid communication with GP practices.

**Figure 16: 2020/21 antimicrobial stewardship audit results - clinical indications**




[17] Department of Health. UK 5 -year action plan for antimicrobial resistance 2019 to 2024. January 2019. Accessed at: https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024

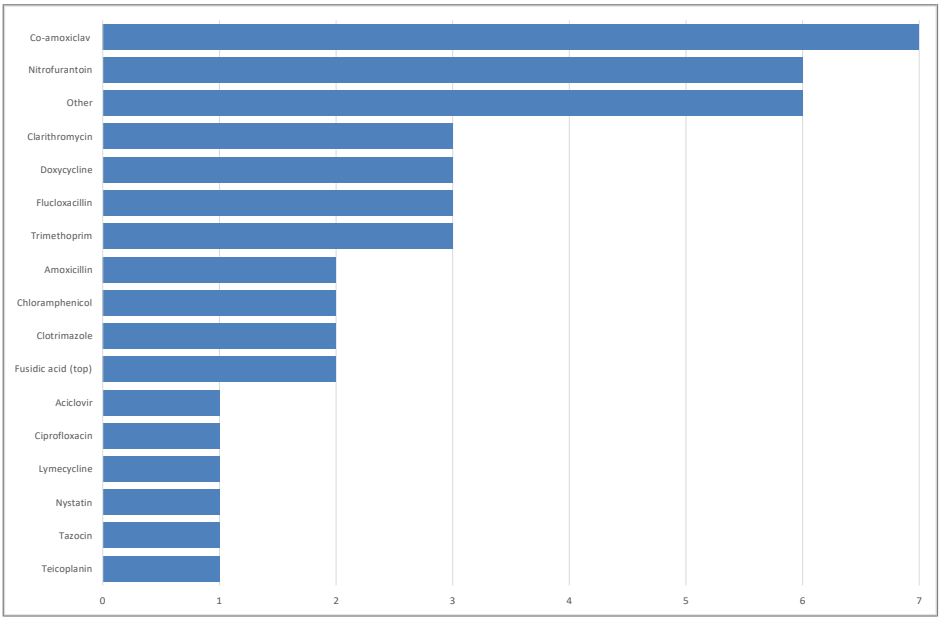
[18] Department of Health. UK 20-year vision for antimicrobial resistance. January 2019. Accessed at: https://www.gov.uk/government/publications/uk-20-year-vision-for-antimicrobial-resistance

[19] Public Health England. Managing Common Infections: Guidance for Primary Care. Updated June 2021. Accessed at: https://www.gov.uk/government/publications/managing-common-infections-guidance-for-primary-care

[20] BBC ONE: The Truth About Antibiotics

Annual audits over the last 5 years have indicated that within our in-patient units, urinary tract infection remains the most common infection. Co-amoxiclav is the most commonly prescribed antibiotic and because it is a broad spectrum antibiotic, it renders patients more susceptible to Healthcare Associated Infections (HCAI's) such as *Clostridium difficile*. The graphs below show results from the 2020 audit.

**Figure 17: 2020/21 antimicrobial stewardship audit results - clinical indications**




The medicines management team provides leadership and support for antimicrobial resistance issues affecting the trust. During 2020/21, this has included:

- Annual audit for inpatient units. Data was collected over a one week period in November 2020 in both mental health and community health services inpatient wards to World Antimicrobial Awareness Week. 52 patients were identified as having received antimicrobials which was an increase from the same period in 2019 (45%). UTIs were the most frequently recorded infection (15) within the wards; just 3 cases had no indication recorded, which suggests that prescribing may have been empirical. Action points were identified and the report was discussed at both medicines management groups as well as quality meetings.
- Specific antimicrobial resistance information sessions provided at all mandatory training days run by the medicines management team for both doctors and nurses.
- Attendance and contribution to the quarterly trust infection prevention and control meeting (antimicrobial lead pharmacist). This meeting was expanded to include a separate dedicated session for antimicrobial resistance.
- Contribution to requests for formulary updates for both mental health and community health services in line with national and local guidance (antimicrobial lead pharmacist)
- Response to ad hoc requests for information pertaining to antimicrobials and antimicrobial resistance.

## 8.0 CONTROLLED DRUGS

Following the publication of the fourth report of the Shipman Inquiry "*The Regulation of Controlled Drugs in the Community" on 15 July 2004*, legislation was put in place for the control of narcotics (such as morphine, methadone and buprenorphine) and other drugs that are liable to abuse, which are collectively known as 'controlled drugs' (CDs). This requires the appointment of a Controlled Drug Accountable Officer (CDAO) with responsibility for all aspects of the safe and secure management of controlled drugs in the organisation. This role is currently fulfilled by the Chief Pharmacist. Responsibilities of the CDAO include:

- Ensuring that safe systems are in place for the management and use of controlled drugs
- Monitoring and auditing these systems: every dose of must be accounted for
- Investigating concerns and incidents related to controlled drugs

### 8.1 Monitoring of safe management and use

Safe systems for the management and use of controlled drugs are set out in the Trust's policy and procedures for the safe and secure handling of medicines (CLPG13, Appendix 3). The handling of controlled drugs within in-patient areas is checked quarterly by members of the pharmacy team, and any issues are raised with the ward manager for resolution.

The pharmacy team works closely with wards where compliance is identified to be poor through either audit or incidents. It is also possible that use of agency nursing staff may be a factor although the Trust policy does not depart from national CD regulations, which registered healthcare professionals are expected to be familiar with. The most common reasons for wards not achieving 100% compliance were largely gaps in record keeping, such as:

- Current list of nursing staff authorised to order CDs being out of date.
- Not signing for the receipt of CDs in the order book.
- Not recording entries in words and figures.
- Headings on new pages in the CD books not meeting legal requirements.
- Crossing out errors in CD records (clear annotation is mandatory rather than any attempt to delete).
- Patient's own CDs being entered in the incorrect section of the register, or not entered at all.
- Insufficiently frequent (weekly) / inaccurate balance checks, leading to avoidable stock discrepancies, particularly for liquid dosage forms.

These are long-standing issues and will be addressed by trust-wide training programme in 2021/22.

**Table 20: Quarterly CD monitoring 2020/21**

KEY: **Compliant: 100%, Partial compliance: 85 – 99%, Poor compliance: < 85%**

| MENTAL HEALTH | Apr – Jun | Jul – Sep | Oct – Dec | Jan - Mar |
|---|---|---|---|---|
| Alpine, Brockfield House | 81% ⇩ | 95% | 100% | 100% |
| Ardleigh, The Lakes | 78% ⇩ | 71% | 90% | 95% |
| Assessment Unit, Basildon MHU | 71% ⇩ | 75% | 88% | 88% |
| Aurora, Brockfield House | 100% ⇔ | 100% | 100% | 100% |
| Beech, Rochford Hospital | 100% ⇧ | 74% | *83%* | 100% |
| Bernard, Clacton Hospital* | CLOSED | CLOSED | CLOSED | CLOSED |

| MENTAL HEALTH | Apr – Jun | Jul – Sep | Oct – Dec | Jan - Mar |
|---|---|---|---|---|
| Byron Court, Billericay | 96% ⇔ | 95% | 86% | 83% |
| Causeway, Brockfield House | 100% ⇔ | 100% | 100% | 93% |
| Cedar, Rochford Hospital | 100% ⇧ | 75% | 88% | 95% |
| Chelmer, Derwent Centre | 87% ⇩ | 68% | 68% | 67% |
| Christopher Unit, Linden Centre | 88% ⇩ | 87% | 83% | 83% |
| Clifton Lodge, Westcliff-on-Sea | 91% ⇧ | 89% | 100% | 90% |
| Dune, Brockfield House | 95% ⇩ | 95% | 100% | 100% |
| ECT Suite, Basildon MHU | 100% ⇔ | 100% | 100% | 100% |
| ECT Suite, Linden Centre | 100% ⇔ | 100% | 95% | **95%** |
| ECT Suite, Colchester | 100% ⇔ | 95% | 83% | 93% |
| Edward House East, Linden Centre | 95% ⇧ | 90% | 90% | 94% |
| Edward House West, Linden Centre | 95% ⇧ | 86% | 90% | 94% |
| Finchingfield, Linden Centre | 90% ⇩ | 77% | 91% | UNAVAILABLE |
| Forest, Brockfield House | 95% ⇩ | 100% | 100% | 100% |
| Fuji, Brockfield House | 100% ⇧ | 95% | 100% | 100% |
| Galleywood, Linden Centre | 91% ⇧ | 77% | *83%* | 74% |
| Gloucester, Basildon MHU | 96% ⇧ | 100% | 92% | 91% |
| Gosfield, The Lakes | 91% ⇧ | 96% | 88% | 73% |
| Grangewater, Basildon MHU | 83% ⇩ | 90% | 96% | 82% |
| Hadleigh, Basildon MHU | 100% ⇧ | 100% | 100% | 89% |
| Henneage, Kings Wood Centre | 91% ⇩ | 78% | 91% | 91% |
| Ipswich Road, Colchester | 100% ⇔ | 100% | 100% | 90% |
| Kelvedon, Basildon | 82% ⇩ | 100% | CLOSED | CLOSED |
| Kitwood, St Margaret's Hospital | 90% ⇔ | 86% | 100% | 100% |
| Lagoon, Brockfield House | 100% ⇔ | 96% | 100% | 100% |
| Larkwood, St Aubyn Centre | 95% ⇩ | 82% | 82% | 71% |
| Longview, St Aubyn Centre | 91% ⇧ | 87% | 64% | 79 % |
| Meadowview, Thurrock Hospital | 92% ⇩ | 77% | **79%** | 91% |
| Peter Bruff, Kingswood Centre | 88% ⇩ | 92% | 88% | 78% |
| Poplar, Rochford Hospital | 100% ⇧ | 67% | 79% | 83% |
| Rainbow Unit, Linden Centre | 100% ⇔ | 84% | 85% | 84% |
| Rawreth Court, Rayleigh | 100% ⇔ | 95% | 95% | 100% |
| Robin Pinto Unit, Luton | UNAVAILABLE | 100% | 90% | 100% |
| Roding, St Margaret's Hospital | 100% ⇔ | 95% | 95% | 90% |
| Ruby, Crystal Centre | 95% ⇩ | 52% | 81% | 87% |
| Stort, Derwent Centre | 71% ⇩ | 70% | 78% | 83% |
| Thorpe, Basildon MHU | 88% ⇩ | 88% | 83% | 74% |
| Topaz, Crystal Centre | CLOSED | CLOSED | CLOSED | CLOSED |
| Tower, Clacton Hospital | 83% ⇩ | 88% | 92% | 100% |
| Willow, Rochford Hospital | CLOSED | CLOSED | 74% | 91% |
| Woodlea, Bedford | 95% ⇩ | 100% | 100% | 91% |

| WEST ESSEX | Apr – Jun | Jul – Sep | Oct – Dec | Jan – Mar |
|---|---|---|---|---|
| Avocet, Saffron Walden Hospital | 75% ⇩ | 71% | 78% | 100% |
| Beech, St Margaret's Hospital, Epping | 90% ⇩ | 91% | 91% | 100% |
| Plane, St Margaret's Hospital, Epping | 92% ⇩ | 96% | 96% | 100% |
| Poplar, St Margaret's Hospital, Epping | 86% ⇩ | 100% | 96% | 100% |
| Cumberledge IC Centre, Southend | CLOSED | CLOSED | 92% | 92% |
| Mountnessing Court, Billericay | CLOSED | CLOSED | CLOSED | CLOSED |

## 8.2 Mandatory occurrence reports

*The Controlled Drug (Supervision of Management and Use) Regulations 2013* were published to ensure good governance concerning the safe management and use of Controlled Drugs in England and Scotland. One of the requirement of the regulations is that the Controlled Drug Accountable Officer of a designated body provides a quarterly occurrence report to the local NHS England CDAO. This report provides details of any concerns relating to the management or use of controlled drugs, based on the quarterly controlled drug checks and any incidents involving CDs which have been reported via DATIX. A summary of the quarterly CD checks and a copy of the occurrence report are presented to both MMGs for discussion.

Trusts are required to participate in their Controlled Drug Local Intelligence Networks (CDLINs). EPUT moved from an Essex CDLIN to one covering Hertfordshire, West Essex, Mid and South Essex in 2019. Two virtual CD LIN meetings were convened in 2020/21, both of which were attended by the EPUT CDAO.

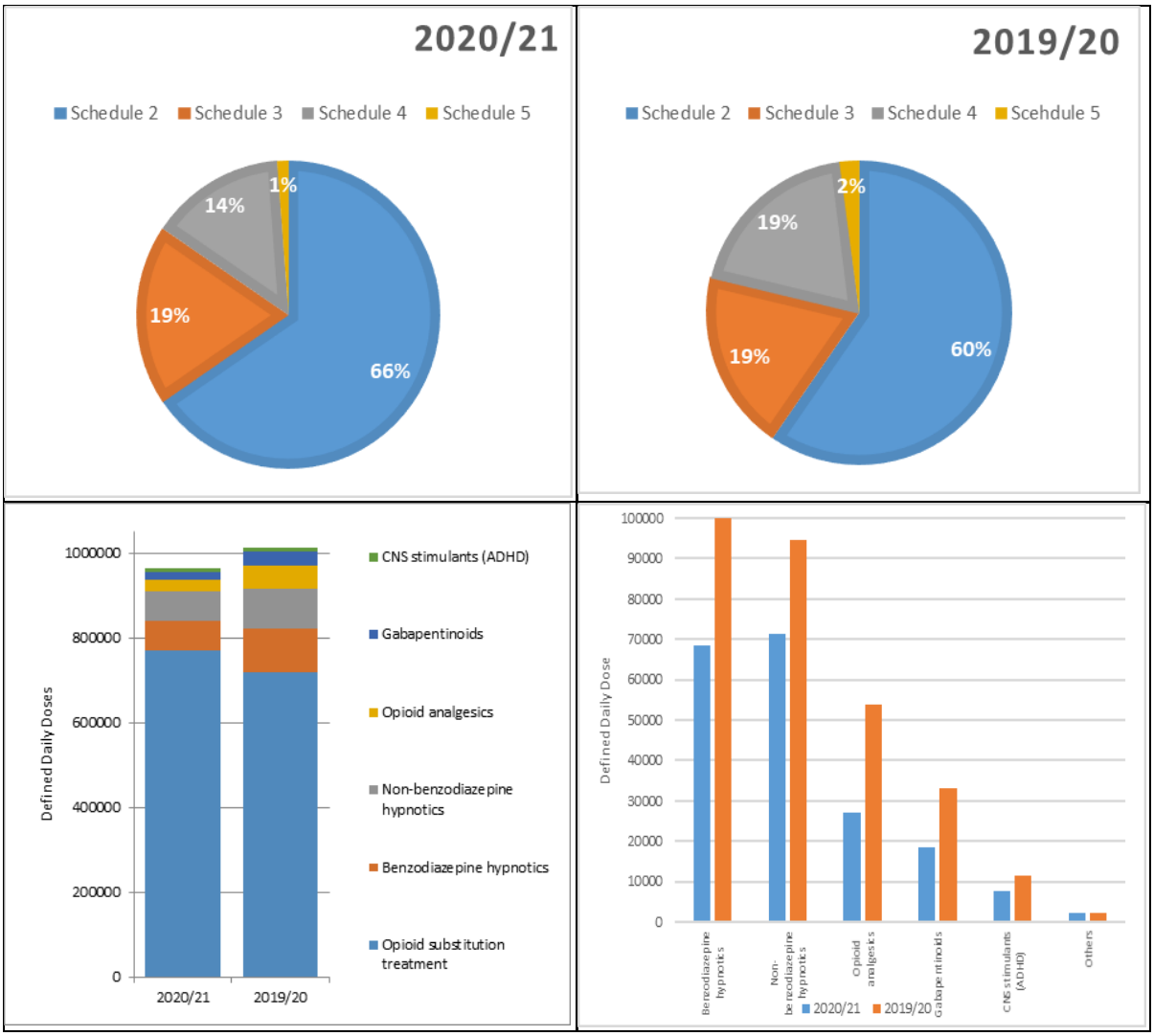
**Table 21: Summary of occurrences, incidents and concerns relating to CDs reported to the CDLIN in the quarterly occurrence reports**

| Category / Type of incident | | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | 2020/21 Totals |
|---|---|---|---|---|---|---|
| **Patient Safety Incidents** | Prescribing | 1 | 4 | 3 | 4 | **12** |
| | Dispensing | 1 | 6 | 3 | 7 | **17** |
| | Administration | 7 | 5 | 9 | 6 | **27** |
| | Other | 0 | 1 | 4 | 5 | **10** |
| **Unaccounted for losses** such as theft and fraud (from the organisation), unexplained stock discrepancies, lost prescriptions / requisitions | | 8 | 9 | 7 | 6 | **30** |
| **Accounted for losses** such as spillages, breakages | | 10 | 3 | 1 | 5 | **19** |
| **Patient / public** such as fraud and theft (by patients / public), misrepresentation by patients | | 1 | 2 | 9 | 7 | **19** |
| **Professional individuals of concern** These are relevant individuals i.e. people who work in health or social care | | 0 | 0 | 0 | 0 | **0** |
| **Governance issues** such as CD safe custody, staff competence, audit, statutory requirements, SOPs | | 24 | 50 | 33 | 33 | **140** |
| **Record keeping** | | 50 | 218 | 167 | 177 | **612** |
| **Total** | | 102 | 298 | 236 | 250 | **886** |

Most reported occurrences are those identified during the quarterly CD checks where each departure from the CD regulations within inpatient wards is counted under the categories of governance, or record keeping. Every dose of a controlled drug must be accounted for and in the absence of regular stock level balance checks it is difficult to trace lost doses. Complying with the trust procedures in place and notifying the pharmacy team as soon as a discrepancy is noted means that irregularities (such as spillages and overages) can be accounted for.

CD incidents tend to occur in either the delivery of palliative care services (injectable CDs are often required continuously to keep end of life patients comfortable), or substance misuse services. Controlled drugs used in palliative care in the patient's own home are the legal property of the individual they have been prescribed for, and it is their responsibility to ensure that storage is in safe custody. The 19 incidents attributable to the Patient / public category are inherently more probable in the "home" environment and misappropriation of opiates is an ongoing public health concern. Clients of substance misuse services are particularly prone to losing prescriptions for methadone or buprenorphine, or the medicines themselves.

**Figure 18: Use of controlled drugs by volume (DDDs)**



## 8.3 Controlled drug utilisation

Controlled Drug activity at EPUT is largely composed of Schedule 2 prescribing where full controls (the highest controls outside special Home Office licensing) apply, followed by Schedule 3 which are subject to prescription writing requirements but not necessarily safe custody or the need to maintain registers. Schedule 4 CDs are subject to minimal controls, i.e. no specified prescription writing requirements, custodial arrangements and register are required, although the abuse potential is recognised. Schedule 5 CDS are exempt from virtually all Controlled Drug requirements (other than retention of invoices for two years), and can be obtained over the counter.

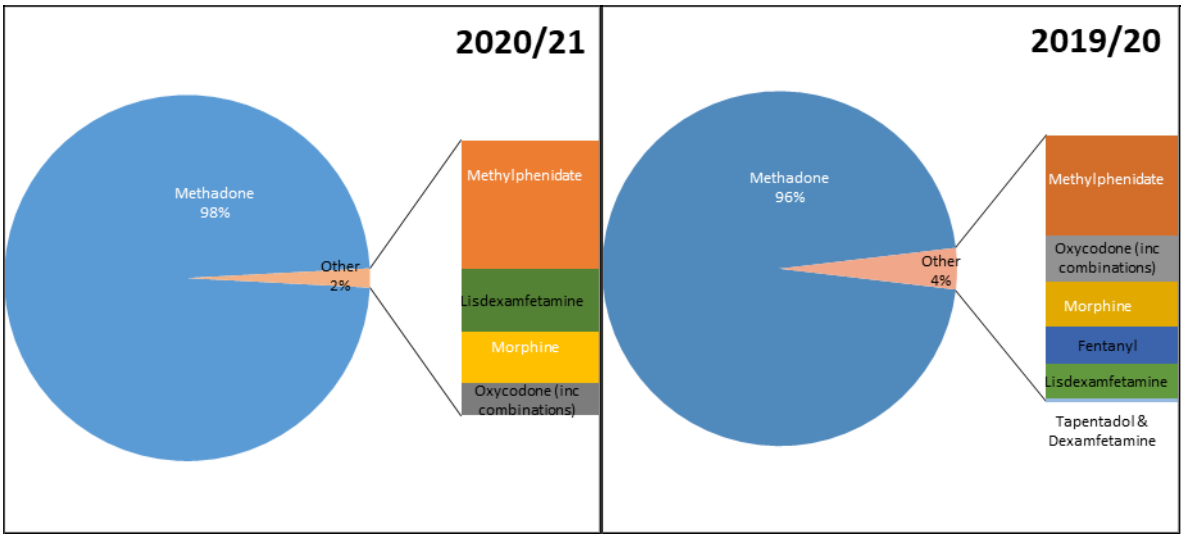
Controlled drugs are most commonly used within substance misuse services where opiate substitution treatment (OST) accounts for 79.8% of the Trust's use by volume, growth of 6.8% points since 2019/20. Benzodiazepines and other hypnotics ('z-drugs') accounted for approximately 14.5% of CD usage, followed by opioids and gabapentinoids (reclassified as Schedule 3 at the beginning of 2019/20) at 2.8% and 1.9% respectively. With the exception of steroids and phenobarbitone, which saw growth from a very low baseline, the use of other CDs decreased significantly.

EPUT inpatient services were reconfigured during COVID-19 pandemic, with less inpatient mental health beds open; the Cumberledge Intermediate Care Centre (CICC), which provides step down care to acute patients was closed for infection control purposes, and Mountnessing Court - housing elderly and vulnerable patients, moved to Brentwood Community Hospital. The CHS beds decanted were repurposed for acute overflow during a time of national emergency.

## 8.4 Schedule 2 controlled drugs

Drugs in schedule 2 include the opioid analgesics and drugs used to treat addiction. They are subject to full controlled drug requirements relating to prescriptions, safe custody (except secobarbital), and the need to keep pharmacy registers and ward CD record books. Schedule 2 drugs accounted for 65.5% of the CDs used by volume in 2020/21, an increase of nearly 6% compared to 2019/21.

**Figure 19: Use of schedule 2 controlled drugs by volume (DDDs)**



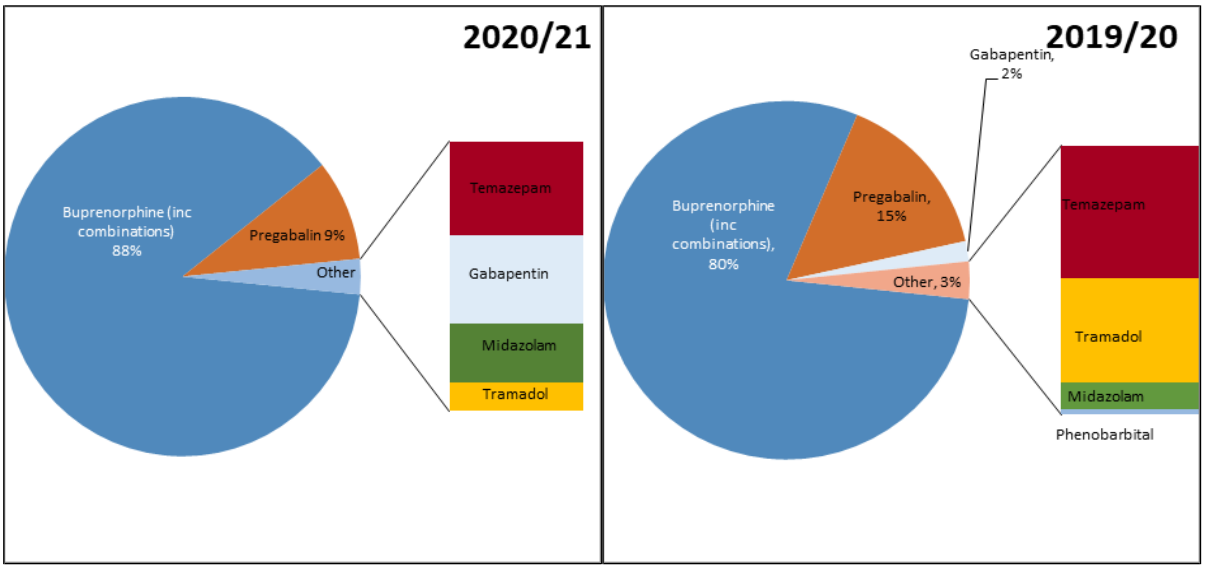

The drug prescribed in the greatest quantity was once again methadone in the treatment of substance misuse; at 98.2% of the whole schedule this dominated Schedule 2 activity. Methylphenidate for the treatment of ADHD followed at 0.8% and then lisdexamphetamine (a pro-drug of dexamphetamine, again used for ADHD but considered to have less abuse

potential) at 0.4% respectively, nearly 20 times the supply of dexamphetamine itself (0.2%). This is consistent with the recommendations made by NICE CKS and the EPUT treatment guidelines. Morphine, oxycodone and fentanyl - prescribed in older people's and palliative care services for pain control, were the next most commonly prescribed Schedule 2 drugs at 0.31%, 0.20% and 0.8% of Schedule 2 usage respectively. Methadone accounted for 64.31% of overall CD prescribing by volume, an increase of nearly 7% points from 2019/20.

## 8.5 Schedule 3 controlled drugs

Schedule 3 controlled drugs include most of the barbiturates, buprenorphine, midazolam, tramadol, temazepam and the z-drugs. They are subject to special prescription requirements (which were removed for temazepam in 2015) but not to the safe custody requirements (except for buprenorphine, diethylpropion, tramadol and temazepam) of schedule 2 CDs.

**Figure 20: Use of schedule 3 controlled drugs by volume (DDDs)**




The schedule 3 CD prescribed in the greatest quantity was buprenorphine at 87.2%, an increase in proportion of over 8% points compared with 2019/20 accounted for by an additional 6,900 doses prescribed. In 2020/21, 85.2% of buprenorphine doses were issued for the treatment of opioid addiction either alone, or in combination with naloxone (suitable where diversion is a risk), with the remaining 24.8% used for the management of severe pain. Buprenorphine accounted for 16.6% of overall CDs (an increase of 1.6% over 2019/20). This was followed by pregabalin and gabapentin accounting for 1.92% of Schedule 3 CDs prescribed, legitimately prescribed for neuropathic pain, epilepsy and anxiety. Much like opioids, increased gabapentinoid prescribing has implications for patient safety, misuse and diversion and have a known association with drug related deaths; the combination with alcohol is potentially fatal. (Pregabalin arguably presents a greater risk because it is absorbed faster post-ingestion). Gabapentin and pregabalin became schedule 3 CDs in April 2019 in recognition of the compound risk to the public, much as tramadol did in June 2014. These now need to be requisitioned and prescribed in the same way as CDs; safe custody requirements do not apply which may contribute to a lack of recognition by non-prescribing staff of the revised classification.

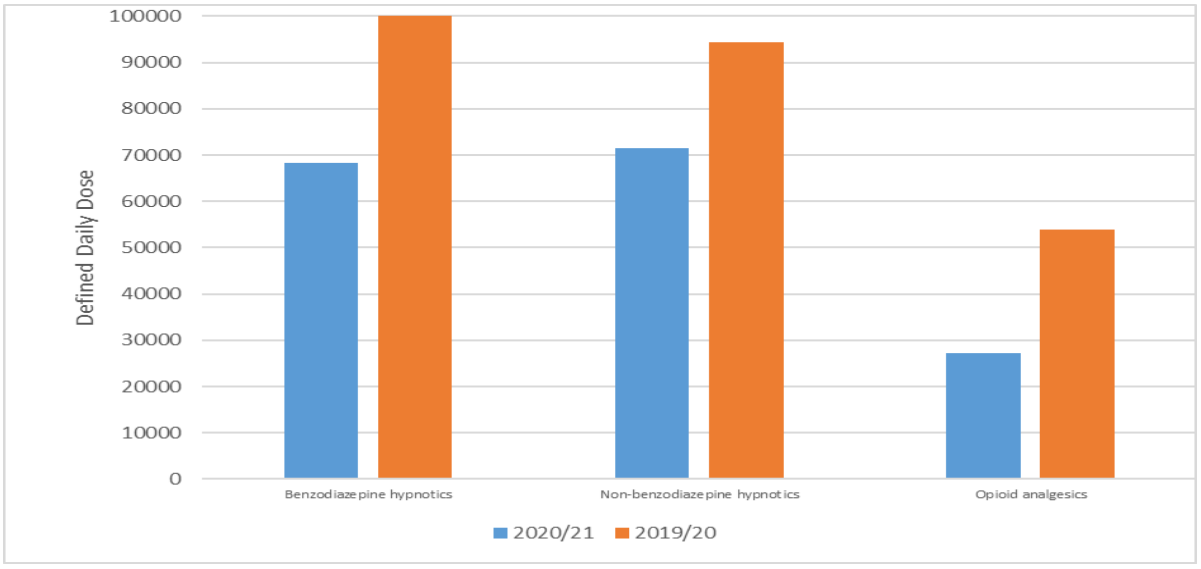
## 8.6 Schedule 4 and 5 controlled drugs

Schedule 4 controlled drugs include benzodiazepines and the non-benzodiazepine hypnotics, zopiclone and zolpidem (Part 1). Caution is advised when prescribing these, indications are largely limited to epilepsy (neurologist-initiated), anxiety or insomnia that is severe, disabling, or causing the patient extreme distress and short-term prescribing is

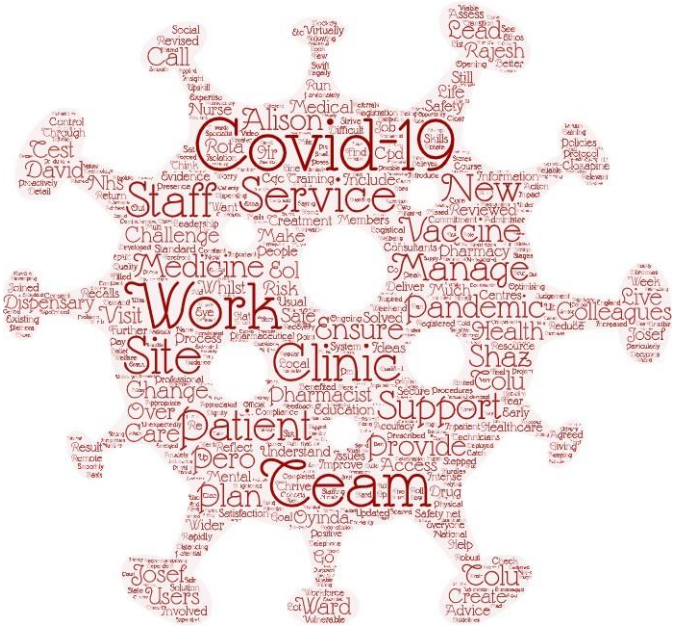
recommended in order to reduce the risk of dependence. Although benzodiazepines can be appropriately prescribed for agitation in a mental health setting, they can cause a paradoxical increase in aggression and ward staff will be aware of this risk. Conversely, abrupt withdrawal after established use can have clinical consequences and so this needs to be managed carefully by a specialist service. Certain steroids and hormones liable to abuse, such as anabolic steroids and growth hormone – used to increase muscle mass and enhance performance in competetive sport, for example - also fall under this classification (Part 2). Schedule 4 CDs formed 14.4% of the total doses of CDs prescribed in 2020/21, a nearly 5% reduction from 2019/20.

Schedule 5 CDs include low strength opiates such as codeine and dihydrocodeine. Although potentially liable to misuse and dependence they are subject to minimal controls, and are available over the counter at pharmacies in low doses in combination with paracetamol. This combination serves to reduce the abuse potential as the maximum dose of paracetamol is just 4g daily before serious harm may occur, a warning that is evident on every pack. The over-the-counter supply of paracetamol itself is limited to just 32 tablets (a 4 day supply) in order to reduce the potential of harmful overdose. In common with the gabapentinoids and tramadol, there is evidence to suggest that the CD status of codeine, dihydrocodeine and pholcodeine – particularly when prescribed as seemingly innocuous cough syrups - is not universally recognised at cinician level. Just 1.2% of the number of prescribed doses of CDs fell within Schedule 5.

**Figure 21: Use of schedule 4 and 5 controlled drugs by volume (DDDs)**



## 9.0 THE PANDEMIC YEAR AS TOLD BY THE PHARMACY SENIOR MANAGEMENT TEAM




***Virus***[21][ **vahy**-ruhs ]*: an ultramicroscopic (20 to 300 nanometers in diameter), metabolically inert, infectious agent that replicates only within the cells of living hosts, mainly bacteria, plants, and animals: composed of an RNA or DNA core, a protein coat, and, in more complex types, a surrounding envelope.*

2020/21 was the year that COVID-19, the unfathomably tiny but insidious bag of RNA with the sole mission to self-replicate brought much of the world to a standstill and the remainder scrambling to survive; the more complex the system, the higher the disruptive impact appeared. Pharmacy is one such system which appears deceptively simple when it runs well; its complexity quickly becomes apparent when it the system of inter-dependent services needed to be reproduced within a pandemic setting. Thus the EPUT Pharmacy Senior Management Team (SMT) found rapid adaptation to the new landscape necessary as it considered what to start, stop and continue during a time of huge uncertainty. Services were reconfigured rather than stopped, and a close eye kept on developments as science cast further light on the nature of the virus and how to identify and mitigate against its associated risks.

Pharmacy teams are used to fighting multiple fires and frequently manage the impact of risks generated within distant parts of the system, and the stoic nature of the pharmacy team meant that they took the work in their stride to review working practice in the new world. By applying a systematic approach based on expert guidance and collaboration with other pharmacy and clinical teams within the healthcare system, they were able to find solutions for the key practical questions identified:

- **Acute disturbances:** How do we manage patients with acute disturbances or delirium during this pandemic?
- **Clozapine:** How do we ensure service provision for the 600 patients across Essex on clozapine that require weekly clinical assessment? How can this accommodate patients that test COVID positive without compromising the strict but necessary safety criteria?
- **Stabilised treatment-resistant psychosis**: How do we ensure that high risk-patients such as those on antipsychotic depots receive continuity of treatments should the supply chain be disrupted?

[21] Definition source:dictionary.com

- **End of Life Care:** How do we maintain a high quality of palliative care treatment without inadvertently exposing these patients to COVID-19? How do we guide a less experienced temporary workforce in this area to provide consistent care and recognise the clinical thresholds for seeking our advice? How do we manage the high risk end of life patients who themselves contract COVID but do not meet the threshold for hospital admission, within their own homes? How do we differentiate the emerging symptoms of COVID from end-of-life deterioration, or that the standard treatments used do not contribute to the worsening of COVID presentation, such as respiratory distress?
- **Lithium:** how do we manage the increased risk of toxicity in patients affected by COVID? How do we distinguish therapeutic deterioration from an atypical presentation of COVID?
- **Patient's own Drugs (PODs) in the inpatient setting**: sight of these medications mean that unintended medication errors during hospital stays are often averted, yet present an enhanced infection risk. How do we balance the competing risks in favour of safe and effective care?
- **Medicines rationalisation**: each contact increases the risk of transmitting COVID between patients and ward staff. Can we adjust medication regimens to protect both by limiting the frequency of dosing?
- **Venous Thromboembolism (VTE):** the reduced mobility necessitated by infection control measures heightens the risk of VTE, as does COVID itself. Patients being stepped down from acute services into EPUT wards are at particular risk. How do we proactively manage this enhanced risk through the use of daily medication including injectables?
- **Prescription logistics:** How can remote consultations provide pharmacotherapy? Unlike primary care where the electronic transfer of prescriptions is standard practice, we don't yet have an electronic system of prescribing so we are reliant on an analogue methods which means transferring paper prescriptions and tolerating a delay or the risk that it never reaches the patient. How do we unite the patient with their medication in a timely manner?
- **Acute Kidney Injury:** risks late detection and worse outcomes when contact with patients is reduced. National guidance was produced in response to this universal risk.
- **Pharmacy workforce decimation in the event of catastrophe:** if the unthinkable happens and our whole team of skilled staff is taken out by the pandemic, how do we ensure that patients still receive their medication in a safe and structured matter from staff that have limited experience of dispensing? A supreme act of selflessness that was thankfully never triggered but remains available in the event of a crisis.

The clinical priority as ever was safety, and in spite the practical constraints of infection control measures a suite of clinical advice in response to these questions was developed very quickly, and distributed to clinicians to support changes in practice. Makhan Chohan, Deputy Chief Pharmacist played a pivotal leadership role in co-ordinating the pharmacy SMT to maintain operational provision to mental health and learning disability services during this time. The full list of protocols produced can be found on the COVID-19 pages of the Trust Intranet.

What follows details the professional experiences of key members of our SMT during the pandemic.

## 9.1 Community Health Services

**Alison Dossetter**

***"I work with brilliant staff who go above and beyond every day"***

**Current Role:** Lead Pharmacist, West Essex Community Health Services (from June 2016)

**Previous Role and Organisation:** Alison trained in the acute sector in 1993; after 10 years she then moved to primary care commissioning, where she remained until 2016.

Alison joined EPUT via SEPT in 2016 in need of a challenge, and she found her current role provides exactly that. The transition from a team of commissioning pharmacists to a single pharmacist in a provider role was just the first; since then every year has thrown up new demands and Alison has drawn on her considerable experience to meet them head-on, taking pride in getting things done.

For example, community nurses attend to an increasing number of palliative care patients as there is a shift away from acute and hospice settings for End of Life (EoL) care with a preference to care in the patient's own home. Learning to use syringe pumps – a technology that is key to keeping seriously unwell patients comfortable - can be a daunting and steep learning curve, particularly for newly-qualified Band 5 nurses. Thankfully Alison is very experienced with the medicines management aspects of syringe pumps and is on hand to talk colleagues through setting them up, working closely with Tracy Reed (Clinical Lead for End of Life care), and offers ongoing guidance beyond the initial training she gives. It takes repeated practice to become comfortable using such devices, which are often used to deliver high risk drugs; ultimately good quality patient care and safety must be the priority and Alison is there to help ensure that this happens. Alongside the End of Life champions across WECHS, there is always someone who can hold a colleague's hand through the process.

Alison loves the variety of her role which also requires maintaining a range of different policies, procedures and guideline to support non-prescribing colleagues. She is the go-to pharmaceutical source for the multi-disciplinary teams of community nurses, heart failure, diabetes and respiratory specialists, physiotherapists, podiatrists, immunisation and sexual health services amongst others. She is ready for anyone that walks through her open door with a question; no two days are the same! Alison is also the antimicrobial stewardship pharmacy lead for EPUT and an Antimicrobial Guardian.

**The COVID-19 pandemic:** presented huge logistical issues for a community team that provided face-to-face patient care as GP practices closed their front doors. Many of her community nurse colleagues had to continue with their clinical responsibilities without access to the signed authorisations required to administer medicines. EoL was an area that was particularly dependent on intense clinical support, and a gap in service meant rapid and painful deterioration of vulnerable patients looked unavoidable; Alison proactively worked with the clinical lead for end of life care and the CCG to create robust guidelines that mitigated this risk. This also involved ensuring that the relevant medications were in place on all of the mental health inpatient wards. In the absence of official guidance from NHS England during the early stages of the pandemic, Alison had to take decisions without

precedent; for example, where access to controlled drugs was compromised and she worked with a local GP to create an electronic solution to the hurdles faced. Any travel time Alison herself saved through technology was rapidly filled with new problems to be solved as the work intensified.

The goalposts seem to be ever-shifting during the pandemic as many procedures needed to be thoroughly revised and updated to reflect the changes. This meant understanding the implications of the wider system so its component parts operated consistently. This accelerated further as Alison supported the Chief Pharmacist in setting up the new COVID vaccination centres at the end of November 2020. Site visits to assess the suitability for the storage and handling of vaccines sat alongside and could sometime conflict with other logistical assessments, such as access, health & safety, security etc but Alison's expertise was taken seriously by the site leads. Along with other senior colleagues, she was a presence on the opening day of vaccination centres to ensure that everything ran smoothly.

Her eye for detail was tested in reviewing the plethora of national protocols, Patient Group and Specific Directions and Standard Operating Procedures, which required constant revision as more was understood about the vaccines themselves, and the patient cohorts expanded. Alison believes in keeping the patient impact at the forefront of her work and always goes the extra mile; if serving the patient's best interests is not possible within existing mechanisms, she will find an appropriate legaly compliant solution.

When asked what she likes best about EPUT, Alison responds without hesitation: "Working with brilliant staff who go above and beyond every day".

**Oyepero Olasehinde-Williams *(Pero)***

***"We completed the medicines management aspect of COVID vaccination training virtually for over 2,000 healthcare workers to work in the COVID vaccination sites"***

**Current Role:** Lead Pharmacist, South East Essex Community Health Services (from April 2019)

**Previous Role and Organisation:** Care Homes Pharmacist at South East Essex CCG

**In her own words:** "My current role involves supporting all the Community Health Service teams under EPUT in South East Essex, including the inpatient units. I ensure the services run safely, by achieving all medicines management requirements. The teams also refer complex medicine issues to me as required. I line manage the two pharmacists in SEE CHS, one in the inpatient unit and the other is the Immunisation Pharmacist".

**The COVID-19 pandemic:** presented the following specific challenges for Pero and her team. Reflecting on this time, Pero says: "At the start of the pandemic, the two intermediate care centres moved to Brentwood Community Hospital, and we had to support the medicines management aspect of the move. Mountnessing Court moved unexpectedly over the weekend, and I had to help relocate all their medicines to Chelford Court unexpectedly over the weekend with a one-hour notice".

"When CICC was to return to Rochford joined the project team that planned their return and provided the medicines management support, for example revamping their stock list to match the new service they planned to provide. During that time, we completed the medicines management aspect of COVID vaccination training virtually for over 2,000 healthcare workers (registered and unregistered), who wanted to work in the Covid vaccination sites. This is still ongoing."

Pero also supported the roll out of the 18 COVID vaccination sites by:

- Ensuring all sites were registered with Immform accounts, so they were able to receive COVID vaccines.
- Authoring Patient Specific Directions for the COVID vaccines, and reviewing the National Protocols, Patient Group Directions and Standard Operating Procedures required for sites to administer the vaccines.
- Supporting the staff at five vaccination sites with additional medicines management training on the first day of operation. Some of this involved working outside usual working hours and days including working full days on weekdays, Saturdays and Sundays.
- Supporting three sites receive their first ultra low temperature (ULT) (-70°C) Pfizer delivery
- Supporting three sites with additional medicines management training on their first day of Pfizer vaccine use, providing updates on the preparation processes of the Pfizer vaccines and ensuring the teams where confident in processes.

Of her work with established community teams, Pero had to ensure the teams were still able to run their clinics safely and provide them with required information as needed, for example by supporting the Essex Sexual Health Team transition their working practices to telephone consultations. “I worked with the other providers e.g. PROVIDE to ensure this was done in a safe way and the teams provided with the required information and templates to do so , and we also wrote standards where required”. Recalling how the pandemic affected the breadth of all services within her remit, Pero notes “the school immunisations team also had to make many adjustments during the pandemic and we were involved in ensuring the team were able to vaccinate children safely”.

## 9.2 Mental Health & Learning Disabilities

**Oyindamola Adeniyi *(Oyinda)***

***"When I joined, I immediately fell in love with mental health pharmacy. I like the way of working and the difference effective treatment make in people's lives and that of their families."***

**Current Role:** Senior Clinical Pharmacist, Specialist Services (from June 2019)

**Previous role and Organisation:** Specialist MH Clinical Pharmacist, SEPT and EPUT from 2011

**In her own words:** "I joined SEPT as a specialist MH Clinical Pharmacist 10 years ago, with the responsibility of providing clinical pharmacy services to inpatient units within several different mental health sub-specialties including Secure Services, Child and Adolescent Mental Health Services, Learning Disabilities, Adult and Older adult services. Prior to this I was working in community pharmacy, so this was my first exposure to mental health pharmacy. I immediately fell in love with it, I liked the way of working and the difference effective treatment make in people's lives and that of their families. I also found working with SEPT to be highly rewarding, with good support for professional development. I completed the Post Graduate Certificate and Diploma in Psychiatry Therapeutics, and Independent Non-Medical Prescribing course whilst working as a Specialist MH Clinical Pharmacist."

"I started my current role in June 2019 as Senior Clinical Pharmacist for specialist services. Specialist services includes Secure, CAMHS & perinatal inpatients, LD inpatients and Drug & services. I provide leadership oversight for all these services, attending clinical governance and quality meetings and shaping the provision of clinical pharmacy services to them. I also line manage seven pharmacy staff members – four Clinical Pharmacists and three Medicines Management Technicians. In addition, I'm involved with clinical work and work with my team to ensure all aspects of medicines management are provided to a high standard on the units, including attendance at consultant-led multi-disciplinary team meetings to discuss, review and optimise patients' treatment, providing prescribing advice, clinical monitoring of treatment with high risk medicines, medicines administration advice to nurses, patients and/or carers, patient education, medication counselling for patients when needed."

"Most of my clinical work is within the secure services, which is for individuals who have mental illness and that have come into contact with the criminal justice system in some way or those who require treatment in higher security settings due to their illness and the potential risks they pose to themselves and/or others. Some of our service users have complex mental and physical health needs that may require unconventional treatment plans such as use of anti-libidinal medications, use of two long acting injectable antipsychotics in combination, high dose and combination antipsychotics, or ECT. My team and I ensure that treatment plans are regularly reviewed and optimised and that required physical health monitoring is ongoing as required to ensure patient safety."

"One aspect of my role I really enjoy is seeing the journey to recovery service users go through, some of them can be really unwell on admission, and following assessment and initiation of appropriate treatment can recover with their risks fully managed or mitigated

enough to be discharged into the community safely. I recall a particularly unwell patient who had a diagnosis of treatment resistant schizophrenia and needed to be treated with clozapine but had a high risk of non-compliance with oral medication and refusing to have regular blood tests. Following trials of different antipsychotics the patient was started on a high dose and combination treatment plan involving two depot antipsychotics with good response. This was an unconventional treatment plan and needed to be kept under regular review but it was clearly the most appropriate for this particular patient."

**The COVID-19 pandemic:** "Just before the pandemic, we had developed a medicines education course to be delivered to service users within Brockfield House (secure services) as part of the Recovery College model with the aim of educating them about the role of medicines in their recovery, why they may have side effects and how to manage them, and giving opportunity to address any concerns they may have with their treatment. But we had to put this on hold as social distancing rules meant we could not deliver the course in groups as we had initially planned. Instead, we started to have ad-hoc patient education sessions with individual service users on request and as a result of referrals from consultants and multidisciplinary teams. The sessions are used to help service users understand their treatment better and to introduce new treatment plans, giving an opportunity for them to ask questions, correct misconceptions and improve insight to the role of medicines in their care. We have recently started to make brief records of these sessions as they are gaining popularity amongst service users and requests are increasing, which indicates that they've found it useful. And we've had similar comments from some consultants who have referred service users when they want to propose a change in treatment, for example, starting clozapine, as they have observed better patient engagement and consent to treatment plans following these sessions."

"I really enjoy working with my team members and hope to continue to make a difference in supporting service users to get the most out of their medicines and to ensure patient safety."

**Fatimat Aigbekaen *(Tolu)***

***"We're a creative team, and always find ways of making things work. We're focused on common goals and overcome the obstacles through healthy debate"***

**Current Role:** Senior Clinical Pharmacist, Community Mental Health Services (from January 2018)

**Previous role and Organisation:** Lead Pharmacist (West Essex Locality) NEPT from 2011, serving inpatient and community services, including Essex STaRS.

Tolu leads a small team to deliver pharmaceutical care for community mental health services, including for all things clozapine, and antipsychotic depots. "I have always been passionate about community services so was delighted to step into my current role". With it came new challenges, not least the harmonisation of clozapine services across Essex. Previous experience of leading specialist pharmacy service transition was effective preparation for what was to come…

**The COVID-19 pandemic:** resulted in a completely new way of working. With some clinic staff needing to go into isolation, Tolu and her team had to radically reorganise the way their services were delivered and she worked remotely whilst colleagues remained site-based. Recognising the inherent vulnerability of patients requiring clozapine – classified as a high risk drug - three pharmacists proactively contacted over 100 patients by telephone. "What was intended to be a compliance aid assessment quickly became so much more than that" says Tolu. "It became a general welfare check and we alerted medical and nursing colleagues to the clinical issues that emerged". A sizeable proportion of patients prescribed clozapine need additional support to take their medication in the form of compliance aids, which is more resource-intensive than the usual dispensing process. "Whilst our patient calls reduced a small amount of demand on dispensary services, the patients themselves benefited so much more from this safety net. We went a long way in dispelling some of the worry in a group of patients that already live with a heightened state of anxiety, particularly those living alone", Tolu remembers. "Patients told us how much they appreciated these calls".

Tolu's team provided a safety net of a pharmaceutical support service to colleagues, including staff newly deployed to specialist patient-facing clinical roles. In her own words: "There was a lot of fear of the unknown at first. Patients were scared to physically access services, and colleagues were very aware of the potential risks visiting patients, and everyone was doing their best. We were constantly on call as a reliable resource at the end of the phone for the doctors and nurses that needed support, talking people through the service. Whether it was patients were worried about blood test results or colleagues seeking advice, there was no waiting". The revised services also necessitated a number of clinical policies to be written rapidly; the professional community came into its own and Tolu worked closely with colleagues in the College of Mental Health Pharmacist here.

"I had underestimated the role we played in the community team before the pandemic, but the appreciation from our patients and colleagues made it so worthwhile. I got a lot of satisfaction from working directly with patients and clinicians, it gave me an adrenaline rush". So much so that Tolu worked through her exhaustion from her home base, and didn't recognise her atypical symptoms of COVID until her GP made the connection with recurrent

alternative infections. “I was so focused on patient care and running on adrenaline, I didn’t realise how unwell I was”, she reflects, although there are no regrets. “What matters the most since then is that the community team has got to know each other, we’ve forged better working relationships which have gone from strength to strength. We rely on each other as valued partners”. Tolu notes the pharmacy department shares a resilience: “We’re a creative team, and always find ways of making things work. We’re focused on common goals and overcome the obstacles through healthy debate.”

**Shaheen Allymohamed *(Shaz)***

***"It's my job to look after my team"***

**Current Role:** Dispensary Manager, Chelford Court (from January 2020)

**Previous Role and Organisation:** community, hospital (BHRUT) and most recently Mid Essex CCG.

Shaz is an experienced Pharmacy Technician and manages a busy dispensary team of eight pharmacy technicians and one pharmacy support staff. Her team is also highly experienced, some having been employed within the trust and its predecessor organisations for many years. This commitment brings with it a sound organisational memory and strong relationships with other services built up over time, for example the clozapine clinics. The dispensary team is much more than the sum of its parts, and Shaz was to realise the benefits of the collective from the outset.

**The COVID-19 pandemic:** was declared within six weeks of Shaz joining EPUT. The major practical challenge presented was maintaining a full dispensary service given a reduction in staffing and the social distancing restrictions in place – pharmacy supply services are not amenable to remote working! Shaz recalls "my new team was on my side, engaging with me, understanding my thought processes and respecting my high expectations". Together, the dispensary team came up with a viable plan and extended dispensary opening hours from 7am – 9.30pm, six days a week. This was achievable because her team agreed to a new rota of long working days, and part-time members were similarly flexible in providing additional capacity.

Shaz was also conscious of creating a clear separation between her core team and pharmacists, who normally work in the dispensary on a rota basis, for infection control purposes. Medicines Management Technicians stepped up to take on dispensary roles relating to accuracy checking, avoiding the need for clinical pharmacists to have a physical presence on site as well as on the wards. Testament to the co-operative ethos in the dispensary, these operational changes were agreed and embedded within 2 weeks.

Shaz values her team's skills and can see potential for development, expressing her strong belief in staff retention. Everyone in the team takes a lead on wider aspects of the work that supports the smooth-running of the dispensary – such as education and training, rota management, clozapine dispensing, individual improvement initiatives to name a few - and ensures that these are adapted as the wider system changes. The flexibility of the multi-skilled team offers practical support to colleagues in pharmacy stores (for example in managing the increased demands of vaccination distribution), and there are now monthly CPD sessions to upskill team members towards new clinical challenges. Shaz is introducing structured quality improvement methodology to her team, so individuals are not only encouraged to strive further, but can lead on implementing the ideas they generate. Job satisfaction is important to her and she wants everyone to thrive at work, saying "Its my job to look after my team".

**Josef Gyula Elias *(ph: Yosef)***

***"Providing adequate healthcare that allows people to live a life in dignity is a challenge in most countries. I feel passionately about contributing to this goal"***

**Current Role:** Electronic Prescribing and Medicines Administration – ePMA - Clinical Lead (from September 2020)

**Previous role and Organisation:** 15 years' experience with various NHS organisations in England and Scotland as clinical pharmacist, mostly in Mental Health / Substance Misuse services.

**A game-changer:** Josef's work on the ePMA project is a large-scale programme that will transform the way that clinical services are delivered, by providing a robust digital spine that will actively make medicines interactions safer along every step of the pathway from entry to EPUT services to discharge. ePMA directly supports EPUT's strategic goal of continuously improving service user experiences and outcomes, and most importantly is key to making the clinical environment safer. ePMA is now a standard tool within the acute sector, and was a vital piece of infrastructure that enabled Nightingale Hospitals to operate at short notice in 2020/21.That the EPUT ePMA team was convened during the pandemic (a time of temporary service rationalisation and highly restricted practices) signifies the clinical urgency of this transformation.

In common with any innovative leap in healthcare, the success of ePMA is highly dependent on multi-disciplinary leadership at the highest level working closely with EPUT operational services. The logistical challenges introduced by the pandemic made it impossible to take any conventional approaches to secure widespread stakeholder engagement - such as face to face workshops and networking events - but did not negate the need for active support from clinicians at the front end of the change Josef circumvented this disadvantage by working with individual ward teams and found them to be enthusiastic in embracing digital technology to improve the system

**In his own words:** "We regularly meet with all clinical stakeholders working with medication, including prescribers, nurses and pharmacy staff to better understand their concerns and hopes for the future, incorporating our learning in the roll-out of electronic prescribing". "The introduction of electronic prescribing is designed to improve medicines use processes, including prescribing, ordering and administration of medication. This means making the system safer for the patient, less cumbersome and faster for staff, whilst better utilising precious NHS resources to contribute to patient flow". Current semi-analogue methods means there are multiple inefficiencies in the system; for example, time the ward pharmacy team currently spends tracking down information manually could be better utilised face-to-face with patients, supporting the clinical decision-making process and using their prescribing qualifications to optimise medication.

A big picture thinker, Josef comments "With NHS resources becoming increasingly scarce, continuous reports about new crises the NHS is facing and rising patient expectations, it is paramount to address artificial variation in processes and consider more "lean" approaches that improve utilisation of our staff. This means better flow and availability of information for safe clinical decisions, and less absorption of staff-time in activities that either add no value or can be achieved better with use of contemporary technology, for instance scanning medication charts to send them to the pharmacy to order medication, a task many nursing

staff find cumbersome and time-consuming". Highly analytical, Josef has a gift for translating complex concepts into workable solutions.

**The COVID-19 pandemic:** "I think the pandemic made people/services re-think their approaches to work and created incentives for some positive change, including working from home. Nevertheless, challenges it poses include not being able to visit wards and their staff in person, as much information/understanding is missed by relying on video calls/e-mails". Josef's commitment to healthcare through service improvement is palpable. "Providing adequate healthcare that allows people to live a life in dignity is a challenge in most countries. I feel passionately about contributing to this goal by making NHS resources go further and am inspired by the values of the NHS, i.e. making healthcare accessible to all".

**David Heath**

***"People come to me for answers. It's gratifying when I see that people are using the material I have created, are actively referring to it and offering me feedback as practice evolves"***

**Current Role:** Senior Clinical Pharmacist, Education, Training & Governance

**Previous role and Organisation:** Pharmacist for SEPT, 2002 until EPUT merger. Previously pharmacist at Colchester General 2000-2002.

**In his own words:** David is the pharmacy lead for Education and Training. He line manages four pharmacists in the team based at Basildon Mental Health Unit, in addition to five pre-registration trainees in the wider pharmacy team. "I've worked in EPUT and its previous organisations for nearly 20 years and it has been an interesting journey. I've witnessed the evolution from Foundation Trust to University Trust status, and through the merger, and the evolving efforts of the organisation in improving patient care are noticeable". He's been part of the change effort whilst retaining the wisdom of the ages, and serves as a point of reference for those joining the pharmacy department.

David's reputation extends well beyond the pharmacy team; as a doyen of all things clinical he has trained successive cohorts of clinicians - both new and experienced - over the years in his own inimitable style. Committed to engaging colleagues in learning, David creates a lasting impression and it's not unusual for those who have benefited from his clinical wisdom to recognise and greet him many years later in the most unexpected of places in south Essex.

David can take credit for recent updates of the EPUT formulary and clinical protocols in use. His personality and eye for detail makes him well-suited to his role, and he is skilled in taking complex technical information and translating it into understandable real-world scenarios from first principles. This also extends to his teaching practice: "I often break down difficult concepts into key components, and encourage colleagues to think about the 'why' and the context of the case in point". The evidence base for medicines is fast-moving and whilst it can be challenging keeping up to date with developments, David takes a real pride in doing so. This can be very rewarding: "It's gratifying when I see that people are using the material I have created, are actively referring to it and offering me feedback as practice evolves".

Medicines are heavily regulated by statute and although the legislation may seem remote, this is what ultimately shapes safe practice. David likes getting things right and takes care to do so, noting that "Governance is everything; without it the door to chaos is wide open". David's tenacity helps here: "People come to me for answers. If I don't know, sometimes I have to go back to the original legislation and apply this to the new situation from first principles. Everything is evidence-based and sometimes things do change, although not everyone will be familiar with the changes".

**The COVID-19 pandemic:** forced so many changes to clinical practice and David notes that staff were quite willing to engage with this. In common with medical staff across the country, the pre-registration pharmacists under David's tutelage became provisionally registered as the registration examination was deferred. Whilst the former pre-registration pharmacists stepped up admirably within the temporarily reduced pharmacy workforce, the need for

continued clinical supervision was greater than that of a newly qualified “foundation” pharmacist.

Although an experienced line manager, the pandemic tested him in other ways. “I’m sensitive to other people’s lives and pay particular attention to their personal wellbeing”. David found himself gaining swift new expertise in HR, becoming practiced at managing the difficult personal situations experienced by staff, which presented some clinical and HR dilemmas given the vacuum in advice from central government. David reviewed the existing evidence and applied judgement whilst maintaining absolute discretion. “Guarding individual privacy was essential”.

David already works very closely with clinical colleagues across the whole organisation. He sees inter-disciplinary learning around medicines as the way forward, and is keen on connecting MDT training, and triangulation between disciplines. “The active exchange of experience and ideas brings so much more to learning”. He keeps one eye firmly on opportunities for the future whilst maintaining a drive for quality and safety in the present.

**Rajesh Jethwa**

***"I like working in this pharmacy team, as I feel trusted to deliver in my role. With this role, I have plenty of autonomy and feel confident to make decisions. Working at EPUT has been fantastic"***

**Role:** Trust Medication Safety Officer (MSO) and Lead for Pharmacy Learning Disability services. (from April 2019)

**Previous Roles and Organisations:** Resident Pharmacist, Cambridge University Hospital; Specialist Transplant post at Kings College Hospital, London; Medication Safety Officer and Lead for Medicines Optimisation, Mid and South Essex NHS Foundation Trust.

As MSO in 2020/21, some of my key highlights include inter-departmental working to enhance patient safety through reviewing the effectiveness of key tools such as DATIX, early engagement with the Patient Safety Incident Report Framework, convening the Medicines Safety Group and review of medication incident investigation toolkit.

**In his own words:** "In January 2021, I was given the opportunity to take on an acting up role as Clinical Lead for Inpatient Pharmacy Services. with responsibility for the direct line management of six pharmacy staff in North East Essex and West Essex, alongside operational oversight of clinical pharmacy activity at all our of our different Mental Health Inpatient Pharmacy teams. My team is based in Colchester where we provide a clinical pharmacy service to the Acute Adult assessment unit, inpatient wards and Home First Treatment Teams. On a daily basis, we have conversations with patients, clinicians and nurses regarding medicine usage and how medicines can be further optimised to improve patient outcomes. We undertake local pharmacy medicines management audits as well as participating in audits led by other members of the ward multidisciplinary team. This helps us to identify areas for improvement and put the appropriate measures in places to drive improvements, working leaner and smarter".

"The team currently is well engaged in ward MDT meetings where treatment strategies are discussed alongside healthcare professionals, patients and carers. The attendance of pharmacy at these meetings provides the clinicians/service users with assurance that prescribed treatment is safe and effective. The pharmacy team also works very closely with the Home First teams. Requests for mental health medicines and support with clinical queries is often received. Without this service, supply of medicines to patients in a timely manner would be very difficult".

**The COVID-19 pandemic:** meant that optimising medicines needed careful planning to reduce direct contact with patients. Timely medicines reconciliation was one such area: early in the pandemic, Rajesh worked hard with his clinical team to produce a protocol on rationalising medication on admission which was well used as other members of the team stepped in to support the service. He recalls **"**The biggest challenge during the peak of the pandemic was managing staff rotas. The challenge of providing an ongoing and comprehensive clinical pharmacy service on with limited staff was difficult. At one point, my all members of the Colchester team were all tested COVID-19 positive and were unable to work. Putting my leadership hat on, I had to rotate staff from different parts of the service to support this area, in addition to reviewing the local aspects of the pharmacy Business Continuity Plan reviewing service provision as appropriate. On reflection, this was a difficult

time where staff were anxious about their health and I found that regular catch up / team huddles with staff relating to their mental health and wellbeing was crucially important. In addition to this, updates from the Bronze and Silver commands were very useful and timely".

"Despite the pandemic, in autumn 2020 we were advised that inspections by CQC were likely to be resumed and we could be inspected. I felt privileged to be in such a position to co-ordinate CQC Mock Medicine Management inspections for all of our inpatient pharmacy teams. This piece of work allowed us to identify and communicate poor and good areas of practice to ward managers/matrons using action plans. This work also reached the trust compliance team where it was agreed that any medicines management feedback would form part of the service information sheets before a visit/inspection was due to that area. Feedback was well received by ward managers and recommendations were acted on in a timely manner".

Rajesh says: "I like working in this pharmacy team, as I feel trusted to deliver in my role. With this role, I have plenty of autonomy and feel confident to make decisions. Working at EPUT has been fantastic. There are plenty of resources available for staff to obtain support for their mental health and wellbeing especially during such difficult times".

## 10.0 PRIORITIES FOR 2021/22

2021/22 continues to be a challenging year for health services as the pandemic continues. For my team this includes the additional workload involved in ensuring a robust supply chain of vaccine to existing EPUT vaccinations centres; the booster programme means that the majority of vaccination centre will continue to remain operational until at least early 2022 and the 12-15 year old programme (approximately 10 new schools per day) has added an additional dimension. The logistical challenge is immense given the fluctuating capacity of the team which has a knock on effect on all pharmaceutical services, as individual staff members are frequently redeployed to meet the vaccination service needs. Whilst this inevitably has an impact on the coverage of the pharmaceutical care we can offer at a ward level, the greater good has to be the priority. Letting down the population through staff shortages is simply not an option if we are ever to each a position of herd immunity, and my team is proud to be trusted to deliver this key element of the pandemic response.

This does not mean that pharmacy services are standing still; there is much to be done to ensure that we can meet the needs of modern healthcare and I will be updating the strategy for medicine optimisation and pharmacy services by the end of the year that captures my vision for the future. A key priority continues to be the implementation of ePMA, which has been temporarily delayed. This is a very necessary part of the governance infrastructure we need to implement within the trust to make patient care safer across the interface, a proven juncture of risk for patients if key information is missing. In its absence not only is clinical care potentially compromised and skilled staff unable to act to their potential whilst spending time operating a cumbersome manual system, but the whole trust is at a disadvantage in seeking out new business opportunities when neighbouring trusts are already reaping the rewards of this investment. We only have to look at primary care health services to see the revolution that awaits once we embrace the technology.

There is still much work to be done at ward level; the combination of the pandemic and staff turnover suggests that more dedicated time with ward teams can ensure that medicines practices, including controlled drugs, are fully compliant with legislation and the trust is in a position to shine under scrutiny. Patient safety has been revitalised across the trust this year and my team is integrated onto this transformation at a senior level; heightened collaboration and a shared common purpose across directorates means that historical system risks are on a trajectory to obsolescence with seemingly little effort, and that is set to be enhanced by new training resources. My team is ready to try new things, in different ways and to lead the way when it comes to quality improvement. This means adopting proven methodologies to make sustainable changes to practice; we have already started to benefit from QSIR tools and accept that the learning from what doesn't go to plan can be even more valuable in the long-term than getting things right from the outset.

Nationally, there are plans to upskill the pharmacy workforce. Pharmacy staff joining the team already benefit from a sound skills escalator and development plans, but the current landscape does not release the capacity for my most skilled team members to go out and do what they do best: proactively manage a clinical caseload as prescribers and keep service users fit and well in body as well as mind. There is a huge amount of potential for the workforce to cover functions that have historically been delivered by medically trained staff. Once again, the value of patient-facing pharmacists has already been proven in primary care and my ambition is that my team is in a position to proactively help our patients thrive in life; the early detection and avoidance of a mental health crisis is well within our gift, and is what our patients deserve. The wellbeing of my pharmacy team being prioritised in line with EPUT's commitment to the workforce, so we can go out there and perform to our best. These are exciting times for my team, and we'll be looking to consolidate our effectiveness within the organisation whilst keeping one eye on the horizon for new opportunities.

**Appendix 1: Stages in Drug Treatment**

What needs to be considered to ensure the patient derives the maximum benefit from their medication?

1. Feeling unwell, developing a condition, or a medical life event (e.g. pregnancy).
2. Identifying symptoms.
3. Getting a diagnosis (self-diagnosis / pharmacist / nurse / prescriber).
4. Discussing and considering options for treatment. Any non-drug options?
5. Do you agree with the diagnosis and proposed treatment?
6. Choosing a drug treatment that works for that condition.
7. Considering the risks and benefits of that drug for you. What impact will the effects and side effects have on you?
8. Will you comply with the treatment?
9. Considering your existing medical conditions and diseases.
10. Any allergies or reactions to that drug?
11. Considering your existing drug treatments.
12. Choosing a form of the drug. Is this acceptable to you?
13. Choosing a dose of the drug. Is this dose just right for you?
14. Choosing a frequency of the drug. Is this acceptable to you?
15. Choosing a duration of the drug. Is this acceptable to you?
16. Obtaining a prescription for the drug. Is the prescriber available?
17. Getting a supply of the drug. Is the drug readily available in the UK?
18. Storing the drug. Does it need special storage before use, and during use?
19. “In use” considerations. Is it convenient / practical to use this drug on a daily basis, given your life situation? E.g. school.
20. Preparing the drug ready for administration (opening, reconstitution?)
21. Preparing necessary equipment (spoon, syringe, clinic room?)
22. Preparing any support required after the dose, well beforehand, e.g. staff / monitoring equipment / the room.
23. Preparing the body for drug administration (special equipment e.g. IV cannula?)
24. Finding the correct site for administration (leaflet / training).
25. Obtaining the skills for that type of administration (read leaflet / training).
26. Administering the drug.
27. Disposal of clinical waste. Correct clinical and drug waste bins in place?
28. Absorbing the drug. Can you absorb it by the route chosen?
29. Distributing the drug. Can it distribute successfully in your body?
30. Drug causes effects. Are the effects successful?
31. Is any monitoring or observation needed?
32. Drug causes side effects. Are the side effects tolerable, or dangerous?
33. Metabolising the drug. Are you able to metabolise the drug successfully?
34. Excreting the drug. Are you able to excrete the drug successfully so it doesn’t accumulate?

## Appendix 2: MHRA Drug Alerts

| Issue date | Reference | Details | Category | Level | Alert | DATIX Sign Off | Trust Pharmacy Service | ELFT (Robin Pinto & Woodlea only) | PAH (SECHS only) |
|---|---|---|---|---|---|---|---|---|---|
| 07/04/2020 | EL (20)A/20 | **Pharmaswiss Česka republika s.r.o. (affiliate of Bausch & Lomb UK Limited):** Emerade 300 micrograms solution for injection in pre-filled syringe | Class 2: Action within 48 hours | Patient / Pharmacy | EL (20)A 20.pdf | 25/04/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 16/04/2020 | EL (20)A/21 | **TEVA UK Limited:** Levofloxacin 500mg Tablets | Class 4: For information | Pharmacy / Wholesaler | EL (20)A 21.pdf | 18/05/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 20/04/2020 | EL (20)A/22 | **Glaxosmithkline Consumer Healthcare (UK) Trading Limited:** various products | Class 4: Caution in Use | Pharmacy / Wholesaler | EL (20)A 22.pdf | 18/05/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 18/05/2020 | EL (20)A/23 | **Pharmaswiss Česka republika s.r.o. (affiliate of Bausch & Lomb UK Limited)**: Emerade 500 micrograms solution for injection in pre-filled syringe | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 23.pdf | 27/05/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 28/05/2020 | EL (20)A/24 | **Torbay Pharmaceuticals:** Sodium Benzoate (Amzoate) 2g in 10 mL Sterile Solution for injection | Class 4: For information | Pharmacy | EL (20)A 24.pdf | 16/07/2020 | Not stocked | Not stocked at ELFT, no action needed | Action taken for affected batch |
| 08/06/2020 | EL (20)A/25 | **Torbay Pharmaceuticals:** Epistatus (Midazolam) 10mg/mL Oromucosal Solution (Multi Dose Bottles) | Class 4: For information | Pharmacy / Wholesaler | EL (20)A 25.pdf | 09/06/2020 | Not stocked | Not stocked at ELFT, no action needed | Action taken for affected batch |
| 30/06/2020 | EL (20)A/26 | **Drugsrus Ltd (distributor) / Tenolol Ltd (MA Holder):** Depo-Provera 150mg/ml Injection (1ml Vial) | Class 4: For information | Pharmacy | EL (20)A 26.pdf | 30/07/2020 | Not stocked | Not stocked at ELFT, no action needed | Action taken for affected batch |
| 02/07/2020 | EL (20)A/27 | **BCM Specials Limited:** Mepacrine Hydrochloride 100 mg Tablets | Class 2: Action within 48 hours | Pharmacy | EL (20)A 27.pdf | 30/07/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 15/07/2020 | EL (20)A/28 | **Dr Reddy's Laboratories (UK) Limited:** Nitrofurantoin 50 mg Tablets | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 28.pdf | 30/07/2020 | Affected batch not stocked | Action taken for affected batch | Action taken for affected batch |
| 15/07/2020 | EL (20)A/29 | **Ferring Pharmaceuticals Limited**: Desmopressin nasal spray (all strengths) | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 29.pdf | 30/07/2020 | Not stocked | Not stocked at ELFT, no action needed | Action taken for affected batch |

| Issue date | Reference | Details | Category | Level | Alert | DATIX Sign Off | Trust Pharmacy Service | ELFT (Robin Pinto & Woodlea only) | PAH (SECHS only) |
|---|---|---|---|---|---|---|---|---|---|
| 20/07/2020 | EL (20)A/30 | **Aspar Pharmaceuticals Limited**: Ibuprofen 200mg and 400mg tablets | Class 4: For information | Pharmacy / Wholesaler | EL (20)A 30.pdf | 30/07/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 21/07/2020 | EL (20)A/31 | **Ennogen Pharma Limited:** Trimogal 100mg and 200mg Tablets | Class 4: For information | Pharmacy / | EL (20)A 31.pdf | 30/07/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 23/07/2020 | EL (20)A/32 | **Pfizer Limited:** Ecalta 100mg powder for concentrate for solution for infusion | Class 4: For information | Pharmacy | EL (20)A 32.pdf | 27/07/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 23/07/2020 | EL (20)A/33 | **Accord Healthcare Limited:** Irinotecan Hydrochloride Concentrate for Solution for Infusion 20mg/ml (5ml vial) | Class 3: Action within 5 days | Pharmacy / Wholesaler | EL (20)A 33.pdf | 30/07/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 29/07/2020 | EL (20)A/34 | **Kyowa Kirin Limited:** Abstral 200 microgram sublingual tablets | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 34.pdf | 07/09/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 03/08/2020 | EL (20)A/35 | **Accord-UK Ltd:** Digoxin Tablets BP 250 micrograms | Class 3: Action within 5 days | Pharmacy / Wholesaler | EL (20)A 35.pdf | 07/09/2020 | Affected batch not stocked | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 03/08/2020 | EL (20)A/36 | **Crescent Pharma Ltd:** SyreniRing 0.120 mg/0.015 mg per 24 hours, vaginal delivery system | Class 4: For information | Pharmacy | EL (20)A 36.pdf | 07/09/2020 | Not stocked | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 04/08/2020 | EL (20)A/37 | **Pharmaram Ltd:** Clexane 4,000 IU (40mg)/0.4ml Syringes | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 37.pdf | 07/09/2020 | Affected batch not stocked | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 10/08/2020 | EL (20)A/38 | **Calderdale and Huddersfield NHS Foundation Trust (trading as Huddersfield Pharmacy Specials):** Phosphates Solution for Infusion 500ml | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 38.pdf | 07/09/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 13/08/2020 | EL (20)A/39 | **Fresenius Kabi Ltd & Calea UK Ltd:** SmofKabiven extra Nitrogen Electrolyte Free | Class 4: For information | Pharmacy | EL (20)A 39.pdf | 07/09/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 24/08/2020 | EL (20)A/40 | **Sanofi:** Fasturtec 7.5 mg, 1.5 mg/ml powder and solvent for concentrate for solution for infusion | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 40.pdf | 07/09/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 01/09/2020 | EL (20)A/41 | **GL Pharma GmbH:** Oxylan 40mg prolonged-release tablets | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 41.pdf | 07/09/2020 | Affected batch not stocked | Not stocked at ELFT, no action needed | Action taken for affected batch |

| Issue date | Reference | Details | Category | Level | Alert | DATIX Sign Off | Trust Pharmacy Service | ELFT (Robin Pinto & Woodlea only) | PAH (SECHS only) |
|---|---|---|---|---|---|---|---|---|---|
| 02/09/2020 | EL (20)A/42 | **Kingsley Specials Ltd:** Multiple Products | Class 4: For information | Pharmacy / Wholesaler | EL(20)A 42.pdf | 15/10/2020 | Affected batch not stocked | Not stocked at ELFT, no action needed | Action taken for affected batch |
| 07/09/2020 | EL (20)A/43 | **Accord Healthcare Limited:** Amlodipine 10mg Tablets | Class 3: Medicines Recall. Action within 5 days | Pharmacy / Wholesaler | EL(20)A 43.pdf | 15/10/2020 | Affected batch not stocked | Not stocked at ELFT, no action needed | Action taken for affected batch |
| 10/09/2020 | EL (20)A/44 | **Ratiopharm UK Limited and Generics [UK] Limited t/a Mylan:** Zopiclone Tablets | Class 4: Medicines Defect Information | Pharmacy | EL(20)A 44.pdf | 15/10/2020 | Action taken for affected batch | Not stocked at ELFT, no action needed | Action taken for affected batch |
| 16/09/2020 | EL (20)A/45 | **Beachcourse Limited, Orifarm A/S, OPD Laboratories Limited, Strathclyde Pharmaceuticals Limited, Quadrant Pharmaceuticals Limited and Lexon UK:** Parallel Distributed Medicines, Multiple Products | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 45.pdf | 15/10/2020 | Not stocked | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 29/09/2020 | EL (20)A/46 | **Theramex Ireland Ltd T/A Theramex HQ UK Ltd:** AlfaD Capsules | Class 3: Action within 5 days | Pharmacy / Wholesaler | EL (20)A 46.pdf | 23/12/2020 | Affected batch not stocked | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 06/10/2020 | EL (20)A/47 | **Boots Dermacare:** 1% w/w Hydrocortisone Ointment | Class 2: Action within 48 hours | Patient / Pharmacy / Wholesaler | EL (20)A 47.pdf | 23/12/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 14/10/2020 | EL (20)A/48 | **Sanofi:** Epilim 500mg Gastro-Resistant Tablets | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 48.pdf | 23/12/2020 | Affected batch not stocked | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 14/10/2020 | EL (20)A/49 | **Accord Healthcare Ltd:** Metoprolol 50 mg Tablets | Class 3: Action within 5 days | Pharmacy / Wholesaler | EL (20)A 49.pdf | 23/12/2020 | Affected batch not stocked | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 29/10/2020 | EL (20)A/50 | **Theramex Ireland Ltd T/A Theramex HQ UK Ltd:** AlfaD 0.25 microgram Capsules | Class 3: Action within 5 days | Pharmacy / Wholesaler | EL (20)A 50.pdf | 23/12/2020 | Affected batch not stocked | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 09/11/2020 | EL (20)A/51 | **Intrapharm Laboratories Ltd:** Kolanticon Gel 200ml | Class 4: Caution in Use | Pharmacy | EL (20)A 51.pdf | 23/12/2020 | Affected batch not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 11/11/2020 | EL (20)A/52 | **medac GmbH (T/A medac Pharma LLP):** Sodiofolin 50mg/ml Solution for Injection 100mg/2ml | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 52.pdf | 23/12/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |

| Issue date | Reference | Details | Category | Level | Alert | DATIX Sign Off | Trust Pharmacy Service | ELFT (Robin Pinto & Woodlea only) | PAH (SECHS only) |
|---|---|---|---|---|---|---|---|---|---|
| 12/11/2020 | EL (20)A/53 | **Mylan UK Healthcare Ltd:** Ancotil 2.5 g/250 ml Solution for Infusion | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 53.pdf | 23/12/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 25/11/2020 | EL (20)A/54 | **Kyowa Kirin Limited:** Abstral 200 microgram sublingual tablets | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL(20)A 54.pdf | 23/12/2020 | Not stocked | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 26/11/2020 | EL (20)A/55 | **Kent Pharmaceuticals Ltd:** Betahistine dihydrochloride 8mg and 16mg Tablets | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 55.pdf | 23/12/2020 | Affected batch not stocked | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 27/11/2020 | EL (20)A/56 | **Aventis Pharma Limited (t/a Sanofi):** Largactil 50mg/2ml Solution for Injection | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 56.pdf | 23/12/2020 | Not stocked | Not stocked at ELFT, no action needed | Action taken for affected batch |
| 03/12/2020 | EL (20)A/57 | **Lupin Healthcare (UK) Limited:** Simvador 10mg, 20mg and 40mg Tablets | Class 3: Action within 5 days | Pharmacy / Wholesaler | EL (20)A 57.pdf | 23/12/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 14/12/2020 | EL (20)A/58 | **Generics [UK] Limited t/a Mylan:** Perindopril Erbumine 2 mg Tablets; Perindopril Erbumine 4 mg Tablets; Perindopril Erbumine 8 mg Tablets | Class 4: For information | Pharmacy | EL (20)A 58.pdf | 23/12/2020 | Affected batch not stocked | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 15/12/2020 | EL (20)A/59 | **Fairmed Healthcare GmbH:** Co-Careldopa 25mg/100mg tablets | Class 4: For information | Pharmacy | EL (20)A 59.pdf | 15/05/2021 | Action taken for affected batch | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 16/12/2020 | EL (20)A/60 | **Merck Sharp & Dohme Limited:** Zerbaxa 1g/0.5g Powder for Concentrate for Solution for Infusion | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 60.pdf | 23/12/2020 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 29/12/2020 | EL (20)A/61 | **medac GmbH (T/A medac Pharma LLP):** Sodiofolin 50mg/ml Solution for Injection 100mg/2ml | Class 2: Action within 48 hours | Pharmacy / Wholesaler | EL (20)A 61.pdf | 15/05/2021 | Not stocked | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 18/01/2021 | EL (21)A/01 | **Intrapharm Laboratories Ltd:** Kolanticon Gel 500ml | Class 3: Medicines Recall – Action Within 5 days | Pharmacy / Wholesaler | EL (21)A 01.pdf | 15/05/2021 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 08/02/2021 | EL (21)A/02 | **Thame Laboratories:** Itraconazole 10mg/ml Oral Solution | Class 2: Medicines Recall – Action Within 48 Hours | Patient / Pharmacy / Wholesaler | EL (21)A 02.pdf | 15/05/2021 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |

| Issue date | Reference | Details | Category | Level | Alert | DATIX Sign Off | Trust Pharmacy Service | ELFT (Robin Pinto & Woodlea only) | PAH (SECHS only) |
|---|---|---|---|---|---|---|---|---|---|
| 11/02/2021 | EL (21)A/03 | **Gilead Sciences Ltd:** AmBisome Liposomal 50 mg Powder for dispersion for infusion | Class 4: Medicines Defect Information – Caution in Use | Patient / Pharmacy / Wholesaler | EL (21)A 03.pdf | 15/05/2021 | Not stocked | Not stocked at ELFT, no action needed | Action taken for affected batch |
| 16/02/2021 | EL (21)A/04 | **Eaststone Limited:** MidaBuc – Midazolam (as HCL) 10mg/mL Oromucosal Solution | Class 4: Medicines Defect Information – Action Within 48 Hours | Patient / Pharmacy / Wholesaler | EL (21)A 04.pdf | 15/05/2021 | Not stocked | Not stocked at ELFT, no action needed | Affected batch not stocked at PAH |
| 17/02/2021 | EL (21)A/05 | **SyriMed:** Clonidine hydrochloride 50micrograms/5ml Oral Solution | Class 3: Medicines Recall. Action Within 5 Days | Pharmacy / Wholesaler | EL (21) A 05.pdf | 15/05/2021 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 01/03/2021 | EL (21)A/06 | **Orion Corporation T/A Orion Pharma (UK) Ltd:** Easyhaler Salbutamol Sulfate 100 micrograms per actuation/200 micrograms per actuation inhalation powder | Class 3: Medicines Recall. Action Within 5 Days | Pharmacy / Wholesaler | EL (21)A 06.pdf | 15/05/2021 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 09/03/2021 | EL (21)A/07 | **Accord-UK Ltd:** Diazepam 2mg/5ml Oral Solution Sugar Free | Class 4: Medicines Defect Information | Pharmacy / Wholesaler | EL (21)A 07.pdf | 15/05/2021 | Action taken for affected batch | Not stocked at ELFT, no action needed | Action taken for affected batch |
| 15/03/2021 | EL (21)A/08 | **Thame Laboratories:** Itraconazole 10mg/ml Oral Solution | Class 3: Medicines Recall. Action Within 5 Days | Pharmacy / Wholesaler | EL (21)A 08.pdf | Missing from Datix. Email sent 13/06/21 | Not stocked | Not stocked at ELFT, no action needed | Not stocked at PAH, no action needed |
| 18/03/2021 | EL (21)A/09 | **Macarthys Laboratories Limited T/A Martindale Pharma:** Caffeine Citrate 10mg/ml Solution for Injection | Class 4: Medicines Defect Information | Pharmacy / Wholesaler | EL (21)A 09.pdf | Missing from Datix. Email sent 13/06/21 | Not stocked | Not stocked at ELFT, no action needed | Action taken for affected batch |

**Acknowledgments:**

2020/21 has been a partcularly challenging year for the whole of the NHS in inumerable ways; the EPUT pharmacy team have taken on a significant increase in workload compared with the usual full pharmaceutical service, as key members of staff were heavily involved in setting up and supporting COVID vaccinations centres across Essex and Suffolk, work that is ongoing in 2021/22.

Collating this report was heavily supported by a number of individuals on behalf of their teams, and I would like to thank the following:

| | |
|---|---|
| Oyindamola Adeniyi | Senior Clinical Pharmacist, Specialist Services |
| Fatimat (Tolu) Aigbekaen | Senior Clinical Pharmacist, Community Based Services |
| Shaheen Allymohammed | Dispensary Manager |
| Kim Baker | PA to Dr Hilary Scott |
| Makhan Chohan | Deputy Chief Pharmacist |
| Alison Dossetter | Lead Pharmacist, WECHS |
| Joseph Gyula Elias | ePMA Clinical Lead |
| Julie Evans | Lead Pharmacy Technician, Procurement and IT |
| David Heath | Senior Clinical Pharmacist, Education, Training & Governance |
| Rajesh Jethwa | Senior Clinical Pharmacist, Inpatient Services |
| Oyepero Olasehinde-Williams | Lead Pharmacist, SEECHS |
| Philip Stevens | Risk & Legal Analysis and DATIX System Manager |
| Adam Tree | ePMA Project Manager |
| Cirin Verghese | Clinical Effectiveness Team Leader |
| Jonathan Kerr | Director, Rx-Info Ltd |

***Mona Sood***
***Interim Deputy Chief Pharmacist & Medicines Safety Officer***

***Dr Hilary Scott***
***Director of Pharmacy & Accountable Officer for Controlled Drugs***

***September 2021***

| | | |
|---|---|---|
| | | **Agenda Item No: 7h** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **Trust Green/Sustainability Plan** | | | | | |
| **Executive/Non-Executive Lead:** | Trevor Smith, Chief Financial Officer | | | | | |
| **Report Author(s):** | Charles Hanford, Interim Director of Estates Transformation | | | | | |
| **Report discussed previously at:** | Executive Operational Committee: 18 October Finance and Performance Committee: 18 November | | | | | |
| **Level of Assurance:** | **Level 1** | ✓ | **Level 2** | | **Level 3** | |

| **Risk Assessment of Report – all reports must relate to a key risk on the Board Assurance Framework (BAF) – *mandatory section*** | |
|---|---|
| State which BAF risk(s) this report relates to (risk ID and short form title e.g. BAF63 Learning) | |
| Are you recommending a new risk for the EPUT BAF? | No |
| If Yes describe the risk to EPUT's organisational objectives | |
| If Yes, is this an escalation from another EPUT risk register? | No |
| If Yes, will this risk have an action plan? | No |
| If No describe what measures will you use to monitor mitigation of the risk in lieu of an action plan? | |
| Does this report mitigate the BAF risk(s)? | No |

| **Purpose of the Report** | | |
|---|---|---|
| This report provides the Board of Directors with EPUT's proposed Green Plan. | **Approval** | ✓ |
| | **Discussion** | ✓ |
| | **Information** | ✓ |

## Recommendations/Action Required

The Board of Directors is asked to:

1 Approve the Plan and support the approach to environmental sustainability within EPUT and the broader community

## Summary of Key Issues

This report sets out the Trusts intent to progress Green initiatives across the range of its sites and services in order to achieve positive environmental outcomes.

Key areas of action and activity will include asset management and utilities, travel and logistics, capital projects and sustainable care models.

There is an expectation that all Trusts to have their sustainability plan approved by Trust Boards before February 2022.

This document has been recommended by the Executive Operational Committee.

Finance and Performance Committee requested further consideration as part of implementation delivery on a range of matters including leadership and embedding across the organisation, areas for priority, timelines and any staffing impacts re charging points and a deeper understanding of the sustainable assessment tool data that supports the options for change. These matters will be picked up and reported through The Executive Team and into Finance & Performance Committee each quarter.

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

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| | | | |

| Supporting Documents and/or Further Reading |
|---|
| EPUT Green Plan |

| Lead |
|---|
| Trevor Smith<br>**Executive Chief Finance Officer** |

# Essex Partnership University NHS Foundation Trust

## 2021 Green Plan

October 2021

# Foreword

*The Essex Partnership University Foundation Trust (EPUT),Trust Board are committed to improving the health and wellbeing of our teams and the community we serve, now and into the future. We will achieve this not only from the provision of world class clinical services but by also embedding environmental sustainability into our operations, culture and our spheres of influence. We recognise the enormous responsibility and privilege we carry, and strive to deliver the best possible health outcomes, as well as ensuring that any plans and decisions we make will protect and enhance the environment we live in: it is our duty to protect the community from harm in all ways.*

*All public services are facing challenges, and the demands on these services and people are increasing in a time when our economy is being challenged, and even if funds were plentiful, we still need to care for our planet, and we therefore have a responsibility to our children and future generations to grant them a legacy of a thriving, healthy environment..*

*The wider NHS is also facing challenges from the impact of COVID 19 on the physical wellbeing and mental health of our community, and we are striving to deliver the best possible outcomes which are also considered and incorporated, into the longer term sustainability goals of our Plan.*

*Our Green Plan sets out how we as a Community and Mental Health Trust, will operate in a sustainable manner that benefits both the Trust and the community we serve, and sets out clear targets for measuring success towards achieving a Net Zero Carbon future. This Green Plan is a public document giving our commitment and drive to be a more sustainable organisation that documents our aspiration to reach Net Zero Carbon by 2050, and this document fundamentally outlines how we intend to achieve this.*

# Contents



# Introduction

Essex Partnership University NHS Foundation Trust (EPUT, or the Trust) provides mental health services to over one million residents in Essex. We employ 4,390 staff working across over 60 sites with approximately 750 in-patient beds and 15,000 community patients.

The Trust was created in 2017 through the merger of the North & South Essex Partnership University NHS Foundation Trusts. The merger was completed on 1 April 2017 and represented the first successful merger of two NHS Foundation Trusts.

The Trust's overall vision is to provide care that is outstanding in quality, transforming the lives of individuals and families every day. We want our communities to have total confidence in our services, our staff to feel a strong sense of belonging and satisfaction and our partners to be proud to work purposefully with us.

We are committed to providing high quality healthcare services in an environmentally sustainable manner. A sustainable healthcare service works within the available environmental and social resources protecting and improving the health of the community, now and for future generations. This means working to reduce carbon emissions, minimising waste and pollution, making the best use of finite resources, building resilience to a changing climate, and nurturing community strengths and assets.

This 2021 Green Plan sets out our vision and overall direction to achieve our aims by putting in place a coordinated, strategic and action-orientated approach to sustainability.

# Green Plan

This is Essex Partnership University NHS Foundation Trust's **first Green Plan**, given the recent establishment. It covers the period from 2021-2026.

This plan:

- Sets out the national and local **context** of sustainability within the healthcare sector;
- Presents a comprehensive overview of the **drivers** for the NHS and our Trust in becoming more sustainable;
- Provides an overview of **current resource use** by the Trust;
- Estimates the Trust's current **carbon footprint** and sets a **target for reduction**;
- Presents the outputs of the Sustainable development assessment using the **Sustainable development assessment tool**;
- Reflects on progress to date and sets out **actions** to improve sustainability of the Trust;

Progress towards implementing the Green Plan will be reported on annually and, in alignment with NHS guidance, undergo a mid-term review in 2023/24.

It will be updated in 2026 to set an new plan for the following 5 years.

# Drivers for action

Left unchecked, the climate emergency will have a catastrophic impact on public health. If infrastructure, such as hospitals and water supplies, struggle to adapt to climate change, this will impact the NHS' capacity to respond to these public health threats. According to the World Health Organisation (WHO), the direct cost of climate change to the global healthcare industry is predicted to be between US$2-4 billion per year by 2030, with an additional 250,000 deaths per year worldwide. It is therefore imperative to act now to protect our healthcare systems from the worst impacts of climate change.

Sustainable healthcare in the NHS is driven and supported by a combination of national and international policy, legislative and mandated requirements as well as healthcare specific requirements from the Department of Health and NHS England.

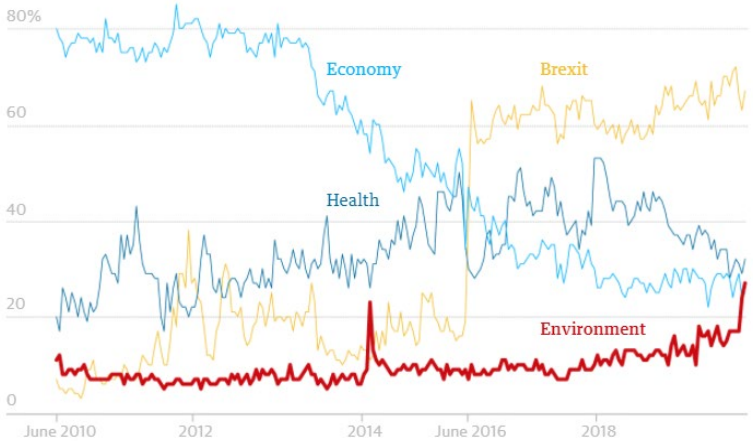
- **Global initiatives** are focused on limiting warming to below 2°C, aligning to the pledges outlined in the Paris Agreement based on the recommendations of the IPCC. The UN Sustainable Development Goals (SDGs) launched in 2015 provide a framework for driving change in addressing poverty, public health and climate change amongst other issues of central importance.
- **National initiatives** are also driving change; In June 2019 the UK Government became the first major economy in the world to pass laws to end its contribution to global warming by 2050 by setting a target of achieving net-zero emissions by 2050. If successful, it will help to reduce climate impacts at both the local and national scale as well as delivering public health co-benefits resulting from cleaner air and leading a more active lifestyle.

# Drivers for action

**There are also NHS-specific drivers for action:**

- **Delivering a 'Net Zero' National Health Service** was published in 2020 and represented a step-change in ambition for the environmental performance of the NHS. It supersedes the targets set out in the 2019 Long Term Plan and makes a firm commitment to a net zero NHS. For controlled emissions, it outlines a target of net zero by 2040 with an interim target of 80% reduction by 2028 – 2032. For emissions not controlled but influenced by the NHS, the net zero target is for 2045 with an 80% reduction by 2036 – 2039.
- The **2018 National Adaptation Programme** provides an overview of requirements and actions relating climate change mitigation and adaptation measures.
- The **2019/20 NHS Standard Contract** makes it a contractual obligation for NHS Trusts to manage their resources sustainably and to have a Board approved Sustainable Development Management Plan (SDMP) or Green Plan.

Another key driver of change is **public concern** for the environment, which has reached record a high. In the face of repeated storms and flooding across the UK, as well as the Extinction Rebellion protests and school strikes, over a quarter of Britons cited the environment as one of the three most important issues facing the country in a 2019 YouGov poll. Furthermore, an NHS SDU survey highlighted that 98% of NHS staff believe it is important for the health and care system to support the environment.




Over a quarter of Britons say the environment is one of the three most important issues facing the country [1]

[1] https://yougov.co.uk/topics/politics/articles-reports/2019/06/05/concern-environment-record-highs

# Our environmental impact

Resources consumed by the Trust contribute towards our carbon footprint and wider environmental impact. We can reduce the environmental impact associated with our consumption by either a) reducing our absolute consumption, or b) sourcing sustainable resources. As well as our direct emissions (those that originate from assets we operate) it is important to account for indirect emissions (those that originate outside of the ownership or control of the Trust). This covers a wide range of activities along our value chain, from the production and supply of goods that we use, to the disposal of waste we generate, and the transport of staff and patients to the Trust.

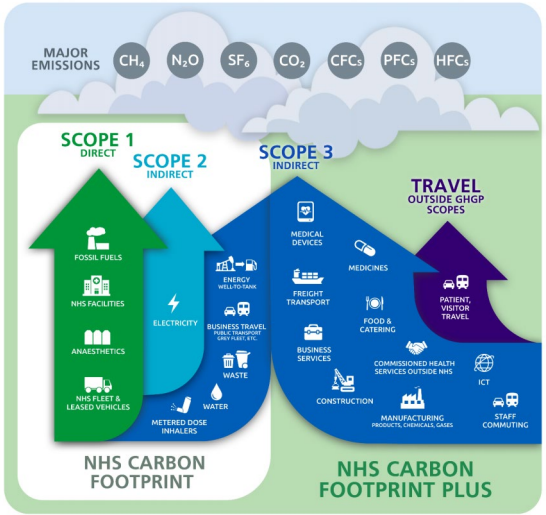
The NHS Sustainable Development Unit defines emissions according to four areas of influence:


| | |
|---|---|
| **Core** | Elements in direct control of the Trust, such as our building's energy usage and NHS travel, i.e. utilities, waste, business and fleet travel and anaesthetic gases. |
| **Procurement** | Supply chain activities to supply goods, services and capital projects to the Trust. |
| **Commissioned** | Core, procurement, and community emissions associated with healthcare commissioned outside of the NHS, where the data is not sufficient to disaggregate between emission sources. |
| **Community** | Patient travel, staff community, and the use of GHGs from inhalers. |

It is important that we take a holistic view of our environmental impact and try to address all four areas of influence. However, we acknowledge that as emission sources become further removed from our direct influence (e.g. community emissions) it becomes harder to obtain data to accurately calculate the emissions, as well as implementing measures to reduce the emissions. This is recognised in the NHS Sustainable Reporting Portal' (SRP) tool, and the emissions associated with the harder-to-obtain data sources are calculated according to economic proxies.

For target setting, it is important to ensure the availability of quality data going forward to allow for accurate and regular reporting against the target. It is also important to consider the level of influence the Trust has over that emission source, for realistic carbon reductions to be achieved as a result of our action. For these reasons it has been recommended that only core emissions are included in a carbon reduction target alongside a commitment to engage with our staff, supply chain, and community to reduce other indirect emissions.

# Clarifying note: emission scopes




For clarity, emission sources can be categorised according to different standards and conventions. The 2020 report *'Delivering a 'Net Zero' National Health Service'* refers to an NHS carbon footprint and an NHS carbon footprint plus, as well as emission scopes 1, 2 and 3. The three emission scopes originate from the Greenhouse Gas Protocol for carbon accounting. They are defined as:

- **Scope 1.** Direct, on-site emissions from owned or directly controlled sources
- **Scope 2.** Indirect, off-site emissions from the generation of purchased energy (predominately electricity)
- **Scope 3.** All other indirect, off-site emissions that occur in an organisation's supply chain

The NHS carbon footprint is analogous to the Core emissions as defined by the SDU. The NHS carbon footprint plus combines all four emission sources: core, procurement, commissioned and community. To maintain consistency with the Sustainable Reporting Portal, this report presents the footprint according to the SDU's classification.

https://ghgprotocol.org/sites/default/files/standards/ghg-protocol-revised.pdf

# Current status of resource use

The consumption of resources (energy, water, pharmaceuticals etc.) is required for the Trust to delivery services to the community and achieve our vision. Whilst necessary, we recognise that improper resource management contributes to global and local issues such as climate change and water and air pollution. It is our aim to consume resources sustainably and minimise our impact on the environment as much as feasibly possible without compromising on the delivery of our services. This can be done through enhanced efficiencies, more circular supply chains and procurement of renewable energy sources.

The Trust is transparent with its use of resources and includes a summary of energy and water consumption in our main annual report each year. As part of this Green Plan the Trust used the NHS 'Sustainable Reporting Portal' (SRP) tool to facilitate sustainability reporting and allow for an associated carbon footprint to be calculated for our activities (including emissions originating in the Trusts' value chain outside of our direct control – procurement, community and commissioned emissions – that are sometimes referred to as 'Scope 3' emission).

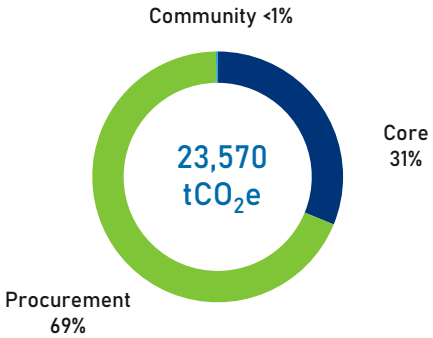
For the purposes of this report, the Trust has collected data and used the SRP tool to calculate the resource use over the previous two financial years (FY 18/19, FY 19/20).

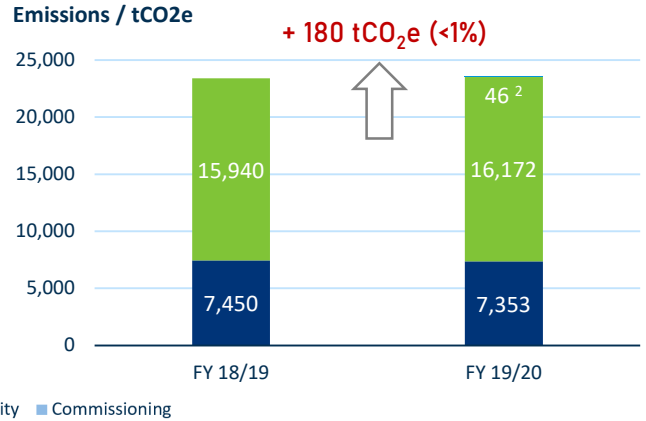
## Key indicators of environmental performance:

| | Electricity | Gas | Water | Waste-to-landfill |
|---|---|---|---|---|
| | **kWh** | **kWh** | **m³** | **tonnes** |
| **FY 18/19** | 8,792,542 | 17,744,769 | 90,314 | 272.0 |
| **FY 19/20** | 8,988,287 | 18,532,199 | 73,707 | 709.2 |
| **+/-** | **+ 195,745** | **+ 787,430** | **- 16,607** | **+ 437.2** |

# Our carbon footprint

It is important to understand the environmental impact of our resource consumption and identify hotspot areas where reductions can be prioritised. We have calculated our carbon[1] footprint for the two previous financial years using data collected by the Trust and using the NHS 'Sustainable Reporting Portal' tool. Our carbon footprint for FY 2019/20 was 23,570 $tCO_2e$, which was broadly consistent with our footprint for FY 2018/19. A more detailed breakdown of our emissions is presented on the page 10.



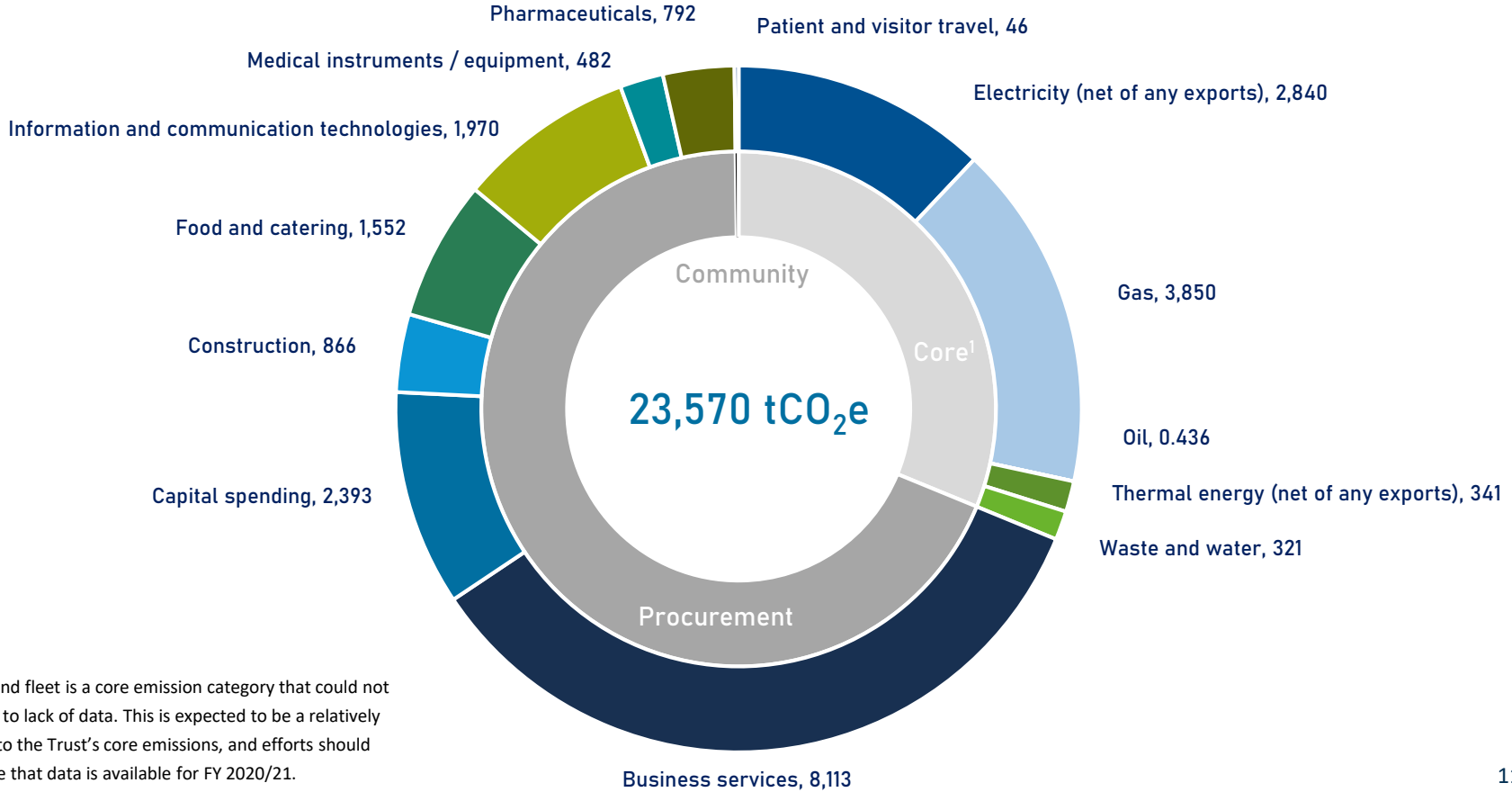




Emissions associated with the procurement of goods & services is estimated to account for over two-thirds of our overall footprint, which demonstrates the need to engage and work with our suppliers to reduce our overall environmental impact (*see 'Corporate Approach'*). Our core emissions are predominately made up of our energy consumption in buildings, and reductions should initially be identified through site-specific energy audits as well as engaging with users of our assets (more details are provided in the later sections).

[1] Carbon in this context refers to carbon dioxide equivalent ($CO_2e$), a unit used in footprinting to account for the major greenhouse gases.

[2] Community emissions relate to patient transport mileage, which has not widely collected until 19/20; Mid & South Essex CCGs only began collecting this information from April 2020.

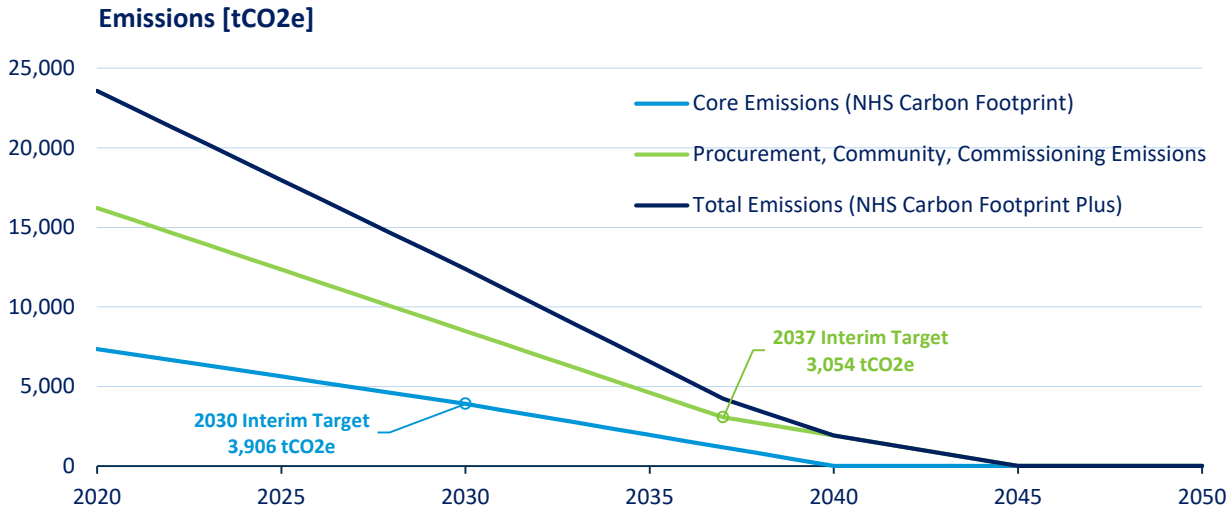
# Our carbon footprint – FY 19/20




[1] Business travel and fleet is a core emission category that could not be quantified due to lack of data. This is expected to be a relatively large contributor to the Trust's core emissions, and efforts should be made to ensure that data is available for FY 2020/21.

# Greenhouse gas targets

As part of this Green plan, we align to the national strategy of delivering a net zero NHS and **commit to making our activities net zero as soon as possible**. This is an ambitious decarbonisation pathway and will require significant investment and buy-in from all levels to achieve. The scale of decarbonisation required to achieve the target is shown below. **We will report our progress against these targets annually.**




This aligns with the NHS' targets for achieving net zero for controlled core emissions by 2040, with an interim target of 80% reduction by 2028 – 2032, and net zero for emissions not controlled but influenced by the NHS by 2045, with an 80% reduction by 2036 – 2039.

As the 'delivering a net-zero NHS' report uses a 1990 baseline, the measured footprint for the FY 19/20 year has been adjusted to allow for the 80% interim targets to be calculated. It should be noted that this pathway is inclusive of the data received for the latest financial year and the footprint and subsequent targets should be updated when more data becomes available (e.g. business travel).

# Sustainable development assessment tool (SDAT)

The SDAT is a qualitative self-assessment tool developed by the Sustainable Development Unit that allows for organisations in NHS England to monitor their sustainable development work, measure progress, and make plans for the future. The Trust's areas of focus are aligned to the ten modules in the SDAT:

- Corporate approach
- Asset management and utilities
- Travel and logistics
- Adaptation
- Capital projects
- Green space and biodiversity
- Sustainable care models
- Our people
- Sustainable use of resources
- Carbon / greenhouse gases

In each module, organisations are assessed across four themes (governance and policy, core responsibilities, procurement and supply chain, and working with staff, patients and communities) and asked to respond "yes", "no", "in progress", or "N/A" to a series of statements – "yes" meaning the statement has been achieved. A percentage score for each module is generated based on the answers, as well as the Trust's progress towards the UN's sustainable development goals (see below).

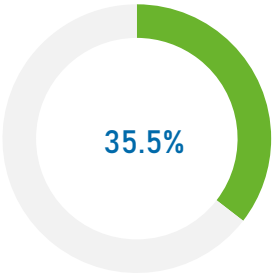
UN Sustainable Development Goals

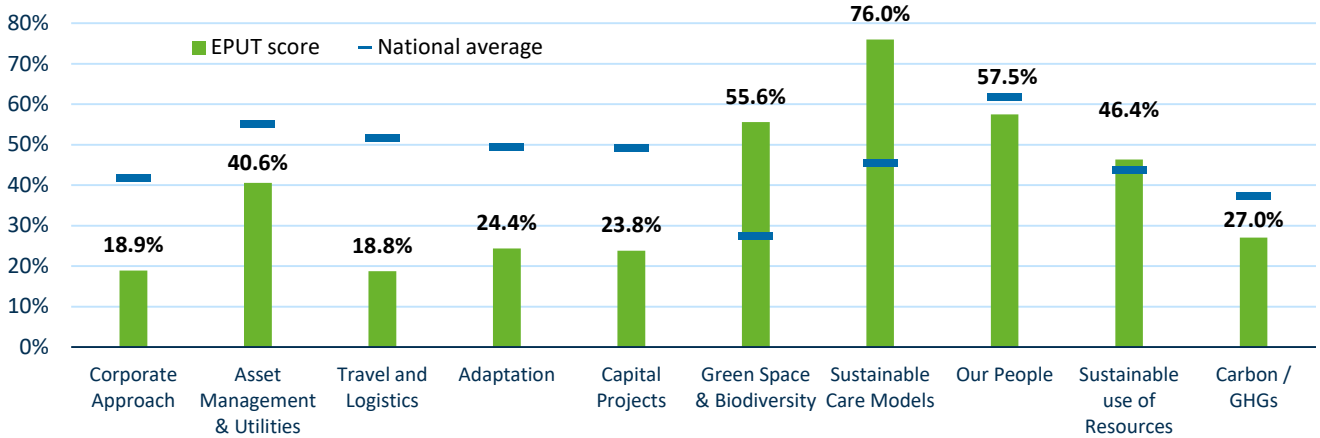
# Sustainable development assessment tool (SDAT)

The Trust's overall SDAT score for 2019/20 is 35.5%. We have achieved good results across several areas but recognise that our overall performance falls below the median score for a mental health & learning disability trust (42.9%[1]). This was the Trust's first year using SDAT and so allows us to evaluate underperforming areas to be prioritised for action. As part of this Green Plan, **we commit to achieving an average SDAT score of 50% by 2025.**

Further detail on each specific module is provided in the following pages. Module scores have been correlated to data availability and internal communication channels. Areas with higher scores were those with structured policies and where formal data collection process exist. Efficient data consolidation and ensuring that the personnel completing the SDAT are fully informed will be critical in the process going forward. As data availability improves, scores are also likely to improve.

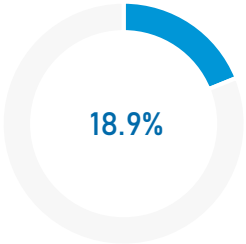
We commit to improving our sustainable performance, but acknowledge that funding and resources will be required to implement recommendations in this report to do so. This report does not look to quantify the level of resource required, and further work to estimate the investment needed should follow.




[1] Sustainable development unit figures – further detail of benchmarking is presented in Appendix A.

# CORPORATE APPROACH




We are committed to providing the best quality services, with the best possible leadership and workforce and sustaining EPUT and the health care delivery systems in which we operate. Our corporate approach and strategic objectives are centred around delivering on this commitment, and each year the Trust develops an operational plan to support delivery of our mission and purpose statements.

Sustainable development of the Trust is integral to our strategic planning and is represented throughout the organisation: a named Board sustainability lead; non-executive director champion for sustainability; and a sustainable development manager. However, we recognise that a more holistic approach to sustainability and social value can be integrated within our corporate approach, and will continue to iterate our approach to achieve this in the Trust's delivery of services; upcoming policy reviews (e.g. strategic priorities, procurement policy) will consider these elements, and a concerted effort on reporting & communication will enhance internal and external engagement.

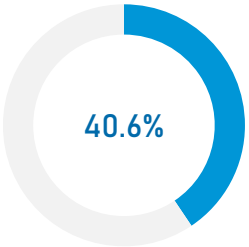
**We have**

- Engaged with key stakeholders in the development of our strategic direction, including staff, the public, service users, carers, the Council of governors, and Sustainable Transformation Partnership leads;
- Established leads for sustainable development through the organisation, including at Board level, and supported the leads with relevant training.

**We will**

- Develop a list of Board-approved focus areas, with associated KPIs, relating to sustainable development and social value;
- Biannually report to the Board on the Trust's progress and actions towards achieving the KPIs;
- Align our internal systems to readily monitor and report on the focus areas against the agreed KPIs;
- Include a 5% weighting towards sustainability & social value in tenders, with a set list of questions and quantifiable indicators that relate to the focus areas;
- Establish a group of 'Green Champions' across the organisation.

# ASSET MANAGEMENT AND UTILITIES




The efficient operation and management and the Trust's assets and spaces is central to achieving EPUT's sustainability ambitions, as well as realising cost savings.

The Trust has already made inroads to bring sustainability into an asset management strategy – through the procurement of green electricity, formal training of key staff, installation of emerging low-carbon technologies (e.g. ground source heat pumps), and securing external funding for energy efficiency projects.

EPUT should consolidate the work to-date and seek to tailor a methodical approach to asset management that allows for the development and implementation of site-specific measures. Training should be expanded to a wider audience and dissemination of the project outputs, lessons learnt, and key sustainability considerations should support the work to encourage a culture of sustainability across everyone who interacts with the Trusts' assets.

## STRATEGIC PLANNING

| | |
|---|---|
| We have | – Embedded sustainability into our estates strategy and site master plan, which is regularly revised to capitalise on emerging trends (e.g. from COVID – 19). |
| We will | – Perform energy audits of high-consuming sites to identify energy and waste saving opportunities across energy efficiency, low-carbon heating, renewable energy, and transport;<br>– Develop site-specific energy strategies with a prioritised list of actions, each with an timeline and owner. Align to the ambitions set out in the NHS Improvement Net Zero Carbon Programme. |

# ASSET MANAGEMENT AND UTILITIES

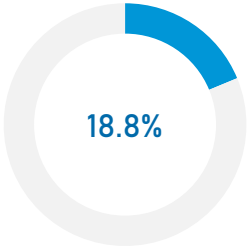
**PROCUREMENT.** Sustainability should be embedded into the Trust's procurement strategy, with whole-life costing consistently used to support the business case of highly efficient assets.

| | |
|---|---|
| We have | – Procured 75% of our supplied electricity through a Green tariff for the FY 2020/21;<br>– Successfully secured £470k of NHSI funding for a LED rollout scheme;<br>– Included weighted questions related to sustainable behaviour, working practices and aspirations in all new requests to tender<br>– Procured 100% of our supplied electricity through a Green tariff in 2021;. |
| We will | – Use whole-life costings as a basis for comparative procurement decisions accounting for the lifetime cost of energy and water;<br>– Meet minimum energy performance standards for new lighting and IT equipment (e.g. monitors);<br>– Continue to seek sources of funding to support the wider rollout of sustainable assets, including the exploration of novel financing mechanisms such as crowdfunding (see '*Finance*'). |

**TARGETED TRAINING & KNOWLEDGE SHARING.** Support staff who regularly interact with Trust assets through formalised training, CPD and knowledge sharing exercises that instil best-practice operation and maintenance of Trust assets.

| | |
|---|---|
| We have | – Enrolled all staff in an environmental awareness online training module, and included it in the induction process for new staff;<br>– Supported the Trusts sustainable development manager with formalised training. |
| We will | – Offer formal training, CPD, and access to knowledge sharing opportunities for energy managers;<br>– Create an internal knowledge sharing forum for facilities management professionals where best-practice, lessons learnt, and challenges related to energy efficiency can be discussed. |

# TRAVEL & LOGISTICS




Road transport contributes approximately a fifth (21%) of the UK's total greenhouse gas (GHG) emissions and remains a significant challenge to national decarbonisation. As well as GHG emissions, road transport is a significant source of other air pollutants that are directly damaging to human health (e.g. nitrogen oxides and particulate matter).

As a rural trust we depend upon the use of vehicles to deliver our services, including staff commuting and patient transport. We also acknowledge that there is an environmental impact associated with the delivery of goods and services to our organisation from third-party suppliers, as well as from patients travelling to our sites in their own vehicles. It is our ambition to reduce the environmental impact associated with travel and logistics and draft a formalised Travel Plan and Hierarchy to set out ways of doing so.

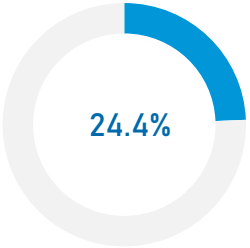
**We have**

- Effectively shifted working partners due to COVID-19 with reduced transport;
- A cycle-to-work scheme to encourage active staff travel, with the provision of facilities to support active travel (e.g. showers, secure bike parking) at several sites;
- A requirement of Director-level approval for all air travel and leased cars.

**We will**

- Engage with staff members (e.g. through PULSE survey – see SDAT module *'Our People'*) to understand their commuting habits and explore desire for active travel options, electric vehicle infrastructure etc;
- Draft a Sustainable Travel Plan informed by engagement with staff members (see resources made available by the Energy Saving Trust for reference);
- Seek Board approval for the Travel Plan and disseminate around the organisation;
- Investigate the installation of electric vehicle charging points and seek to electrify our fleet;
- Improve data collection/handling to allow for annual calculation of transport emissions (including business travel and patient transport);
- Complete the Healthy Outcomes Travel Tool (HOOT) to better quantify the impacts of the Trust's travel (inc. air and noise pollution);
- As part of our wider carbon reduction target, commit to cutting business mileage and fleet air pollutant emissions by 20%.

# ADAPTATION




The impacts of climate change are beginning to be felt across the UK as the magnitude and frequency of extreme weather events are increasing. The UK Met Office predicts a sustained move towards warmer, wetter winters and hotter, drier summers, as well as rising sea levels. These changes pose a physical risk to us as an organisation and the local community. It is our responsibility to adapt to the changes and increase our climate resilience such that we can continue to deliver our services and keep patients and staff safe.

Although climate change is a global issue its' impact on different regions will often be discrete and localised, with some areas experiencing more severe impacts than others. True resilience should account for the impact of climate change on those the Trust regularly engages with and who are dependent upon to deliver local services (e.g. core suppliers). We will develop an Adaptation Plan that will look to formalise our approach to climate change adaptation, both locally and in supply chain hotspots.

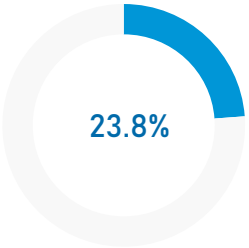
**We have**

- Emergency Plans in place to respond to some of the main local impacts of climate change (e.g. heat waves) relating to UK Climate Projections 2009;
- Successfully responded to a resilience test exercise involving our main stakeholders (emergency services and local authority) and using the learnings from the exercise to inform our Emergency Preparedness, Resilience and Response (EPRR) strategy.

**We will**

- Identify a clear Adaptation lead within the Trust, responsible for coordinating adaptation planning, resilience and emergency preparedness;
- Form an interdisciplinary working group to lead work updating our climate adaptation risk assessment and plan, with reference to the latest UK Climate Projections (UKCP18);
- Consider how the affect of climate change will impact stakeholders we heavily rely upon to deliver our services and include mitigating actions in our resilience planning;
- Develop and communicate our Adaptation plan and response strategy to our staff so that they know how to respond to severe incidents.

# CAPITAL PROJECTS

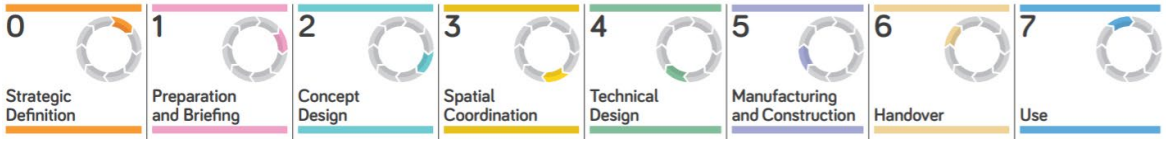



Capital projects involve the construction of new infrastructure or significant adjustment of existing infrastructure. Due to their magnitude and longevity the impact of capital projects are often 'locked in' for years, and it is important that sustainability is considered throughout the project lifecycle to ensure that it results in sustainable outcomes. In the context of the Trust, recent capital projects have involved the adjustment of existing infrastructure and there have been no new-build projects of significance.

We endeavour to put the correct processes in place such that any major refurbishment or new development can be implemented with the appropriate consideration of it's environmental credentials. The process should aim to facilitate effective collaborations at each stage of project development (pre-design → design → construction → handover → in use) to ensure sustainability is embedded into the development and use of any capital project. It is important that we, as the client, engage with stakeholders throughout the development stages to mandate sustainability.

## RIBA Plan of Work 2020:

As the client we have to engage with stakeholders involved in each stage to ensure sustainability is embedded in capital projects.



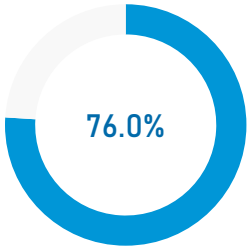

**We have**

- Pre-qualification questionnaires to seek assurance of social value outcomes (e.g. local business, considerate contractor) from contractors;
- Clearly defined and established responsibilities and processes within the Capital Projects team.

**We will**

- Develop a set of ambitious sustainability aims and objectives (e.g. kWh/$m^2$, $m^2$ $_{greenspace}$ / $m^2$ $_{total}$) that are clearly defined in the design brief of capital projects and communicated to contractors;
- When published, align to the UKGBC's NHS-specific net zero standard for new builds;
- Where appropriate, use lifecycle costing as a basis for financial decisions rather than capital costs.

# SUSTAINABLE CARE MODELS (SCM)




An established care model provides a consistent and targeted approach to delivering health services and instils protocols to be routinely followed in service delivery. For a Trust to habitually operate in an efficient and sustainable manner it is crucial that sustainability is embedded in their care models. As well as the environmental benefits, financial, clinical and social co-benefits are born from holistic and successfully-implemented SCMs.

Recognising their importance, NHS England has undertaken several initiatives in an attempt to optimise and standardise care models across England, most recently the Getting It Right First Time (GIRFT) programme.

The Trust operates *several* care models that are tailored to the local population and specific provision of services, all of which aim to provide the best quality services. Our service delivery is constantly reviewed to ensure that the best care is being delivered in the most efficient way, and it is part of our three strategic objectives for 2021/22 to work with system partners, commissioners and service users to co-produce and co-design service improvement plans.

**We have**

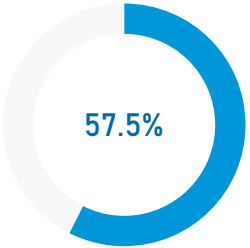
- Engaged with staff and patients to inform some of our most critical care models (e.g. crisis care);
- A corporate objective to transform services through the use of new clinical models and pathways and technology;
- Included environmental considerations into our care mechanisms where suitable (e.g. the use of video assessments to avoid unnecessary travel).

**We will**

- Include a qualitative assessment of sustainability as a key decision matrix (alongside clinical, social, and financial indicators) in our review of future care models, considering how different models of care impact use of resources, finance and infrastructure.
- Engage with the GIRFT programme to identify areas of good practice and agree where changes can be made to our current care models. This will include adopting appropriate recommendations from the relevant GIRFT report when published[1].

[1] https://gettingitrightfirsttime.co.uk/girft-reports/

# OUR PEOPLE




Systemic change across the Trust will be required for us to align to the UK's net-zero target (*see Drivers for Change*), and every person within the organisation has a part to play. To achieve sustained change across the Trust it is important to secure buy-in across the organisation. Therefore, we are committed to ensuring that staff can engage with and support activities within our Green Plan.

In a survey conducted by the NHS Sustainable Development Unit, nearly all respondents (98%) felt it was important that the health and care system works in way that supports the environment, for example through improved resource efficiency, reducing carbon emissions, and reducing waste. It is our responsibility to ensure that EPUT staff members feel they can provide the best quality services in a sustainable manner, and engage with them to improve our service delivery, where it is felt improvements can be made.

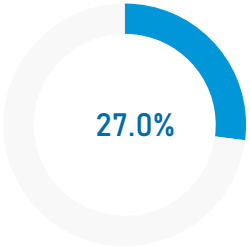
**We have**

- Continued to prioritise the health and wellbeing of our workforce, for example through the cycle-to-work scheme, fitness classes and wobble rooms. This year we were accredited by Mindful Employers UK as a Mindful Employer for a third year running;
- Extensively engaged with our staff to explore any concerns and issues (one confidential annual staff survey and two weekly PULSE surveys) and prioritised attention areas based on the results.

**We will**

- Perform a PULSE staff survey on the Trust's environmental performance to identify areas where staff members feel the Trust can operate more efficiently and sustainably in the delivery of care;
- Engage with national sustainability campaigns (e.g. SDU Sustainability health and care campaign, Earth Day) to promote awareness in the organisation and encourage sustainable behaviour;
- Build and disseminate knowledge around the organisation through internal communications, knowledge building events, and targeted training where appropriate;
- Form a staff-led 'Green Champions' group to allow staff members who are passionate about sustainability in health care to engage with the Trust's activities.

# CARBON & GREENHOUSE GASES




The man-made release of greenhouse gases is resulting in a warming climate & environmental degradation. Whilst carbon dioxide is the most well-known and significant contributor, there are several other gases that lead to atmospheric heating (e.g. methane, anaesthetic gases) – these are collectively referred to as greenhouse gases.

In 2019, the UK committed to bring all greenhouse gas emissions to net zero by 2050 to end their contribution to global warming. England's health and care system is responsible for 4-5% of the country's total carbon footprint, and has a crucial role to play in achieving the target. In response, the NHS has committed to reaching net zero "as soon as possible" and is currently developing an action plan setting out a pathway to achieving this target. As part of this Green Plan, we have committed to aligning to the NHS target and will look to adopt and personalise the recommendations in the upcoming action plan.

Please refer to Resource use section for more information on our carbon footprint and commitments to carbon management.

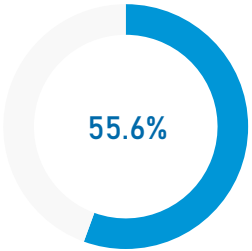
**We have**

- Formed a working group and completed the Sustainable Reporting Portal (SRP) footprinting tool to calculate our emissions profile for the previous two financial years;
- Identified data gaps and formalised a data collection process to streamline the calculation and reporting of the Trust's emission profile.

**We will**

- Align to the national strategy of delivering a net zero NHS and commit to making our activities net zero as soon as possible, including interim targets covering our full value chain emissions – see '*greenhouse gas targets*' for more details.
- Develop a GHG reduction plan made up of site-specific energy strategies with a prioritised list of actions for each site;
- Improve our reporting on mileage from our fleet vehicles, so that emissions can be calculated;
- Annually measure and transparently report (both internally and externally) our GHG emissions.

# GREEN SPACE AND BIODIVERSITY




The co-benefits provided by green space and biodiversity, both to the environment itself and those that interact with it, are well understood. We have a responsibility to maximise the opportunity potential of green space and biodiversity across our estate. Doing so will increase the Trust's resilience to climate change related events, whilst simultaneously improving the experience of those that interact with the estate (both staff and patients). We also recognise that our procurement decisions can encourage the productive management of biodiversity external from the Trust's own estate, for example by procuring sustainably-sourced food produce.

It should be noted that, in the context of a mental health trust, several measures that could be applied to enhance green space/biodiversity are not appropriate and additional security measures are warranted to safeguard patients. Several SDAT criterion are therefore not applicable to our Trust. However, we will work within these constraints in an effort to maximise the potential.

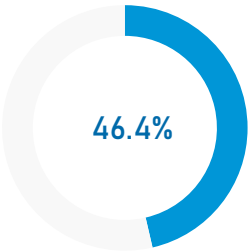
**We have**

- Minimised the use of pesticide and other toxic substances in the management of our green spaces;
- Used local recycling centres to dispose of garden waste;
- Performed a risk assessment for all green areas and ensure that they are suitable and safe for mental health patients.

**We will**

- Recognise and favour catering and food providers that can demonstrate their sustainability credentials;
- Develop and seek board approval of a green space action plan that sets out our approach to maximising the use of the Trust's green space. This will recognise the separation required for patients, staff and public spaces and be tailored to their requirements.

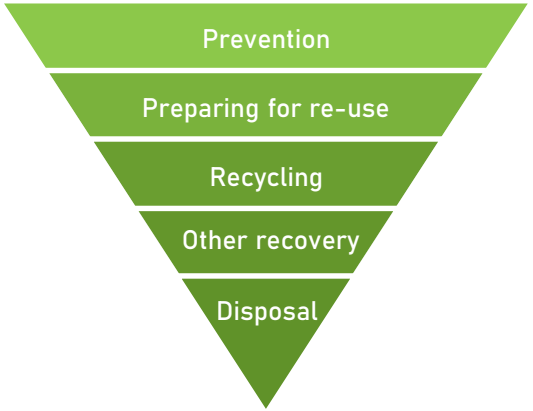
# SUSTAINABLE USE OF RESOURCES




The efficient and sustainable use of resources is prerequisite for the Trust achieving its' sustainability goals. In addition to the positive environmental impact, there are several co-benefits that can be realised through the sustainable use of resources (e.g. cost savings, local procurement, provision of fresh healthy catering).

Currently, facility managers recognise and implement the waste hierarchy in the Trust's key operations to optimise resource consumption. We aim to expand this across all departments and embed the reduce-reuse-recycle mantra in all Trust activities. To achieve this, there has to be a conscious acknowledgment by those who interact with the Trust as well as the provision of resource to facilitate sustainable behaviour within the Trust.

***The waste hierarchy:***




**We have**

- A waste policy that sets out general compliance with regulations and looks to minimise waste to landfill;
- Applied the principles of the waste hierarchy to key procurement activities (e.g. IT equipment, office furniture);
- Provide healthy and sustainable food choices for patients;
- Follow an established system for recording the use of hazardous substances and chemicals on the estate, and provide training to relevant; staff (e.g. cleaning) to minimise the use of hazardous substances.

**We will**

- Set a target to achieve 'Zero Waste to Landfill' by 2025;
- Communicate our Waste strategy across the Trust and develop initiatives to encourage sustainable behaviour;
- Provide the necessary facilities (e.g. recycling bins) across the Trust to promote sustainable treatment of waste;
- Provide targeted training to all facility managers in the waste hierarchy and it's application.

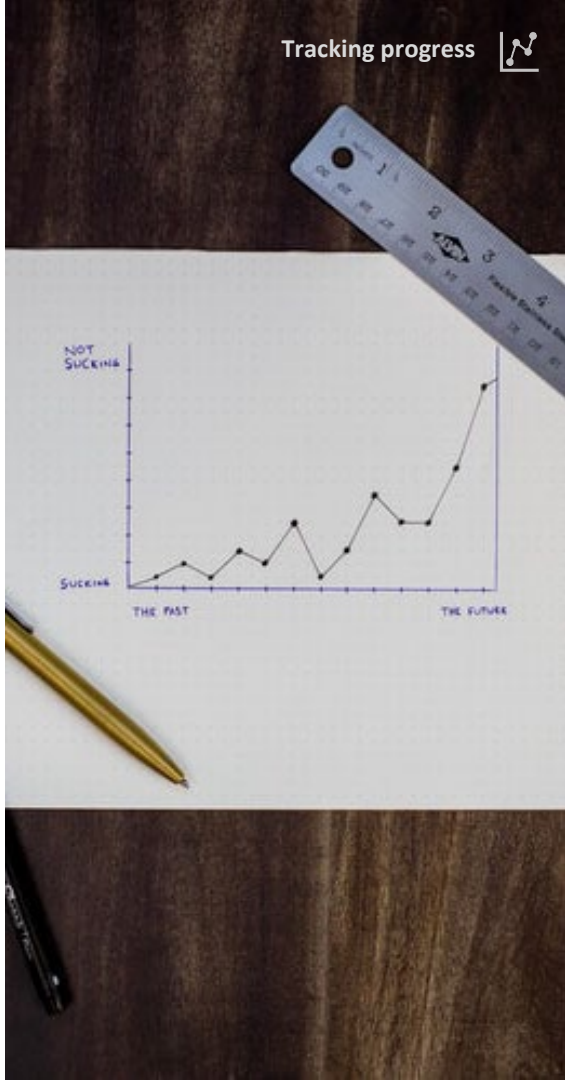
# Tracking progress and reporting

This Green Plan represents the Trust's first year of completing the SDAT and SRP tools, and has identified several recommendations to improve our sustainability performance. Tracking our progress in the implementation of these measures and being transparent in our reporting is a core element of the Green Plan approach. Recognising that, we commit to:

- Using the Action Plan (Appendix A) as a basis for a live sustainability action log that will be regularly reviewed and updated throughout the year.
- Completing the SRP and SDAT tools each year, and including the key findings in our annual reporting;
- Annually report to the Board on our progress against key targets:
    - Achieve an average year-on-year GHG reduction of 3% to reach a 15% reduction by 2025, relative to 2018/19;
    - Average SDAT score of 50%
- Annually review and update our climate change risk assessment

Whilst the SDU's bespoke tools streamline the tracking and reporting process, it is important to recognise the additional resource requirement associated with these commitments. The Trust's sustainable development manager will have oversight of the tracking and reporting processes, and it is recommended that the following Groups are formalised to support the process:

- Cross-faculty SDAT working group *(see following slides - Data collection process - SDAT)*
- Cross-faculty SRP working group *(see following slides - Data collection process - SRP)*
- Green champions group *(see 'Communication' section)*



# Data collection process – Sustainable Reporting Portal (SRP)

A streamlined and formalised data collection and consolidation process is essential for the Trust to annually report on their environmental performance and monitor progress against targets and KPIs. For this Green Plan, a cross-faculty working group was formed to complete the data collection process. It is the responsibility of the Sustainable Development Manager (SDM) to co-ordinate the process and provide overall oversight.

Taking lessons learnt from the exercise, a formalised data collection process is outlined below that should be followed for the SRP submission in future years:

PROCESS

**1.** The SDM to issue a data request (based on the template provided by the Carbon Trust) in May each year to the responsible departments

**2.** Data for the previous financial year to be submitted to the SDM by the end of July each year.

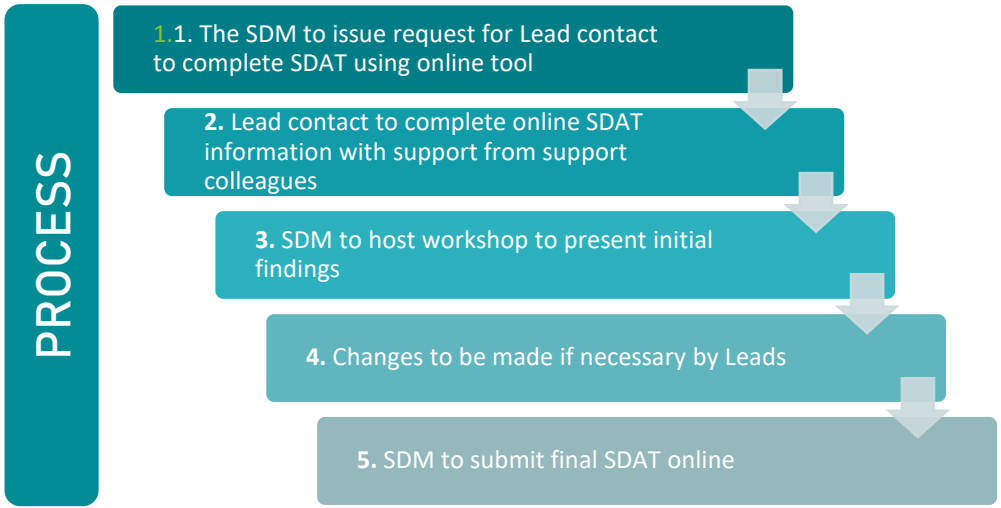
**3.** The SDM should input and submit the data in the SRP

| Data | Responsible department/role |
|---|---|
| **General Trust information** | Sustainable development manager |
| **Energy** | Sustainable development manager |
| **Water** | Sustainable development manager |
| **Waste** | Estates and facilities |
| **Plastic** | Procurement |
| **Business Travel** | Human resources |
| **Other Travel** | Contracts manager |
| **Air pollution** | Sustainable development manager |
| **Social value** | Compliance and Assurance |
| **Anaesthetic gases** | N/A (negligible use) |
| **Spend profile** | Procurement |

# Data collection process - Sustainable development assessment tool SDAT

As with the SRP, establishing a data collection and consolidation process is key for the Trust to regularly and efficiently report on their environmental performance using the SDAT. Ensuring year-on-year consistency in the process is harder to achieve due to the qualitative nature of the assessment, however best efforts should be made to ensure that annual consistency is achieved for each module. It is the responsibility of the Sustainable Development Manager (SDM) to co-ordinate the process and provide overall oversight.

The suggested process for completing the SDAT each year is outlined below:



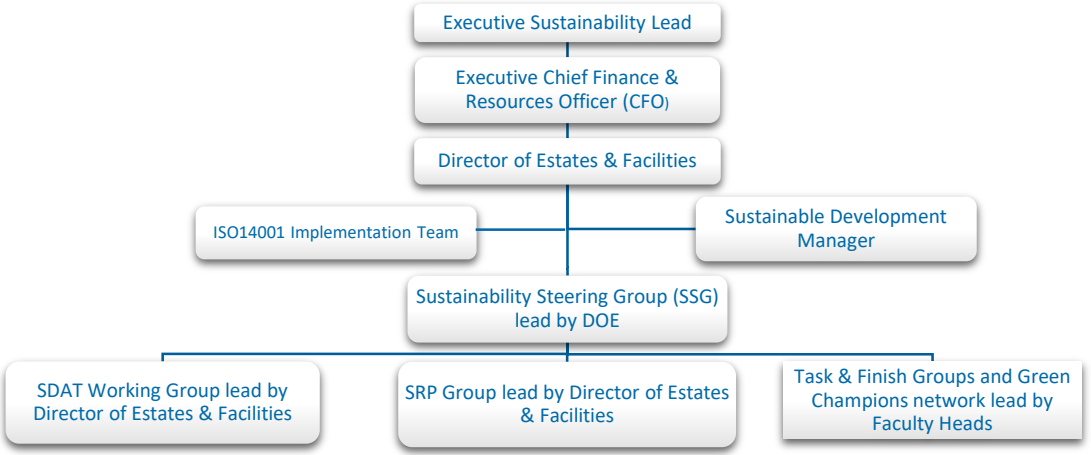

| SDAT Module | Lead | Support |
|---|---|---|
| **Corporate approach** | Compliance and assurance | Sustainable development manager |
| **Asset management and utilities** | Property and development manager | Sustainable development manager; Procurement; Estates and facilities |
| **Travel and logistics** | Fleet manager | Procurement; Grey fleet manager |
| **Adaptation** | Sustainable development manager | EPRR Lead; Estates and facilities; Assurance |
| **Capital projects** | Capital planning manager | Sustainable development manager; Property and development |
| **Green space and biodiversity** | Estates and facilities manager | Procurement and contracts |
| **Sustainable care models** | Associate Director | Director of mental health |
| **Our people** | Human resources | - |
| **Sustainable use of resources** | Estates and facilities manager | Sustainable development manager |
| **Carbon / greenhouse gases** | Sustainable development manager | - |



# *Trust Strategy & Operational Implementation*

## Governance

EPUT's Green Plan is approved by Trust Board on an annual basis, with an annual progress report submitted half way through the year. In addition to this , the executive team are actively supporting the implementation of ISO14001 quality management system as a means of engendering a broader understanding of the collective responsibility while introducing a system of reporting and improvement against an agreed base line that lends itself to external audit with collective accountability



OUR VOICE

# Communication

To achieve our interim sustainability targets and ultimately align to the NHS's ambition of reaching net-zero greenhouse gas emissions, we need staff, service users and the public to understand the reasons for taking action and how they can contribute to a more sustainable system. The Trust has already created a culture of staff engagement and use a wide range of communication methods, which we will leverage in our sustainability engagement.

Our communication and engagement strategy should span both internal and external stakeholders, and be owned by our boards and staff members. With a view to achieving this, we will look to:

**Internally**

- Create a 'Green Champions' group of staff members that are passionate about the delivery of a sustainable health service. The Group will be supported with formal training and access to CPD events, with a view to supporting the Sustainable Development Manager with internal and external communications.
- Seek out opportunities for carbon reduction via a partnership approach with procurement colleagues and copy with excellence, from sister Trusts where appropriate such as furniture recycling and a strategy of re-use of items that have traditionally been sent to landfill.
- Routinely integrate sustainability into our established internal communications (lunchtime learning, intranet portal, weekly e-mail newsletter) to disseminate the knowledge of energy managers, sustainable development managers etc. throughout the Trust

**Externally**

- Engage with the wider ICS to ensure we move forward with a common purpose and agreed strategy while promoting our efforts regarding sustainability through case studies and articles on our website, as well as

# Risk and opportunities

Risks and opportunities related to sustainable development are managed by the Trust sustainability lead in conjunction with estates managers utilising the accepted estates and facilities governance structures .

Significant risks and opportunities associated with compliance obligations, objectives, targets and project delivery are reported through the estates expert group and if necessary escalated upwards to the Trust executive via the appropriate papers and reports.

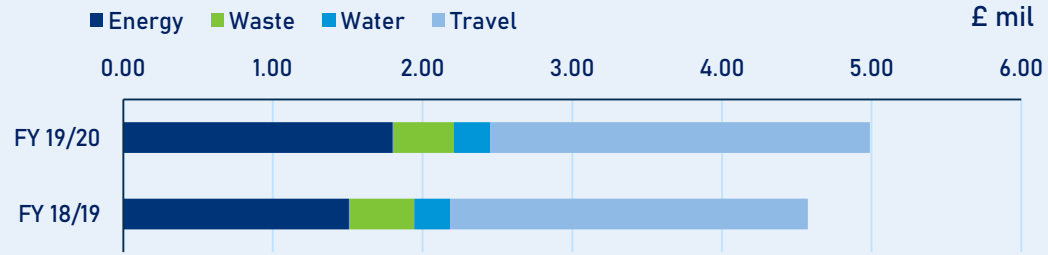
These risks and opportunities are also communicated to the to Trust Board through the annual health and safety report but also by exception in the event that the level achieves that of what is considered to be a corporate risk.

As noted in the Adaptation section of this strategy, the Trust is required to complete a Climate Risk Assessment. This will be a priority to ensure not only the risks are identified but specific approaches to managing those risks are considered and implemented. This is considered a BAU function as the governance processes outlined within this document are in place and are being used to mitigate or manage the risks associated with the environmental agenda.

# Finance

The efficient operation of assets contributes to the financial sustainability of the Trust, as well as achieving environmental co-benefits. The Trust's expenditure across core areas (energy, waste, water, and transport) for FY 19/20 was £4,988,000 – a 9.1% increase on the previous year.

Core spending




Energy (across all fuels and suppliers) and travel costs are the two largest contributors to the Trust's expenditure and should be prioritised for cost reductions. Under normal conditions, the operating costs of electric vehicles (EVs) can be significantly lower (~60%) than that of petrol/diesel vehicles[1], and the Trust should identify vehicles suitable for electrification in their travel plan to yield reductions in operating costs *and* emissions. Business cases should consider lifetime cost rather than capital cost, and include available Government grants for both EVs and charging infrastructure.

Whilst beneficial from an emissions perspective, we acknowledge that the changing of fuel types in certain situations (e.g. gas boiler → electric heat pump) can have a social and economic impact, and the improper installation and/or operation of electrified technologies can result in increased costs and reduced user comfort. It is important to *not* consider this type of measure as a like-for-like replacement, and feasibility studies should accompany business cases to ascertain the wider impacts of any change. However, it is expected for the term of this Green Plan that the majority of energy saving measures will be related to energy efficiency (e.g. LED roll-out, enhanced insulation) and the electrification of heat sources will be concentrated in the term of our next Green Plan (2025 – 2030). This will be made clearer in site-specific energy strategies.

[1] https://www.edfenergy.com/electric-cars/costs

# Finance

The recommendations proposed in this report create a step-change in the Trust's sustainability ambitions and will require a concerted resource commitment to achieve. Estimating the direct financial commitment requires detailed analysis and should be underpinned by site-specific actions. However, novel and opportune ways of accessing financing are starting to emerge that could support the investment required in tandem with conventional financing. For example:

**Covid-19 stimulus**

The UK Government announced (July 2020) a £1 billion investment in a Public Sector Decarbonisation Scheme to offer public sector bodies with grants to fund both energy efficiency and low carbon heat upgrades. The Trust should look to pursue this opportunity, and use short term Covid-19 stimulus packages to help facilitate decarbonisation and improve the viability of projects with more marginal business cases.

**Crowdfunding and community investment**

A 2019 study by the University of Leeds[1] identified that crowdfunding can play a useful role as a new model of flexible and competitive finance for the UK's public sector, and provided three case studies across NHS Trusts. Engagement with these novel financing mechanisms should be conducted to assess their suitability to EPUT's specific requirements.

[1] Financing for Society: Assessing the Suitability of Crowdfunding for the Public Sector

# Update on Actions – Developing an Electric Vehicle Charging infrastructure

One of the highest priority actions identified in Annex B, within Travel and Logistics section is to develop a strategy which reduces emissions associated with the vehicle fleet we control, and our ‘grey’ fleet of vehicles we can influence. Government is commitment to phasing out the sale of all fossil fuel vehicles UK wide by 2030 and moving to zero emissions by 2035. Electric vehicles will play an important role in this endeavour.

As a result, we have committed to providing Electric Vehicle Charging Points (EVCPs) at strategic hubs within our estate. This will be an evolving roll out where we will provide chargers primarily for our managed fleet and we will monitor EVCP usage by employers, patients and visitors to assist with future additions.

To achieve this we will:-

- Conduct feasibility surveys on our main sites and to assist in project managing installation of EVCPs and testing the available electrical capacity in support of this key initiative.
- Provide suitable infrastructure to enable the installation of the chosen EVCPs
- Conduct training so that parking/EV charging data can be usefully managed and utilised
- Ensure that the current managed fleet is replaced with electric vehicles by 2030
- Ensure that fleet mileage and travel data is made available, to inform future roll out of EVCPs

# Annex A: SDAT Benchmarking

## Overall SDAT score by organisation type:

| Organisation Type | LQ | Median | UQ |
|---|---|---|---|
| England (all trust types) | 35.4 | 47.6 | 58.8 |
| Acute – large | 36.2 | 48.7 | 64.1 |
| Acute – medium | 31.6 | 37.9 | 47.6 |
| Acute – small | 35.3 | 46.0 | 57.0 |
| Acute – specialist | 38.4 | 40.4 | 42.3 |
| Acute – teaching | 40.6 | 55.1 | 59.0 |
| Ambulance | 38.7 | 50.8 | 55.9 |
| CCG | 44.0 | 58.5 | 59.9 |
| Community | 63.4 | 63.7 | 63.9 |
| Mental health & learning disability | 35.4 | 42.9 | 54.4 |

## SDAT module scores (all trust types):

| Module | LQ | Median | UQ |
|---|---|---|---|
| Adaptation | 36.9 | 49.4 | 76.0 |
| Asset management & utilities | 38.7 | 55.1 | 65.2 |
| Capital projects | 28.5 | 49.2 | 67.5 |
| Carbon / GHGs | 21.6 | 37.4 | 55.9 |
| Corporate approach | 27.5 | 41.8 | 62.9 |
| Green space & biodiversity | 19.5 | 27.4 | 46.6 |
| Our people | 49.2 | 61.9 | 72.3 |
| Sustainable care models | 27.8 | 45.5 | 59.9 |
| Sustainable use of resources | 29.2 | 43.8 | 64.1 |
| Travel and logistics | 38.8 | 51.7 | 66.7 |

- Figures obtained from the SDU and accurate as of 09/09/2020
- Scores only include published assessments (i.e. those where the user has agreed that figures can be shared outside of the SDU)
- Where an organisation has submitted multiple assessments over time, only the most recent assessment is included in the analysis

# Annex B: Action Plan

| ID | Topic | Item description | Action required | Action owner | Quick win |
|---|---|---|---|---|---|
| **HIGH PRIORITY** | | | | | |
| 1 | Corporate approach | Define and report progress against core focus areas | **a.** Develop a list of Board approved focus areas, with associated KPIs,relating to sustainable development and social value. **b.** Align our internal systems to readily monitor and report on the focus areas against the agreed KPIs. **c.** Biannually report to the Board on the Trust's progress and actions towards achieving the KPIs. | Compliance and Assurance<br>Sustainable Development Manager | |
| 2 | Asset management and utilities | Audit hotspot areas | Perform energy audits of all sites to identify energy and waste saving opportunities across energy efficiency, low carbon heating, renewable energy, and transport. | Estates and Facilities | |
| 3 | Asset management and utilities | Carbon reduction strategy for hotspot areas | Develop site specific energy strategies with a prioritised list of actions, each with an timeline and owner. Align to the ambitions set out in the NHS Improvement Net Zero Carbon Programme. | Estates and Facilities | |
| 4 | Travel and logistics | Develop a Board approved Sustainable Travel Plan | Develop and seek Board approval for a Sustainable Travel Plan. | Compliance and Assurance<br>Sustainable Development Manager | |
| 5 | Travel and logistics | Improve data handling | Improve data collection/handling to allow for annual calculation of transport emissions (including business travel and patient transport). | Fleet Manager<br>Contracts and Procurement | |
| 6 | Adaptation | Define a lead | Identify a clear Adaptation lead within the Trust, responsible for coordinating adaptation planning, resilience and emergency preparedness. | Sustainable Development Manager | ✓ |
| 7 | Adaptation | Update climate change risk assessment | Form an interdisciplinary working group to lead work updating our climate adaptation risk assessment and plan, with reference to the latest UK Climate Projections (UKCP18). | EPRR, Estates and Property,<br>Sustainable Development Manager | |
| 8 | Capital projects | Define sustainability aims and objectives for all capital projects | Develop a set of ambitious sustainability aims and objectives (e.g. kWh/m2, m2 greenspace / m2 total) that are clearly defined in the design brief of capital projects and communicated to contractors. | Property and Development | ✓ |
| 9 | Sustainable care models | Integrate sustainability into care model selection | Include a qualitative assessment of sustainability as a key decision matrix (alongside clinical, social, and financial indicators) in our review of future care models, considering how different models of care impact use of resources, finance and infrastructure. | Strategy and Contracting | |
| 10 | Carbon and greenhouse gases | Report against carbon reduction targets | Annually measure and transparently report (both our GHG emissions.internally and externally) | Sustainable Development Manager | |
| 11 | General procurement Asset management and utilities | Prioritise lifetime costs over capital costs | Use whole-life costings as a basis for comparative procurement decisions accounting for the lifetime cost of energy and water. | Contracts and Procurement Estates and Facilities | ✓ |

# Annex B: Action Plan

| ID | Topic | Item description | Action required | Action owner | Quick win |
|---|---|---|---|---|---|
| **MEDIUM PRIORITY** | | | | | |
| 12 | Corporate approach | Integrate focus areas into procurement | Include a 5% weighting towards sustainability & social value in tenders, with a set list of questions and quantifiable indicators that relate to the focus areas. | Contracts and Procurement | ✓ |
| 13 | Corporate approach | Employee involvement | Establish a group of 'Green Champions' across the organisation to allow staff members who are passionate about sustainability in health care to engage with the Trust's activities. | Sustainable Development Manager | |
| 14 | Asset management and utilities | Provide training for energy managers | Offer formal training, CPD, and access to knowledge sharing opportunities for energy managers. | Human Resources | |
| 15 | Travel and logistics | Healthy Outcomes Travel Tool | Complete the Healthy Outcomes Travel Tool (HOTT) to better quantify the impacts of the Trust's travel (inc. air and noise pollution). | Sustainable Development Manager | ✓ |
| 16 | Adaptation | Develop adaptation strategy | Develop an adaptation plan to formalise our approach to climate change adaptation, both locally and in supply chain hotspots. | Sustainable Development Manager | |
| 17 | Capital projects | Align to best-practice standards | When published, align to the UKGBC's NHS-specific net zero standard for new buildings. | Property and Development | |
| 18 | Green space and biodiversity | Procure from sustainable food providers | Recognise and favour catering and food providers that can demonstrate their sustainability credentials. | Contracts and Procurement | ✓ |
| 19 | Green space and biodiversity | Develop a Green Space Action Plan | Develop and seek Board approval of a green space action plan that sets out our approach to maximising the use of the Trust's green space. This will recognise the separation required for patients, staff and public spaces and be tailored to their requirements. | Compliance and Assurance<br>Sustainable development manager | |
| 20 | Sustainable use of resources | Waste facility provision | Provide the necessary facilities (e.g. recycling bins) and signage across the Trust to promote sustainable treatment of waste. | Facilities | ✓ |
| 21 | Other – employee engagement | Conduct a PULSE staff survey | Perform a PULSE staff survey on the Trust's environmental performance to a) identify areas where staff members feel the Trust can operate more efficiently and sustainably in the delivery of care, and b) to understand their commuting habits and explore desire for active travel options, electric vehicle infrastructure etc. | Human Resources<br>Sustainable Development Manager | ✓ |

# Annex B: Action Plan

| ID | Topic | Item description | Action required | Action owner | Quick win |
|---|---|---|---|---|---|
| **LOWER PRIORITY** | | | | | |
| **23** | Asset management and utilities | Promote knowledge sharing amongst energy professionals | Create an internal knowledge sharing forum for facilities management professionals where best-practice, lessons learnt, and challenges related to energy efficiency can be discussed. | Estates and Facilities<br>Sustainable Development Manager | |
| **24** | Sustainable care models | Engage with the 'get it right first time' (GIRFT) programme | Engage with the GIRFT programme to identify areas of good practice and agree where changes can be made to our current care models. This will include adopting appropriate recommendations from the relevant GIRFT report when published. | Strategy and Contracting<br>Sustainable Development Manager | ✓ |
| **25** | Our People | Enhance knowledge management | Build and disseminate knowledge around the organisation through internal communications, knowledge building events, and targeted training where appropriate. | Human Resources | |
| **26** | Our People | Leverage national sustainability events to promote internal awareness | Engage with national sustainability campaigns (e.g. SDU Sustainability health and care campaign, Earth Day) to promote awareness in the organisation and encourage sustainable behaviour. | Human Resources<br>Sustainable Development Manager | |
| **27** | Sustainable use of resources | Waste hierachy training | Provide targeted training to all facility managers in the waste hierarchy and it's application. | Human Resources | |

The Carbon Trust is a company limited by guarantee and registered in England and Wales under company number 4190230 with its registered office at 4th Floor Dorset House, Stamford Street, London SE1 9NT.
Published in the UK: 2020.

| | | |
|---|---|---|
| | | **Agenda Item No: 7i** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 of November 21** |

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

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

| **Purpose of the Report** | | |
|---|---|---|
| This report provides the Board of Directors with the opportunity to review the current position with regard to the Freedom to Speak up service. | **Approval** | |
| | **Discussion** | ✓ |
| | **Information** | ✓ |

| **Recommendations/Action Required** |
|---|
| The Board of Directors/ Committee is asked to:<br>Note the contents of the report |

## Summary of Key Issues

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

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

• The appointment of local FSUGs in every NHS organisation, now a requirement of the NHS Standard Contract.
• The establishment of the Care Quality Commission's National Guardian, with Dr Henrietta Hughes first National Guardian appointed in October 2016.
• An integrated policy and a common procedure for employees to raise concerns.

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

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

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

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

The guardian role is not an easy role but a rewarding one. The expectation of the National Guardian Office (NGO) is high and broad, as patient safety and staff well-being is at its heart. There have been 20,388 cases raised (1 April 2020 to 31 March 2021) nationally.

The National Guardian office is proud to have recently appointed Dr Jayne Chidgey-Clark following the departure of Dr Henrietta Hughes who stepped down after being the National Guardian since 2016. Dr Chidgey-Clark is a clinical leader and registered nurse, with more than 30 years' experience in the NHS, higher education, voluntary and private sectors. Her most recent roles include as non-executive director at NHS Somerset Clinical Commissioning Group (CCG) where she was a Freedom to Speak Up Guardian.

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

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

The National Guardian Office:

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

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

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

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

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

Fair recruitment process and banding for Freedom to Speak up Guardians.
Dedicated time for the role.
Access and support from CEO and other senior leaders.
Guardian wellbeing and resilience - support for guardians.

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

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

The overall purpose of the Guardian Service is to:

- Support the organisation in further developing a culture of openness and freedom for staff to raise concerns about patient safety and anything that gets in the way of delivering care as part of everyday practice.
- Support staff to raise concerns about patient safety directly with their line manager/supervisor.
- Work in partnership with managers where staff are unable to raise the patient safety concern themselves.
- Escalate raised concerns that are not acted upon by managers with the Chief Executive.

- Where concerns about patient safety raised by staff are not acted upon internally, the Principal Guardian is expected to take the matter externally to the National Guardian for investigation.
- Provide training across the organisation on the raising concerns agenda.

This report provides details on:

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

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

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

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

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| MDP | Management development programme | TASI | Therapeutic and Safe Intervention |
| LD | Leadership Development. | MST | Microsoft Teams |
| | | | |

## Supporting Documents and/or Further Reading

## Lead

**Report prepared by:**

**Yogeeta Mohur**
**EPUT Principal Freedom to Speak Up Guardian**

**On behalf of:**

**Sean Leahy**
**Executive Director of People and Culture**

**Agenda Item 7i**
**Trust Board of Directors**
**24 of November 2021**

**EPUT**

# FREEDOM TO SPEAK UP GUARDIAN SERVICE

## 1.0 PURPOSE OF REPORT

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

## 2.0 EXECUTIVE SUMMARY

### 2.1 EPUT's Freedom to Speak Up Guardian Service

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

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

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

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

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

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

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

## 2.2 Overview of activity/progress in 2021 continuing from last year.

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

## 2.3 Concerns Raised

Data is reported to the National Guardian office on a quarterly basis. Since April 21 till end of September 21 (The last two quarters) we have had 117 concerns reported through to the Freedom to speak up. This does not include details of concerns raised through the Trust Whistleblowing process, but does include all concerns diverted from the previous 'I'm Worried About' system). We have had 62 people who responded to whether they would use the service again with 42 people stating that they would use the service again, 5 answered no and the rest may be and don't know. Some colleagues have given written feedback of their experiences and overall we have had really positive responses from colleagues who have highly appreciated and recommended this service to other colleagues.

## 2.4 Number of staff who have received training is below:

The following table details training activities that have taken place in respect of the agenda from April 2021 until end of October this year:

| **Training Type** | **Approximate Number of attendees** |
|---|---|
| MDP Raising Concerns Training for Managers | 26 |
| Leadership Training | 51 |
| Allied Health Profession students | 83 |
| Junior Doctors training<br><br>North East<br>Mid<br>West | <br><br>24<br>18<br>18 |
| Student Nurses:<br><br>North and south<br><br>South East Essex and West Community | <br><br>596<br><br>170 |

## 2.5 Emerging Themes

The following themes have been noted from the concerns raised from 1 April 2020 to end of September 2021. Please note that individuals may have raised more than one issue as part of their 'raised concern':

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

| | |
|---|---|
| | **No of concerns Oct/Nov/Dec 20** |
| | |
| Patient Safety | 5 |
| Staff Safety | 14 |
| Bullying and Harassment | 26 |
| Infrastructure/Environmental | 14 |
| Other | 15 |
| **Total** | **74** |
| | |
| | **Jan/Feb/March 21** |
| Patient safety | 8 |
| Staff safety | 12 |
| Bullying and Harassment | 43 |
| Infrastructure/Environmental | 6 |
| Other | 12 |
| **Total** | **81** |
| | |
| **April/ May/ June 21** | |
| Patient safety | **5** |
| staff safety | **3** |
| Bullying and harassment | **43** |
| Infrastructure/ Environmental | **5** |
| Other | **8** |
| **Total** | **64** |
| | |
| **July/August/September 21** | |
| Patient safety | **9** |
| Staff safety | **3** |
| Bullying and harassment | **31** |
| Infrastructure/Environmental | **4** |
| Other | **7** |
| **Total** | **53** |

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

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

Freedom to speak up training has also been delivered to our doctor colleagues. We continue to work with the training department to promote the Freedom to speak up agenda and encourage staff from different backgrounds/professions to join us and promote this agenda further. On our intranet page staff can see at a glance the list of local guardians and their professional background as well as geographical base therefore giving staff the choice of which local guardian to approach.

With regards to the recording of those raising concerns who have protected characteristics, currently the only data collected is in respect of race and it is optional for people to do so or

not. Again this is not an area showing any trends to report. Concerns reported by staff from a white background are fairly equal to that reported by the BAME staff members and we have been working with our colleagues from HR as well as the BAME network to support individuals.

From April this year until end of October this year we have:

- 5 x grievances and 11 x harassment complaints (substantive or fixed term workers).
- 15 x temporary worker complaints of grievance or harassment.
- 6 x capability (formal) procedures.

**2.6 Challenges**

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

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

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

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

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

Staff have had the opportunity to use the open door policy and access the Executive Director for People and Culture as well as our CEO and spoke directly about their work experience in EPUT. Having access to our senior leaders really gives staff that feeling of worth and being

valued. This also upholds our values of being open, compassionate and empowers colleagues. We also have live sessions open where staff can attend and ask the Executive Team questions directly. I have had a lot of colleagues who have praised this platform as this shows our senior leaders robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.

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

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

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

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

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

When colleagues contact the platform, often they are rather distressed, so it is important that they are given the time to ventilate their feelings and look at a realistic ways of how they can be supported and sign-posted accordingly. Often colleagues do not report concerns because they want to take any formal actions,(especially concerns related to bullying and harassment), but to feel listened to by someone completely impartial that they can have access to.

### 2.7 Successes

As noted in the report in May this year, the profile of the Freedom to Speak Up service has significantly risen through the support of the Communications Team and the concerted effort during the National Speak up month which is in October. Last year and again this year we spoke of the alphabets of speaking up, encouraging people to think of what word resonates with them when they think of speaking up. We had the pleasure of inviting Dr Henrietta Hughes, ex National Guardian last year in the speak up month and this October we had the regional officer Annie Ng who attended our Live event to continue to raise awareness of the agenda.

We will continue to publish 'you said we did' for concerns raised. These provide high level information on concerns raised and the action taken by the Trust to resolve them and detail

the improvements put in place as a result. They can be located on the Freedom to Speak Up intranet page.

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

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

### 2.8 Feedback

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

The majority of comments reflected a positive experience of the service, however there were some responses from people who felt that nothing had changed for them. As noted in section 2.6 timeliness of response continues to play a huge part in staff feeling that something has changed for them as well as detailed responses from managers on how they looked into the matter and any actions taken. We will continue to survey people to continue to use feedback as a reflection and how to continuously make improvements to our services.

A number of people said that they would be happy to share their story of raising concerns. We welcome colleagues to share their experience at the board meeting to hear directly from them about their experience of using the Freedom to speak up platform and what they would like to see differently and what can we learn from their experience and improve.

Some of the comments we received include:

*''The service was supportive, and unbiased, they offered me advice and guidance across a very challenging time, I am very appreciative of their help''.*

*''I found it supportive and without this platform I would felt lost at the time of my situation and am just grateful I had one Avenue I could go to other than my line manager.''*

*'' I was supported by the F2Sup, Awesome support''*

*"I found the F2SU guardian really helpful and supportive but that the guardian had no real power to act''*

*''Speaking Up is one of the best innovation EPUT is exercising at this moment''.*

### 2.9 Conclusion

As previously noted EPUT has good processes in place to manage concerns raised by staff and this service is an addition to the Raising Concerns (Whistleblowing) Policy and Procedure. The challenge is to continue to raise awareness and understanding of the Freedom to Speak Up process and to help staff overcome barriers to speaking up. As noted previously the key

issue is culture, both of people feeling able to raise concerns and then managers to act on them in a timely manner. The crucial part is to thank the person for raising issues as unless we know of concerns, one cannot address them and have lessons learnt as a result.

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

As noted the pandemic has unfortunately slowed some of our promotional work down, however as noted we continue to provide support to staff during this time.

**Actions planned 2021 and beyond:**

In 2020/21 the following have been identified as key items to be taken forward as part of the work plan:

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

## 3.0 ACTION REQUIRED:

The Board of Directors is asked to:

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

**Report prepared by:**

Yogeeta Mohur, EPUT Principal Freedom to Speak Up Guardian

**On behalf of:**

Sean Leahy, Executive Director of People and Culture

**Agenda Item No: 8a (i)**

| SUMMARY REPORT | BOARD OF DIRECTORS PART 1 | 24 November 2021 |
|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **Board of Directors Audit Committee Assurance Report** | | | | | |
| **Executive/Non-Executive Lead:** | Janet Wood, Chair | | | | | |
| **Report Author(s):** | Carol Riley, Audit Committee Secretary | | | | | |
| **Report discussed previously at:** | Assurance Reports provided to the Board following Audit Committee Meetings. | | | | | |
| **Level of Assurance:** | **Level 1** | ✓ | **Level 2** | | **Level 3** | |

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

| **Purpose of the Report** | | |
|---|---|---|
| This report provides the Board of Directors:<br><br>• Assurance to the Board that the duties of the Audit Committee, which include Governance, Risk Management and Internal Control, have been appropriately complied with. | **Approval** | |
| | **Discussion** | |
| | **Information** | ✓ |

**Recommendations/Action Required**

The Board of Directors is asked to:

1 Note the contents of the report
2 To confirm acceptance of assurance given in respect of risks and actions identified
3 To Request any further information or action.

**Summary of Key Issues**

- Internal Audit Progress Report
- LCFS Progress Report
- External Audit
- Finance Procedures
- Wavier of Standing Orders
- Statement of Financial Write Offs
- Governance Update
- Losses and Special Payments
- Use of Consultants/Legal Services
- Director Expenses
- H2 Financial Plan

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

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| | | | |
| | | | |

| Supporting Documents and/or Further Reading |
|---|
| |

| Lead |
|---|
|  <br>Janet Wood<br>**Chair of Audit Committee** |

**Agenda Item: 8a (i)**
**Board of Directors**
**Meeting: 24 November 2021**

**EPUT**

# ASSURANCE REPORT FROM THE AUDIT COMMITTEE CHAIR

## 1.0 PURPOSE OF REPORT

This report is provided by the Chair of the Audit Committee, a sub-committee of the Board of Directors to provide assurance to Board members that the duties of the Audit Committee which include Governance, Risk Management and Internal Control have been appropriately complied with.

## 2.0 EXECUTIVE SUMMARY

**Audit Committee Meeting 9 November 2021**

The Audit Committee met on the 9 November 2021 and approved the minutes of the meeting held on 15 September 2021. These minutes are available to Board members on request.

At the meeting held on 9 November 2021 the following matters were discussed:

1. **Internal Audit**

**Internal Audit Progress Report 2020/21**
The following report has been finalised:

- Complaints – Received moderate assurance

The following report has been issued in draft:

- Inpatient Deaths
- Site Visits
- Trust Accommodation

**Local Counter Fraud Service Progress Report**

**Referrals**
The Committee received an update on the current investigations/referrals.

**Fraud Awareness Week 14-20 November 2021**
Members were informed of the above and agreed that this would be promoted via Communications.

2. **External Audit**

**Charitable Fund Accounts 2020/21**
The above accounts are in the process of being reviewed.

3. **Finance Procedures**
The following procedure was approved:

- Tendering and Quotations (FP09/07)

The following procedures were deferred for 3 months:

- Cost Improvement Procedure (FP09/17
- Patient Property and Money Procedure (FP09/02)
- Welfare Department Procedure (FP09/02a)

4. **Waiver of Standing Orders**
During the period from 1 September 2021 to 31 October 2021, standing orders for competitive quotations were waived on nine occasions to the value of £290,728.38 (including VAT). It was noted that two of these related to the mass vaccination to the value of £87,202.38.

For the same period, standing orders for competitive tenders were waived on one occasion to the value of £142,195.20 with the order relating to the combined insurance renewal.

5. **Statement of Financial Position Write Offs/Write Backs/Impaired Debts Write Offs**
There were no write offs to report.

6. **Governance Update**
The Committee received an update on the following:

- Board Assurance Framework
- Government Development Plan
- Accountability Framework
- Review of Standing Committees to the Board

7. **Losses and Special Payments**
As at end of month 6, the Trust is reporting losses and special payments of £2,300.92.

8 **Use of Consultants/Legal Services**

**Legal Services**
The total spend on legal expenses for the first six months of the year is £165k (2020/21 comparator: £141k). Of this, £135k has been spent with panel firms.

**Consultancy Services**
The total spend on consultancy / professional fees for the same period is £1,970k.

The 2021/22 year to date spend is higher than the comparator period in 2020/21 due to the timing of the rollout of the mass vaccination programme and safety first agenda.

9. **Director Expenses**
The Directors expenses for the first six months of the financial year total £334 and have been claimed by two members of the board. Expenses for the twelve months of the previous financial year were £2,497 claimed by 13 members of the Board.

10. **H2 Financial Plan**
The timetable for the H2 Plan submission was presented to the Committee.

## 3.0 MANAGEMENT OF RISK

The Audit Committee is not responsible for managing any of the Trust's significant risks (as identified in the Board Assurance Framework).

## 4.0 NEW RISKS

There are no new risks that the Audit Committee has identified that require adding to the Trusts' Assurance Framework, nor bringing to the attention of the Board of Directors.

## 5.0 ACTION REQUIRED

**The Board of Directors are asked to:**

1. Note the summary of the meeting held on 9 November 2021.
2. Confirm acceptance of assurance given in respect of risk.
3. Request further action/information as required.

Janet Wood
Non Executive Director
**Chair of Audit Committee**

| | |
|---|---|
| | **Agenda Item No: 8aii** |

| | |
|---|---|
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **Board Safety Oversight Group Assurance Report – November 2021** | | | | | |
| **Executive/Non-Executive Lead:** | Alison Rose-Quirie, Non-Executive Director | | | | | |
| **Report Author(s):** | Richard James – Director of Transformation | | | | | |
| **Report discussed previously at:** | ESOG | | | | | |
| **Level of Assurance:** | **Level 1** | ✓ | **Level 2** | | **Level 3** | |

| **Risk Assessment of Report** | |
|---|---|
| Summary of Risks highlighted in this report | |
| State which BAF risk(s) this report relates to | **BAF63 - Learning and Improving**<br>**BAF10 - Ligature Reduction**<br>**BAF45 - CQC**<br>**BAF50 - Skills, Resource and Capacity**<br>**BAF67 - CAMHS Tier 4** |
| Does this report mitigate the BAF risk(s)? | Yes/ ~~No~~ |
| Are you recommending a new risk for the EPUT BAF? | ~~Yes~~/ No |
| If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register. | |
| Describe what measures will you use to monitor mitigation of the risk | |

| **Purpose of the Report** | | |
|---|---|---|
| This report provides the Board of Directors an update on the progress of projects and programmes linked to the safety priorities within the safety strategy.<br><br>• Safe Staffing<br>• EPUT Culture of Learning<br>• Ligature Risk Reduction<br>• Engagement & Supportive Observations | **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

N/A

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

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

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

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| ECOL | EPUT Culture of Learning | | |
| PMO | Programme Management Office | | |
| PID | Project Initiation Document | | |

## Supporting Documents and/or Further Reading

Since its inauguration in August 2020, The Executive Safety Oversight Group (ESOG) has met on a weekly basis to oversee the development, planning and delivery of the Trust wide safety strategy.

The Board Safety Oversight Group (BSOG) provides assurance that the safety strategy is being delivered to the agreed time, cost and quality parameters and has been meeting monthly since November 2020.

This report has been provided to update for the Trust Board on the progress of projects and programmes that are linked to the safety priorities within the safety strategy.

**Safe Staffing**

EPUT identified the need to understand and address levels of substantive and flexible employees across the Trust inpatient wards.

Daily sit rep calls with direct escalation points through to the executive team have continued in addition to the daily executive stand up and weekly executive safety oversight group. This enables issues to be addressed immediately with daily resolution at the appropriate level of authority.

A crucial element of this programme has been to convert flexible workers into substantive posts and funding has been allocated to enable this. To date, 29 members of staff have been converted, mainly into unqualified Support Worker roles. We are using qualitative data to track reductions in the use of flexible/agency workers. We will also now use this data to expand recruitment via other methods.

Safecare system changes and refresher training has been completed with the goal to move from three staff systems to one for viewing and reporting staffing levels. An updated escalation process has been developed which will form part of the new safe staffing policy (currently in development) and identification of workforce planning challenges and strengths/opportunities will help form our ongoing action plan.

The next phases of the programme include a staffing/establishment review, migration from Safer Staffing system to Safecare, agree the approach to take regarding rostering (e.g. centralisation). A staffing narrative review to validate data and building of a broader qualitative picture of staffing across inpatient wards will be undertaken.

EPUT currently has circa 377 registered nurse vacancies across all directorates. To reduce this deficit a pilot to recruit nurses from overseas has taken place (seven started in October and three will arrive in November). Following the success of this pilot scheme we have initiated an international recruitment programme to further recruit, train and place at least 185 nurses by December ‘22.

**EPUT Culture of Learning (ECOL)**

The Trust recognised the need for evidence of the embedding and sustenance of lessons identified in the organisation. The ECOL project represents our commitment to excellence and a willingness to learn from the actual experience of others. The vision for ECOL is for lessons learnt to be an **‘Always Event’** with learning embedded into the practice of our people and safety procedures are followed at all times.

A scoping procedure was initiated where all existing processes around lessons learned, systems and historic action plans were reviewed. Subject matter experts in learning lessons, serious incident reporting and data management engaged throughout to inform and refine from a

resource, engagement and technical requirement. The project looked for best practice externally to EPUT both within the health service field as well as other industries such as the military and aviation.

A number of solutions have been explored for both the recording of lessons as well as how to openly distribute key findings, operational improvements and guidelines. Whilst multiple options are available for the logging of lessons, the working group propose that continuing to use Datix would be advantageous as it is familiar to those on site.

Wide engagement has taken place on all aspects of the project, ensuring every avenue is explored in terms of socialising across corporate and clinical teams. Working and steering groups have been established and include members from multiple areas of the organisation.

The vision for ECOL has been shared with multiple populations via one-on-one stakeholder discussions and presentation on EPUT's all staff update. This work continues with representatives from communications and a commitment has been made to design an ongoing communications and adoption package to help embed ECOL ways of working.

**Ligature Risk Reduction**

The reduction of ligature risks across our wards is of paramount importance to the Trust, any potential avenue for self-harm should be recognised and removed as soon as possible. This project initially aimed to review historic action plans in order to build a list of required works whilst agreeing new minimum standards to be adhered to in the future.

A decision was made to audit our wards against the new minimum standards, carry out a gap analysis process and then plan remedial works as a key estates priority.

The project not only ensures that new minimum standards are met across all existing wards, but also builds a robust and repeatable audit process and continuous improvement model which will be transitioned to a business-as-usual activity.

Remediation work within the CAMHs units are nearing completion however, availability of materials and skilled resource has contributed to some delays, but overall progress has been positive given these challenges and the volume of estates work in totality.

The Transformation PMO team and Estates team have been working collaboratively to revise and simplify the governance process for prioritisation and funding approval of estates work. Reconciliation against the completed work and the historic action plans will be undertaken to ensure that all actions have been addressed.

**Engagement & Supportive Observations**

EPUT is engaged in a national piece of work to develop CQC standards for inspections in relation to observation and engagement. Collaboratively we implemented daily and weekly documentation checks across all mental health and specialist services with comprehensive audits being carried out using the Perfect Ward app. Recording forms have been rolled out to all mental health and specialist services through the revision of the Trust policy and procedures. Moving forward, the effectiveness and content of documentation used to record engagement and observations will be part of the discussions when reviewing the policy.

EPUTs annual audit will continue to use the data collected from the Perfect Ward app and we have produced a range of short informational films which will describe the key elements of observation and engagement with an emphasis on record keeping.

Regular task and finish group meetings are taking place between operational and corporate teams. The compliance and corporate nursing team continue to monitor documentation regarding observation and engagement during site visits.

A pilot of Oxehealth's digital e-Observation software is planned for December. This pilot will explore the clinical and business benefits that can be applied when using a real-time observation tool for capturing, recording and modifying levels of patient observations. This digital approach provides us with a reporting and trending dashboard for analytics, allowing for greater insight and intelligent data availability.
The expected benefits of using e-Observation include an increase in the quality and flexibility of observation recording as well as observation level changes/approvals resulting in a potential reduction in patient safety impacting events.

**Lead**

**Name: Alison Rose-Quirie**
**Job Title: Non-Executive Director**

| | | |
|---|---|---|
| | | **Agenda Item No:8(a)iii** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **Finance & Performance Committee Assurance Report** | | | | | |
| **Executive/Non-Executive Lead:** | Loy Lobo<br>Chair of the Finance and Performance Committee<br>Paul Scott<br>Chief Executive Officer | | | | | |
| **Report Author(s):** | Amy Tucker<br>Senior Performance Manager | | | | | |
| **Report discussed previously at:** | Finance & Performance Committee | | | | | |
| **Level of Assurance:** | **Level 1** | | **Level 2** | ✓ | **Level 3** | |

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

| **Purpose of the Report** | | |
|---|---|---|
| This report provides the Board of Directors with details that:<br>• The Finance and Performance Committee (FPC) is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objective and impact on quality are being managed effectively. | **Approval** | |
| | **Discussion** | |
| | **Information** | ✓ |

**Recommendations/Action Required**

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance provided
3 Request any further information or action.

**Summary of Key Issues**

Please note this assurance report for the Board is a bi-monthly report and will cover items discussed in October and November.

**Performance Report**

The Executive Director of Operations presented an update to the Committee on each of the inadequate performance areas for month 6 and 7, and gave the Committee assurance that each of the areas identified are closely monitored and the challenges are well known. Substantial actions and system changes are being made to address each area and there are robust plans in place.

In October 2021 there were 4 areas of **inadequate performance** (5* in September):

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

*Following three months of recovery and target attainment CPA Reviews is no longer rated inadequate.

During the October meeting the Clinical Director of Psychological Services attended to present the challenges faced by the service and which mitigating actions are being deployed.

In November, the Director of Mental Health North East & West attended the meeting to outline factors that are impacting on flow through inpatient units within the organisation and what plans and trajectories are in place to monitor this.

Members of the Committee praised the detailed information given by both and for providing a clear picture of the challenges and providing assurance of the steps being taken to resolve these.

**Financial Update – Month 7 Results**

The Director of Finance updated the Committee on the current financial position at Month 7 (M7).

- The Trust has reported a small YTD deficit which is consistent with M6 Results.
- The Trust has seen an improvement in efficiency delivery in M7 supporting increased confidence in delivery of the 21/22 financial plan. A forecast outturn assessment with risk and opportunities will be provided to F&P.
- The Capital programme is £2.4m behind plan with a majority relating to timing of delivery of the dormitory projects with forecasted recovery in future months.
- MHIS continue to report an underspend position with Partnership dialogue underway to support recruitment initiatives and the development of a recruitment business cases.
- No concern over cash position and Trust continuing to ensure suppliers are paid timely with YTD performance at 94% volume; 89% value.

Members were grateful to the Director of Finance and were pleased to note we are on target.

**Sustainability Development Plan**

The Transformation Director of Estates and Facilities presented the 2020 Green Plan to the Committee. The Committee welcomed this plan and its ambitions with the agreement that a risk register will be included.

**Contracts Update**

The Director of Contracting and Business Development presented an update of the status of Contracting and Business Development activities.

Members of the Committee thanked the Director of Contracting and Business Development for their update and the assurance given to the new Lighthouse service EPUT will be taking the lead on.

**Policy Extension Request**

In October, the Committee approved the extension of the policies & procedures listed below:

- Social Media Policy
- Organisational Change Policy
- Time off for Trade Union Duties Policy
- Grievance Policy
- Maintaining High Professional Standards (MHPS) Conduct & Capability Policy for Medical & Dental Staff
- Flexible Working Policy
- Managing Temporary Worker Conduct & Complaints Policy

In November, the Committee approved the extension of the policies & procedures listed below:

- Private & Independent Practice for Medical Staff
- Flexible Working Policy & Procedure
- Remediation Policy
- Medical Appraisal Policy

**Any Risks or Issues**

During the October meeting the Committee agreed that psychology recruitment should be included on the risk register. An action was approved for the Interim Director of Risk & Compliance and the Clinical Director of Psychological Services to incorporate these risks in to the Trust Risk Register. During the November meeting there were no risks or issues identified.

**Any Other Business**

There was no other business.

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

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

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

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

| **Acronyms/Terms Used in the Report** | | | |
|---|---|---|---|
| | | | |

| **Supporting Documents and/or Further Reading** |
|---|
| Accompanying Report |

| **Lead** |
|---|
| **Loy Lobo**<br>**Non-Executive Director** |

**Agenda Item 8(a)iii**
**Board of Directors Meeting Part 1**
**24 November 2021**

# FINANCE AND PERFORMANCE COMMITTEE ASSURANCE REPORT

## 1.0 Purpose of Report

This report is provided by the Chair of the Finance and Performance Committee, Loy Lobo to provide assurance to Board members that the performance operational, financial and governance as at Month 6 September 2021 and month 7 October 2021

The Finance and Performance Committee (FPC) is constituted as a standing committee of the Board of Directors. The Board of Directors has delegated responsibility to this committee for the oversight and monitoring of the Trust's financial, operational and organisational performance in accordance with the relevant legislation, national guidance, the Code of Governance and current best practice from 1 April 2017.

The Committee is required to ensure that risks associated with the performance and governance arrangements of the Trust are brought to the attention of the Board of Directors and/or to provide assurance that these are being managed appropriately by the Executive Directors.

## 2.0 Quality and Performance Report

This report covers the position for month 6 and month 7.

The report has been aligned to the CQC scoring metrics in order to align the monitoring of key performance indicators, using inadequate, requires improvement, and good as the principles for the prioritisation of focus.

**Performance and Quality**

In October 2021 there were 28 indicators within target (28 in September).

In October 2021 there were 4 areas of **inadequate performance** (5* in September):

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

* Following three months of recovery and target attainment CPA Reviews is no longer rated inadequate.

In October 2021 there were 9 areas **requiring improvement** (10* in September):

- Patient Harm (increasing number of incidents awaiting sign off and degree of harm)
- Incident Reporting Rates
- MH Restrictive Practice (restraints)
- Cardio Metabolic Assessments / SMI
- Inpatient Capacity Older Adults
- Inpatient Capacity Specialist
- IAPT (Access Rates for CPR & NEE)
- Sickness Absence
- Temporary Staffing (Agency)

*Essex STaRS was subsequently not graded in October whilst data was being awaited.

The Executive Director of Operations presented an update to the Committee on each of the inadequate performance areas, and gave the Committee assurance that each of the areas identified are closely monitored and the challenges are well known. Substantial actions and system changes are being made to address each area and there are robust plans in place.

During the October meeting the Clinical Director of Psychological Services attended to present the challenges faced by the service and which mitigating actions are being deployed.

In November the Director of Mental Health North East & West attended the meeting to outline factors that are impacting on flow through inpatient units within the organisation and what plans and trajectories are in place to monitor this.

Members of the Committee praised the detail provided by both the Clinical Director of Psychological Services and the Director of Mental Health North East & West for providing a clear picture of the challenges and assurance of the steps being taken to resolve these.

## 3.0 Financial Position – Month 7

The Director of Finance updated the Committee on the current financial position at Month 7.

### H2 Plan Update

1. Second half of the year (H2) ICS plan submitted and accepted by Regional office. No amendments to draft plan were required. ICS H2 plan is a breakeven with efficiency requirements of £32m / 2.9%.
2. The Trust's H2 plan was approved under agreed delegated authority arrangements. The Trusts detailed submission is required to be submitted by 25 November with Board approval scheduled for 24 November. Trust's H2 plan is breakeven with required efficiency target of £6.3m / 2.7%. Further work to develop recurrent efficiency solutions for 22/23 was recognised.
3. The H2 plan removes uncertainty of Trust's income baseline and includes additional income of £36m above H1 plan. A majority of this income will be matched with costs e.g. pay award and FYE of initiatives (Provider Collaborative).
4. Audit Committee received a process assurance paper on H2 planning which was shared with External Auditors.

### M7 Results

1. The Trust has reported a small YTD deficit which is consistent with M6 Results.
2. The Trust has seen an improvement in efficiency delivery in M7 supporting increased confidence in delivery of the 21/22 financial plan. A forecast outturn assessment with risk and opportunities will be provided to F&P.
3. The Capital programme is £2.4m behind plan with a majority relating to timing of delivery of the dormitory projects with forecasted recovery in future months.
4. MHIS continue to report an underspend position with Partnership dialogue underway to support recruitment initiatives and the development of a recruitment business cases.
5. No concern over cash position and Trust continuing to ensure suppliers are paid timely with YTD performance at 94% volume ; 89% value.

Members were grateful to the Director of Finance and were pleased to note we are on target.

## 4.0 Sustainability Development Plan

The Transformation Director of Estates and Facilities presented the 2020 Green Plan to the Committee.

The plan detailed the ambitions of the Trust, the direction of travel, and the good practical things the Trust has already deployed. Work is ongoing across multiple Directorates to embed new practice, to ascertain new advances, and to standardise our approach with other Trusts.

The Committee welcomed this plan and its ambitions with the agreement that a risk register will be included.

## 5.0 Contracts Update

The Director of Contracting and Business Development presented an update of the status of Contracting and Business Development activities.

The Director of Contracting and Business Development confirmed there are no active tenders in progress following the submission of two tenders during October 2021. It was also confirmed that the Mid and South Essex Community Collaborative Board has approved EPUT contracting for and delivering the Lighthouse Child Development Centre Service, which will now be subject to due diligence and mobilisation.
The Executive Director of Operations provided assurance that long term plans will be in place to manage this new service.

Members of the Committee thanked the Director of Contracting and Business Development for their update and the assurance given to the new Lighthouse service EPUT will be taking the lead on.

## 6.0 Policy Extension Requests

In October, the Committee approved the extension of the policies & procedures listed below:

- Social Media Policy
- Organisational Change Policy
- Time off for Trade Union Duties Policy
- Grievance Policy
- Maintaining High Professional Standards (MHPS) Conduct & Capability Policy for Medical & Dental Staff
- Flexible Working Policy
- Managing Temporary Worker Conduct & Complaints Policy

In November, the Committee approved the extension of the policies & procedures listed below:

- Private & Independent Practice for Medical Staff
- Flexible Working Policy & Procedure
- Remediation Policy
- Medical Appraisal Policy

## 7.0 Any risks or issues

During the October meeting the Committee agreed that psychology recruitment should be included on the risk register. An action was approved for the Interim Director of Risk & Compliance and the Clinical Director of Psychological Services to incorporate these risks in

to the Trust Risk Register. During the November meeting there were no further risks or issues identified.

## 8.0 Any Other Business

There was no other business.

**Report prepared by:**

**Amy Tucker**
**Senior Performance Manager**

**On behalf of:**

**Loy Lobo**
**Chair of the Finance and Performance Committee**

| | | |
|---|---|---|
| | | **Agenda Item No: 8aiv** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **Quality Committee Assurance Report** | | | | | |
| **Executive/Non-Executive Lead:** | Rufus Helm, Non-Executive Director | | | | | |
| **Report Author(s):** | Gill Mordain, Strategic Advisor, Quality and Improvement on behalf of Professor Natalie Hammond, Executive Nurse | | | | | |
| **Report discussed previously at:** | N/A | | | | | |
| **Level of Assurance:** | **Level 1** | ✓ | **Level 2** | ✓ | **Level 3** | |

| **Risk Assessment of Report** | |
|---|---|
| Summary of Risks highlighted in this report | This report provides information on discussions that have taken place at Quality Committee, inclusive of assurance given from all accountable sub-committees, performance dashboards inclusive of challenge and mitigation against risks. |
| State which BAF risk(s) this report relates to | BAF38 C19 Emergency Planning<br>BAF 55 Independent Enquiry<br>BAF45 CQC<br>BAF63 Learning<br>BAF10 Ligature Reduction |
| Does this report mitigate the BAF risk(s)? | Yes |
| Are you recommending a new risk for the EPUT BAF? | No |
| If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register. | N/A |
| Describe what measures will you use to monitor mitigation of the risk | N/A |

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

| **Recommendations/Action Required** |
|---|
| The Board of Directors are asked to:<br>1 Note the content of this report<br>2 Confirm acceptance of assurance given in respect of actions identified to mitigate risks<br>3 Request any further information and or action. |

## Summary of Key Issues

The Quality Committee has reviewed the work of all sub-committees and all performance and quality dashboards accountable to the Quality Committee. This report is provided to give assurance of the review and challenge initiated.

This report confirms that the Quality Committee has been given assurance that all work streams are in place and actions are being taken to mitigate risks.

- Assurance is provided that all sub-committees are delivering against agreed action plans and schedules of business
- Positive progress continues to be made against core areas of delivery
- Corporate teams are focusing their efforts on supporting operational teams with both frontline delivery and putting arrangements in place to reduce risk
- Against each sub-committee agenda risks have been identified and where possible actions to mitigate have been taken

Due to the rapidly changing landscape, the scope of work is reviewed against each sub-committee and actions taken to mitigate risk on an ongoing basis

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

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

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

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| EPUT | Essex Partnership University NHS FT | PD | Personality Disorder |
| PICU | Clinical Commissioning Group | SMI | Severe Mental Illness |
| ALOS | Average length of stay | CQC | Care Quality Commission |
| OPEL | Operational Pressure Escalation Level | BAF | Board Assurance Framework |

## Supporting Documents and/or Further Reading

## Lead

Natalie Hammond
Executive Nurse

SAB/Meeting Cover Report Template/rev.2 October 21

**Board of Directors Meeting**
**Part 1**
**24 November 2021**

# QUALITY COMMITTEE ASSURANCE REPORT

## 1 Purpose of Report

This report is provided to the Board of Directors by the Chair of the Board of Directors Quality Committee. As an integral part of the Trust's agreed assurance system, the report is designed to provide assurance to the Board that:

- Risks that may affect the achievement of the Trust's objectives and impact on quality are being managed effectively. This is an integral part of the Trust's agreed assurance system;
- The Committee is discharging its terms of reference and delegated responsibilities effectively.

## 2 Executive Summary

### 2.1 Minutes of previous meetings

The minutes of the Quality Committee meetings held on 9 September 2021 and 14 October 2021 were approved as correct accounts of the meetings.

**Summary of discussions and issues identified as well as assurances provided at the October and November meetings:**

### 2.2 <u>15 October 2021</u>

**2.2.1 Quality Performance Report:** The Committee received the report that gave an updated position as at August 2021. The report incorporates 53 performance/ quality indicators with 32 identified as Indicators for review by the Quality Committee. In addition, five physical health indicators reported to commissioners were included.

There were 20 indicators within target and 4 areas of inadequate performance:

- CPA 12 Month Reviews – In August performance continued to improve for the third consecutive month. 95.8% of CPA reviews have been completed in August, up from 92.5% in July. It was noted that the indicator will be downgraded from inadequate once the Trust maintains this performance for three months
- Inpatient MH Capacity (Adults & PICU) – The adult average length of stay on discharge continued to increase in August and is consistently failing to achieve stays that are in-line with or shorter than the NHS benchmark. The Committee discussed the need to focus on patients who have been on inpatient ward for over six months to identify the obstacles. It was noted that Covid was proving to be an obstacle affecting flow and capacity.
- Clients not seen in 12 months – It was noted that outstanding actions are reducing week on week and as a result the task and finish group met for the final time on 17 August 2021 with one follow up meeting scheduled for November.
- Psychology – As a result of demand significantly outweighing capacity, and services suffering a legacy burden of under-investment until 2020/21, wait times across all MDTs in SEE to access second phase psychological interventions remain lengthy. It was noted that accessible focused assessments are in place to support delivery of clinically informed treatment

and safety plans.

The Committee noted that in August there were 6 areas requiring improvement and were given assurance that actions were being taken within all areas. Positive developments in relation to VTE, physical health checks and falls were noted.

**2.2.2 Learning Disability Improvement Standards** The Committee received an update on the progress and status of the work underway to comply with the Learning Disability Improvement Standards. It was noted that a relaunch meeting had taken place with limited attendance. This led to a review and wider discussion with peers and neighbouring Trusts about approaches to continue embedding of the standards. As a result it was agreed that the Trust would take a QI approach to drive delivery.

**2.2.3 CQC Compliance Update:** The Committee received an update and assurance on the key CQC related activities that are being undertaken within the Trust. It was noted that the CQC's final report regarding CAMHS services was published on 15 September 2021. In their report the CQC had re-rated the CAMHS service as 'inadequate'. The report identified 22 areas of improvement and these issues have been drawn into an action plan by the CAMHS Intensive Clinical Support Group. The Committee were assured that many of the actions had already been achieved as work had progressed as soon as feedback was received.

Assurance was given that the Compliance Team are continuing to test action plans that have been completed to ensure actions have been embedded. A new compliance framework is under development with the aim to utilise available information to identify potential areas of risk which will work alongside a new safety walkaround process.

**2.2.4 Learning from Deaths – Mortality Review Quarter 1:** The Committee were presented with a report that was compliant with nationally mandated reporting requirements with additional commentary to provide increased levels of assurance. The report included details of the grade of review to which the deaths are being subjected and a discussion took place regarding the implementation of the Patent Safety Incident Response Framework. It was noted that the Mortality Review Sub-Committee has in place a full dashboard to review deaths covering above the mandatory requirements by including death of patients who had contact with the EPUT element of the substance misuse service in the 6 months preceding their death. A full discussion was held and assurance sought against case note reviews in progress.

The Committee were advised that the learning model within the report was understated and does not represent the full picture of the amount of work being undertaken to align PSIRF and the mortality agenda.

**2.2.5 Patient Story:** The Committee received a patient story of a female patient who had a long history of an eating disorder and had recently been in a specialist eating disorder unit but due to rapidly physical deterioration had required an acute hospital admission for feeding. The patient had been resistive to treatment and required frequent restraint to be fed and prevent self-harm .EPUTs liaison team and consultant psychiatrist were asked to provide initial support.

NHSE, CCGs, Acute hospital, EPUT, Private Provider, Professionals and Senior Managers were involved in multi-agency meetings in an attempt to find an appropriate care facility and to support n the current day to day care and treatment of the patient. EPUT agreed to admit the patient although it was acknowledged that staff may not have the knowledge and skills to achieve sufficient progress but were

confident of the ability to provide a psychologically safe environment. With the support of external agencies and strong rapport between the patient and the ward team the patient made significant progress very quickly and is eating and drinking well. The Committee noted the positivity of this story and commended the cross organizational arrangements that were put in place to achieve positive outcomes.

**2.2.6 Annual Data Security & Protection Toolkit Report:** The report presented a summary of the activities and achievements of the Information Governance Team with regards to the DSPT submission during the past year (June 2020 – June 2021) and assurance/progress on developments within the Information Governance agenda. Details were given in relation to organisational compliance with legislative and regulatory requirements relating to the handling of information and assurance of ongoing improvement to managing risks to information.

The Committee noted the following key points:

- IG Training – Trust achieved compliance with 95.5% of staff trained
- Cyber Team – Achieved Cyber Essential Plus Certification
- Final submission made on 30 June 2021 – Trust achieved 'Standards Exceeded'.

**2.2.7 Pharmacy and Medicines Optimisation Annual Report 2020-21:** The report provided the Quality Committee with information on activities undertaken during 2020/21 in relation to the safe, secure and effective management of medicines and medicines optimisation.

The Committee thanked Hilary Scott and the pharmacy team for their hard work during what has been a very difficult period. It was agreed that this report should be presented to the Trust Board, in order to highlight the pandemic stories shared by the team.

**2.2.8 Physical Health Sub-Committee:** The report outlined the finding of a physical health sub-committee deep dive. It was noted that the sub-committee has been reviewed following its transfer from the Executive Medical Director's portfolio to that of the Director of Nursing in May 2021. The terms of reference have been updated and the following five priority actions have been agreed to focus on trust wide activities:

- Harm Free care
- Equally Well
- Deterioration & Resuscitation
- Advancing Clinical Practice
- Whole Person Collaborative

The Committee were assured that a balanced scorecard style dashboard is under development to track progress and report on the following four areas:

- Key priorities
- Risks and issues
- Projects
- Performance.

**2.3 <u>11 November 2021</u>**

**2.3.1 Combined Assurance Report:** The Committee received an update of key actions being undertaken receiving assurance that all actions were progressing on target. It was noted that a number of risks remained evident as follows:

- The rise in safeguarding cases and work in relation to the MHA is an

increasing pressure. The Committee discussed and were assured that MHA is being appropriately used and recognized the pressure in the system.

- The lack of availability of defilation pads. Discussion took place regarding stock management and it was explained that this appeared to be a Brexit issue and the issue of the lack of alert regarding limited stock was being escalated to NHS England.
- Staff resources continues to be an issue affecting a range of factors including training, meeting arrangements and service delivery. It was noted that a wide scale programme was being delivered to improve performance in relation to the recruitment and retention of staff.
- Electronic systems and over write arrangements.

The Committee noted a wide range of positive assurance from sub-committee updates. It was acknowledged that staffing resources are an issue and it was confirmed that a proposal has been agreed by the Executive Team to appoint twenty three Physician Assistants to support activity across inpatient areas.

It was queried why there was not a report from the Patient and Carer Sub-Committee but assurance was given that a large scale review is taking place and a decision would be made in the new future regarding the need for the Committee alongside reporting arrangements. It was agreed that these factors would be considered as part of the governance review.

The Committee was assured that proactive action was being taken against all risks.

**2.3.2 LOSC and Learning Collaborative Terms of Reference:** Following the introduction of the Trusts Patient Safety Strategy early in 2021 a strong focus has been placed on building a culture of learning. With the appointment of the Director of Patient Safety structures and committee arrangements have been reviewed to maximize the learning from incidents and events to ensure appropriate arrangements are put into place to enhance patient safety and quality of care. The Committee received a report outlining revised terms of reference for the Learning and Oversight Committee and the terms of reference of a Learning Collaborative Group.

The Committee following a discussion on maximizing resources, avoiding duplication and linking with quality improvement approved the proposal for change. The link to work of the Military of Defence was positively noted and Moriam ADEKUNLE was commended for the work she had instigated since joining the Trust.

**2.3.3 HSSC Annual Report:** The Committee received the annual report and acknowledged that the Covid pandemic had impacted on this area of work with staff being limited to physically access Trust locations. It was noted that as a result teams had prioritized ligature assessments for inpatient units and health and safety inspections at community locations. It was noted that where possible virtual assessments were undertaken and followed up with site visits, when safe to do so. Despite the restrictions it was noted that there had been a number of key achievements and priority areas had been agreed for 21/22.

**2.3.4 Safeguarding Annual Report:** The Committee received an updated report following feedback at the last meeting. It was noted that minimal amendments had been required but the communications team had reviewed the document. The Committee confirmed their approval for this to be considered by the Trust Board.

**2.3.5 IPC Board Assurance Framework:** A verbal update was provided in relation to the IPC Framework. The Trust continues to work in line with national guidance but has instigated enhanced measures where it has been considered necessary. It was

noted that further guidance was expected and this would be brought to the next Quality Committee meeting for discussion and approval.

**2.3.6: Establishment Review Annual Report:** The Committee received a verbal update on work being undertaken to secure safe staffing across the Trust. It was noted that a two stage process was being followed with the first stage focusing on a benchmarking exercise with other mental health Trusts. The second stage would involve a full multi-disciplinary team review using the MHOST tool. The Committee acknowledged the complexity of this piece of work and supported the approach that was being taken. There was some discussion regarding the most appropriate Committee for sign off and it was agreed that further discussion would take place to align discussions with People and Culture or Quality Committee to avoid duplication.

**2.3.7 Ligature Risk Update Report:** A report was provided setting out an overview of the action that is currently underway and that which is planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate. It was noted that the number of fixed point ligatures had reduced and that clear reporting arrangements are in place to LRRG who are reviewing all areas of the agenda.

**2.3.8 Patient Story**: The Committee heard a patient story of a male patient who had died following an overdose of medication and consumption of alcohol. In the six months prior to his death the patient received regular medical reviews and significant contact with his care co-ordinator until the month prior to his death where the team felt that due to his progress contacts should reduce with a view to discharge planning.

The patient died during the Covid-19 pandemic and remote contact was made with the family. There was a delay in notifying a team member of the incident and as a result a team member attempted to contact the family that caused them distress. Learning from this the team now meet every morning virtually to ensure all team members are aware of incidents and are able to act appropriately. Further discussions are taking place in relation to learning and building family engagement.

**2.3.9 Mental Health Community Service User Survey 2021:** It was advised that the outcomes of the Community Service User Survey had been received. Key insights from the programme were noted as follow:

- 25% of respondents felt that they were not involved enough in decision making surrounding their care
- 30% of respondents felt that in the last 12 months there had been insufficient contact from health professional sin relation to medication
- 45% of respondents felt that possible side effects of medication had not been discussed
- 55% of respondents felt that in the last 12 months they were not supported with their physical health needs
- 65% of respondents felt that post discharge they did not feel supported in finding financial advice, and/or work.

The Director of Patient Experience described the work he was undertaking to review the agenda and ensure that individuals with lived experience felt empowered to coproduce key components of the agenda. Work has commenced with NHSI/E and quality improvement approaches would be taken to drive the agenda although work was at an early stage. The

Committee received the positive feedback and the plan for supporting engagement in the improvement of services.

**2.4. Policies and Procedures**

**The Committee approved the following policies and procedures:**

- CP34 Copying Letters to Patients Policy – for Approval
- NICE Policy and Procedure

**Policy extensions were agreed for the following:**

- CLP19 Research Conduct & Processes Policy
- CP64 Mortality Policy Review
- CPG9f Transfer/Transportation of Records and Information/ Data Procedure
- Section 5 – Management of MRSA – MH & CHS Procedure
- Section 6 – Clostridium Difficile
- RM12 Assured Safe Catering Policy
- RM09 Security Policy
- CPG50a IT&T Security Procedure

**2.5. Risks/Hotspots:**

The Committee identified:

- No risks to be escalated to the corporate risk register
- No risks or issues to be raised with other outstanding committees
- No recommendations to the Audit Committee linked to the internal audit programme

**Report prepared by:**
Natalie Hammond, Executive Nurse

**On behalf of:**
Amanda Sherlock/Rufus Helm, Non-Executive Directors Chair and Vice Chair of the Quality Committee

| | | |
|---|---|---|
| | | **Agenda Item No: 8av** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **People Equality and Culture Committee Assurance Report** | | | | | |
| **Executive/Non-Executive Lead:** | Manny Lewis, Chair of the People Equalities and Culture Committee | | | | | |
| **Report Author(s):** | James Day<br>Interim Trust Secretary | | | | | |
| **Report discussed previously at:** | Committee Chair | | | | | |
| **Level of Assurance:** | **Level 1** | ✓ | **Level 2** | | **Level 3** | |

| **Risk Assessment of Report** | |
|---|---|
| Summary of Risks highlighted in this report | People, Capacity and Equality |
| State which BAF risk(s) this report relates to | BAF 50 - Skills Resources and Capacity<br>BAF 61 - Address inequalities and meet people plan ambitions<br>BAF 62 – Support Staff |
| Does this report mitigate the BAF risk(s)? | No |
| Are you recommending a new risk for the EPUT BAF? | No |
| If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register. | |
| Describe what measures will you use to monitor mitigation of the risk | |

| **Purpose of the Report** | | |
|---|---|---|
| This report provides the Board of Directors with details that the People Equality and Culture Committee (PECC) is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objectives are being managed effectively. It also provides assurance to the Board of Directors that the Committee is addressing the key items within its remit.<br><br>Directors are also asked to approve the Terms of Reference of the Committee as approved by the Committee, contained in the linked paper and appendix accompanying this report. | **Approval** | |
| | **Discussion** | |
| | **Information** | ✓ |

## Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Accept the Assurance provided
3 Request any further information or action.

## Summary of Key Issues

**General**

The first meeting of the People, Equality and Culture Committee (PECC) was welcomed by all involved as having been packed with relevant, detailed and good quality material, enthusiastically and expertly delivered. It had been a good start, with substantial assurance provided on the work underway to address the issues of concern.

The primary format was that of presentations and discussion following a framework provided by a good quality rolling slide set, with each agenda topic summarised in turn.

An innovation was that of the receipt of a contribution by pre-recorded video, indistinguishable from a “live” but still virtual contribution.

The slide deck is available via the TSO.

Terms of reference were considered and approved, and are the subject of a separate but linked Board paper under the PECC agenda heading which requests Board approval.

A future meeting pattern was set, utilising the afternoons of the mornings occupied by the F&P Committee, thus maximising synergies and maximising governance and attendance linkages.

**Topics Discussed with summary outcomes**

- Executive Director Objectives – Shared, noted and welcomed
- People and Culture Directorate Structure – Progress and future intention noted and endorsed
- Staff Engagement – Update provided. The progress and plans, supported by data, to be returned to the committee quarterly
- Safe Staffing Programme – Detailed discussion on encouraging flexible working, the transition from Bank to permanent and the development of supportive systems. Details of the operation of the new staffing budgeting regime to be returned to the Committee within the quarter
- Recruitment, On-Boarding and Retention – Exciting opportunities to adopt a transformative and customer service based model shared, drawing upon Marketing and Communications options. Progress, supported by developed KPIs and data, to be returned to the December meeting to demonstrate rapid grip including covering time to hire and overseas recruitment
- Equality Diversity and Inclusion – The rapid progress and grip on EDI made since the appointment of LH was noted and celebrated. Future meetings to see high level data supporting improvement trends, and soft data to be shared to allow early resolution of emerging issues
- Learning and Development – Valuable current update provided. December meeting to feature a deep dive into the issues highlighted to include workforce models and what was required to establish an EPUT University School to better manage student progress and training

- HR Services update – Granular statistics provided and discussed including performance on disciplinary and grievance cases and the causes and mitigation of sickness absence. Future statistics to reflect any over or under representation on BAME staff
- Marketing and Communications – Exciting summary via video presentation of the website development and Essex-wide recruitment campaign. JB to present to next Committee meeting and Marketing and Comms. to report to the Board and CoG on initiatives as soon as possible.
- People Strategy – Draft to be brought to the December meeting
- Patient Experience – To be considered in the December meeting presented by MS
- Innovation – Each meeting to have a slot for discussion on relevant items of innovation from any source.

A separate December date would be fixed with the agreed pattern of meetings commencing in January 2022

Manny Lewis
Chair
People, Equality and Culture Committee
November 2021

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

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

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

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| | | | |

## Supporting Documents and/or Further Reading

## Lead

*Add signature*

James Day

**Name** James Day
**Job Title** Interim Trust Secretary

| | | |
|---|---|---|
| | | **Agenda Item No: 8av** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **People Equality and Culture Committee Assurance Report** | | | | | |
| **Executive/Non-Executive Lead:** | Manny Lewis, Chair of the People Equality and Culture Committee | | | | | |
| **Report Author(s):** | James Day<br>Interim Trust Secretary | | | | | |
| **Report discussed previously at:** | People Equality and Culture Committee | | | | | |
| **Level of Assurance:** | **Level 1** | ✓ | **Level 2** | | **Level 3** | |

| **Risk Assessment of Report** | |
|---|---|
| Summary of Risks highlighted in this report | People, Capacity and Equality |
| State which BAF risk(s) this report relates to | BAF 50 - Skills Resources and Capacity<br>BAF 61 - Address inequalities and meet people plan ambitions<br>BAF 62 – Support Staff |
| Does this report mitigate the BAF risk(s)? | No |
| Are you recommending a new risk for the EPUT BAF? | No |
| If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register. | |
| Describe what measures will you use to monitor mitigation of the risk | |

| **Purpose of the Report** | | |
|---|---|---|
| This report provides the Board of Directors with the opportunity to consider and approve the new Terms of Reference for the People Equality and Culture Committee, as recommended by the Committee | **Approval** | |
| | **Discussion** | |
| | **Information** | ✓ |

| **Recommendations/Action Required** |
|---|
| The Board of Directors is asked to:<br>1 Note the contents of the report<br>2 Approve the Terms of Reference<br>3 Request any further information or action. |

| Summary of Key Issues |
|---|
| The Terms of Reference for the new People Equality and Culture Committee, as discussed and approved by the Committee and Committee Chair, are attached as an appendix to this cover sheet. Directors are asked to approve the same. |

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

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| Supporting Documents and/or Further Reading |
|---|
| Appendix 1<br>People Equalities and Culture Terms of Reference |

| Lead |
|---|

*Add signature*

James Day

**Name** James Day
**Job Title** Interim Trust Secretary

# PEOPLE, EQUALITY AND CULTURE COMMITTEE (PECC)

# TERMS OF REFERENCE

## AUTHORITY AND ACCOUNTABILITY

The People Equality and Culture Committee is constituted as a standing committee of, and accountable to, the Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

The Committee is authorised by the Board of Directors to act within its Terms of Reference. All members of staff are directed to co-operate with any request made by this Committee.

The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary to exercise its functions.

The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

These terms of reference shall be read in conjunction with the Trust's Scheme of Delegation, Standing Orders, Constitution and Standing Financial Instructions, as appropriate.

## PURPOSE & ROLE

To continually strive to improve the experience of all employees, ensuring EPUT demonstrates compassionate leadership and is a place individuals choose to work.

To foster and to maximise the opportunities from the link between the quality of employee experience and the quality of patient experience.

To ensure the Trust drives talent management and develops individuals at every level of the organisation.

To oversee and scrutinise the development of, and delivery against, the Trust's People Strategy.

To provide assurance to the Board that the People performance indicators are being monitored and targets met.

To support the achievement of a stable, permanently staffed core workforce, with efficient, modern recruitment practice and high levels of retention, health & wellbeing.

To support the development of the organisational culture, promoting the Trust's values.

To support the development of effective employee communications and engagement, promoting openness and freedom to speak up.

To support the development of a diverse workforce, securing equality & inclusion across the Trust.

To challenge and escalate any areas of concern relating to the achievement of the Trust's People strategy and ensure that mitigations are in place.

To keep abreast of wider sector developments and policy direction in order to inform the Board on options for the Trust's future strategic direction.

To oversee People transformation and innovation and contribute to the delivery of the Trust's wider transformation and innovation programmes.

To have oversight of workforce development and initiatives, workforce design, workforce planning, organisational development, Board development, talent management, mandatory training and cultural initiatives

To consider and monitor implementation of the NHS People Plan and the opportunities presented for system working.

To consider and review high-level workforce and culture risks and their mitigations.

**MEMBERSHIP**

The membership of the committee shall be:

- Three Non-Executive Directors. One of these members will be appointed as Chair of the Committee.
- Executive Director of People and Culture
- Executive Chief Operations Officer

Members should attend at least 75% of meetings a year

**QUORUM**

A quorum shall consist of no less than two Non-Executive Directors and two Executive Directors. Substitutions will be allowed with advanced notice to the Chair.

## ATTENDANCE

Only members of the committee have the right to attend committee meetings.

At the invitation of the committee, the following individuals will be in attendance as and when required:

- Executive Medical Director
- Executive Nurse
- Trust Secretary
- Executive Chief Finance Officer
- Communications and Engagement
- Organisational Development
- Patient Experience
- Quality Improvement
- Equality and Diversity
- Workforce development lead
- Workforce Transformation Lead
- Freedom to Speak Up Guardian

- Other persons may be invited by the committee to attend a meeting to assist in deliberations.

The PA to the Executive Director of People and Culture will be in attendance as support to the committee or as agreed by the members

A Nominated Governor will be invited to observe the Committee meeting.

## CONFLICTS OF INTEREST

Where Executive Directors or senior management are involved in decision-making, advising or supporting the People and Culture Committee, care should be taken to recognise and avoid conflicts of interest.

## FREQUENCY OF MEETINGS

Meetings shall be held monthly. Extraordinary meetings may be called to discuss additional items as determined by the Chair.

Where appropriate, reports may be sought and matters may be considered electronically. In these circumstances, any outcome or decision made must be noted at the next meeting to ensure a formal record is captured within the minutes.

## REPORTING AND MINUTES

Formal minutes shall be taken of all committee meetings. Minutes of the meetings, resolutions and any action agreed will be recorded and circulated to Committee members for approval.

The Committee Chair will report to the Board of Directors after each meeting, advising the Committee has met and the decisions it has made. If requested to do so it will provide further information to the Board of Directors including the terms of any advice it has received and considered.

An exception report will be presented to Trust Board highlighting key risks, achievements, themes and trends relating to workforce and culture

## MONITORING AND EFFECTIVENESS

The Committee shall undertake an annual review of its performance against these terms of reference to ensure its effectiveness in discharging the functions delegated to it by the Board of Directors and in achieving the Trust's objectives. The results of this review shall be reported to the Board of Directors

## REVIEW

The Terms of Reference shall be reviewed by the Committee and Board of Directors at least annually.

Date approved by People and Culture Committee: November 2021
Date approved by Board of Directors: November 2021
Date of review: November 2022

| | | |
|---|---|---|
| | | **Agenda Item No: 9i** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **Covid 19 Assurance Report** | | | | | |
| **Executive/Non-Executive Lead:** | Paul Scott, Chief Executive | | | | | |
| **Report Author(s):** | Jane Cheeseman, Head of Compliance and Emergency Planning | | | | | |
| **Report discussed previously at:** | N/A | | | | | |
| **Level of Assurance:** | **Level 1** | ✓ | **Level 2** | | **Level 3** | |

| **Risk Assessment of Report** | |
|---|---|
| State which BAF risk(s) this report relates to (risk ID and short form title e.g. BAF63 Learning) | • BAF38 Emergency Planning<br>• BAF50 Skills Resource and Capacity<br>• BAF42 Financial Plan<br>• BAF43 Surge Planning<br>• BAF44 Learning from C19 |
| Are you recommending a new risk for the EPUT BAF? | No |
| If Yes describe the risk to EPUT's organisational objectives | N/A |
| If Yes, is this an escalation from another EPUT risk register? | N/A |
| If Yes, will this risk have an action plan? | N/A |
| If No describe what measures will you use to monitor mitigation of the risk in lieu of an action plan? | N/A |
| Does this report mitigate the BAF risk(s)? | No |

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

**Recommendations/Action Required**

The Board of Directors are asked to:

1 Note the content of this report.
2 Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3 Note the Covid 19 Gold risk register and summary mitigations (Appendix 1)
4 Request any further information and or action

**Summary of Key Issues**

**Background**

- The country has now been dealing with the corona virus outbreak for 20 months. The Trust's arrangements continue to be in place and are working effectively.
- Nationally we remain at a level 3 incident response
- Covid rules were lifted on 19th July 2021 removing all legal limits on social contact with the exception of self-isolation following positive test or contact. The NHS remains with Covid-19 restrictions in place
- We remain aware that the virus is still in general circulation
- We continue to monitor prevalence amongst our patients and staff

**Command Structure**

- The Gold/Silver and Bronze Command meetings continue to be held with frequency depending on current risk.
- The (virtual) Incident Control room operational times continue to run 8am until 6pm 7 days a week
- The Covid Risk Register is regularly reviewed and updated by Gold and Silver Command.
- National daily / regular sit reps remain in place.
- 17 individuals now hold the full Strategic Command training certificate. In addition a further 7 staff have been scheduled to attend the training in 2021 which will provide the Trust with 24 'Gold Command' trained individuals.

**Current Impact**

- There have been 5 reported outbreaks within the trust, since the last report, 3 of which have since been closed from outbreak status
- There have been no further reported patient or staff deaths as a result of Covid-19 since last reporting
- At time of writing we have a total of 42 staff off sick due to Covid-19 and there are 12 Covid-19 confirmed patients

**Trustwide Response**

- From 11th November 2021 all care staff are required to provide they are fully vaccinated to gain entry into care homes. This is applicable to both EPUT staff how work in our care homes and EPUT staff who provide care into other care homes. The HR project has ensured EPUT is compliant with this new requirement.

- IPC Guidance has continued to be updated for covid-19 control measures. Changes to routine swabbing frequency; admission/return from leave risk assessments reflecting changes in swabbing frequencies and updated travel guidance; strengthening the visiting procedure to reduce the risk of further outbreaks. All updated guidance has been cascaded to staff via Gold/Silver and Bronze commands and via trust communications.

- Preparation continues for the Covid-19 Statutory Inquiry commencing next spring 2022 and has been built into BAF 38 Emergency Planning document. A requirement of the statutory inquiry was to identify a single point of contact which has been confirmed as the Executive Director of Projects who is also the Accountable Emergency Officer (AEO).

**Communication**

- Decisions made by the Command meetings and any changes in guidance continue to be communicated to all staff through the regular production of the Live briefings and the Wednesday Weekly publication

**Risks**

- There is one extreme new risk open on the Covid 19 Risk Register (Mass Vaccination 12 – 15 age group programme Suffolk) with controls in place. (Attached as Appendix 1)
- All risks are currently under review as part of the EPUT BAF refresh project.

**Learning**

Learning continues to be a key part of the Trust response to Covid 19 and a number of activities are continuing to take place, alongside some new initiatives to support our staff such as:

- IPC learning summary of 5 key messages presented at the live event and via communications
- The Science and Technology Committee and the Health and Social Care Committee joint inquiry, Coronavirus: lessons learnt to consider several key issues that emerged during the first wave of the pandemic. The inquiry looked in detail at key areas of the response to covid-19
    - Pandemic Preparedness;
    - Border controls

- Lockdown and social distancing
- Testing and Contact tracing
- The impact of the pandemic on social care;
- The impact of the pandemic on specific communities; and
- The procurement and roll-out of covid-19 vaccines.

A summary is provided in Appendix 2

| 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:** The Government has confirmed any appropriate and reasonable expenditure related to Covid-19 will be supported. All costs identified in year ended 31/3/20 have been agreed and funded. | | | ✓ |
| **Governance implications** | | | ✓ |
| **Impact on patient safety/quality** | | | ✓ |
| **Impact on equality and diversity** | | | ✓ |
| **Equality Impact Assessment (EIA) Completed** | **~~YES~~/NO** | **If YES, EIA Score** | |

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| PPE | Personal Protective Equipment | IPC | Infection Prevention and Control |
| MSE | Mid and South Essex | STP | Sustainably and Transformation Partnership |
| HR | Human Resources | | |

| Supporting Documents and/or Further Reading |
|---|
| Covid Assurance Report<br>Gold Command Covid Risk Register Summary (Appendix 1)<br>Science and Technology Committee and the Health and Social Care Committee joint inquiry Summary Coronavirus: lessons learnt (Appendix 2) |

| Lead |
|---|
| **Paul Scott**<br>**Chief Executive** |

# ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

## COVID 19 ASSURANCE REPORT

### 1. Purpose of Report

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

### 2. Background

The country has been dealing with the corona virus pandemic for over 20 months and the Trust's arrangements continue to be in place and working effectively. Nationally we remain at a level 3 incident response and the national growth rate has reportedly remained the same.

As you are aware the Government lifted Covid rules on 19th July 2021 removing all legal limits on social contact with the exception of self-isolation following positive test or contact. Yet, the NHS remains with Covid-19 restrictions in place and we remain vigilant to the fact that the virus is still very much in general circulation. As such we continue to monitor prevalence amongst our patients and staff and respond promptly to guidance as and when provided.

### 3. Command Structure

The command structures remain in place with a joint Silver and Gold command meeting held weekly on a Thursday. The command frequency remains flexible in regards to reducing/ increasing meetings as the outlook for COVID-19 activity over the coming months and as we move towards winter remains uncertain. Bronze command meetings continue to mirror the joint Silver/Gold command to ensure decisions made and information received continues to cascade through the organisation, and that we are responsive to changes required.

The (virtual) Incident Control room remains operational 7 days a week 8am until 6pm in line with the East of England Operational Centre. This is mainly covered by the Compliance and Assurance Directorate with the additional help of other corporate staff on a rota at the weekends buddied by the EPRR leads for support and on call should there be any areas for escalation or Covid-19 Patient Notification System (CPNS) death reporting required.

The regular sit rep submissions required by the Centre continue, namely the National Covid daily sitrep, Community discharge daily sit rep, (both also required at weekends) and the regular Lateral Flow Testing numbers and Long Covid activity.

The incident control inbox continues to receive the national and regional information/guidance alongside a more wider remit of information sharing. The continued monitoring of the inbox ensures that should anything of urgency come through we are able to remain responsive. Any national/ regional guidance, information and/or requests are cascaded to the appropriate Directors and through discussion at the Command meeting for information and consideration of the actions required with a timely response.

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

The Strategic Command training offered for all staff that have a command role has been booked for 2021/22 for those staff who require either a full or refresher course. To date EPUT currently have

17 individuals that hold an in date 'Gold Command' training certificate. In addition a further 7 staff are scheduled to attend training which will provide the Trust with 24 'Gold Command' trained individuals.

## 4. Impact to Date

Since last reporting in September 2021 there has been a slight increase in our reporting of Covid-19 positive cases for staff. At time of writing, we currently have 12 Covid-19 confirmed patients within our services and a total of 42 staff off sick not working due to Covid-19 related illness which is again a slight increase from 39 at last report.

We have not had any further patient deaths to report onto the Covid-19 Patient Notification System (CPNS) for the past 8 months.

Since last reporting, we have had five outbreaks declared to Public Health England 3 of which have since passed the 28 day period and therefore have now been closed from outbreak status. Two outbreaks remain open (1 CHS and 1 MHS) with ongoing monitoring and reporting. To note an outbreak is classified by PHE when there are 2 or more cases in one area at a period of time, which was the threshold met in each of the teams where the outbreaks have occurred. All processes for an outbreak are followed as advised through joint meetings with NHSE, CCG's and PHE.

The regular lateral flow testing of both our patients and asymptomatic staff continues across the trust.

## 5. Trustwide Response

There have been a number of Trustwide changes in line with guidance received such as;

The implementation for care homes to have to prove staff are fully vaccinated to be allowed to enter went live on 11th November 2021. The HR project continues to support the implementation of the new double vaccination requirements for care homes and are setting up Vaccination status as a skill on health roster. This is to allow management to plan workforce where there is a need to visit care homes and to ensure bank workers booked that are required to work in care homes have been vaccinated. This is also part of the pre- employment checks in place for those whose job role requires care home visitation / working.

Changes to IPC Guidance have been reviewed and include updated covid-19 control measures in regards to changes to routine swabbing frequency (from 14 days to every 7 days); changes to admission/return from leave risk assessments to reflect the changes in swabbing frequencies and the updated travel guidance; updated managing visiting within EPUT inpatient and care home settings. The strengthening on the visiting procedure supports the attempt to reduce the risk of further outbreaks. All updated guidance has been cascaded to staff via Gold/Silver and Bronze commands and via trust communications.

In relation to the previously reported supply disruption to Becton Dickinson's (BD) blood specimen collection portfolio we have been advised that due to the mitigations in place and the efforts of colleagues across the NHS the supply situation has stabilized. To reflect the current position, and to avoid putting further pressure on stock, as the situation continues to recover, the change to the guidance issued on 16 September was agreed in that testing activity in acute trusts, community hospitals and mental health trusts, in line with best practice guidance can, local stocks permitting, resume. We continue to order little and often during this period of recovery and to restock gradually.

Information regarding a potential issue with ICN Blue Tree IIR Facemasks indicated that these are labelled Type IIR however information from the manufacturer indicated that these may not meet technical specifications for splash protection. A safety alert was sent out via DATIX to ensure all services checked their stock and guided on the actions to take if affected stock identified to ensure removal would not deplete supply.

As previously reported it was announced that there will be a Covid-19 Statutory Inquiry commencing next spring 2022. This is part of an entire Government response, UK wide and has been built into our BAF 38 Emergency Planning document. A requirement of the statutory inquiry was to identify a single point of contact which has been confirmed as the Executive Director of Projects who is also the Accountable Emergency Officer (AEO). Preparation for the Statutory Inquiry is underway however the terms of reference are yet to be announced.

## 6. Communication

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

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

## 7. Risks

The Trust Covid risk register has remained a live document with the risks constantly being updated to reflect the changing environment and are detailed in the summary Covid Risk Register in Appendix 1. There are currently 1 Extreme Risk, 14 High Risks and 7 Medium Risks open.

The Extreme risk currently facing the Trust is the ability at short notice to support the Suffolk 12-15 age group programme then it may be unable to meet the required timescale resulting in an impact on existing targets.

There are new CRR risks around mass vaccinations relating to 12-15 year age group (Essex and BLMK) and mass vaccinations 12-15 year age group (Suffolk) and two risks have been added around mandatory vaccinations – one relating to unvaccinated staff visiting care homes and one in relation to the recent announcement regarding potential mandatory vaccination for health and social care staff.

## 8. Learning

Learning continues to be a key part of the Trust response to Covid 19 and a number of activities as reported previously are continuing to take place, alongside some new initiatives to support our staff such as:

IPC 5 key messages for the learning summary at presented at the live event and via communications

- Need for Covid-19 Risk Assement's on admission
- Wearing of PPE
- Staff NHS app evidence
- Staff contact with positive cases and isolation requirements. Reminding of need for IPC contact to ensure track and trace undertaken.
- Reminder that guidance on social distancing and PPE requirements for NHS remains

Since March 2020 the Science and Technology Committee and the Health and Social Care Committee have been holding separate inquiries examining the Government's response to the covid-19 pandemic. These inquiries began as covid-19 reached the UK and have continued throughout the first wave of the pandemic and beyond, examining the response to the pandemic as it happened. In October 2020, the two Committees launched a joint inquiry, Coronavirus: lessons learnt to consider several key issues that emerged during the first wave of the pandemic and identify what lessons need to be learnt.

The inquiry looked in detail at six key areas of the response to covid-19;

- The country's preparedness for a pandemic;
- The use of non-pharmaceutical interventions such as border controls,
- Social distancing and lockdowns to control the pandemic; the use of test, trace and isolate strategies;
- The impact of the pandemic on social care;
- The impact of the pandemic on specific communities;
- And the procurement and roll-out of covid-19 vaccines.

Across these areas they identified several key issues which have had a major impact on the UK response to covid-19, and should be a key focus for the Government as it seeks to learn the lessons from the pandemic. A summary of the inquiry is provided in Appendix 2.

## 9. Action Required

The Board of Directors are asked to:

1. Note the content of this report.
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3. Note the Covid 19 Gold risk register and summary mitigations (Appendix 1)
4. Request any further information and or action

**Report compiled by:**
**Jane Cheeseman,**
**Head of Compliance and Emergency Planning**

**On Behalf of**

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

**Table 1 – COVID RISK REGISTER 2021/22 Summary of Risks as at November 2021**

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

| Risk ID | Potential Risk | Exec Lead | Standing Committee | Action Plan/ Monitoring | Mitigating Actions/ Controls in Place | Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance | Actions outstanding / further mitigating actions required |
|---|---|---|---|---|---|---|---|
| ~~BAF38~~ CRR90 | If EPUT does not manage Covid19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements | NL | Quality Committee | EPRR | • Business Continuity Plans in place and undergoing constant review<br>• Command structure in place<br>• Sit rep daily monitoring<br>• Covid intranet page and range of staff training in place<br>• Covid dashboard issued weekly to monitor prevalence<br>• Mirrored to Covid19 Risk Register<br>• Action plan developed and approved by ESOG with Covid19 assurance report<br>• Executive Lead for Emergency Planning confirmed as NL as well as single point of contact for Covid Inquiry<br>• Non-Executive Lead for Emergency Planning in place<br>• Paper on lessons learnt taken to Executive Team and disseminated more widely including next steps for new ways of working<br>• Demonstrating lessons learnt from Covid19 through bi-monthly Trust Board reports and EPRR quarterly report<br>• Promoted awareness of rules around use of new medial methods which can be called as evidence for inquiry<br>• BAF action plan completed | **Risk score remains at threshold 5 x 2 = 10**<br><br>**Target date – ongoing throughout pandemic**<br><br>**Level 1: Action Plan completed**<br>**Level 2: EPRR Team/ IPC Team**<br>**Level 3: EPRR Standards** | • Prepare for Covid19 Statutory Inquiry<br>• Review emergency planning processes in light of Covid-19 experience<br>• Hold internal emergency planning exercise<br>• |

| Risk ID | Potential Risk | Exec Lead | Standing Committee | Action Plan/ Monitoring | Mitigating Actions/ Controls in Place | Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance | Actions outstanding / further mitigating actions required |
|---|---|---|---|---|---|---|---|
| ~~BAF51~~ CRR92 | If EPUT does not effectively direct and implement the adult mass vaccination programme then it will not meet its deliverables/ timescales resulting in a failure of the programme in MSE and SNEE | NL | Quality | Monitoring by Project Management Group | • A risk register set up specifically related to the Mass Vaccination programme to strengthen governance around the project<br>• New BCPs developed for vaccination centres<br>• Programme Board in place<br>• Working in partnership, with Local Resilience Forums, Local Authorities and other providers to deliver the programme<br>• Clinical oversight and governance in place at all vaccination centres<br>• All costs passing through NHSE and laptop costs supported by skill mix work<br>• Robust communication in place with vaccination centres<br>• Good coverage in both MSE and SNEE with robust joint working (rationale for reducing consequence to 4)<br>• Moving towards phase 3 preparation for mainstreaming the vaccination programme to become business as usual<br>• 'Big weekender' event 4,500 people were contacted inviting them for earlier appointments and second doses brought forward where feasible<br>• No licences being extended as part of phase 3<br>• Pre-assessment model developed by EPUT now approved by Region<br>• Managing alternative models for vaccination delivery including pop ups and large trailer, drive through pilot and buses<br>• Maintaining workforce at vaccination centres (and other delivery centres) with forward planning to identify workforce challenges<br>• Maintaining vigilance and awareness on security and potential criminal activity at vaccine sites<br>• 12-15 age group School Immunisation Teams now delivering vaccines mainly through school environments<br>• 780,000 vaccinations delivered<br>• Delivery of phase 3 booster programme commenced on 20 September via a range of delivery models including GP led, Community pharmacies and large scale vaccination centres<br>• Mirrored from Corporate Risk Register | **Risk score unchanged 4 x 3 = 12**<br><br>**Target date is ongoing for the duration of the mass vaccination programme**<br><br>**Target 4 x 2 = 8** | • Implement phase 3 from early September to late February 22 in line with national guidance<br>• Maintain watching brief on variable vaccine supply and impact on programme<br>• Assessment of recently published national security guidance to draw out any actions |

| Risk ID | Potential Risk | Exec Lead | Standing Committee | Action Plan/ Monitoring | Mitigating Actions/ Controls in Place | Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance | Actions outstanding / further mitigating actions required |
|---|---|---|---|---|---|---|---|
| CRR93 | If EPUT is asked at short notice to support the Suffolk 12-15 age group programme then it may be unable to meet the required timescale resulting in an impact on existing targets | NL | Quality | Project Board | • Programme Board in place<br>• Working in partnership, with Local Resilience Forums, local Authorities and other providers to deliver the programme<br>• Clinical governance and oversight in place<br>• Robust communication in place<br>• New risk reviewed by NL 04/11 Maintain watching brief on variable vaccine supply and impact on programme<br>• Mirrored from Corporate Risk Register | **Mass Vaccinations 12-15 age group**<br><br>Initial Risk Score<br>4 x 4 = 16<br><br>Target date and score Dec 2021<br>4 x 2 = 8<br><br>Level 1: Project Board | • Maintain watching brief on variable vaccine supply and impact on programme |
| CRR94 | If EPUT is asked at short notice to support the Suffolk 12-15 age group programme then it may be unable to meet the required timescale resulting in an impact on existing targets | NL | Quality | Project Board | • None at this stage<br>• New risk reviewed by NL 04/11<br>• Agreed with NHSE/I that recovery of any costs to EPUT are made<br>• Mirrored from Corporate Risk Register | **Mass Vaccinations 12-15 age group Suffolk**<br><br>Initial risk score<br>4 x 5 = 20<br><br>Target date and score | • Deliver additional sessions in Suffolk<br>• Discussions taking place with NHSE/I and existing contract holder HCT<br>• Develop a plan to support the Suffolk programme<br>• Ensure Essex programme has sufficient school nursing staff |

| Risk ID | Potential Risk | Exec Lead | Standing Committee | Action Plan/ Monitoring | Mitigating Actions/ Controls in Place | Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance | Actions outstanding / further mitigating actions required |
|---|---|---|---|---|---|---|---|
| CRR83 | If the Covid19 crisis continues then EPUT may experience an adverse impact on its financial plan as a knock on from system wide financial planning resulting in additional risk for EPUT to its sustainability | TS | F&PC | | • The Trust's 21/22 financial plan has been set to deliver a breakeven position. The plan includes £8.1m of Covid allocation for H1.<br>• Continuous monitoring of the financial position through reporting to F&PC, EOSC finance and performance meetings and the Board will continue.<br>• Continue to monitor financial situation, Covid19 and Mass Vaccination costs to ensure recovery.<br>• Efficiency requirements are included in the financial plan and schemes under development. Some internal schemes developed and others in development alongside combined work with ICS and NHSI/E.<br>• The ICS has also undertaken a financial sustainability exercise. Year to date M12 Covid19 costs of £16.2m with M7-M12 recovery anticipated from M&SE and H&CP<br>• Planning for anticipated reduction in system monies of 3.5%<br>• Mirrored from Corporate Risk Register | **Risk score unchanged 4 x 3 = 12**<br><br>**Target March 22 Threshold 4 x 2 = 8**<br><br>**DE-ESCALATED TO CRR FROM BAF**<br><br>**Level 1: F&PC EOSC**<br>**Level 2: Audit Committee ICS Sustainability Exercise** | • H2 guidance and allocations expected 24 September with the expectations of a fixed efficiency target of 0.82% will apply and a discretionary target applied to the ICS based on Financial Improvement Targets (FIT). In addition to expect a 5% reduction in Covid-19 allocation.<br>• H2 guidance received and on the Agenda for Audit Committee 9/11<br>• |

| Risk ID | Potential Risk | Exec Lead | Standing Committee | Action Plan/ Monitoring | Mitigating Actions/ Controls in Place | Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance | Actions outstanding / further mitigating actions required |
|---|---|---|---|---|---|---|---|
| CRR79 | If EPUT's alternative approach to seasonal flu is unsuccessful then it may suffer outbreaks in the workforce resulting in failure to meet national programme of expectations | Natalie Hammond | Command Structure | • | • Project management in place<br>• Clinical oversight in place<br>• Plan in place to commence flu programme in September in conjunction with Covid boosters<br>• Weekly task and finish group in place | **Risk Score 4 x 4 = 16**<br><br>**Target March 22 Score 4 x 2 = 8**<br><br>**Above threshold** | • Awaiting national and regional communications about approach<br>• Ensure local measures as ready prior to programme starting<br>• Encourage uptake of flu vaccinations in conjunction with offer of Covid boosters |
| CVG19 | If EPUT does not manage Infection and Prevention Control (IPC) during COVID19 then infections may increase resulting in a negative impact on the pandemic | NH | Quality | Monitoring by Command Structure | • Assurance visits being undertaken and clinically held action plans<br>• IPC Board Assurance Framework (national document) updated bi-monthly<br>• New guidance reviewed and implemented through Command structure as received<br>• National recommendations derived from other organisations during C19 are reviewed against EPUT measures<br>• C19 secure procedures are in line with IPC guidance<br>• IPC Dashboard developed to monitor potential risk areas<br>• Live event w/c 18 October to mitigate risk | **Risk score 4 x 3 = 12**<br><br>**Risk score at threshold 4 x 2 = 8**<br><br>**Ongoing** | • Monitor increase in outbreaks<br>• Reiterate compliance with current guidance<br>• Undertake patient risk assessment and follow isolation flow chart on inpatient areas |

| Risk ID | Potential Risk | Exec Lead | Standing Committee | Action Plan/ Monitoring | Mitigating Actions/ Controls in Place | Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance | Actions outstanding / further mitigating actions required |
|---|---|---|---|---|---|---|---|
| CVG33 | If EPUT does not ensure that staff are Fit Tested for the variation of FFP3 masks coming through the PPE push system then it may delay the utilisation of these masks resulting in lack of PPE for aerosol generating procedures | NH | Quality | Monitoring by Command Structure | • Plan in place for the ongoing requirement for fit testing<br>• Appointed to fixed term role so Fit Testing programme has a sustained resource<br>• Plan reviewed | **Risk score 4 x 3 = 12**<br>**Ongoing**<br>**Target 4 x 2 = 8** | • Monitor<br>• New IPC guidance to be issued Nov 21 |
| CVG51 | If EPUT staff do not follow the rules and guidance issued around PPE then there will be breaches resulting in the potential for outbreaks and related staffing issues and harm to patients | NH | Quality | Command Structure | • Staff continuously reminded that they must not breach PPE by car sharing, removing masks in handover meetings etc.<br>• Training including PPE Self-Assessment<br>• Policies and procedures<br>• Appropriate access to PPE with no incidents<br>• Responded to alerts<br>• Command continually updated on PPE use and stock levels | **Risk Score 5 x 3 = 12**<br>**Ongoing**<br>**Target 5 x 2 = 10** | • Continue with vaccination programme for patients and staff<br>• Continue reminders around PPE<br>• Monitor recent increase in outbreaks |
| CVG37 | If EPUT does not maintain Covid-19 secure risk assessments then premises may not conform to guidance resulting in a possible spread of infection | PS | Quality | Command structure | • Covid19 Secure risk assessments completed locally and reviewed by a member of risk team before approval<br>• Datix is monitored in order to pick up any risks<br>• Identification of buildings where assessments complete<br>• Developed process for managing the out of date secure risk assessments | **Risk score 4 x 3 = 12**<br>**December 21**<br>**Target 4 x 2 = 8** | • Anticipate new guidance in November<br>• |

| Risk ID | Potential Risk | Exec Lead | Standing Committee | Action Plan/ Monitoring | Mitigating Actions/ Controls in Place | Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance | Actions outstanding / further mitigating actions required |
|---|---|---|---|---|---|---|---|
| CVG10 | If EPUT is unable to maintain its planned capital programme through lack of contractor access then delays or deferments may occur resulting in increased pressure on the capital programme in recovery | TS | F&PC | Command structure | • Capital projects continuously under review<br>• Building contractors have returned to BAU<br>• No delay identified and no significant risk to future programme<br>• Situation continues to be managed<br>• Meeting took place 5 October around managing contractors on care home sites | **Risk score 3 x 3 = 9**<br><br>**Ongoing**<br><br>**Target 3 x 2 = 6** | • Contractors working within social distancing guidelines still an issue |
| CVG45 | If EPUT does not manage clinical waste during COVID19 then hazardous material may be stored longer at a local level resulting in the potential for spread of infection and harm to patients and staff | TS | F&PC | Command structure | • Procurement put in place alternative storage arrangements whilst there was an issue with the contractor<br>• Contact maintained with contractor<br>• Environment agency are aware of any issues and understand the necessity to store waste on site in locked cages<br>• Team of clinicians, risk management, infection control and estates set up to market test the service | **Risk score at threshold 4 x 2 = 8**<br><br>**Target March 22**<br><br>**Ongoing** | • Facilities continue to monitor the situation around issues with collection of clinical waste during the second wave<br>• Specification for total waste contract (following extension to April 2022) will be reviewed along with Risk and Infection Control to take the service out to the market as a combined service or separately<br>• Carry out market testing using multi-disciplinary team |
| CVG48 | If EPUT does not manage staff levels, staff engagement and input for recording of lateral flow staff testing then resource requirements may not be met resulting in failure to deliver the staff testing project and asymptomatic testing | NH | Quality | Command structure | • Staffing risk assessment completed with identified mitigating actions<br>• NHS Lateral Flow Testing Webinar attended<br>• Range of learning from other Trusts produced regionally<br>• Weekly Task and Finish Group and Project Team to ensure project continues with phase 3 roll out<br>• Dashboard monitoring<br>• Nationally moved to staff sourcing own LFT from Government and recording onto Government Website<br>• Increased LFTs to daily | **Risk score 4 x 3 = 12**<br><br>**Ongoing**<br><br>**Target 4 x 2 = 8** | • Some gaps in staff reporting their LFT<br>• Continue to monitor<br>• Recognise in addition to regular asymptomatic LFTs that new IPC guidance looks to managing staff in contact with Covid 19 back to work on a balance of risk assessment.<br>• |

| Risk ID | Potential Risk | Exec Lead | Standing Committee | Action Plan/ Monitoring | Mitigating Actions/ Controls in Place | Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance | Actions outstanding / further mitigating actions required |
|---|---|---|---|---|---|---|---|
| CVG52 | If EPUT does not have sufficient resource/ finance to effectively project manage and deliver the asymptomatic testing programme across the Trust then it may not meet the deliverables and timescales and potential failure of the programme | NH | Quality | Command structure | • EPUT distributes Covid19 swab testing kits for asymptomatic patient facing staff<br>• Page dedicated to asymptomatic testing on InPut including video guides, manager action lists, FAQs and self-testing guide<br>• Live event held on asymptomatic testing including the video<br>• Daily submission using form on InPut to report on LFT for the previous day, 7/7.<br>• Delivering phase 3<br>• Assess what business as usual will look like – asymptomatic testing may be commissioned with EPUT to fund – moved to national process<br>• Funding is part of reduced Covid 19 funding programme going forward | **Reduce risk score to threshold 4 x 2 = 8**<br><br>**Ongoing**<br><br>**Target 4 x 2 = 8** | |
| CVG55 | If EPUT continues to experience ward closures due to Covid19 outbreaks then availability of beds to acutely ill patients may diminish resulting in additional community/ virtual support and potential harm to patients | AG | Quality | Command structure | • Mitigation in place for swabbing, lateral flow testing on wards<br>• ICP Dashboard developed to help identify wards at potential risk<br>• Daily sit reps provide information on any Covid positive patients/Staff<br>• Outbreak management process in place<br>• Extend completion date in line with national lockdown easing | **Risk score 5 x 2 = 10 at threshold**<br><br>**June 21**<br><br>**Target 5 x 2 = 10** | • Continue to revisit this risk following lifting of restrictions |

| Risk ID | Potential Risk | Exec Lead | Standing Committee | Action Plan/ Monitoring | Mitigating Actions/ Controls in Place | Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance | Actions outstanding / further mitigating actions required |
|---|---|---|---|---|---|---|---|
| CVG24 | If EPUT does not ensure that staff have the new range of skills required to deal with the C19 crisis then appropriate care may not be delivered to patients resulting in potential harm to patients and challenges for staff | NH | Quality | Command structure | • Competency skills assessment carried out in wave 1 reviewed<br>• IPC competency self-assessments<br>• Covid care pathway document in place and updated with any new guidance | **Risk score at threshold 5 x 2 = 10**<br><br>**Ongoing**<br><br>**Target 5 x 2 = 10** | • Continue to review training in line with national guidance |
| CVG57 | If EPUT continues to experience delays in staff Covid investigations then RIDDOR submissions may be may more than 12 months late resulting in failure to comply with regulations and manage staff safety | NH | Quality | Command structure | • In May IPC took over responsibility for staff Covid sickness investigations to confirm if RIDDOR reportable<br>• Regular RIDDOR outcome meetings in place to agree submissions<br>• Additional resource in place to support investigation<br>• Draft letter to HSE<br>• Presented paper to Executive Team with actions to resolve the issues<br>• Process agreed, paper to ET and backlog worked through with new methodology and ongoing RIDDOR part of closure outbreak meetings<br>• Met with legal adviser and agreed that any staff member involved in an outbreak and contracted Covid-19 will have RIDDOR process instigated<br>• | **Risk score 4 x 2 = 8**<br><br>**Ongoing during C19 crisis**<br><br>**Target 4 x 2 = 8** | • Volume of outstanding investigations to be addressed<br>• Regular reporting to Silver Command<br>• Communications to staff and HSE being discussed with legal team<br>• Update SOP in accordance with legal advice<br>• |

| Risk ID | Potential Risk | Exec Lead | Standing Committee | Action Plan/ Monitoring | Mitigating Actions/ Controls in Place | Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance | Actions outstanding / further mitigating actions required |
|---|---|---|---|---|---|---|---|
| CVS29 | If EPUT staff do not comply with Covid-19 requirements and Covid Secure arrangements then the safety of patients and colleagues are put at risk resulting in a dip in staff morale, the potential for increased cases and the CQC requesting significant improvements | AG | Quality | Command structure | • Number of outbreaks has reduced to zero<br>• Reduction in breaches of Covid secure<br>• Local guidance in place<br>• Ensuring continuous rigour of PPE and IPC is reinforced through Bronze command | **Risk score at threshold 4 x 2 = 8**<br><br>**Ongoing** | |
| CVS30 | If EPUT does not manage the levels of fatigue within the organisation then sickness levels may rise resulting in a failure to deliver services in a safe way | SL | PIT | Command structure | • Wobble rooms where practicable<br>• Take a break initiative promoted<br>• Annual leave guidance updated<br>• Wellbeing events and mindfulness<br>• Wellbeing Festival Summer 21<br>• Rest nest sessions<br>• PULSE survey to be reinitiated August 21<br>• Discussions at Senior Leadership Team<br>• Refocus on the environmental factors that are affecting staff stress levels e.g. excessive workloads and demands | **Risk score 4 x 3 = 12**<br><br>**Ongoing**<br><br>**Target 4 x 2 = 8** | • Continue to encourage staff to take up offers of online support<br>• Senior and local leaders to address environmental factors affecting staff morale and wellbeing through discussion focus<br>• Commitment to transfer bank and agency staff to permanent posts<br>• Full establishment review |

| Risk ID | Potential Risk | Exec Lead | Standing Committee | Action Plan/ Monitoring | Mitigating Actions/ Controls in Place | Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance | Actions outstanding / further mitigating actions required |
|---|---|---|---|---|---|---|---|
| CVS25 | If EPUT is unable to meet the rehabilitation needs of Covid-19 patients in recovery then their recovery from Covid-19 may be delayed, resulting in possible adverse health and socioeconomic outcomes for the patient and associated impacts on their families & carers. | AG | Quality | Command structure | • National and local guidance in place on Covid rehabilitation<br>• Piloting 'Living with Covid' Recovery App from AHSN for the West Essex Long Covid assessment service – has evidenced outcomes in supporting access and flow in Covid assessment services<br>• AHP led Fatigue management training delivered in EPUT and on behalf of partners<br>• Other Long Covid services led via respective ICS systems in Essex all governed by a regional approach with second funding imminent to support all systems | **Risk score at threshold 4 x 2 = 8**<br>**Ongoing**<br>**Target 4 x 2 = 8** | • Continue engagement with ICS/ STP workstreams regarding Covid recovery<br>• Continue collaborative work to address gaps in knowledge and skills<br>• Work with partner agencies across Essex to devise treatment plans<br>• Staff issues re Long Covid covered by support groups and continuous monitoring of data |
| CVG58 | If EPUT does not manage unvaccinated staff that may need to enter care homes then staff may be refused entry resulting in vaccinated staff carrying out additional work | AG | Quality | Command structure | • HR working with individuals and operational managers around unvaccinated staff and those returning to work from long term leave<br>• Monitoring of situation has identified no or little impact on service delivery<br>• All staff vaccinated within Estates and Facilities, Pharmacy, Specialist Services (that may visit care homes) | **Risk score 3 x 3 = 9**<br>**Target 3 x 2 = 6** | • Medical staffing team working with medical staff to ascertain current position<br>• Continue to monitor situation |
| CVG59 | If EPUT does not manage implementation of the mandatory vaccination for front line staff then recruitment and retention may be impacted resulting in sub-optimal service delivery | SL supported by AG | PECC | Command structure | • HR already planning for mandatory vaccinations | **Risk score 4 x 4 = 16**<br>**Target April 22** | • Further targeted communications to unvaccinated staff<br>• Review mandatory vaccination announcement<br>• Currently 700 bank/ mass vaccination staff with no vaccination details held (no response to disclosure request)<br>• Plan for 5-10% of front line workers not yet vaccinated |

**Table 2 – Heat Map against 5 x 5 scoring matrix**

| | RISK RATING | | | | | |
|---|---|---|---|---|---|---|
| | Consequence | | | | | |
| | | 1 | 2 | 3 | 4 | 5 |
| Likelihood | 1 | | | | | |
| | 2 | | | | CVG45 CVG52 CVS25 CVS29 CVG57 | CRR90 CVG24 CVG55 |
| | 3 | | | CVG10 CVG58 | CRR83 CRR92 CVG33 CVG37 CVG48 CVS30 CVG51 CVG19 | |
| | 4 | | | | CVG 59 CRR93 CRR79 | |
| | 5 | | | | CRR94 | |

**Appendix 2**

**ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST**

**Covid-19 Lessons Learnt – National Report Summary**

## 1. Introduction

The purpose of this report is to provide a summary of the national Coronavirus inquiry lessons learnt. Since March 2020 the Science and Technology Committee and the Health and Social Care Committee have been holding separate inquiries examining the Government's response to the Covid-19 pandemic. These inquiries began as Covid-19 reached the UK and have continued throughout the first wave of the pandemic and beyond, examining the response to the pandemic as it happened. In October 2020, the two Committees launched a joint inquiry, *Coronavirus: lessons learnt*, to consider several key issues that emerged during the first wave of the pandemic and identify what lessons need to be learnt.

## 2. Summary of Findings

The national report was predominately focused on the response to the pandemic in England. The inquiry looked in detail at six key areas of the response to Covid-19;

- The country's preparedness for a pandemic;
- The use of non-pharmaceutical interventions such as border controls
- Social distancing and lockdowns to control the pandemic; the use of test, trace and isolate strategies;
- The impact of the pandemic on social care;
- The impact of the pandemic on specific communities; and
- The procurement and roll-out of Covid-19 vaccines.

Across these areas they identified several key issues which have had a major impact on the UK response to Covid-19

1. The UK's pandemic planning was too narrowly and inflexibly based on a flu model which failed to learn the lessons from SARS, MERS and Ebola. The result was that whilst the pandemic planning had been globally acclaimed, it performed less well than other countries when it was needed most.

2. In the first three months the strategy reflected official scientific advice to the Government which was accepted and implemented. When the Government moved from the 'contain' stage to the 'delay' stage, that approach involved trying to manage the spread of Covid through the population rather than to stop it spreading altogether. This amounted in practice to accepting that herd immunity by infection was the inevitable outcome, given that the United Kingdom had no firm prospect of a vaccine, limited testing capacity and a widespread view that the public would not accept a lockdown for a significant period. The UK, along with many other countries made a serious early error in adopting this fatalistic approach and not considering a more emphatic and rigorous approach to stopping the spread of the virus as adopted by many East and South East Asian countries. The fact that the UK approach reflected a consensus between official scientific advisers and the Government indicates a degree of groupthink that was present at the time which meant they were not as open to approaches being taken elsewhere as they should have been.

3. It was also a serious mistake to get to the point where community testing was stopped early in the pandemic. A country with a world-class expertise in data analysis should not have faced the biggest health crisis in a hundred years with virtually no data to analyse. This problem was compounded by a failure of national public bodies to share such data available with each other, including between national and local government.

4. There should have been more challenge to Public Health England to increase testing capacity at the outset. Instead testing capacity appeared to be accepted for too long as a fait accompli.

5. The structures for offering scientific advice lacked transparency, international representation and structured challenge. Protocols to share vital information between public bodies were absent. The Civil Contingencies Secretariat was inadequately resourced, including with specialist expertise which had been removed. Scientific accomplishment was hampered by operational inadequacy.

6. Although it was a rapidly changing situation, given the large number of deaths predicted it was surprising that the initially fatalistic assumptions about the impossibility of suppressing the virus were not challenged until it became clear the NHS could be overwhelmed. Even when the UK strategy did change dramatically in March 2020, it was because of domestic concern about the NHS being overwhelmed rather than a serious decision to follow emerging international best practice.

7. There was a desire to avoid a lockdown because of the immense harm it would entail to the economy, normal health services and society. In the absence of other strategies such as rigorous case isolation, a meaningful test and trace operation, and robust border controls, a full lockdown was inevitable and should have come sooner.

8. Although some criticised the then Secretary of State for announcing it unilaterally, and with little public support from elsewhere in Government and the NHS, the testing target of 100,000 tests a day was important to galvanise the system to drive the massive increase in testing capacity that was required. However it was a significant failing that such a personal initiative was needed in the first place.

9. It was a remarkable achievement for the NHS to expand ventilator and intensive care capacity, including through the establishment of Nightingale hospitals and the ventilator challenge. Overall, the majority of Covid-19 patients with a clinical need for hospital care received it. However, the price paid to deliver this was significant interruption to NHS core services including in areas like cancer which are time critical.

10. Despite being one of the first countries in the world to develop a test for Covid in January 2020, the United Kingdom failed to translate that scientific leadership into operational success in establishing an effective test and trace system during the first year of the pandemic. The slow, uncertain, and often chaotic performance of the test, trace and isolate system severely hampered the UK's response to the pandemic. This was partly because NHS Test and Trace was only established when daily infections had risen to 2,000. The result was that the Test and Trace operation ultimately failed in its stated objective to prevent future lockdowns

11. The test and trace operation followed a centralised model initially, meaning assistance from laboratories outside PHE was rebuffed. The same was true for contact tracing, where the established capabilities of local Directors of Public Health and their teams were not effectively harnessed during the initial response to the pandemic, despite local approaches proving effective in places where they were pursued. It is now clear that the optimal structure for test and trace is one that is locally driven with the ability to draw on central surge capacity.

12. Evidence that inadequate financial support was a barrier for some people, and the inability of contacts to be released from isolation if they tested negative contributed to lower compliance with isolation instructions.

13. The Government and the NHS both failed to recognise the significant risks to the social care sector at the beginning of the pandemic. Until the social care working group was established in May 2020, SAGE either did not have sufficient representation from social care or did not give enough weight to the impact on the social care sector. Without such input and broader expertise, Ministers lacked important advice when making crucial decisions. This, coupled with staff shortages, a lack of sufficient testing and PPE, and the design of care settings to enable communal living hampered isolation and infection control, meant that some care providers were unable to respond to risks as

effectively as they should. This had devastating and preventable repercussions for people receiving care and their families and put staff providing social care at risk.

14. The lack of priority attached to social care during the initial phase of the pandemic was illustrative of a longstanding failure to afford social care the same attention as the NHS. The rapid discharge of people from hospitals into care homes without adequate testing or rigorous isolation was indicative of the disparity. This, combined with untested staff bringing infection into homes from the community, led to many thousands of deaths which could have been avoided.

15. It is impossible to know whether a circuit breaker in the early autumn of 2020 would have had a material effect in preventing a second lockdown given that the Kent (or Alpha) variant may already have been prevalent. In this decision not to have a circuit breaker, the UK Government did not follow the official scientific advice. Ministers were clearly over-optimistic in their assumption that the worst was behind us during the summer months of 2020.

16. Unlike many governments, UK Ministers were correct to identify that a vaccine would be the long-term route out of the pandemic and presciently supported the research and development of a number of Covid-19 vaccines, including the Oxford/AstraZeneca vaccine. A significant part of the success of the Oxford/AstraZeneca vaccine was due to the Government's early investment in research and development which originally started with the UK Vaccines Network set up in 2016. That investment and support through successive governments has clearly paid off.

17. The result has been a UK vaccination programme encompassing discovery, purchase and full vaccination of over 80% of the adult population by September 2021 one of the most effective initiatives in the history of UK science and public administration and which was delivered by the NHS. Millions of lives will ultimately be saved as a result of the global vaccine effort in which the UK has played a leading part. In the UK alone, the successful deployment of effective vaccines has, as at September 2021, allowed a resumption of much of normal life with incalculable benefits to people's lives, livelihoods and to society.

18. Treatments for Covid are another area where the UK's response was genuinely world-leading. The RECOVERY Trial had, by mid-August 2021, recruited just over 42,000 volunteers worldwide to mount randomised trials of Covid-19 treatments. Establishing the effectiveness of dexamethasone and the ineffectiveness of hydrochloroquine were vital contributions to the worldwide battle against Covid-19 and estimated to have saved over a million lives globally.

19. The UK regulatory authorities—principally the MHRA and the JCVI—approached their crucial remit with authority and creativity. Allowing the results of clinical trials to be submitted on a rolling basis made the UK the first Western country in the world to approve a vaccine. The bold decision to extend the interval between doses allowed more people to be vaccinated more quickly and so protected the population.

20. The establishment of the Vaccine Taskforce outside of the Department of Health and Social Care, and comprising a portfolio of experienced individuals from industry, healthcare, science and Government was vital to its success. The Government was right to act to accelerate the delivery of institutions like the Vaccines Manufacturing Innovation Centre and to have invested further in manufacturing capacity.

21. However, existing social, economic and health inequalities were exacerbated by the pandemic and combined with possible biological factors contributed to unequal outcomes including unacceptably high death rates amongst people from Black, Asian and Minority Ethnic communities. Increased exposure to Covid as a result of people's housing and working conditions played a significant role. Black, Asian and minority ethnic staff in the NHS, faced greater difficulty in accessing the appropriate and useable Personal Protective Equipment. The experience of the Covid pandemic underlines the need for an urgent and long term strategy to tackle health inequalities and to address the working conditions which have put staff from Black, Asian and minority ethnic communities at greater risk.

22. Likewise the disproportionately high mortality rates that people with learning disabilities and autistic people have suffered throughout the pandemic has highlighted the health inequalities faced by this group. While pre-existing health conditions undoubtedly contributed to the increased mortality risk, they were compounded by inadequate access to the care people with learning disabilities needed at a time of crisis. This was a result of restrictions on non-Covid hospital activity, and, significantly, because of access restrictions which prevented family members and other carers accompanying people with learning disabilities in hospital to perform their expected advocacy role. “Do not attempt CPR” notices were issued inappropriately for some people with learning disabilities. Plans for future emergencies should recognise that blanket access restrictions to hospital may not be appropriate for patients who rely on an advocate to express their requirements.

Summary Prepared by:

**Amanda Webb**
**Senior Emergency Planning and Compliance Officer**

**Jane Cheeseman**
**Head of Compliance and Emergency Planning**

| | | |
|---|---|---|
| | | **Agenda Item No: 9ii** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **Ligature Risk Management Q2 Report** | | | | | |
| **Executive/Non-Executive Lead:** | Paul Scott, Chief Executive Officer | | | | | |
| **Report Author(s):** | Jane Cheeseman, Head of Compliance and Emergency Planning | | | | | |
| **Report discussed previously at:** | Health Safety and Security Committee<br>Executive Safety Oversight Group | | | | | |
| **Level of Assurance:** | **Level 1** | | **Level 2** | ✓ | **Level 3** | |

| **Risk Assessment of Report** | |
|---|---|
| Summary of Risks highlighted in this report | BAF10 (CRR81) - If EPUT does not reduce ligature risks then serious incidents will occur resulting in a failure to deliver our Safety First, Safety Always ambitions |
| State which BAF risk(s) this report relates to | BAF 10 |
| Does this report mitigate the BAF risk(s)? | No |
| Are you recommending a new risk for the EPUT BAF? | No |
| If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register. | N/A |
| Describe what measures will you use to monitor mitigation of the risk | N/A |

| **Purpose of the Report** | | |
|---|---|---|
| This report provides an overview of the action that is underway currently and that which is planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's in-patient estate. | **Approval** | |
| | **Discussion** | ✓ |
| | **Information** | |

**Recommendations/Action Required**

The Board of Directors is asked to:

1 Discuss the contents of this report
2 Identify any further actions required.

**Summary of Key Issues**

**Independent Assurance**

As previously reported BDO - The Trust's internal independent auditors completed an audit in May 2021 that focussed on the operational ward and staff compliance with Ligature Risk Assessment and Management policy and procedure. BDO provided the Trust with substantial assurance over the design of the controls and moderate assurance on the effectiveness of the controls reflecting the same assurance provided from their Ligature Risks audit undertaken remotely in 2020/21. The action plan developed following the audit continues to be taken forward through the Ligature Risk Reduction Group (LRRG). Currently 2 actions have been fully addressed with the remaining 4 in progress.

The Trust is still awaiting the final report from the peer review undertaken with East London Foundation Trust (ELFT). Following receipt of the draft report an action plan was developed which is being overseen by LRRG. This will be revisited once the final report is received.

**Governance**
The Ligature Risk Reduction Group (LRRG) continues to be held monthly; chaired by the Executive Chief Operating Officer. The Quarterly Ligature reports are shared with the Trust Quality Committee and Trust Board of Directors to provide assurance reporting and risk escalation.

The Ligature Policy and Procedure continues to be reviewed as new guidance and learning is published.

Ligature Environmental Risk Assessments of all Mental Health and Learning Disability wards continues, undertaken by a team of professionals from Health and Safety, Estates and the Ward. The new approved electronic assessment tool ensures that all national safety alerts are considered when received. Actions identified are shared with the Ligature Risk Reduction Group who monitor until completion.

Ligature risk remains on the BAF 10 (CRR81) and the full action plan continues to be reviewed and monitored regularly

**Continuous Learning - Ligature Incidents**
The Ligature Risk Reduction Group continues to receive incident analysis to identify learning and review national and local safety alerts.

**Enhancing Environment**
The LRRG has and continues to develop agreed risk reduced environmental standards that inform the Trust's investment and patient safety improvement works programme. The trust has also instigated a project team looking at the trust standards and how these can be applied universally across the inpatient estate.

**Culture - Staff Training**
The trust continues to provide the bespoke TIDAL ligature risk assessment training for EPUT staff who undertake ligature risk inspections within our mental health wards. The uptake of the training is monitored via LRRG where operational leads are advised of the need to ensure more staff enrol on the training.

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

| **Acronyms/Terms Used in the Report** | | | |
|---|---|---|---|
| BAF | Board Assurance Framework | LRRG | Ligature Risk Reduction Group |
| CQC | Care Quality Commission | ELFT | East London Foundation Trust |
| EERG | Estate Expert Reference Group | | |

| **Supporting Documents and/or Further Reading** |
|---|
| Ligature Report |

| **Lead** |
|---|
| **Paul Scott**<br>**Chief Executive Officer** |

**EPUT**

# LIGATURE RISK MANAGEMENT – Quarter 2

## 1.0 Introduction

This report provides an update of the action that is underway and that which is planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate.

The Trust is committed to continuously improving systems and processes that facilitate robust risk identification and management, carrying out patient safety improvement works to create safer physical environments and to creating a risk aware culture. The Board of Directors has identified the potential risk associated with this agenda as one of the most significant potential risks that may prevent achievement of the Trust strategic objectives and this potential risk is therefore recorded in the Board Assurance Framework (ref CRR81). An action plan is in place to mitigate this potential risk. Reports on the action that has been taken are provided regularly to the Board of Directors. This report aims to assure members that the focus on mitigating this potential risk continues to be a priority.

Whilst this report does confirm that the focus on mitigating risk continues to be strong and progress continues to be made, members are reminded that managing ligature risk associated with the physical environment must be considered in the wider context of care provision that includes staffing, security, patient risk assessment, observation and care planning. It also has to be recognised that the Trust's inpatient environments (consistent with many providers of mental health services) will rarely be entirely free of fixed ligature points because most were not designed to mitigate the potential risks being identified currently and/or there are no design solutions to eliminate identified potential risk entirely from all infrastructure, fixtures and fittings.

## 2.0 Independent Assurance

### Internal Audit

The Trust's internal independent auditors (BDO) carried out an audit between the 10th and 20th May 2021 that focussed on the operational ward and staff compliance with Ligature Risk Assessment and Management policy and procedure. The audit incorporated visits to 16 of the trusts inpatient mental health wards. A final report has been produced advising that overall, BDO were able to provide the Trust with substantial assurance over the design of the controls and moderate assurance on the effectiveness of the controls. This reflects the same assurance provided from their remote (due to Covid19) Ligature Risks audit undertaken in 2020/21.

Good practices were acknowledged and a number of recommendations made to consider for both the inspection team and operationally at ward level. An action plan has been developed and agreed to address and embed each of the recommendations that have been made. The action plan is monitored through the LRRG and to date there are two actions that have been fully addressed with the remaining 4 in progress.

### CQC New Inspection Criteria

The CQC are currently updating the previously reported 2020 briefing guide for inspection teams. As soon as the revised guidance is available, a review against the criteria will be undertaken to provide assurance of the trust position against meeting the new or updated criteria.

**ELFT Review**

As previously reported EPUT has been working with East London Foundation Trust (ELFT) to undertake peer reviews. The purpose being to identify improvements that could be made to EPUT ligature processes through shared learning with ELFT. The review was undertaken at the end of March 2021 and a draft report was recently received giving the opportunity for factual accuracy checking which was completed with no material changes identified. The report has been considered in detail by the Ligature Risk Reduction Group, Executive Safety Operational Committee and the Quality Committee. The report highlights good practice and provides some recommendations for EPUT to consider.

We are still awaiting the final report but have moved ahead with development of an action plan to take forward recommendations which is being overseen by LRRG.

## 3.0 Governance

The Ligature Risk Reduction Group (LRRG) continues to be held each month; chaired by the Executive Chief Operating Officer. Quarterly Ligature reports are shared with the Trust Quality Committee and Trust Board of Directors to provide assurance reporting and risk escalation.

The Ligature Policy and Procedure has continued to be reviewed as new guidance and learning is published. The next full annual review is due for completion by March 2022

Ligature Environmental Risk Assessments of all MH and LD wards continues undertaken by a team of professionals from H&S, Estates and the Ward. A review of the assessment tool has been undertaken to ensure this considered all national safety alerts when received and the new electronic assessment tool has been approved and implemented. Actions identified are shared with the Ligature Risk Reduction Group who monitor until completion.

As previously reported a protocol is in place to safely include a person with lived experience (PWLE) as part of the inspection team. Unfortunately, since the full on-site inspections have recommenced (previously paused due to the pandemic) there has been limited progress with this initiative as no further inspections have as yet been undertaken with the inclusion of a PWLE due to Government and Trust guidance. This is currently being reviewed with the Patient Experience team to ensure involvement going forward and that mutually agreed dates are secured to join the inspections.

The Ligature BAF (CRR81) risk is reviewed on a monthly basis and has been fully reviewed and updated for 2021/22. The BAF is included in the Quality Committee papers and details the ongoing ligature risk reduction actions, progress and controls.

The Estates Expert Reference Group, chaired by the Executive Chief Finance Officer, has increased in frequency to oversee a wide range of environmental patient safety improvement works identified as a result of ligature risk assessment and setting of agreed standards by the Ligature Risk Reduction Group.

## 4.0 Continuous Learning

Ligature incident dashboards on Datix have been developed and rolled out to all mental health, LD and specialist service ward managers. The dashboard identifies any ligature incidents and gives staff a real time picture of incident activity to identify any emerging trends for action.

The Trust's approach to identifying and mitigating potential risk is constantly subject to reflection and review, informed by independent review (as detailed in point 2.0 above), incident data and internal scrutiny.

The Ligature Risk Reduction Group continues to receive incident analysis to identify learning and review national and local safety alerts.

## 5.0 Policy and Procedure Implementation

Following a review of the policy and procedure, LRRG agreed to a change from 6 monthly inspections to inspection's being completed within 12 months for all inpatient areas, with a six month review also undertaken. The six-month review will not be a formal ligature risk assessment however it will be reported on and used to:

- Coach, support and educate staff regarding ligature
- Follow up outstanding actions from ligature inspections
- Audit compliance with the policy, procedure and appendices
- Identify good practice and ideas for improvement

The policy was approved in March 2021 and the change to annual ligature risk inspections with 6 monthly reviews has been implemented. It is believed this will strengthen the ligature assessment process and give an opportunity to enhance staff understanding and implementation of policy requirements. Compliance checks within the risk team continue to ensure all ligature risk assessment tools and reports are completed correctly and in line with policy.

## 6.0 Enhancing Environments

The LRRG has and continues to develop agreed risk reduced environmental standards that inform the Trust's investment and patient safety improvement works programme. The environmental standards have been updated to take into account all known safety alerts and ligature learning. The trust has instigated a project team looking at the trust standards and how these can be applied universally across the inpatient estate.

## 7.0 Culture – Staff Training

All staff working within a mental health/LD inpatient settings are required to complete the ligature awareness on-line training package (launched in March 2018 and reviewed December 2019) "Preventing Suicide by Ligature" on an annual basis. The training package details:

- Definitions relating to the management of ligature
- Background and trends in suicide and self-harm
- Ligature hazards and risks and there management
- Principles of good practice in the prevention of suicide
- Emergency procedures and equipment
- Policy and procedures, related training and links.

Overall trust compliance with training as of the end of September 2021 was 92% broken down as follows:

- Bedford 89%
- South Essex 93%
- North Essex 92%

The trust continues to provide the bespoke TIDAL ligature risk assessment training for EPUT staff who undertake ligature risk inspections within our mental health wards. The training is delivered over 2 full days by TIDAL training; attendees include clinical staff Band 6 and above, members of the risk team and estates staff who undertake ligature risk assessments. To date 60 staff have been trained as follows:

- 38 Ward Staff B6 and above
- 14 Estates staff
- 7 Corporate/Risk Staff

The overall aim of the sessions is to equip and skill staff members to be confident in identifying ligature risks and to continue to monitor and update risk assessments for their individual work areas.

The uptake of the training is monitored via LRRG where operational leads are advised of the need to ensure more staff enrol on the training. It was agreed that TIDAL training be paused over the summer months to account for a potential increase in annual leave being taken. The next TIDAL training session is booked for November and is fully subscribed.

## 8.0 Conclusion

The summary of information provided in this report is by its nature only potentially a snapshot of the work that is taking place by frontline clinical staff, risk and estates specialists and the wider leadership team.

It is intended that the information provides sufficient assurance that the Trust continues to take action and mitigating the risk of ligature seriously.

## 9.0 Action Required

The Board of Directors are asked to:

- Discuss the contents of this report
- Identify any further actions required

**Report Prepared By:**
Jane Cheeseman
Head of Compliance and Emergency Planning

**On behalf of:**
Paul Scott
Chief Executive Officer
12 November 2021

| | | |
|---|---|---|
| | | **Agenda Item No: 10a** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | **24 November 2021** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | **Safe Working of Junior Doctors Quarterly Report** | | | | | |
| **Executive/Non-Executive Lead:** | Dr Milind Karale – Dr Gladvine Mudempilly to present | | | | | |
| **Report Author(s):** | Dr Sethi, Consultant Psychiatrist and Guardian of Safe Working Hours | | | | | |
| **Report discussed previously at:** | N/A | | | | | |
| **Level of Assurance:** | **Level 1** | ✓ | **Level 2** | | **Level 3** | |

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

| **Purpose of the Report** | | |
|---|---|---|
| This report provides the Board of Directors assurance that doctors in training are safely rostered and that their working hours are compliance with the Terms and Conditions of the Service. | **Approval** | |
| | **Discussion** | |
| | **Information** | ✓ |

| **Recommendations/Action Required** |
|---|
| The Board is asked to note the findings of the report.<br>1. Note the contents of the report |

| Summary of Key Issues |
|---|
| 1 There are 11 Exception Report raised by trainees.<br>2 No fines were issued in this quarter.<br>3 There are gaps in the on call rota which are filled by MTI and LAS doctors. |

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

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

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

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| Supporting Documents and/or Further Reading |
|---|
| |

| Lead |
| --- |
| Dr Prabha Sethi<br>Guardian of Safe Working |

# Quarterly Report on Safe Working of Junior Doctors

## 1 Purpose of Report

The purpose of this report is to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.

## 2 Executive Summary

This is the seventeenth quarterly report submitted to the Board on safe working of junior doctors for the period 1 July to the 30 September 2021. The Trust has established robust processes to monitor safe working of junior doctors and report any exceptions to their terms and conditions.

**Exception Reporting: (**11 exception reports in this quarter)

All 11 exception reports related to trainee doctors having to work extra hours beyond their shifts. Time in lieu was given in all but one case, where the doctor was paid for additional hours.

**Work Schedule Report**

Work schedules were sent out to all trainees who commenced their placements on the 4th August 2021

**Doctors in Training Data**

| | |
|---|---|
| Number of doctors in training posts (total inclusive of GP and Foundation) | 133 |
| Number of doctors in psychiatry training on 2016 Terms and Conditions | 71 |
| Total number of vacancies | 16 |
| Total vacancies covered LAS/ MTI/Agency | 10 |
| Total gaps | 6 |

**Agency**

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

| Locum bookings (internal bank) by reason* | | | | | |
|---|---|---|---|---|---|
| Reason | Number of shifts requested | Number of shifts worked | Number of shifts given to agency | Number of hours requested | Number of hours worked |
| Vacancy/Maternity/ sick/COVID | 143 | 143 | 0 | 1592 | 1592 |
| Total | 143 | 143 | 0 | 1592 | 1592 |

**Actions taken to resolve issues:**

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

1. Rolling Adverts on NHS Jobs. Few International Fellow doctors have been recently appointed.

2. Emails are sent to former GP and FY trainees if they would like to join the bank to do on-calls-this is now part of the termination process for GP's and FY's so they can express an interest in covering extra shifts when they leave EPUT

**Fines:** None.

**Issues Arising:**

1. Refurbishment work at on call rooms and Doctor's room at various sites of the Trust are underway, work at Linden Centre is complete.

2. Trainees raised concerns on difficulty in finding supervisors to complete short psychology cases which is part of their ARCP requirements and to gain competency. The matter has been escalated to the relevant Clinical Leads.

## 3 Action Required

Board is asked to note the findings of the report.
No major concerns were raised by doctors at the Junior Doctors Forum apart from points above.

Report prepared by

Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours
October 2021

| | | |
|---|---|---|
| | | **Agenda Item No: 11a** |
| **SUMMARY REPORT** | **BOARD OF DIRECTORS PART 1** | 24 November 2021 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Report Title:** | CQC Compliance Update | | | | | |
| **Executive/Non-Executive Lead:** | Paul Scott, Chief Executive | | | | | |
| **Report Author(s):** | Amanda Webb, Senior Emergency Planning and Compliance Officer | | | | | |
| **Report discussed previously at:** | Executive Safety Oversight Group<br>Quality Committee | | | | | |
| **Level of Assurance:** | **Level 1** | | **Level 2** | ✓ | **Level 3** | |

| **Risk Assessment of Report** | |
|---|---|
| Summary of Risks highlighted in this report | |
| State which BAF risk(s) this report relates to | BAF45 - CQC Inspections and Learning<br>BAF67 - If EPUT does not plan to resettle the CAMHS Tier 4 service then recovery of services is compromised resulting in remaining closed to admissions |
| Does this report mitigate the BAF risk(s)? | No |
| Are you recommending a new risk for the EPUT BAF? | No |
| If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register. | N/A |
| Describe what measures will you use to monitor mitigation of the risk | N/A |

| **Purpose of the Report** | | |
|---|---|---|
| This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and requirements. | **Approval** | ✓ |
| | **Discussion** | ✓ |
| | **Information** | ✓ |

**Recommendations/Action Required**

The Board of Directors is asked to:

1 Note the contents of the report
2 Identify any further action that is required to be taken
3 Approve the CQC Action Plan to submit to CQC as final version

**Summary of Key Issues**

**Meeting Registration Requirements**

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

**CQC Inspections**

One CQC action plan is currently open following the CAMHS inspection. As at the end of October 2021, 49 (81%) individual actions have been reported as complete, 13 (19%)

individual actions are in progress and are not yet due for completion and 0 individual actions are overdue

**Internal Compliance Programme**
The compliance team have actively started undertaking site inspection to areas where available information has identified potential areas at risk of non-compliance. The schedule moving forward will work alongside the ward heatmap indicators.

In addition the Compliance Team has been focusing work on the following areas:

- CAMHS Support Visits and auditing
- Intensive Clinical Support Group (CAMHS)
- Inpatient Support Group (Adult Acute, Secure Services and Older Adults)
- Action Plan Testing
- Ward Heat Maps / Internal Insight Indicator further development
- Quarterly PHSO action plan testing
- Deep dives (CICC, Assessment Unit, Christopher Unit & Cedar Ward)

**CQC Action Plan Testing**
As previously reported the Compliance Team are continuing to test action plans completed to ensure actions have been embedded. Where gaps are found these are escalated to the appropriate Trust Committee to action.

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

| Acronyms/Terms Used in the Report | | | |
|---|---|---|---|
| CQC | Care Quality Commission | LRRG | Ligature Risk Reduction Group |

| Supporting Documents and/or Further Reading |
|---|

Accompanying Report – CQC Compliance
Appendix 1 – CQC Action Plan
Appendix 2 - Summary of ward and team visits in October 2021

**Lead**

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

**Agenda Item 11a**
**Board of Directors**
**24 November 2021**

**ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST**

# CQC Compliance Update

## 1. Introduction

This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and requirements.

## 2. Meeting Registration Requirements

EPUT is fully registered with the CQC and currently has conditions imposed for CAMHS.

In September 2021 the Trust approached the CQC requesting that the conditions be reconsidered following improvement work and it has been agreed that Poplar Unit can start to take admissions with no more than 2 per week.

The Trust is required to notify the CQC of any locations used to deliver the regulated activity 'Treatment of disease, disorder or injury' by the submission of an updated Statement of Purpose. The Statement of Purpose has been regularly updated due to the decommissioning of some of the Mass Vaccination Locations.

## 3. CQC Inspections

### 3.1. Unannounced CQC Inspection (CAMHS May 2021)

Following an unannounced inspection in May by the CQC at the three children and young people's mental health services (CAMHS) T4 inpatient wards in Essex (EPUT), the CQC served a Notice of Decision (NoD) under Section 31 of the Health and Social Care Act 2008.

The CQC imposed conditions, taking the decision to suspend admissions to all three of the CAMHS T4 wards (Larkwood, Longview and Poplar) with immediate effect in June 2021. As outlined above following improvements made and assurances provided to the CQC it has been agreed that Poplar Unit can start to take admissions with no more than 2 per week.

The final report was published by the CQC on 15th September 2021 and the CQC has re-rated our CAMHS service from 'Outstanding' in 2019 to 'inadequate'. The report has identified 22 areas for improvement (13 Must Do, 9 Should Do). The Trust has developed an enhanced action plan to address the concerns raised (Appendix 1) that was submitted to the CQC on 12th October as required and will require Board approval prior to sharing as the final version to the CQC.

As at the end of October 2021, 49 (81%) individual actions have been reported as complete, 13 (19%) individual actions are in progress and are not yet due for completion and 0 individual actions are overdue. A breakdown of progress is provided in the table below:

| Action Type | Must Do / Should Do Actions | | | | Specific Actions That Address Must Do/Should Do Actions | | | |
|---|---|---|---|---|---|---|---|---|
| | Total Actions | Actions Complete | Actions Within Timescale | Actions Past Timescale | Total Actions | Actions Complete | Actions Within Timescale | Actions Past Timescale |
| Must Do | 13 | 8 | 5 | 0 | 46 | 39 | 7 | 0 |
| Should Do | 9 | 4 | 5 | 0 | 19 | 13 | 6 | 0 |
| **TOTAL** | **22** | **12** | **10** | **0** | **67** | **49 (81%)** | **13 (19%)** | **0** |

## 4. Internal Compliance Programme

Please see appendix 2 for summary of ward and team visits undertaken in October 2021

### CQC Preparation

As previously reported self-assessments have been completed by all inpatient units and supports visits have been undertaken in Q1 by the Compliance or Nursing Team.

Self-assessment tools have been circulated to the Community Services (both MHS and CHS) to support services with their CQC preparation. Directorate analysis will be provided to highlight any areas of concerns in addition to a deeper review of any main areas of concerns. Support visits have been arranged to a random selection of Community Service ensuring all geographical areas are covered

### Ward Heat Maps

A new process is being developed utilising data available in the organisation to give a picture of the wards against a range of key indicators. These indicators will provide an internal insight framework and will be used to celebrate wards who are performing well and put support packages in place for those where improvement is needed.

The Executive Team reviewed the first iteration of the new heat map indicators and requested for some additions which were included in the second version.

The compliance team have been actively undertaking site visits to areas where available information has identified potential areas at risk of non-compliance. The schedule moving forward will work alongside the ward heat map indicators.

Compliance visits are summarised in appendix 2.

### Clinical Support Groups/Deep Dives

<u>CAMHS Intensive Clinical Support Group</u>
The Compliance Team continue to facilitate the established CAMHS Intensive Clinical Support Group with weekly meetings and continuous checking and monitoring of the Support plan which was developed following the Serious Incident on Longview prior to the CQC unannounced Inspection. The actions required as part of the CQC visit have been incorporated into the Support Plan.

Following receipt of the CQC Inspection final report, a CQC action plan was developed and will be monitored through the group.

Inpatient Clinical Support Group
The Adult Intensive Clinical Support Group ended following completion of their CQC action plan and action plan testing. However it was felt that this forum had continued benefits for shared learning and it has been agreed that an Inpatient Clinical Support Group will continue (this includes representatives from all inpatient areas). Terms of reference are being developed for the group.

CICC Deep Dive
A deep dive was initiated at CICC following a serious fall. A project group was established who have undertaken a deep dive focused on falls this included:

- Falls lead visit to the ward to review falls processes
- Records auditing
- Training review
- Staff engagement

The review found that some improvements were needed to record keeping and that there is a disconnect between nursing staff and therapy staff. The review has made a number of recommendations which are being taken forward by the unit.

Rawreth Court Deep Dive
A deep dive was initiated at Rawreth Court following concerns raised by the CQC. A project group has been established and deep dive undertaken. The deep dive has made recommendations which are being taken forward by the unit. The deep dive has been closed.

Assessment Unit Deep Dive
A new deep dive has been initiated at the Assessment Unit following a request for information from the CQC. A project group has been established and scope agreed. The review has made a number of recommendations which are being taken forward by the unit. The next step of the deep dive will be to undertake a compliance team visit to the unit.

Christopher Unit Deep Dive
A new deep dive has been initiated at Christopher Unit following concerns raised by the Freedom to speak up guardian. A project group has been set up and scope has been agreed.

## 5. CQC Guidance / Updates

**State of Care Report 2020/21**
The CQC have published this year's report *State of Care* that reflects on how the system has dealt with the COVID-19 pandemic and highlights key areas affecting the system as a whole across four common themes.

1. **People's experiences of care**
   - The impact of the pandemic on many who use health and social care services has been intensely damaging. Many people have struggled to get the care they need, and there is also evidence that some people have not sought care and treatment as a result of COVID-19.
   - Health and social care staff are exhausted and the workforce is depleted.
   - The need for mental health care has increased, with children and young people particularly badly affected.

2. **Flexibility to respond to the pandemic**
   - The vital role of adult social care was made clear during the pandemic, but urgent action is needed to tackle staffing issues and the increased pressures and stresses caused by staff shortages.

- The NHS was able to expand its critical care capacity to respond to the needs of the patient population at a time of crisis, although it put extra pressure on staff and other types of care and treatment.

**3. Ongoing quality concerns**

- Following reviews of high-risk mental health services, the CQC are concerned that people continue to be put at risk in a small number of services where there are warning signs of closed cultures.
- The CQC continue to have concerns about delays in authorisations, which mean that individuals are deprived of their liberty longer than necessary, or without the appropriate legal authority and safeguards in place.

**4. Challenges for systems**

- Collaborative working was varied among the local systems that were reviewed. Cross-sector working was helped by good communication, information sharing and shared values.
- There was a lack of integration of adult social care providers into system-level planning and decision-making.
- Workforce planning is highlighted as a major priority and challenge for local systems and providers. Recruitment and staff retention continue to be severe problems.

The CQC summarised that ensuring services work for people locally has always been the challenge for everyone involved in health and care. For those leading services now, it means increasingly thinking of themselves as leaders for their area as well as their organisation. The goal for these leaders must be to use what has been learned from the pandemic around collaboration and with that build both a better understanding of the health and care needs of their local area accompanied by a single, fully resourced and outcome focused plan; that includes all health and care professionals and everyone else involved in health and care.

The full report can be found at: *State of health care and adult social care in England 2020/21*,

## 6. CQC Action Plan Testing

The compliance team is now involved in a range of action plan testing including following CQC visits and PHSO action plan testing. Work is currently underway to look at developing one central learning plan, which will focus on the testing findings and assurance of action embedding.

Compliance action plan testing found some gaps in embedded actions following the completion of CQC Action Plans. These have been previously reported to Executive Safety Oversight Group where it was agreed that the gaps found should be allocated to the appropriate Trust Committees to agree and take forward appropriate actions to ensure changes have been embedded.

## 7. Recommendations and Action Required

The Board of Directors is asked to:

1. Note the contents of this report
2. Identify any further action that is required to be taken.
3. Approve the CQC Action Plan to submit to CQC as final version

Report Prepared by:

Amanda Webb
Senior Emergency Planning and Compliance Officer

On behalf of:
**Paul Scott**
**Chief Executive**

**Appendix 1**

**(May 2021 – CAMHS)**
**Action Plan V3 (Update 5th November 2021)**

## Introduction – What did the CQC tell us?

The CQC undertook an unannounced inspection on the 11th and 12th May 2021 within the CAMHS Unit at St Aubyns Centre following a serious incident resulting in the death of a Young Person and subsequent information requests. The requests included incident trends, restraint and seclusion numbers, duration of time spent in seclusion, safeguarding numbers, staffing rates/fill rates and further information regarding a specific self-harm incident. Further visits were undertaken to Poplar Adolescent Unit on the 19th May 2021 and to St Aubyns on the 25th May 2021.

On the 4th June 2021, the CQC served a Notice of Decision (NoD) under Section 31 of the Health and Social Care Act 2008. The CQC imposed conditions, taking the decision to suspend admissions to all three of the CAMHS T4 wards (Larkwood, Longview and Poplar) with immediate effect. The Trust was asked to take 5 immediate actions all of which were completed and evidence provided back to the CQC in line with timescales set.

The final report was published on the 15th September 2021 and circulated to the senior leadership team and all staff on the day of publication. It was also shared with Board members in part 1 of the Board of Directors meeting on the 29th September 2021. The final report confirmed the CQC has re-rated our CAMHS service as 'inadequate' and raised significant areas of concern, including safe staffing levels, robust observation and engagement processes and timely learning from patient safety incidents.

The report includes 22 Requirement Notice actions to take forward. Under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we are required to send to the CQC a written report of the action we are going to take to meet the Health and Social Care Act 2008, associated regulations and any other legislation that the CQC have identified we are in breach of. The report of actions is required for presenting to the CQC by 13th October 2021

## What are we doing?

Following the serious incident in April 2021 the Trust initiated a CAMHS Clinical Intensive Support Group immediately to identify issues that lead to the incident and develop a clinical support framework for the ward and action plan to address issues identified. The clinical support group has been established as a multi-disciplinary group with representatives from the ward, ward leadership team, medical team, AHPs, corporate services, quality services and senior Trust leadership. The group has been established working on a "Plan – Do – Study – Act" principle, grounded within a quality improvement methodology, and has been structured to ensure full engagement and empowerment of the ward staff and leadership. This group will utilise a range of expertise within the trust.

The development of this action plan has been iterative and dynamic responding to different feedback at different times. After the CQC visits in May the Intensive Clinical Support Group considered initial verbal feedback and extended the action plan developed to address the issues identified. This plan was further enhanced following the receipt of the Notice of Decision under Section 31 to take into account actions identified by the CQC.

Following publication of the CQC report the Trust has developed a detailed action plan, set-out below, which aims to resolve the issues identified by the CQC from the inspection and to ensure action has been fully embedded in practice and facilitates change. The action plan has been developed with

**What are we doing?**

consideration for any cultural changes that may be required to address the issues identified, especially where issues have been identified in previous inspections. The action plan has been developed from the work already undertaken by the Intensive Clinical Support Group. A managers assurance report sits alongside this action plan which has identified key metrics used to monitor effectiveness and embedding of actions taken.

**Potential Risks**

If EPUT does not act on the Section 31 Notice conditions imposed on its registration of CAMHS services or meet the timeframes set within the S31 Notice there is the potential for further regulatory actions to be taken.

If EPUT does not act on the Requirement Notices stipulated in the report of findings further enforcement actions may be imposed

It is a criminal offence not to comply with conditions of registration, or to continue to provide a regulated activity after registration has been suspended or cancelled. CQC considers breaches of such provisions can amount to a serious offence. This approach is reflected in CQC's criteria for prosecution. The offence can apply to failure to comply with conditions, suspension or cancellation for any reason. This means, for example, that in relation to those regulations for which a breach does not in itself amount to a criminal offence, a condition, suspension or cancellation of registration may be imposed. Failure to comply with that registration, suspension or cancellation could then result in prosecution.

**Resources / Investment Required To Deliver Our Plan**

There are a number of actions identified where reviews / investigation needs to be undertaken to identify the solution to fully address the concern raised by the CQC. The outcome of the reviews / investigations may identify solutions where additional resource would be required to fully resolve the issue. The following CQC requirement actions have been identified as potentially requiring additional resources dependent on the outcome of a review / investigation:

- M1. The trust must ensure that there are enough staff on shift to keep patients safe, carry out any physical interventions safely and meet patient needs. Funding will be required to support establishment uplift.
- S2. The trust should ensure that patients have access to nurse call bells. Funding will be required to fit panic strips
- M5. The trust must ensure that staff are patient centred and talk about patients with kindness, dignity and respect. (Regulation 10(1)). Funding will be required to complete Estates work identified.

## Monitoring of Progress

| Action Type | Must Do / Should Do Actions | | | | Specific Actions That Address Must Do/Should Do Actions | | | |
|---|---|---|---|---|---|---|---|---|
| | Total Actions | Actions Complete | Actions Within Timescale | Actions Past Timescale | Total Actions | Actions Complete | Actions Within Timescale | Actions Past Timescale |
| Must Do | 13 | 8 | 5 | 0 | 46 | 39 | 7 | 0 |
| Should Do | 9 | 4 | 5 | 0 | 19 | 13 | 6 | 0 |
| **TOTAL** | **22** | **12** | **10** | **0** | **67** | **49 (81%)** | **13 (19%)** | **0** |

| RAG Key | Action Progress Key |
|---|---|
| Grey – action not started / not due | Grey – action not started / not due / evidence or assurance not yet identified |
| Green – actions complete | Green – all actions complete |
| Amber – actions in progress | Green – action evidence identified (✓ indicates evidence is held on file in compliance office) |
| Red – actions passed timescale / risk identified | Green – assurance of action being embedded |
| | Amber – assurance of action shows gaps in embedding |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **M1. The trust must ensure that there are enough staff on shift to keep patients safe, carry out any physical interventions safely and meet patient needs. (Regulation 12(1)).** | | | | | | |
| The service did not have enough nursing and support staff to keep patients safe. | Establishment uplift for CAMHS units had been agreed prior to CQC inspection.<br><br>Please note that at the time of the CQC inspection there were 10 patients as identified by EPUT CAMHS Consultants, not suitably placed for their clinical presentation or were awaiting a discharge package (LSU, ED, LD or Social Care Placement). A number of these young people therefore required increased staffing resource above the usual staffing for these units.<br><br>Over the period the CQC reviewed there was a national pandemic (wave 2) which cause staffing shortages across all NHS services. | Review to be undertaken looking at recent staffing requirements to identify staffing levels required with current patient cohort | IC | June 2021 | Review complete to fully understand staffing needs on the unit and rotas adjusted accordingly<br><br>**ACTION CLOSED** | |
| | | Ensure shifts are filled in-line with Rotas | MO / LS | Sept 2021 | Shift planning improved across the wards (including block booking, earlier rota development, closer links with Trust Bank Office) resulting in reduction in number of unfilled shifts across all 3 wards<br><br>Monitored through sitrep escalations, weekly assurance report and monthly safer staffing reporting.<br><br>**ACTION CLOSED** | |
| | | Undertake review of roster management | MO / KG / AW / SH | July 2021 | Updated roster to ensure additional HCA and RMN's are placed in Health Roster<br><br>Rostering support provided to all wards.<br><br>Increase in confidence of staff using the system and using it to make requests etc.<br>**ACTION CLOSED** | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| | | Develop continuity plan and escalation processes for shifts when roster is not met | IC | July 2021 | Daily sit rep with directors in place.<br>Escalation process flow chart implemented<br><br>**ACTION CLOSED** | |
| | | Develop and implement situation reports (SitReps) for daily monitoring | DC / IC | July 2021 | Daily monitoring of the staffing levels via the OPEL SITREP and safer staffing calls along with the support of a rostering specialist allocated to the three wards to support the robust rostering management.<br><br>Trust–wide 'Inpatient Senior Oversight Huddle' implemented. Held Monday's 1.30 pm to gain assurance and proactively manage the week ahead to ensure that EPUT services are safe for providing patient care<br><br>**ACTION CLOSED** | |
| | | Develop incentives for permanent Staff recruitment and retention to eliminate vacancies following up-lift (see M2) | KG | Oct 2021 | Incentives in place for recruitment and retentions of staff include;<br>- Appointment of band 6 leadership roles<br>- Uplift Band 5's to top of pay scale<br>- 10% premium for newly qualified, once in post | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| | | | | | for 6 months £2,000 bonus will be paid<br>- CPD and career development inc advanced nurse practitioners and CAMHS speciality degree<br>- OT sensory integration training<br>- Preceptors x 7<br>- premium for newly qualified from RemCo<br><br>**ACTION CLOSED 29.10.21** | |
| | | Develop incentives for Psychology Staff | CF | Dec 2021 | Psychology incentive approved and now recruiting (see new action below)<br>Developing advert details<br>**ACTION CLOSED 29/10/21** | |
| | | **NEW ACTION (added 29.10.21)**<br>Monitor recruitment of psychology staff | CF | Dec 2021 | **Update 29/10/21**<br>Advert out and have a contingency plan if no interest | |
| | | Explore use and development of activity coordinator role for the wards | GW | Nov 2021 | Activity coordinators appointed managed by OT.<br><br>The role is being removed from Health Roster nursing line and moved to OT line management to ensure not pulled into the number or used for routine ward tasks.<br><br>**ACTION CLOSED** | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **Action Status: M1. The trust must ensure that there are enough staff on shift to keep patients safe, carry out any physical interventions safely and meet patient needs. (Regulation 12(1)).** | | | | | | |

| Actions | Action Evidence | | Action Assurance | |
|---|---|---|---|---|
| 1 action open (in timescale) | Rota on Health Roster | | Establishment uplift +4 on each unit | |
| | Escalation process flow chart | | Staffing Fill Rate W/C 27th Sept 2021 (90% target)<br>89% Qualified / 98% Unqualified<br>Staffing Fill Rate W/C 18th Oct 2021 (90% target)<br>87% Qualified / 97% Unqualified | ✓ |
| | Daily Sit Rep Proforma | | Vacancy Rate August 2021 (<11% target)<br>Larkwood 9.4% / Longview 14.9% / Poplar 7%<br><br>Vacancy Rate September 2021 (<11% target)<br>Larkwood 3.5% / Longview 0.7% / Poplar 3.5% | ✓ |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **M2. The trust must ensure that staffing establishments are regularly reviewed in order to meet patient needs. (Regulation 12(1)).** | | | | | | |
| Staffing establishments were not regularly reviewed in response to current patient need. Managers did not accurately calculate and review the number and grade of nurses and healthcare assistants for each shift. The service did not have enough staff on each shift to carry out any physical interventions (for example, restraint) safely and complete patient observations. (Pg2)<br><br>Staffing establishments were not regularly reviewed in response to current patient need; Larkwood ward had recently had its establishment increased to seven, despite consistently requiring 21 staff to meet the needs of patients for the six weeks pre-dating our inspection visit. (Pg6) | The trust undertakes an annual Safer Staffing review that goes to Board. This was postponed over the Covid pandemic with the last review presented January 2020.<br><br>For 2021 the establishment review is being linked to the new Safety Strategy staffing project.<br><br>There is no formula applied to calculating numbers as it is fluid and based on clinical judgement and dynamic changing day by day to respond to the needs of the current patient cohort.<br><br>The service is able to demonstrate planned and actual staffing numbers on the daily situation report which shows the consideration and review of numbers to maintain safer staffing. | Increase safe staffing from 5 staff per shift to 7 per shift for each of the 3 wards. | DC/ IC | April 2021 | Up lift in staffing levels undertaken.<br>The increase to 7 provided funding for another 4.8 RMN and 4.8 HC on each ward significantly increasing the establishment.<br>**ACTION CLOSED** | |
| | | Undertake a review of the staffing establishment using MHOST (Mental Health Optimal Staffing Tool) an evidence based and multidisciplinary NHS safer staffing support tool. | AW | April 2022 | Working with NHSI/E on training for undertaking this review and dependant on NHSI/E for timescales.<br><br>While awaiting MHOST launch we are:<br>• working with local systems as well as provider collaborative on medium and long term staffing considerations<br>• using local escalation tools, daily sit reps and daily ward risk reviews to review staffing levels<br>• Working to QNIC ratio standards<br><br>Training to be held November and plan to run the MHOST 21 day cycle w/c 10th January | |

| **Action Status: M2. The trust must ensure that staffing establishments are regularly reviewed in order to meet patient needs. (Regulation 12(1)).** | | | |
|---|---|---|---|
| **Actions** | **Action Evidence** | **Action Assurance** | |
| 1 action open (in timescale) | Rota on Health Roster | Establishment uplift +4 on each unit | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **M3. The trust must be assured as to the skills and experience of agency staff who work on the wards. (Regulation 17(1)).<br>M4. The trust must ensure that the wards are staffed with regular and familiar staff so as to not impact on the quality of patient care. (Regulation 12(1)).** | | | | | | |
| Bank and agency staff use was high, and managers were not assured as to the skills and experience of agency staff.<br><br>The lack of regular and familiar staff impacted on the quality of patient care.<br><br>Staff did not always understand the needs of the patients. We saw evidence where unfamiliar staff did not always understand the needs of the patients they were caring for. (Pg2)<br><br>Carers told us that incidents often happen due to the bank and agency staff not having sufficient knowledge of the patient's and their risks and whilst the patient was being observed on enhanced observations. Carers told us staff do not always understand the patients complex needs. (Pg4)<br><br>Two carers stated that quite often incidents happen due to the bank and agency staff not having | As per other NHS Trusts, EPUT only used agencies from the approved National Agency Framework. In order for an agency to be on the framework the agency training standards have to meet a certain criteria which is set out by the framework.<br><br>The trust has received details of the physical intervention training that is provided by the agencies that specifically provide staff to our CAMHS units to check the standards that the provider operate under. All agencies use the same 3- 4 external training company to provide the physical intervention training and all operate to similar or same standards which include skills for health standards, national occupational standards, | Undertake a review of all bank and agency staff workers used over the 3 units | DC<br>KG | July 2021 | Review undertaken, which includes a review of how regularly bank/agency staff have worked on each unit, the training and skills and assessment of experience.<br>**ACTION CLOSED** | |
| | | From the completed review of bank and agency staff put in place named regular bank/ agency staff to work on the CAMHS Units | KG | Aug 2021 | From this initial review a list of familiar temporary workers has been identified and agreed with each ward.<br><br>Worked through skills/ training of these and developed induction checklist for each.<br><br>List will be regularly updated to reflect any new agency staff members.<br>**ACTION CLOSED** | |
| | | Develop a rota that meets staffing requirements including right staff with right training and competency skills | IC | Aug 2021 | Shifts are released on the roster and running to rolling 3 month cycle<br><br>Known list of temporary staff booked, to ensure familiarity on the Wards. | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| sufficient knowledge of the patient's and their risks. Staff told us the wards used a lot of unfamiliar agency staff. Staff told us this impacted on patient care and their workloads. (Pg6)<br><br>Bank and agency staff use was high, and managers were not assured as to the skills and experience of agency staff. From November 2020 to May 2021, Larkwood ward used bank and agency for 4970 shifts, Longview for 2671 shifts and Poplar for 1796 shifts. Not all staff on shift were able to carry out any physical interventions (for example, restraint) safely. Agency staff were not always trained in the same physical intervention training approved by the trust. We reviewed four agency staff records; none of the staff were trained in TASI (The trust approved physical intervention technique). (Pg6)<br><br>Permanent staff knew about any risks to each patient, not all agency staff did. (Pg7)<br><br>The service did not have enough nursing and support staff to keep patients safe. Wards were not staffed safely and regularly under | care certificate standards and NICE guidance<br><br>In the event an agency worker does not have the required training e.g. physical intervention, agreement is obtained from the booking manager to ensure they have the required skill set on shift. This is then recorded on the health roster system when the agency worker is booked. | | | | Block booked from known list of staff<br><br>Introduced flexibility with staffing across wards to support each other making cover easier.<br><br>Changes made to Rota format including activity co-ordinators into own line and identifying when W/Ms are part of the numbers.<br><br>Utilise daily sit reps for escalation<br>**ACTION CLOSED** | |
| | | Develop ongoing system to ensure oversight of competencies, experience, training and skills of all agency and bank staff on CAMHS wards | KG | July 2021 | Agreed review must happen before person can be booked on system.<br><br>Staff who are non-compliant in areas of online and classroom training, supervision and TASI will not be able to work until compliancy is met and will be removed from the bank if they fail to take action to become compliant<br>**ACTION CLOSED** | |
| | | Review local induction recording processes on all CAMHS wards | MO | Aug 2021 | Development of specific local induction for both PICU and GAU and induction checklist reviewed. | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| the numbers planned to keep patients safe. (Pg6)<br><br>The lack of regular and familiar staff impacted on the quality of patient care. (Pg6) | | | | | CAMHS induction pack created. All new starters in to CAMHS will complete a 9-5 shift for their first week, where they will complete all their mandatory training and CAMHS induction.<br>**ACTION CLOSED** | |
| | | Develop system for recording of local inductions for Temp staff | LS | Sept 2021 | Shared drive set up with folder for all completed inductions to be scanned into<br>**ACTION CLOSED** | |
| | | Monitor CAMHS induction of new staff in order to ensure the new induction process is robust. | DC / LS | Oct 2021 | Process in place to check sign off with the new starters. This started in September.<br><br>Local induction tool has been implemented, compliance of induction is uploaded to the system and leadership doing spot checks.<br><br>Evaluation so far has found new induction is effective. Compliance visits booked to test effectiveness.<br><br>Assurance received from Compliance visit inductions are in place and evidence available.<br>**ACTION CLOSED** | |

| Details from the Report | **Identification:** What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| | | Undertake gap analysis of agency workers training in regards to TASI and the managing violence and aggression training that is provided by the agencies to ensure the standards meet the required level that is approved by the Trust. | KG | Oct 2021 | Review undertaken All agency had control and restraint training (PMVA same a TASI) which is fit for practice for mental health workers. Framework agencies are providing other MH Trusts.<br>**ACTION CLOSED** | |
| | | Confirm all staff on known list have necessary competencies, experience, training and skills | KG | Aug 2021 | All framework agencies use the same 3- 4 external training company to provide the physical intervention training and all operate to similar or same standards which include skills for health standards, national occupational standards, care certificate standards and NICE guidance<br><br>List of CAMHS required training identified and all bank staff on known list checked against list.<br><br>Offering different ways staff can come in to do their training.<br><br>Appropriate number of courses being put on and scheduled throughout the year. | |

| Details from the Report | **Identification:** What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| | | | | | Process implemented where training is to be completed before a staff member can start their first shift.<br><br>Staff non-compliant in areas of online and classroom training, supervision and TASI will not be able to work until compliancy is met and will be removed from the bank if they fail to take action to become compliant<br><br>All new starters to CAMHS complete a 9-5 shift for their first week, where they will complete all their mandatory training and CAMHS induction.<br>**ACTION CLOSED** | |
| | | Review handover processes to ensure clear information being provided to all staff on shift | SH | Nov 2021 | Handover process review undertaken. While it was found two different methods are used both meet handover requirements and are effective.<br><br>Monitoring of handover ongoing by senior CAMHS staff. Feedback has been positive.<br><br>There is a longer term Trust project looking at using | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| | | | | | electronic whiteboards which CAMHS will be part of **ACTION CLOSED** | |

**Action Status:**
**M3. The trust must be assured as to the skills and experience of agency staff who work on the wards. (Regulation 17(1)).**
**M4. The trust must ensure that the wards are staffed with regular and familiar staff so as to not impact on the quality of patient care. (Regulation 12(1)).**

| Actions | Action Evidence | | Action Assurance | |
|---|---|---|---|---|
| All actions complete | M3.M4. AGENCY Ringfence 22.09.21 | ✓ | Bank and Agency Usage (using unknown staff) W/C 24/09/21<br>Larkwood 19% / Longview 36% / Poplar 47%<br><br>Bank and Agency Usage (using unknown staff) W/C 22/10//21<br>Larkwood 50% / Longview 13% / Poplar 13% | |
| | M3.M4. Bank CAMHS skill 22.09.21 | ✓ | | |
| | M3.M4. CAMHS induction Larkwood evidence seen in s/drive folder | ✓ | | |
| | M3.M4. Staff Induction Poplar | ✓ | | |
| | M3.M4. CAMHS induction Longview evidence seen in folder held on ward | ✓ | | |
| | M3.M4. CQC Report Back on Actions 02.07.21 | ✓ | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **M5. The trust must ensure that staff are patient centred and talk about patients with kindness, dignity and respect. (Regulation 10(1)).** | | | | | | |
| One carer stated their relative had complex needs which staff did not understand. They told us that staff did not always know how to deal with challenging behaviour and their relative had been told “do not shout you are disturbing other patients”. (Pg11) | Range of methods in place to seek feedback from young people and carers. Feedback is shared with staff through operational meetings | Undertake review of complaints and compliments to understand what service users and families have feedback in the past and look at what actions were taken to address issues raised | LS | Nov 2021 | Review undertaken no complaints received only compliments.<br><br>YP’s have created a questionnaire to be used to seek their feedback.<br><br>**Update 05/11/21** | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| One carer told us that sometimes staff use the wrong pronouns or question their relative's identity. They told us one staff member had said "but she still looked like a boy". (Pg11) | | | | | Questionnaire has been circulated across CAMHS Wards.<br><br>Ward are reviewing outcomes and are bringing feedback to monthly meeting | |
| We could not always be assured that patients' needs and preferences were being taken into consideration. On day two of our inspection Care Quality Commission staff witnessed a staff member respond to a patient request for access to regular staff as, 'We will not have young people dictating to us who does what observations.' (Pg12) | | Focus on expectations of Trust values and staff attitudes at individual supervisions, handovers and team meetings | LS | Nov 2021 | Assurance given that all staff including medical supervisions are including values and attitudes discussions.<br><br>**Update 05/11/21**<br>Engaging conversation at last team meetings and discussed in nurturing staff meeting 4th Nov 2021<br>**ACTION CLOSED 05/11/21** | |
| Access to the seclusion room was not dignified or safe for patients. Both Larkwood ward and Longview wards are situated in the same building. Larkwood ward had a seclusion room. If Longview ward needed to put patients in seclusion at any time the patients would only be able to access this via the corridor between the two wards which was visible from the reception area, or via the courtyard which other patients could be in which could compromise the patient's emotional safety, wellbeing, dignity and privacy. (Pg12) | | Utilise existing well established forums to have focused discussion on ensuring we are person centered and talk/treat young people with kindness, dignity and respect | CP | Nov 2021 | Team meetings have caring as standing agenda item<br><br>Map and Talk sessions (Nursing Staff)<br><br>DBT Consult (open to all)<br><br>Consider conversation with Nurturing network<br><br>Psychology imp lementing new training for all staff, to assist with how to approach YP and talk to them.<br><br>**Update 29/10/21** | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| | | | | | Widened out existing sessions at St Aubyns to have discussions and doing bite size training with staff<br>Looking at doing feedback form for staff as evidence<br>**ACTION CLOSED 05/11/21**<br>Now ongoing | |
| | | Explore training for staff on the new Trustwide Clinical Guidance for working with people from LGBTQ groups | LS | Nov 2021 | Training date booked for 19th November 2021 and all staff encouraged to attend including bank staff.<br>Looking at how we can also extend to agency staff.<br><br>**Update 29/10/21**<br>Also looking at CAMHS specific training | |
| | | Longview ward to have dedicated HTU/Long Term Segregation room ensuring access is dignified and safe | FB | Jan 2022 | Funding secured, LTS room designed and agreed works will start on 14th October 2021 with timescale of 12 week programme.<br>**Update 29/10/21**<br>Works have started and progressing | |

**Action Status:**
**M5. The trust must ensure that staff are patient centred and talk about patients with kindness, dignity and respect. (Regulation 10(1)).**

| Actions | Action Evidence | | Action Assurance | |
|---|---|---|---|---|
| 3 actions open (in timescale) | Team Meeting minutes showing person centred discussion | | | |
| | YP Created questionnaire | | | |
| | Feedback from questionnaire outcome | | | |
| | Staff feedback form | | | |
| | LGBTQ training package | | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **M6. The trust must ensure that patients are able to return from leave at their request and there are staff in place to accommodate this. (Regulation 12(1)).** | | | | | | |
| A patient was unable to return from leave when the ward was short staffed. On the first day of our inspection, a patient was unable to return to the ward from extended leave at the time they made their request as no staff were available. The patient expressed a need for increased support. The patient was told they would need to wait until the evening (request made in the afternoon) and if their mental health became unmanageable, they should attend Accident and Emergency. (Pg6) | At the specific moment in time when the young person requested to return to the ward; staff could not facilitate this, it should be noted that staff had confirmed with the carer that the patient was in a safe place and that there was no immediate cause for concern at the time of the request.<br><br>A clinical judgement was made that a taxi and escorting staff member could be (and was) arranged for later in the day, therefore the patient did return to the ward on the same day following their request.<br><br>All young people going on leave have a crisis/contingency plan that is agreed in ward review and reviewed at point of starting leave. The plan is a shared plan with community teams include OOH support. | Ensure nursing staff are able to attend ward reviews (as this is where leave is agreed) | LS | Oct 2021 | Nursing staff are in attendance<br>**ACTION CLOSED** | |
| | | Explore use of Trust vehicle for transporting patients back from leave | LS | Oct 2021 | Assurance received vehicles can be used where appropriate and risk assessment completed. Staff must hold a D1 on their diving licence to use the vehicle.<br>**ACTION CLOSED** | |
| | | Increase in staffing levels – please see staffing actions above | | | | |

| Action Status: M6. The trust must ensure that patients are able to return from leave at their request and there are staff in place to accommodate this. (Regulation 12(1)). | | | | |
|---|---|---|---|---|
| **Actions** | **Action Evidence** | | **Action Assurance** | |
| All actions complete | Weekly ward reviews – showing nursing attendance | | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **M7. The trust must ensure that staff follow policy and procedures on the use of enhanced support when observing patients assessed as being higher risk of harm to themselves or others minimising the opportunity for patients to self-harm, This includes, but not limited to, observing patients at their prescribed times, and at irregular intervals. (Regulation 12(1)).** | | | | | | |
| Carers told us that incidents often happen due to the bank and agency staff not having sufficient knowledge of the patient's and their risks and whilst the patient was being observed on enhanced observations. (Pg4)<br><br>Staff missed opportunities to prevent or minimise harm and did not always act to prevent or reduce risks. Following a serious incident where a patient was harmed, staff identified learning relating to observations. Despite this, issues remained with observations. Staff did not always follow the trust policy and procedures on the use of enhanced support when observing patients assessed as being at higher risk harm to themselves or others. We reviewed 12 patient observation records. Staff had not carried out patient observations at the intervals prescribed in eight out of 12 observation records we reviewed. Staff did not always sign patient observation records. As a result of staff poor observation practice patients had been harmed, this included incidents of patients tying ligatures and self | Need to understand why there is inconsistent implementation of Trust policy and procedure<br><br>Change in process so all services consistently meeting Trust policy and procedure. Have an agreed process for how decisions to change observation levels are recorded across inpatient services<br><br>Issues identified when having variable levels of observation<br><br>A Trustwide Observation and Engagement Project is underway that CAMHS units are linking into. The project is undertaking a full report of the policy and procedure and exploring the potential of utilising technology for recording observations (this would include an alert if observations are missed) | Undertake review of shift management and allocation of observation and engagement | SMc<br>LS<br>BO'D | Sept 2021 | Trial working principle of no more than 3 patients on level 2 allocated to one member of staff to ensure observations are carried as prescribed in line with policy<br><br>It should be noted that trial has been successful but will need further review once wards open to more patients.<br><br>**ACTION CLOSED** | |
| | | Explore option of development of a crib sheet to assist staff in understanding observation levels, risks and best ways of engagement | CF | Aug 2021 | Crib sheet developed and trailed with further review that identified<br><br>Positive Behavioural Support plan work superseded this piece of work.<br><br>Information will be featured on the plans for a dashboard (to be located in staff office).<br><br>Training provided to ensure Care Plans are being created correctly, which will support the PBS for each patient.<br>**ACTION CLOSED** | |
| | | Ensure robust processes are in place for communication of patient | IC | Sept 2021 | Process implemented documented in induction | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| harming whilst on enhanced observations. (Pg7) | | observation levels to all staff. | | | pack and included in Operational Policy.<br><br>Staff are to inform the nurse in charge prior to a patient moving observation area i.e. going to their bedroom to ascertain/ confirm a patients observation levels.<br><br>Communicated through handovers and allocation of tasks to staff. Also taken forward by the NIC re any changes/actions required following the daily MDT handover Meetings.<br><br>Audit evidences that the correct observation levels are being undertaken<br>**ACTION CLOSED** | |
| | | Develop observation and engagement audit which includes looking at if observations were carried out in accordance with policy and procedure (as prescribed and irregular intervals) | JC/ RP | July 2021 | Audit tools (daily and weekly versions) developed issued to all wards.<br><br>Audit tool taken forward and active on perfect ward app with training provided and recorded for future learning.<br><br>Daily and weekly audits regularly undertaken with improvements noted.<br>**ACTION CLOSED** | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| | | Develop Observation and Engagement information video for staff induction that covers the essential aspects of the Policy and Procedure Engagement and Supportive Observations (CLP8) | NA/ RP | ~~Oct 2021~~ Nov 2021 | Filming underway aiming for completion by end of November 2021.<br><br>YP want to produce a video to be used as part of an induction for new admissions.<br><br>**Update 29/10/21**<br>On track for November completion | |
| | | Ensure and monitor that staff assigned to undertake observation and engagement sign the completed records | LS RP | Sept 2021 | Further development of the observation and engagement audit undertaken to ensure captures checking staff have signed for the level of observation completed and additional question added to check oversight sign off at the end of a shift/sheet for levels 2,3 and 4.<br><br>Audit questions added to Perfect Ward App for immediate use on the daily audits.<br>**ACTION CLOSED** | |

**Action Status: M7. The trust must ensure that staff follow policy and procedures on the use of enhanced support when observing patients assessed as being higher risk of harm to themselves or others minimising the opportunity for patients to self-harm, This includes, but not limited to, observing patients at their prescribed times, and at irregular intervals. (Regulation 12(1)).**

| Actions | Action Evidence | | Action Assurance | |
|---|---|---|---|---|
| 1 actions open (in timescale) | Induction Pack | | Observation and Engagement Audit w/c 01.10.21<br>Larkwood 100% / Longview 100% / Poplar 100%<br>Observation and Engagement Audit w/c 22.10.21<br>Larkwood 100% / Longview 100% / Poplar 100% | |
| | Operational Policy | | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| | Obs Videos (in development) | | | | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **M8. The trust must ensure staff have access to enough and multiple sizes of tear proof clothing items to meet patient needs (Regulation 10(1)). M10. The trust must ensure that staff are responsive to patient needs (Regulation 10(1)).** | | | | | | |
| Staff were not always responsive to patient needs. There was a lack of suitable tear proof clothing on both Larkwood ward and Longview ward. (Pg2)<br><br>A patient told us they felt exposed as they were not wearing appropriately sized tear proof clothing. (Pg4)<br><br>Staff did not always have the correct items of clothing to respond to risks posed by patients on Larkwood ward and Longview ward. Staff on these wards did not have access to adequate tear proof clothing items. (Pg7)<br><br>Staff were not always responsive to patient needs which impacted on patients' privacy and dignity. There was a lack of suitable tear proof clothing on both Larkwood and Longview wards. A patient told us they felt exposed as they were not wearing appropriately sized tear proof clothing. (Pg11) | Tear resistant closing is not regularly used and is only used for immediate management of self-harm and only for patients that are in seclusion or being nursed in long-term segregation, with the decision-making and agreement of the MDT. The guidance for this is contained in the Trusts Seclusion and LTS policy CLP41<br><br>There is suitable tear proof clothing for patients on the units, however, at the time of the inspection there was one specific patient that required an adult size suite and this had to be requested from one of the adult wards.<br><br>Over the Covid pandemic there has been difficulties in obtaining the tear proof clothing stocks. There are different types and styles of tear proof closing and one design in particular that is | Ensure range of sizes are available on each of the wards including option of adult sizing. | LS | Sept 2021 | Worked with provider directly to commission preferred design of tear proof clothing. Arrangements in place to be able to order directly with company to ensure good stock levels.<br><br>Process in place for obtaining clothes from other units in an emergency.<br><br>**ACTION CLOSED** | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| Both Larkwood ward and Longview ward did not have enough tear proof clothing for patients who were currently using it. Managers were aware of this, but this had not been escalated or additional tear proof clothing sought. Care Quality Commission staff escalated this to the senior leadership team. (Pg15) | easier to damage and was chosen not to be used. | | | | | |

**Action Status: M8. The trust must ensure staff have access to enough and multiple sizes of tear proof clothing items to meet patient needs (Regulation 10(1)).**
**M10. The trust must ensure that staff are responsive to patient needs (Regulation 10(1)).**

| Actions | | Action Evidence | | Action Assurance | |
|---|---|---|---|---|---|
| All actions complete | | Tear proof clothing stock | | | |

| Details from the Report | **Identification:** What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **M9. The trust must ensure that lessons learned are shared effectively across all wards and the wider service where appropriate. (Regulation 17(1)).** | | | | | | |
| Lessons learned were not always completed in incident forms or shared effectively across wards. (Pg2)<br><br>Managers investigated incidents and but did not share lessons learned with the whole team and the wider service. (Pg10) | Datix is set up only to record new lessons learnt so currently not an expectation that staff should always complete the lessons learn section. This will be reviewed as part of the Trust new Culture of learning project.<br><br>CAMHS have volunteered to be pilot service for new culture of learning. | Review all incidents reported over last 3 months and identify lessons learnt. | LS | Oct 2021 | Review completed and Datix updated with lesson learnt. Work undertaken to analyse the learning and share themes with staff with band 6's taking forward. Working with Datix team to look at how we use the system better to pick up learning themes and sharing with staff going forward **ACTION CLOSED** | |
| | | Enhance leadership structure with new Service Manager for the 3 units. | LS | Sept 2021 | New service manager has brought single oversight of all incidents and ability to ensure learning is immediately shared. **ACTION CLOSED** | |
| | | Ensure that the ongoing learning identified on the DATIX system is shared with staff | LS/ TM | Nov 2021 | Shared mailbox (CAMHS shared learning) set up to share lessons across the 3 wards. Initially substantive staff and then extend to regular bank /agency. Will review contact list every 3 months.<br><br>Process reviewed to give assurance in place that emails have been read by staff and use of mailbox communicated to staff<br><br>Process agreed linking with safeguarding team to share the learning from incidents.<br><br>Will continually inform team meetings and supervisions | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| | | | | | **ACTION COMPLETE** | |

**Action Status: M9. The trust must ensure that lessons learned are shared effectively across all wards and the wider service where appropriate. (Regulation 17(1)).**

| Actions | | Action Evidence | | Action Assurance | |
|---|---|---|---|---|---|
| All actions complete | | Datix Incidents | | Lessons Learnt completed on incidents W/C 01.10.21<br>100% | |
| | | Service Manager JD | | | |
| | | Shared Mailbox | | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **M11. The trust must ensure that all staff understand the needs of the patients they are caring for. (Regulation 10(1)).** | | | | | | |
| Staff did not always understand the needs of the patients. We saw evidence where unfamiliar staff did not always understand the needs of the patients they were caring for. (Pg2)<br><br>Carers told us staff do not always understand the patients complex needs. (Pg4)<br><br>Staff did not always understand the needs of the patients. We saw evidence where unfamiliar staff did not always understand the needs of the patients they were caring for. One carer stated their relative had complex needs which staff did not understand. They told us that staff did not always know how to deal with challenging behaviour and their relative had been told “do not shout you are disturbing other patients”. One carer told us that sometimes | Need to ensure all bank and agency staff are familiar with the units and patients – please see staffing actions above. | Review handover processes to ensure clear information being provided to all staff on shift | SH | Nov 2021 | Handover process review undertaken. While it was found two different methods are used both meet handover requirements and are effective.<br><br>Monitoring of handover ongoing by senior CAMHS staff. Feedback has been positive.<br><br>For note: there is a longer term Trust project looking at using electronic whiteboards which CAMHS will be part of **ACTION CLOSED** | |
| | | Further develop use of Positive Behaviour Support Plan (PBS) to include a 1 page summary sheet | CF | Oct 2021 | 1 page PBS plan in place to ensure staff understand the needs of the patients.<br><br>‘Likes and dislikes’ cards developed with YP now available for each patient | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| staff use the wrong pronouns or question their relative's identity. They told us one staff member had said "but she still looked like a boy". However, permanent staff understood and respected the individual needs of each patient. (Pg11) | | | | | Confirmed training undertaken on all 3 wards **ACTION CLOSED** | |
| **Action Status: M11 The trust must ensure that all staff understand the needs of the patients they are caring for. (Regulation 10(1)).** | | | | | | |
| **Actions** | | **Action Evidence** | | **Action Assurance** | | |
| All actions complete | | Patient PBS | | | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **M12. The trust must ensure that staff recognise incidents and report them appropriately, clearly and in line with trust policy. (Regulation 12(1)).** | | | | | | |
| Staff did not always report incidents clearly and in line with trust policy. Lessons learned were not always completed in incident forms or shared effectively across wards. (Pg2)<br><br>The service did not manage patient safety incidents well. Staff did not always recognise incidents and report them appropriately. (Pg10)<br><br>Staff did not always know what incidents to report and how to report them. Staff were not recording all incidents relating to staffing issues. This meant that the senior leadership team may not always be aware of the staffing issues on the wards. (Pg10) | Staff are aware of how to report incidents; which is clearly evidenced by the number reported on the Datix system, along with CAMHS being high reporters and as an organisation we are among the highest reporters as identified by NRLS<br><br>There were not always incident records submitted reflecting staff fill rates gaps.<br><br>See action regarding completion of lessons learnt | Develop clear guidance for staff on when to report staffing issues | AW | Oct 2021 | **Update 05/11/21** Flowchart developed and added into a staffing policy.<br><br>**ACTION CLOSED 05/11/21** | |
| | | NEW ACTION 29.10.21 Flow chart to be discussed in Team meetings | LS | Dec 2021 | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| Staff did not always report incidents clearly and in line with trust policy. We reviewed nine incident forms and lessons learnt was not complete in any of them. This section was blank in five of the incident forms and 'no' was written in this section on the other four incident forms. (Pg10) | | | | | | |
| **Action Status: M12. The trust must ensure that staff recognise incidents and report them appropriately, clearly and in line with trust policy. (Regulation 12(1)).** | | | | | | |

| Actions | | Action Evidence | | Action Assurance | |
|---|---|---|---|---|---|
| 1 actions open (in timescale) | | M12. Staffing Issues Management Incident Reporting Guide v1 | ✓ | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **M13. The trust must ensure that managers are proactive in responding to risk and that risks and issues are dealt with appropriately and quickly. (Regulation (12(1)).** | | | | | | |
| **S9. The trust should ensure that leaders are aware of the risks, issues and challenges in the service to patients and staff.** | | | | | | |
| Not all leaders had the skills, knowledge and experience to perform their roles. Not all ward leaders had a good understanding of the services they managed. Governance processes did not operate effectively at team level and that risks were not always managed well. Managers were reactive in responding to risk. (Pg2)<br><br>Staff did not always know what incidents to report and how to report them. Staff were not recording all incidents relating to staffing issues. | Clear escalation of issues including:<br>• Issues on the wards<br>• Awareness of staffing gaps<br>• Correct size tear proof clothing not available | Enhance CAMHS leadership with development and appointment of a new senior level role of CAMHS Service Manager | DC/IC | July 2021 | Successfully appointed to new senior CAMHS service manager role for oversight and scrutiny<br>**ACTION CLOSED** | |
| | | Implement new shared email for highlighting incidents lessons learnt across the 3 units | LS/ TM | Sept 2021 | Implemented new shared email for highlighting incidents lessons learnt across the 3 units<br>**ACTION CLOSED** | |
| | | Develop escalation process for raising staffing issues | IC | Sept 21 | Escalation flow chart have been developed and implemented.<br>Matrons dip test of this regularly. | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| This meant that the senior leadership team may not always be aware of the staffing issues on the wards. (Pg10)<br><br>Managers were reactive in responding to risk. Larkwood ward was short by seven members of staff on day two of our inspection. Managers were already aware of this, but this had not been escalated. Care Quality Commission staff escalated this to the senior leadership team. (Pg15)<br><br>Both Larkwood ward and Longview ward did not have enough tear proof<br>clothing for patients who were currently using it. Managers were aware of this, but this had not been escalated or<br>additional tear proof clothing sought. Care Quality Commission staff escalated this to the senior leadership team. (Pg15)<br><br>Leaders were not always aware of the risks, issues and challenges in the service to patients or staff (Pg15) | | | | | **ACTION CLOSED** | |
| | | Develop more robust process for tear proof clothing | LS | Sept 21 | See action M8 and M10<br>**ACTION CLOSED** | |

**Action Status: M13. The trust must ensure that managers are proactive in responding to risk and that risks and issues are dealt with appropriately and quickly. (Regulation (12(1)).**
**S9. The trust should ensure that leaders are aware of the risks, issues and challenges in the service to patients and staff.**

| Actions | | Action Evidence | | Action Assurance | |
|---|---|---|---|---|---|
| All Actions Complete | | Service Manager JD | | | |

| Details from the Report | | Identification: What is the issue? | Action Detail | | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|---|---|
| | | Shared email for learning lessons | | | | | | |
| | | Staffing Escalation flow chart | | | | | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **S1. The trust should ensure that ward managers know what guidance the ward follows.<br>S8. The trust should ensure that leaders have a good understanding of the services they manage.** | | | | | | |
| Not all ward leaders had a good understanding of the services they managed. (Pg2)<br><br>Ward managers were not clear on what guidance they were following about how to manage a mixed sex ward. However, the ward complied with guidance and there were no mixed sex accommodation breaches. (Pg5)<br><br>Staff did not always follow best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. The rationale for continued long-term segregation was not always clearly evidenced and not all records justified the continued use of long-term segregation. (Pg8)<br><br>Not all leaders had the skills, knowledge and experience to perform their roles. Not all ward leaders had a good understanding of the services they managed. (Pg15) | Need to ensure ward managers have a good understanding of the Trust guidance on single sex accommodation and have clear oversight of LTS record keeping | Ensure staff are aware of the guidance to follow on how to manage a mixed sex ward – Trust Clinical Guideline Delivering Same Sex Accommodation (CG72) | Ward Mgs | Nov 2021 | Added to team meeting agenda<br><br>**Update 05/11/21**<br>Confirmed discussed and minuted at SAC | |
| | | Ensure scrutiny of LTS recording is being undertaken in line with Trust expectations and policy including scrutiny during LTS episode to ensure full recording and scrutiny at the end after seclusion complete<br><br>Ensure lessons learnt from scrutiny are shared with the teams | LS | Nov 2021 | Staff reminded to undertake scrutiny timely and sharing findings at team meetings and supervision. Process needs further embedding and will pick up regularly in staff meetings.<br><br>LTS Question included in ward managers audit on perfect ward<br><br>All LTS records currently up to date including scrutiny<br><br>**Update 29/10/21**<br>Scrutiny continues<br><br>**Update 05/11/21**<br>Regular cycle in place<br><br>**ACTION CLOSED 05/11/21** | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **Action Status: S1. The trust should ensure that ward managers know what guidance the ward follows. S8. The trust should ensure that leaders have a good understanding of the services they manage.** | | | | | | |

| Actions | | Action Evidence | | Action Assurance | |
|---|---|---|---|---|---|
| 1 action open (in timescale) | | Team meeting minutes showing discussion of mixed Sex Accommodation Policy and Procedure | | | |
| | | LTS recording | | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **S2. The trust should ensure that patients have access to nurse call bells.** | | | | | | |
| Patients did not have access to nurse call systems. We observed a community meeting on one ward and two patients complained about not having call bells and asked staff what they would do in an emergency to gain staff attention. Patients were told nurse call bells would be fitted in their bedrooms within the next few weeks. (Pg5) | Datix incidents show patients stating they have no way of advising they are in distress from within their room. | Consideration to be given to having Panic strip alarms installed in each of the bedrooms. | IC/FB | May 2021 | ACT recommended as existing technology for the use of panic strips to alert for help should a patient be in a bedroom on their own.<br><br>Proposed solution showcased approved.<br>**ACTION CLOSED** | |
| | | Proposed Solution for nurse call system to be costed, approved and fitted. | FB | Nov 2021 | Costed and approved.<br><br>Installation in progress for completion November 2021 | |
| **Action Status: S2. The trust should ensure that patients have access to nurse call bells.** | | | | | | |

| Actions | | Action Evidence | | Action Assurance | |
|---|---|---|---|---|---|
| 1 action open (in timescale) | | | | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **S3. The trust should ensure that staff inform and involve families and carers.** | | | | | | |
| Staff did not always inform and involve families or carers. Two carers stated that they did not think the staff always kept them informed that they don't always explain things such as medication changes. One carer told us they are informed of any incidents their relative had been involved in but not as timely as they would like. Two carers stated that they are not always invited to their relatives review meetings and that information following these meetings is not always shared with them. (Pg13) | The Covid Pandemic has changed relationships with families due to physical visiting being so limited.<br><br>The family therapy staff have put in place contact via Microsoft teams, this has proved successful and getting better involvement.<br><br>Reflection that individual families have different needs and wants and the units would like to explore how we can be responsive to this.<br><br>Reflected on feedback from parents and that we don't have evidence of how we have responded | Set out minimum standard for contact with families working on the premise of regular engagement to share progress not just contact when there has been an incident or change. | LS / Ward Mgs | Nov 2021 | Minimum standard of once per week to ring outside of ward review and then individually tailored to each family<br><br>Outlined in care plans<br><br>Part of Named Nurse/Key worker role as per trust policy.<br><br>**Update 05/11/21**<br>Highlighted to staff via team meetings (in minutes)<br><br>**ACTION CLOSED 05.11.21** | |
| | | Remind staff about involving carers / family at every stage of the young persons care and telling families what action taken following feedback received. | LS / Ward Mgs | Nov 2021 | Key worker session held highlighted involvement<br><br>Weekly emails are sent to carers, with YP consent and recorded if declined.<br><br>Medical staff reminded to call carers before any medicine changes.<br><br>**Update 05/11/21**<br>Highlighted to staff via team meetings (in minutes)<br><br>**ACTION CLOSED 05.11.21** | |
| **Action Status: S3. The trust should ensure that staff inform and involve families and carers.** | | | | | | |
| **Actions** | **Action Evidence** | **Action Assurance** | | | | |

| Details from the Report | | Identification: What is the issue? | Action Detail | | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|---|---|
| All Actions Complete | | Named Nurse Policy and Procedure | | | | | | |
| | | Team meeting minutes showing discussion of minimum standard for communication with families | | | | | | |
| | | S3. CYP_workforce-workshop_flyer | | ✓ | | | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **S4. The trust should ensure that all staff have access to the patient records.** | | | | | | |
| Not all staff were aware of how to access patient records if they did not have a permanent log in to the trust's electronic recording system. The service used a lot of bank and agency staff. Agency staff did not always have access to the providers electronic recording systems and were therefore unable to access patient notes. (Pg9) | All staff are able to access patient records. For temporary staff this can be accessed with guest logins.<br><br>This is a staff awareness issue of allocating a guest login | Ensure all staff are aware and familiar with how to allocate guest logins. | LS | Oct 2021 | All staff now aware and posters added to nursing offices to ensure easy access to process<br>**ACTION CLOSED** | |
| | | Regular bank staff to have own logins | JL | Sept 2021 | All regular staff have own logins<br>**ACTION CLOSED** | |

| Action Status: S4. The trust should ensure that all staff have access to the patient records | | | | |
|---|---|---|---|---|
| **Actions** | | **Action Evidence** | | **Action Assurance** |
| All actions closed | | Posters in nursing office | | |

| Details from the Report | **Identification:** What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **S5. The trust should ensure that patients who require positive behaviour support plan have one.** | | | | | | |
| Not all patients who required a positive behaviour support plan had one. Senior staff told us this was because patients did not want to contribute in writing their plans. (Pg7) | | Promote use of positive behaviour support plan across CAMHS units (PBS) | CF | Oct 2021 | Confirmed all YP have a PBS working to further improve them.<br><br>Noted that the PBS layout is not user friendly. JL & CAMHS staff redesigning template expected 5th Nov for review.<br><br>**Update 29/10/21**<br>Continually raised through range of methods including via training and Team meetings<br>**ACTION CLOSED 29/10/21** | |
| | | A comprehensive PBS will be produced by MDT members in collaboration with the young person within the first two weeks of the young person's admission | LS | Nov 2021 | **15/10/21**<br>Poplar to implement, as new admissions are taken.<br><br>**Update 29/10/21**<br>Ongoing improvement of process in how we complete these. Moving away from just a nurse plan but full MDT plan<br><br>**Update 05/11/21**<br>Remains ongoing process for improvement. All patients have a PBS<br><br>**ACTION CLOSED 05.11.21** | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| | | PBSs will be shared with parents and/or carers with the consent of the young person | CF | Oct 2021 | There is clear box on the PBS to gain consent **ACTION CLOSED** | |
| | | Ensure purpose and use of PBS is detailed in operational policy. | LS | Nov 2021 | Draft developed and circulated for comments<br><br>**Update 29/10/21**<br>Approved and uploaded<br><br>**ACTION CLOSED 05.11.21** | |
| | | **New Action 05/11/21**<br>Add PBS question to Matrons Assurance tool on perfect ward | RP | Dec 2021 | | |

| **Action Status: S5. The trust should ensure that patients who require positive behaviour support plan have one.** | | | | | |
|---|---|---|---|---|---|
| **Actions** | | **Action Evidence** | | **Action Assurance** | |
| 1 action open (in timescale) | | Patient PBS plans | | | |
| | | Operational Policy | | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **S6. The trust should ensure that all staff have regular appraisals.** | | | | | | |
| Not all managers supported staff through regular appraisals of their work. The trust's target rate for appraisal compliance is 90%. At the time of our inspection the average staff appraisal rate for child and adolescent mental health wards from November 2020 to March 2021 was 75.7%. The trust told us that during the global pandemic an extension to appraisals was granted by the trust executive team to all staff to help address the staffing pressures that operational staff were facing at the time. (Pg11) | During Covid-19 appraisal completion was extended trustwide to help support the staffing pressures | Ensure all appraisals have been completed | LS / BO / SM | Oct 2021 | Work undertaken to ensure all staff have an up to date appraisal. Current rates:<br>Larkwood 100%<br>Longview 100%<br>Poplar 87%<br><br>15/10/21<br>Poplar – 1 outstanding due to member of staff on leave<br><br>Confirmed all now completed<br>**ACTION CLOSED** | |
| **Action Status: S6. The trust should ensure that all staff have regular appraisals.** | | | | | | |
| **Actions** | | **Action Evidence** | | **Action Assurance** | | |
| All actions complete | | Appraisal Records | | Appraisal Rates (Target 85%)<br>Larkwood 100% / Longview 100% / Poplar 87% | | |

| Details from the Report | Identification: What is the issue? | Action Detail | Lead | Timescale | Progress / Outcome | RAG |
|---|---|---|---|---|---|---|
| **S7. The trust should ensure that all leaders have the skills, knowledge and experience to perform their roles.** | | | | | | |
| Not all leaders had the skills, knowledge and experience to perform their roles. (Pg2)<br><br>Not all leaders had the skills, knowledge and experience to perform their roles. Not all ward leaders had a good understanding of the services they managed. (Pg15)<br><br>Not all leaders had the necessary experience, knowledge, capability or integrity to lead effectively. (Pg15) | Confirm all leaders have necessary competencies, experience, training and skills | Enhance CAMHS leadership with development and appointment of a new senior level role of CAMHS Service Manager | DC/IC | July 2021 | Successfully appointed to new senior CAMHS service manager role for oversight and scrutiny<br>**ACTION CLOSED** | |
| | | Set up process for Professional Nurse Advocate (PNA) Supervision | JP | Oct 2021 | Information circulated to all staff re PNA support.<br>Dates for availability to be sent out starting in October.<br><br>Drop in sessions have been completed for all CAMHS wards<br>**ACTION CLOSED** | |
| | | Explore leadership training opportunities and development as part of annual appraisal for staff. | LS | Dec 2021 | | |
| | | Leaders to attend the Trusts Management and Development Programme | LS | Dec 2021 | Aiming for enrolment by December 2021 | |
| | | To provide evidence of service improvements as a result of the leadership skills and knowledge | LS | April 2022 | | |

| Action Status: S7. The trust should ensure that all leaders have the skills, knowledge and experience to perform their roles. | | | | | |
|---|---|---|---|---|---|
| **Actions** | | **Action Evidence** | | **Action Assurance** | |
| 3 actions open (in timescale) | | TBC when action complete | | TBC when action complete | |

**Key Leads:**

| **Key Leads:** | | | | | |
|---|---|---|---|---|---|
| Denise Cook, Director | DC | Nicola Jones, Director of Risk & Compliance (Interim) | NJ | Birsharda Angom, Consultant | BA |
| Ian Carr, Associate Director | IC | Jane Cheeseman, Compliance & Emergency Planning | JC | Rana Moharam, Consultant | RM |
| Michael Odell, Clinical Lead | MO | Jo Paul, Practice Development (app) | JP | Josh Westbury, Consultant | JW |
| Brian O'Donnell, Ward Manager (Longview) | BO | Roshni Patel, Clinical Governance | RP | Claudia Foakes, Psychological Services | CF |
| Sean McCarthy, Ward Manager (Larkwood) | SM | Tendai Musundire, Safeguarding | TM | Jan Leonard, IM&T | JL |
| Louise Summers, Service Manager | LS | Fiona Thomas, SI Team | FT | Fiona Benson, Estates and Facilities | FB |
| Glen Westrop, AHP Lead | GW | Nicola Armstrong, Corporate Nursing | NA | Jane Cheeseman Head of Compliance & Emergency Planning | JC |
| Scott Huckle | SH | Angela Wade, Corporate Nursing | AW | Roshni Patel, Corporate Nursing | RP |
| Phil Stevens | PS | | | | |

**END**

**Appendix 2**

**Intensive Support - Deep Dives**
**and**
**Ward Visits Oct 2021**

**Intensive Support / Deep Dives**

| Ward | Date Initiated | Support Level | Source | Deep Dive Lead | Comments |
|---|---|---|---|---|---|
| Longview, Larkwood and Poplar | April 2021 | Intensive Support | PSI and CQC Inspection | | Initiated following CQC inspection<br>Action Plan developed and being implemented |
| CICC | 07.07.21 | Deep Dive | PSI | Ann Nugent | Deep Dive Complete<br>Action plan developed and being implemented |
| Rawreth Court | 13.08.21 | Deep Dive | CQC raised whistleblowing concern | Angela Wade | Deep Dive Closed |
| Basildon MHAU | 17.09.21 | Deep Dive | CQC Info Request | Nicola Jones | Deep Dive underway<br>Action plan being developed |
| Christopher Unit | 04.10.21 | Deep Dive | F2SU Guardian | Angela Wade | Deep Dive underway |
| Cedar Ward | 02.11.21 | Deep Dive | Datix concern<br>Unannounced IPC inspection | Angela Wade | Deep Dive underway |

**Team and Ward Visits October 2021**

| Ward | Visit Type | Visit Date | | Ward | Visit Type | Visit Date |
|---|---|---|---|---|---|---|
| Larkwood ward | Compliance Team CQC | 08.10.2021 | | Larkwood ward | Compliance Team CQC | 19.10.21 |
| Care Coordination Service | Compliance Team CQC | 11.10.2021 | | Specialist MH Recovery Team Mid (QAV) | CCG | 21.10.21 |
| Cherrydown and Meadowview | Director of Nursing Visit | 16.10.2021 | | Clifton Lodge Nursing Home | Compliance Team CQC | 21.10.2021 |
| Poplar Unit | Corporate Nursing Team | 18.10.2021 | | Meadowview Ward | Safety Walkaround / Ligature Review | 21.10.2021 |
| Willow ward | Corporate Nursing Team | 18.10. 2021 | | Tower Ward | Corporate Nursing Team | 22.10.2021 |
| Rainbow Unit | Safety Walkaround / Ligature Review | 18.10.2021 | | Ardleigh Ward | Compliance Team CQC | 25.10.21 |
| Kitwood | Corporate Nursing Team | 19.10.2021 | | CRHT East | Compliance Team CQC | 25.10.21 |
| BMHAU and HBPoS | Safety Walkaround / Ligature Review | 19.10.2021 | | Edward House | Compliance Team CQC | 28.10.21 |

| Ward | Visit Type | Visit Date | | Ward | Visit Type | Visit Date |
|---|---|---|---|---|---|---|
| CRHT West | Compliance Team CQC | 26.10.21 | | Ruby Ward | Compliance Team CQC | 28.10.21 |