Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

2 October 2024

10:00 GMT+1 Europe/London

Training Room 1, The Lodge, Lodge Approach, Runwell, Wickford, Essex, SS11 7XX

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

0 Part 1 BoD draft Agenda Oct 2024 FINAL.pdf

Meeting of the Board of Directors held in Public
Wednesday 2 October 2024 at 10:00

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

PART ONE: MEETING HELD IN PUBLIC
TRAINING ROOM 1, THE LODGE, LODGE APPROACH, WICKFORD, ESSEX, SS11 7XX

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
PRESENTATION **Peer Support** **Matt Sisto, Director of Patient Experience & Participation**				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 7 August 2024	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	No Actions	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	Chief Executive Officer (CEO) Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
7.1	Quality & Performance Scorecard	PS	Attached	Noting
7.2	Committee Chairs Report	Chairs	Attached	Noting
7.3	CQC Assurance Report	AS	Attached	Noting
7.4	Workforce Equality Standards & Action Plan 2024-25	AM	Attached	Approval
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework Report	PS	Attached	Approval
8.2	Health & Safety and VAPR Annual Report	DG / TS	Attached	Approval
8.3	Safeguarding Annual Report 2023-2024	AS	Attached	Approval
8.4	Mental Health Act Annual Report 2023-2024	AS	Attached	Approval
8.5	Trust Response to the Greater Manchester Mental Health Report	AS	Attached	Noting

9	**STRATEGIC INITIATIVES**			
9.1	Estates Strategy	TS	Attached	Approval
10	**REGULATION AND COMPLIANCE**			
10.1	Responsible Officers and Revalidation Annual Report and Statement of Compliance	MK	Attached	Approval
11	**OTHER**			
11.1	Use of Corporate Seal	PS	Attached	Noting
11.2	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
11.3	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
11.4	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
11.5	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
12	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
13	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
14	**DATE AND TIME OF NEXT MEETING** Wednesday 4 December 2024, 10.00, The Lodge Training room 1			
15	**DATE AND TIME OF FUTURE MEETINGS** Wednesday 5 February 2025 10:00, The Lodge Training room 1			

Professor Sheila Salmon
Chair

1. APOLOGIES FOR ABSENCE

Standing item | SS | 1

2. DECLARATIONS OF INTEREST

Standing item | SS | 1

PRESENTATION - PEER SUPPORT, MATT SISITO, DIRECTOR OF PATIENT EXPERIENCE & PARTICIPATION

Information Item | Matt Sisto | 10

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 7 AUGUST 2024

Decision Item | SS | 2

REFERENCES

Only PDFs are attached

Board Part 1 Minutes (Draft) 07.08.2024.pdf

Minutes of the Board of Directors Meeting held in Public

Held on Wednesday 7 August 2024
Training Room 1, The Lodge, Lodge Approach, Runwell, SS11 7XX

MEMBERS PRESENT:

Professor Sheila Salmon	SS	Chair
Paul Scott	PS	Chief Executive Officer
Denver Greenhalgh	DG	Senior Director of Corporate Governance
Dr Milind Karale	MK	Executive Medical Director
Nigel Leonard	NL	Executive Director of Major Projects & Programmes
Andrew McMenemy	AM	Executive Chief People Officer
Ann Sheridan	AS	Executive Chief Nurse
Trevor Smith	TS	Executive Chief Finance Officer / Deputy CEO
Zephan Trent	ZT	Executive Director of Strategy, Transformation & Digital
Dr Ruth Jackson	RJ	Non-Executive Director
Dr Mateen Jiwani	MJ	Non-Executive Director
Diane Leacock	DL	Non-Executive Director
Loy Lobo	LL	Non-Executive Director

IN ATTENDANCE:

Lizzy Wells	LW	Director of Mental Health Inpatient & Emergency Services (for Alex Green)
Elena Lokteva	EL	Non-Executive Director (Observing via MS Teams)
Angela Laverick	AL	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	CJ	Assistant Trust Secretary
Hannah Van Der Puije	HP	Assistant Director Community Specialist Children's Services Southend and Essex
Hilary Scott	HS	Chief Pharmacist
Martine Munby	MM	Director of Communications
John Jones	JJ	Lead Governor
Pam Madison	PM	Deputy Lead Governor
Mark Dale	MD	Public Governor
Stuart Scrivener	SS	Public Governor

There were three members of the Public / Staff Members present.

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

The meeting commenced at 10am

72/24 APOLOGIES FOR ABSENCE

Alex Green	Executive Chief Operating Officer
Jenny Raine	Non-Executive Director

73/24 DECLARATIONS OF INTEREST

None declared.

74/24 PRESENTATION – LIGHTHOUSE CHILD DEVELOPMENT CENTRE PROGRESS

HP delivered a presentation regarding the progress of the Lighthouse Child Development Centre since EPUT started providing the service. HP highlighted the following:

- The service was provided by EPUT from March 2022, inheriting a challenging service.
- Waiting times had improved for the service (from five years to one year) and the Trust was still working to reduce this further. The service was working to ensure parents of children on the waiting list receive a "waiting well-call".
- Pathways now available for the service include ADHD, autism, neurodiversity etc. which allows the service to ensure patients are seen on the right pathway at the time of their appointment.
- The service is providing pre and post-diagnostic sessions and has co-produced the "My Care Bridge" website with parents to ensure they are kept informed of progress of referrals and understand decisions and diagnoses made by the service. This can help with inappropriate referrals, where the individual may not meet the threshold for the service and needs to be referred elsewhere.
- The service is working with system partners to ensure individuals are seen by the appropriate services prior to being referred to the Lighthouse centre, such as speech & language, specialist health visitors etc. The service also works as part of a regular Multi-Disciplinary Team, along with North East London NHS Foundation Trust (NELFT) which provides CAMHS community services. There is also good partnership working with education services to help support children in school.
- A patient story was shared to illustrate how the service has helped a parent and their child, receiving positive feedback and a successful intervention.
- The service had developed a sensory garden, which allowed younger children from schools to visit.
- There were still challenges with the service, including sustaining an effective workforce and ensuring the service is able to meet increased demands.
- The service continues to review itself every six months, working with parents to gain feedback.

<u>Questions & Discussions</u>

- The Board reflected on the significant work undertaken to improve the service and working alongside parents to achieve the improvements. There was a reflection on the need to work with the local community and partners and a query was raised on how this was working. HP advised the relationship with the local community and partners was good and had improved. There are still some challenges to overcome, but colleagues feel these can be met through continued positive close working
- A query was raised regarding inappropriate referrals and if there was an opportunity to triage individuals to avoid unnecessary waits. HP agreed and highlighted the "waiting well call" to liaise with parents and discuss and signpost to other services for relevant support. This can help with early intervention and ensuring the individual is supported before they reach the service.
- A query was raised regarding what led to the reduction in wait time. HP advised that she led by example and undertook clinical work, rather than

solely managing the service. By working with patients, parents and system partners, good relationships had been built which had helped reduce the waiting times.

- The Board discussed the standardisation of the service's structure since being provided by EPUT which had made a significant different and led to an improvement on feedback under the I Want Great Care scheme.
- A query was raised regarding the future of the service, considering the likely increase in demand over the next few years. HP advised the shift from a medical model to a medical/social model had improved the service and hoped other services in Essex would follow a similar model. With the right staff competences and skill mix, there is the potential to move to a standardised medical/social model.

SS thanked HP for the presentation, her positive leadership and extended thanks on behalf of the Board for the team on the positive work undertaken.

HP left the meeting at this point.

75/24 MINUTES OF THE PREVIOUS MEETING HELD ON 5 JUNE 2024

The Board of Directors reviewed the minutes of the meeting held on the 5 June 2024:

- Page 4, Bullet Point 3: "At the end of Month 1, the Trust was £1.5m adrift of the forecast position". This should read "£0.5 adrift of the forecast position."

With this amendment, the Board of Directors agreed the minutes as an accurate record.

76/24 ACTION LOG AND MATTERS ARISING

No action log for this meeting as no actions to carry forward.

77/24 CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

SS presented a report providing a summary of key headlines and information on governance developments in the Trust. SS highlighted the following points:

- Dr Rufus Helm left the Trust on 31 July 2024 after six years following the conclusion of his term of office. MJ was stepping into the role of chair of the Quality Committee to ensure good clinical leadership of the Committee.
- Dr Ruth Jackson had moved into the role of Non-Executive Director, following a period as an Associate Non-Executive Director.
- The elections to the Council of Governors had concluded with the appointment of Nat Ehigie-Obano (Public Governor, West Essex & Hertfordshire), Helen Semoh (Staff Governor, Non-Clinical) and Marie Newland (Staff Governor, Clinical). There were also two new Appointed Governors, Cllr Maxine Sadza (Southend City Council) and Cllr Neil Speight (Thurrock Council).
- The Chair had attended the 20th birthday celebrations for Rawreth Court and Clifton Lodge. The events had been attended by a local MP and other local stakeholders. The Chair had valued the opportunity to meet with families, hear stories and reflect on the outstanding care provided for local people.

The Board received and noted the report.

78/24 CEO REPORT

PS presented a report providing a summary of key activities and information to be shared. PS highlighted the following:

- The Trust continued to service the Lampard Inquiry as best as possible. The opening statements and hearings are expected to commence in September. The Inquiry would be difficult for families and staff and there would be continued support provided to those affected.
- It was important as part of the Inquiry that families and stakeholders have confidence that the Trust has listened to their concerns. PS and encouraged everyone to listen with an open mind to the Inquiry to use what is heard to change services for the better. He advised that members of the Board would be attending the hearings.
- The Secretary of State for Health visited St. Margaret's Hospital in August and was able to see the services provided, seeing the impressive collaboration with social care, ambulance and acute service partners.
- The latest RISE programme graduation took place in July, with the programme going from strength to strength and receiving positive feedback.

PS also noted the anxiety created by the recent riots that had taken place across the country, which he condemned. EPUT had a diverse patient and workforce mix and would continue to ensure patients and staff are supported during this time, including continued liaison with Essex Police.

The Board received and noted the report.

79/24 QUALITY AND PERFORMANCE SCORECARD

PS presented the report, in conjunction with a summary provided in the CEO report and invited Executive Directors to provide any updates in within their remits.

Finance (TS)

- The audit and submission of the annual accounts for the last financial year had been completed.
- The Trust YTD deficit of £5.6m is £1.3m off plan due to high levels of patient demand and patient acuity; a range of measures and actions are being taken to return to plan and deliver the planned deficit for the year.
- Capital investments were ahead of plan with £3.6m in the first quarter.

Operations (LW)

- Some challenges continue for operational services, especially inpatient mental health. Services are in the process of implementing the Time to Care programme, which will support a reduction in out of area placements and length of stay.
- The average length of stay had increased in June, but there had also been an increase in the number of discharges during the month.
- The number of out of area placements had increased at the end of the month, but the rate of increase had slowed, with June seeing the number of placements at its lowest since November 2023.
- Mental health inpatient follow-ups had fallen below the seven-day target. The 72-hour follow-up target has shown a slight reduction, but is above the target. Any breaches to the target are reported and followed up.
- There has been a seasonal reduction in Talking Therapies (IAPT) uptake.
- The Trust's Chief Clinical Information Officer is reviewing patients not seen in 12 months, working through both the adult and older adult consultant caseloads. This scrutiny of the caseloads has proven successful with improvements seen in June.

Nursing and Quality (AS)

- The scorecard showed the number of no harm / low harm incidents for both physical and mental health services as "red". Assurance was provided that the Trust had transitioned to a new patient safety system, which replaced the national reporting system, with work underway to establish correct metrics
- There had been improvements in addressing overdue patient safety action plans
- The Quality Committee is now reviewing all Prevention of Future Death report action plans and safety improvement programmes

People and Culture (AM)

- The Trust is currently above planned trajectory in overall workforce numbers and good progress has been made in reducing of agency usage. Bank staff usage is more challenging, but actions are in place.
- The vacancy rate is within target
- There was an opportunity to be a national exemplar for the NHS People Promise, with national funding available for a People Promise Manager to support the retention of staff

Questions & Discussions

- Finance and Performance Committee had noted every aspect of financial performance in operational services was on target, with Inpatient Mental Health having more pressure than expected. TS advised he was working to support services and confirmed five of the six care units are within financial plans.
- The Board reflected on the increased demand and its impact on the approach to recovery and trajectories. It was encouraging to see the number of discharges increasing as part of the flow and capacity model.
- There was a query regarding plans in place to retain international staff, now that some have been in place for 18 months and may be looking for career progression. AM advised that a national group was in place to review supporting international staff and career progression. At EPUT, the successful RISE programme and other work is in place to provide individuals with opportunities to develop, including ensuring the experience of international staff is reflected in the grading system, accessing dual qualifications with Anglia Ruskin University and giving people the opportunity to use their current skills differently. MK added that international doctors have a career path and hoped that a number who have completed training and qualifications would go onto become consultants.
- There was a query in relation to what the Trust was doing to support multi-professional individuals following graduation. AM advised there were good relationships with ARU and that he is taking this forward to develop further opportunities for individuals as part of the NHS long-term workforce plan.

The Board of Directors received and noted the report.

80/24 COMMITTEE CHAIRS' REPORT

SS introduce a report providing a summary of key assurance and issues identified by Board Standing Committees. SS asked Chairs of the Standing Committees to highlight any points for their relevant Committees.

Audit Committee (TS – on behalf of Elena Lokteva)

- There had been a discussion regarding the timely delivery of the internal audit programme.

Finance and Performance Committee (LL)

- The pressures currently being experienced by mental health inpatient services and the impact on performance was being closely monitored by the Committee.

People, Equality and Culture Committee (DL)

- The Committee had noted the planned reduction in agency staffing.
- The quality of data received by the Committee was discussed, to allow the measurement and comparison of performance and monitoring of performance.
- The Committee had discussed the risk on the Board Assurance Framework (BAF) relating to workforce and had looked for this to be split into specific issues, which would give greater oversight of the issues highlighted.

Quality Committee (MJ – on behalf of Dr Rufus Helm)

- Work was underway to refresh how data is visualised and ensuring the agenda is more focused on quality improvement.
- A deep dive into learning from deaths is currently underway.

The Board of Directors:

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

81/24 CQC COMPLIANCE UPDATE

AS presented a report providing an update on CQC related activities, an update on the Trust CQC action plan, internal assurance of CQC Quality Statement compliance and details of CQC guidance / updates. AS highlighted the following:

- There had been one registration change relating to the registration of the new Executive Chief People Officer.
- There was continued weekly focus on the implementation of the CQC Action Plan, with 88 per cent of actions reported as completed.
- The Evidence Assurance Group with the Integrated Care Boards continued to meet on a monthly basis to scrutinise action implementation.
- The final inspection report for the Brockfield House visit completed in March 2024 was still awaited.
- The Quality Assurance Visits Framework was in place and underway.
- The Trust had received three CQC inquiries since the last report, which had all been responded to.

<u>Questions & Discussions</u>

- The Board discussed the implementation of the Quality Assurance Visits Framework which was helpful in structuring visits, allowing more time spent with people, rather than focusing on metrics. DG advised the visits were a pilot and any feedback was welcome.
- The Board were reminded of the evidence assurance process, which reviews the long-term sustainability of a change. This means the Board may see “red” actions on future reports, but should note it is to ensure a robust process is in place, rather than short-term fixes.

The Board of Directors:

1. **Received and noted the contents of the report for assurance of oversight of progress against the CQC improvement plan.**

82/24 BI-ANNUAL SAFER STAFFING REPORT FOR INPATIENT NURSING

AS presented a report providing an update on the safer staffing review in relation to inpatient nursing. AS highlighted the following:

- The Trust has a successful recruitment campaign in place. There is more to do, but the report shows the improvements. This is also helped by the progression and development of the Time to Care programme.
- The Trust has a health roster in place which supports the safe use of staffing and ensures information is available on a twice-daily basis for review.
- The Trust is starting to utilise evidence based tools, such as MHOST, which reviews acuity and takes a professional review of staffing. The report shows the outcome, but there is more work to do in terms of implementation of the tool and ensuring the data provided is correct.
- The next steps were to work further around the MHOST data to support workforce planning and the next report will include community health service inpatient wards.

Questions & Discussions

- The use of MHOST was considered a good example of improvements taking place in the Trust. The approach shows a change in how wards are staffed, focusing on safety and linking with the new operating model for inpatient services.
- The use of MHOST was considered an insightful use of data, with the caveat that it was a work in progress. Where the MHOST data showed whole-time equivalent (WTE) staffing as lower than current WTE, it was queried whether this was a general trend where the unit is “stand-alone” or a cautious approach to not reduce the WTE. AS advised the MHOST needed to be used for a longer period to understand whether the numbers are a true reflection of the needs of the units.
- There was a comment on the benefits of being able to see where there is variation between wards, which can allow quicker, more informed decision making. The tool will allow for a more proactive approach to staffing.
- There was a query on the flexibility of the tool, asking whether it would be implemented rigidly or if there would be an element of flexibility to consider changing circumstances. AS advised the model provided an opportunity for professional judgement to be built into the system. The tool would be used to focus on acuity and demand.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Confirmed acceptance and assurance given in respect to safer staffing regulations and standards.**

83/24 BOARD ASSURANCE FRAMEWORK

DG presented a report providing a high-level summary of the strategic risks, high-level operational risks (corporate risk register) and progress against actions designed to moderate the risk. DG highlighted the following:

- **SR1 Safety:** The risk is currently linked with the Safety First, Safety Always Strategy, with the three-year report on the agenda. Once this has been closed, the risk would transition to focusing on the Quality of Care Strategy.

- **SR2: People:** Conversations at PECC had highlighted the difficulty in gaining clarity on the risk due to the broad nature and therefore the risk would be split into focused categories, organisational development, staff retention and workforce sustainability.
- **SR5 Lampard Inquiry:** The risk had been reset by NL and the Lampard Inquiry Oversight Committee following the publishing of the Inquiry terms of reference. As the governance arrangements begin to take place and the Trust responds to the inquiry, the overall score will change.
- **CRR99 Safeguarding:** The risk has been deescalated as the big influx of referrals had been managed by the team and is now stable. The risk will continue to be overseen by quality and nursing.
- The Finance & Performance Committee are undertaking deep-dives, to understand what driving risk is and how these are addressed through mitigation.

Questions & Discussions

- The Board commended the progress made with the BAF and noted the deep-dives helping individuals to draw assurance from the mitigations.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Noted the de-escalation of CRR99 Safeguarding Referrals**
3. **Noted the reset of risk SR5 Lampard Inquiry**
4. **Did not request any further information or action.**

84/24 EMERGENCY PREPAREDNESS AND RESILIENCE ANNUAL REPORT

NL presented a report providing assurance that the Trust has effective organisational resilience measures in place to respond to a major incident, critical incident or business continuity issue. NL highlighted the following:

- The Trust scored highly in its self-assessment against the ten domains of the EPRR Core Standards (96.5% compliance).
- There were two key actions relating to the training for colleagues in gold command and an action relating to desk top exercises in Domain 10 of the standards. The training action was on track to achieve 100% compliance with regional training and the desk top exercise action had been completed.

NL advised the report had been considered by the Quality Committee.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Did not request any further information or action.**

85/24 INFECTION CONTROL ANNUAL REPORT 2023/24

AS presented a report providing assurance of infection prevention and control activity during the last financial year using the National IPC Code of Practice criteria. AS highlighted the following:

- The IPC team is fully staffed and has a model that supports the care units.
- The team has undertaken training in the last quarter, working with partners and at a national level to support infection control across the Trust.

AS advised the report had been considered by the Quality Committee.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Confirmed acceptance and assurance given in respect of the risks and actions identified.**

3. **Did not request any further information or action.**

86/24 LEARNING FROM DEATHS – QUARTERLY OVERVIEW OF LEARNING AND DATA (Q3 AND Q4) 2023-24

AS presented a report providing a quarterly overview of learning and data from deaths for Q3 and Q4 2023-24. AS highlighted the following:

- The Trust was compliant with relevant procedures in line with national standards, with good assurance in place.
- The learning identified is fed into the Learning Oversight Sub-Group.
- The information is collected and presented nationally and with partners.
- Work has been undertaken to align the learning from deaths with Patient Safety Incident reporting and clinical governance reviews of incidents.
- There will be a change from 9 September when all deaths in healthcare settings not reviewed by the coroner will be review by medical examiners.
- There is an aim to undertake data analysis to provide additional insights, such as learning around health inequalities.

Questions & Discussions

- The Board discussed the progress made since initially presenting mortality reports. The report demonstrated the link between mortality and PSIRF had been strengthened.
- The Board noted the extensive work done on wards to reduce the number of deaths through fixed point ligatures. There was a comment regarding the number of attempted incidents not reducing and that a further review would be interesting, especially against areas such as purposeful admissions. AS advised work was underway to review incidents of self-harm, such as working with psychology and therapy partners. Out of hours therapy has helped with a reduction, which demonstrates quality improvement initiatives having a more meaningful safety impact for patients and families.
- There was a query regarding how learning is disseminated to staff in clinical services. AS advised that care units have a monthly quality and safety meeting, which is an opportunity to discuss. AS advised the learning starts at the point of the incident and there is work with the care units to ensure staff are working through incidents as part of the twice-daily safety huddles, to identify any immediate learning. This can be taken through to quality oversight and to the Quality Committee for wider learning.

The Board of Directors:

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

87/24 PHARMACY AND MEDICINES OPTIMISATION STRATEGY

ZT presented a report providing the Pharmacy and Medicines Optimisation Strategy for approval. ZT highlighted the following:

- Details were provided of the development of the strategy, looking at the issues and setting out an ambition linked with the overall strategic plan.
- The strategy will support consistency of delivery of digital pharmaceutical services, including the roll-out of electronic prescribing (EPMA) on four wards.

HS highlighted the importance of EPMA making a significant difference to the care of patients.

Questions & Discussions

- There was a comment regarding ensuring staff are able to gain pharmacy advice, including out-of-hours. HS advised there is an on-call pharmacist

available outside of working hours. There is also on site support as EPMA is implemented.

The Board of Directors:

- **Noted the contents of the document.**
- **Approved the Pharmacy and Medicines Optimisation Strategy 2024-2028**

88/24 TIME TO CARE – THERAPEUTIC ACUTE INPATIENT OPERATING MODEL FOR ADULTS AND OLDER ADULTS

LW presented a report providing the new inpatient Acute Operating model as part of the Time to Care programme. LW highlighted the following:

- The model has been developed for adult and older adult inpatient units, which will reduce variation across the wards, to ensure patients receive the same clinical offer and positive outcome.
- The model reflects on purposeful admission, working with the patient and families to understand the purpose of the admission and why the individual cannot be managed in the community.
- The model moves away from the medical model, focusing on multi-disciplinary teams (MDT) and a more therapeutic perspective.
- The therapeutic focus will provide meaningful activity and support recovery, alongside medical and psychological interventions. The aim is to have an average length of stay of 30 days, with meaningful intervention on each of these days, supported by an individualised care plan.
- The model is underpinned by trauma informed care and within the culture of care standards published in November 2023 to ensure there are the same standards across all wards.
- The project to implement the model is currently on track, with active recruiting to posts underway. The mobilisation phase will be led by the leaders of the care units, not just operational service managers, to ensure everyone understands the expectations, principles and outcome of the model.

<u>Questions & Discussions</u>

- The Board discussed the importance of lived experience as part of service delivery and ensure individuals with lived experience are part of the team. LW advised there are peer support worker and family ambassador posts in the model, but should also consider that everyone has a lived experience of healthcare services in some capacity. LW agreed with a comment made around encouraging people with lived experience in more senior roles and ZT provided more detail in the work to recruit more peer support workers and family ambassadors.
- The Board discussed the importance of presenting the new operating model in the public domain, which helps patients and families' expectations of what level of service would be experienced at EPUT. The complex transformation required to implement the model was ambitious, but there was confidence it could be delivered.
- The Board discussed the importance of ensuring inpatient services are seen as part of the overall patient journey and a query was raised regarding how inpatient services would link with community services to understand the next steps for a patient. LW advised stakeholders, community services and individuals with lived experience have been involved in the development of the model. The Health Ombudsman report had recommended a change in language from discharge to transfer, which

acknowledges the patient journey through services. The new model gives inpatient services the opportunity to understand the patient journey whilst on the ward, to help transition into community services at the end of that part of their patient journey.

- The Board noted Time to Care as a five-year programme, so there were opportunities for feedback to be provided by patients and families, with adjustments made as the models progress.

The Board of Directors:

- **Noted the contents and key principles proposed within the new Inpatient Acute Operating Model, as part of the Time to Care Programme.**
- **Gave final approval to proceed to mobilisation phase.**

89/24 DUTY OF CANDOUR ANNUAL REPORT 2023-24

AS presented a report providing details of how Duty of Candour had been implemented across the Trust and the number of times Duty of Candour had been triggered. AS highlighted the following:

- The data in the report for April 2021 to March 2022 should be considered in the context of the Covid-19 pandemic.
- There were a number of workstreams underway, including strengthening incident reporting, undertaking a review of the policy and improving Duty of Candour awareness.
- The Trust was compliant with Duty of Candour statutory timeframes and requirements for 2023/24.

The Board of Directors:

- **Noted the contents of the document.**

90/24 SAFE WORKING OF JUNIOR DOCTORS QUARTERLY REPORT

MK presented a report providing assurance that doctors in training are safely rostered and their working hours are compliant with the terms & conditions of their contract. MK highlighted the following:

- There was a slight increase in the number of exception reports, predominantly due to wards on OPEL 3 and 4, reflecting increased workloads.
- There was an issue raised with trainees not gaining enough experience of undertaking Mental Health Act assessments. A review is underway by Medical Staffing to determine how the experience can be improved.
- There was a Consultant away day which was successful and Consultants were happy Board members attended. There were two areas that were identified from the day - flow and capacity and sharing of practice, and strengthening support for staff attending inquests – which were now being taken forward.

<u>Questions & Discussions</u>

- It was noted that two incidents of doctors working excessive hours had happened within a week of each other in April and queried whether there was anything taking place at the time which caused the incidents. It was advised that April had seen increased demand for services and significant actions had taken place around out of area placements, which may have driven the increased workload for Junior Doctors.
- The report noted trainees in the North part of the Trust reporting that seclusion reviews were not held by Consultants over the weekend. A query was raised around how this was being addressed. MK advised a review of

the on call processes should address the issue going forward, which would be subject to overview and audit.

The Board of Directors:

1. **Noted the contents of the document.**

91/24 SAFETY FIRST, SAFETY ALWAYS STRATEGY THREE-YEAR REPORT

AS presented the final (Year 3) report from the Safety First, Safety Always strategy as part of the transition to the new Quality of Care Strategy. AS highlighted the following:

- The report showed the progress of the strategy, providing details of the work to embed learning and a culture of safety.
- It was good to see the work undertaken in listening to patients and families, increasing the number of Patient Ambassadors and Patient Safety Partners.
- Patient Safety Partners have been put forward for a HSJ Award.
- Details were provided of the work undertaken to reduce self-harm on the wards. There has been an increase in reporting, but moderate and severe harm had reduced.
- There was more work to do to sustain and build confidence with patients, families and partners. The Quality of Care Strategy will now act to take this forward.

Questions & Discussions

- The Board reflected on the content of the report, noting the celebration of achievements and acknowledging more work was required.

The Board of Directors:

- **Received and approved the report for assurance and transition from the Safety First, Safety Always strategy to the new Quality of Care Strategy.**

92/24 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

There was no correspondence circulated to board members since the last meeting.

93/24 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.

94/24 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

MJ reflected on equalities as a result of decision and discussions, noting the following:

- The presentation regarding the Lighthouse Child Development Service had shown improvements to a service, helping to change the level of disparity and improved the level of access.
- The references to feedback and evidence-based tools demonstrated reviewing services and listening to people in decision making.

95/24 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.

96/24 ANY OTHER BUSINESS

There was no other business.

97/24 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.

98/24 DATE OF NEXT MEETING

The next meeting of the Board of Directors is to be held on Wednesday 2 October 2024.

The meeting closed at 12:50

Appendix 1: Governors / Public / Members Query Tracker (Item 097/24)

Governor / Member of the Public	Query	Response
Mark Dale, Public Governor, Essex Mid & South	Over the last 2+ years the Patient Experience Team, have led an explosion of Participation, Coproduction, and Innovation projects. Volunteering is up, Organisationally care units and teams are on a weekly basis asking the team to provide support and Assistance with projects and working with the lived experience leaders in creating a new environment of quality and safety, but however much the work has grown, the investment into the team including staff resources and budgets has not kept up Pace. The Team is about to be around 40% decreased in staffing due to people leaving etc. Lived Experience Ambassadors are being told that due to resource some things are not able to be done because capacity is low. As a person who has used services First and foremost, but also as an EPUT LEA and Governor, with everything we are going through with the inquiry etc., the public face (The Patient Experience Team) needs investment. What plans are there that even in this quite dire financial climate where money is needed to be spent correctly and in the right way, what plans does the board have to deal with the reduction in staffing within the team and what ways can financial investment be found to satisfy budgets and in turn continue to show great results for the whole trust in general.	The Trust maintains committed to the growth and investment in patient experience and participation across EPUT. In relation to colleagues leaving the team, the Executive Director of Strategy, Transformation & Digital has met with the director of the service to ensure recruitment takes place at pace. There has also been a fixed-term post coming to an end and there is work underway to see how the resource can be redirected. There have been significant investments in patient experience and participation, including Complaints Liaison Officers and the I Want Great Care platform as examples. There is a joint review with care units around increasing the impact going forward and will present any strategic opportunities which emerge from this review.
John Jones, Lead Governor / Public Governor, Milton Keynes, Bedfordshire, Luton and the Rest of England	**Duty of Candour Report, Pg394/433:** I see that around 10% of total patient incidents occurring last year were rated with a degree of harm at moderate or more and of those around half were completed at Part 1. Can you explain please what that means, then why only around 10% of those are referred to the patient safety incident response unit, and even fewer continue to part 2, whatever that is?	Duty of Candour is split into two parts. The first part is the apology following the incident and the second part is working with the family as part of the investigation process. Duty of Candour is for incidents that are Moderate Harm and above, so the majority of incidents will not fall into this requirement. The data represents the number that are reported on Datix (incident reporting platform) to determine if a duty of

Governor / Member of the Public	Query	Response
		candour should be haven completed and if it has occurred. The data shows a review is required to ensure reporting via Datix is correct and ensure there is an understanding of when Duty of Candour is required, which is clear in the policy.
Member of Public	The Member of the Public had heard references to the Lampard Inquiry and noted the terms of reference was also looking at the culture of the Trust. The individual had been involved with another Trust at board-level and had noted there were lots of documents advising that training was good, but did not reflect the reality. The Member of the Public asked how the Board understood the reality of a situation behind the reports.	Board Members responded to the question and provided a range of examples of how feedback is received to triangulate feedback provided via Board reports, including: • The annual staff survey and quarterly "pulse" surveys. • Discussions with Junior Doctors who work between organisations so can often provide good feedback. The CEO meets with them on a regular basis and there is also the Medical Staffing Forum. The Executive Chief Operating Officer also attends the Medical Staffing Committee to provide detail on operational matters. • Service Visits undertaken by Board Members to spend time with patients and staff to enable the triangulation of information against what is happening at service level. • Feedback from Students and work is underway to establish a student council. • The Council of Governors provide insight and challenge, and also attend service visits. Governors provide insight from their own experiences and experiences from Foundation Trust members / members of the public. The responses were summarised as there being a constant experience of listening to people and ensuring learning when things do not go right, which is then translated into the Board papers.

4. ACTION LOG AND MATTERS ARISING

Standing item SS 0

No actions

5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Information Item | SS | 5

REFERENCES

Only PDFs are attached

Chairs Report 02.10.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

Report Title:	**Chairs Report (including Governance Update)**					
Non-Executive Lead:	Professor Sheila Salmon, Chair					
Report Author(s):	Angela Laverick, PA to the Chair, Chief Executive & Non-Executive Directors					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		
	SR2 People (workforce)		
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	Yes/ No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	Yes/ No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	Yes/No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

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

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report

Summary of Key Points

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices

Chairs Report (Including Governance Update)

Non-Executive Lead:

Professor Sheila Salmon, Chair

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Lampard Inquiry Hearings

The initial Lampard Inquiry hearings have now taken place. In our opening statement, the Trust apologised to those who have lost loved ones and to those patients whose care has fallen short. Members of the Board attended the hearings and heard the powerful and impactful commemorative statements from families who have lost their loved ones. As a Board, we are clear that we welcome the progress of the Inquiry in the hope that it can deliver the answers that families have been seeking. The Trust continues to engage openly with the Lampard Inquiry Team and would urge any staff member who feels they have experience or information they want to share to do so. Only by being open and transparent can we support Baroness Lampard and her team to deliver meaningful conclusions that will improve mental health care nationally.

2.2 EXPO24 – The Power of Kindness - SNEE ICS with Essex & Suffolk partners

I was delighted to attend this incredible event in Colchester on 13th September. With over 1,400 delegates across multiple sessions and exhibitions, this was a major feat of organisation. The keynote address was given by Sir Terry Waite KCMG CBE, where he reflected on his own experience as a hostage whilst imprisoned for five years in solitary confinement. The day concluded with the ICS "Can do" health and care awards ceremony. Sincerest thanks goes to Susannah Howard and colleagues at SNEE for making this event happen.

2.3 Service visits

The NEDs and I continue with our visits to services across the Trust, to see and hear first-hand the experience of our patients and staff. These visits also include Quality Assurance Visits (QAV) with ICB and governor representation. The QAV pilot exercise has been completed and evaluated. All parties agree that it is beneficial to adopt a collaborative approach and the programme will now be rolled out and fully adopted, with the recommendation to include service user/lived experience representation. Since the last Board meeting, visits have taken place to Cherrydown ward, Roding ward, Kitwood ward, Robin Pinto unit and Peter Bruff ward among others. We have also welcomed local MPs to visit our services, providing a real opportunity for them to see and understand the services we provide in their constituencies.

2.4 Awards and Recognition

I was delighted to hear that the Mental Health Urgent Care Department in Basildon won an East of England regional award in the NHS Parliamentary Awards 2024, and has been shortlisted for the national finals. The unit is the first of its kind in Essex and has helped more than 4,300 people since it opened in March 2023. This is a brilliant achievement - well done to the team!

I am also pleased to share that the Early Intervention in Psychosis (EIP) team in north east Essex have been accredited with the highest rating of Level 4 by the National Clinical Audit of Psychosis. This is a great achievement by the team, who have worked incredibly hard during the last year to make improvements to the service. The EIP team provides specialist treatment and care for people aged between 14 and 65, who may be experiencing symptoms of first episode psychosis. The support is designed to meet an individual's and their family/close friends' needs. The approach is a hopeful and positive one that endeavours to keep in place an individual's personal strengths, healthy activities and interests.

3.0 Legal and Policy Update

3.1 Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), 2023-24

The following link shows the report published on 22 August 2024 that provides official statistics for data collection for the period 1 April 2023 to 31 March 2024. The aim of this publication is to inform users about aspects of DoLS activity, including the profile of people for whom a DoLS application was received, applications completed and their outcome, and applications not completed. **For Information:** Mental Capacity Act 2005, Deprivation of Liberty Safeguards, 2023-24 - NHS England Digital

3.2 UK Covid-10 Inquiry

Module 1: The Resilience and preparedness of the United Kingdom

The following links shows the report presented to Parliament pursuant to section 26 of the Inquiries Act 2005 and ordered by the House of Commons to be printed. **For Information:** UK Covid-19 Inquiry - Module 1: The resilience and preparedness of the United Kingdom (covid19.public-inquiry.uk)

3.3 The 2024 Standard Civil Contract now live

The link below shows the Contract that commenced on 1 September 2024 that contains the Mental Health Guidance. **For Information**: The 2024 Standard Civil Contract now live - GOV.UK (www.gov.uk)

Professor Sheila Salmon
Chair
October 2024

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Information Item | PS | 5

REFERENCES

Only PDFs are attached

CEO Report 02.10.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

Report Title:	**Chief Executive Officer (CEO) Report**					
Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Laverick, PA to the Chair, Chief Executive & Non-Executive Directors					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		✓
	SR5 Lampard Inquiry		✓
	SR6 Cyber Attack		✓
	SR7 Capital		✓
	SR8 Use of Resources		✓
	SR9 Digital and Data Strategy		✓
Does this report mitigate the Strategic risk(s)?	Yes/ No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	Yes/ No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	Yes/No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

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

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report

Summary of Key Points

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

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

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

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

Acronyms/Terms Used in the Report			
HSJ	Health Service Journal	ICB	Integrated Care Board
PICU	Psychiatric Intensive Care Unit	SRO	Senior Responsible Officer
PSIRF	Patient Safety Incident Response Framework	PSP	Patient Safety Partner

Supporting Reports and/or Appendices

Chief Executive Officer (CEO) Report

Executive Lead:

Paul Scott,
Chief Executive Officer

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 Lampard Inquiry

As the Chair has mentioned in her report, the initial hearings of the Lampard Inquiry took place during September 2024. As a Trust we are committed to continuing to engage with the Inquiry and know that many of our staff and those that they care for will have been deeply impacted by some of the opening statements. Support is available for all colleagues, our patients, their families and carers as well as those who work with us and support us.

Colleagues from Board have ensured an EPUT presence at all of the hearings. I know from my own experience in the Inquiry room, listening to the commemorative statements of those who have lost loved ones, that it is impossible not to be in awe of the dignity of family and friends as they remembered their loved ones.

I, and the Board, have been clear since I started of the need to bring change to how we deliver our services. This was based upon feedback from staff, patients and families and brought into sharp focus by the HSE prosecution, the Dispatches programme and Coroners Inquests. We have made big differences to staffing levels, skills, the inclusion of families and patients in service delivery and design, how we work with partners, to our ward environments and how we systemically learn. Whilst I am proud of these changes, I have also been clear that there is more to do. Nothing can make this clearer than the powerful testimonies I have heard over the last few weeks.

1.2 Expanded Role for Director of Strategy, Transformation and Digital

Zephan Trent has taken up a new expanded role from 01 September 2024, which sees him jointly leading Digital Services and Strategy development across both EPUT and Mid and South Essex NHS Foundation Trust (MSEFT). Alongside his existing role at EPUT, Zephan will take on the role of Chief Strategy and Transformation Officer at MSEFT. He will be a non-voting member of the Board at both Trusts.

This move builds on the work that Zephan has led as one of the joint senior responsible officers for the new Electronic Patient Record system for EPUT and MSEFT. Zephan will be splitting his time equally across the two Trusts and his EPUT portfolio will remain unchanged.

The new arrangements are being put in place for a year so that they can be reviewed at that stage. This development presents a huge opportunity to build on the collaboration across the two Trusts, while maintaining separate focus and specialism that the two organisations need to deliver for patients and services users and their families. To ensure that this focus can be maintained, we will put in place appropriate deputy arrangements at both Trusts.

Congratulations to Zephan in his new role and we look forward to continuing to work to drive strategic and digital developments across the two Trusts.

1.3 New Inpatient Care Operating Model

A range of events have been scheduled between September and November for colleagues to find out more about our new model for acute inpatient mental health care and what it means for our patients. The events will be led by senior leaders, professional leads and lived experience ambassadors who have designed the new model. Members of the Board will also be in attendance at each event. The events will be an opportunity for staff to find out more and understand how the model will enhance care for our patients and improve the way we work together and with our patients, their families and our partners.

The new therapeutic model sets out how we will look after the people who need hospital treatment and ensure they receive the assessments and care they need every day to help them become well

enough to return home with any support they need for their ongoing recovery. We are one of the first Trusts in the country to introduce an inpatient care model of this kind, and we have worked hard to bring together learning from the past and the latest national and international recommendations for best practice to create a robust and effective approach to deliver consistently high standards of care.

This clinical operating model is part of our Time to Care programme which has redesigned how we deliver mental health inpatient services to free up more clinical time to spend on direct patient care. This includes our new staffing model, which will expand the capacity and range of skills in our multi-disciplinary teams. Recruitment is currently underway for 336 clinical and non-clinical posts and these new roles will enable us to increase the therapeutic activities we currently offer patients.

1.4 MSE Briefing Session for Local MPs

I recently attended a briefing session for local MPs with colleagues from MSEFT and MSE ICB. The session provided an opportunity to meet with our local MPs, many of whom are newly elected, and provided an update on Trust wide activities within their constituencies. I look forward to continuing to work with our local MPs in the future.

1.5 National Chief Executive's Event

I recently attended an NHS England national Chief Executive's event, which included hearing from NHS Chief Executive Amanda Pritchard and The Rt Hon West Streeting MP, Secretary of State for Health and Social Care where we heard early feedback about the Darzi report (now published) and the work ongoing for a 10 year plan, whilst also working on the priorities for this year.

1.6 Specialist Perinatal Mental Health Team Shortlisted for Award

Our specialist Perinatal Mental Health Team and partners have been shortlisted for the HSJ Awards in the Place Based Partnership and Integrated Care category. The service has recently completed a five year expansion and transformation of its work with health, social care and voluntary and community partners across Essex, Thurrock and Southend. The multi-disciplinary EPUT team work collaboratively with maternity hospitals, GPs, Parents 1st and social care partners across Essex to provide joined up treatment and support for families. The Specialist Perinatal Mental Health service is one of the largest specialist community perinatal mental health services in the country, and has worked collaboratively with health and care partners to provide care for more than 2,700 families this year.

2. UPDATES

2.1 Operations – Alex Green, Executive Chief Operating Officer / Deputy CEO

- Mental health Home Treatment team referrals increased significantly, receiving 355 referrals against a monthly average of 206

- The average length of stay for adult and older adult inpatient mental health services increased in August, remaining outside of target. The length of stay marginally increased on Psychiatric Intensive Care Units (PICU's), but no concerning trend. Occupancy rates remained outside of target, but stable. Inappropriate out of area placements increased, with 22 patients placed and 19 repatriated to EPUT services.

- Mental health inpatient follow-ups remained above target at 84%, with assurance that processes are in place to ensure that patients who are not followed up within timescale are identified and actions are taken to address contact.

- The number of people accessing NHS Talking Therapies (IAPT) services in North East Essex continued to remain below target, with some expected seasonal variation and the service in

Castle Point and Rochford also experienced a fall in access rate. All areas consistently deliver 100% of people commencing therapy and moving to recovery within target.

- Children's Speech and Language Service delivered a marked increase in first to second appointment wait time performance, reporting 92% against the 95% target.

- The Lighthouse Service has continued to improve waiting times, delivering significant reductions; the longest wait at the end of August was 23 weeks, with the lowest number of children waiting since the service transferred to EPUT.

2.2 Finance – Trevor Smith, Executive Chief Finance Officer / Deputy CEO

- Income and Expenditure year to date deficit £9.4m, £3.1m off plan due to high levels of patient demand and acuity within Inpatient Mental Health services leading to overspends in staffing and out of area placements. A range of measures and actions are being taken across the organisation and with system colleagues in order to deliver the planned deficit for the year.

- Capital expenditure totals £5m year to date.

- Cash balances total £27.9m.

2.3 Nursing and Quality – Ann Sheridan, Executive Nurse

Quality of Care
Since the implementation of the Quality of Care Strategy four months ago, the focus has been on building a strong clinical governance system through which all of care units are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating a learning environment in which clinical excellence will flourish

Safety, Effectiveness and Experience of care executive oversight and reporting governance structures are now in place, with Terms of reference and annual work plan complete for each group to support the clinical governance system with identified priorities. These structures align and support each of the care unit monthly quality and safety meetings. The outcomes of the executive oversight meetings report via Executive quality and safety group into the Quality Committee

To date three Quality Senates have taken place with topics ranging from Trauma-informed Care on the 7 May 2024, Move away from Care Programme Approach on 27 June 2024, to Dementia and Mild Cognitive Impairment on 30 July 2024. The senate model supports a more co-produced and clinical involvement in care delivery. The recommendations go into the Effectiveness of Care Group (chaired by the Executive Medical Director) with agreement to take these through Executive team Quality and Safety group to agree the approach for the recommendations with assurance to Quality Committee.

A Business proposal is in development, which aligns to our data strategy ensuring that Quality of Care has relevant data that enables clinical decision making through analysis, thematic review and care outcome evaluation. Workshops with Quality priorities leads, Quality SROs and data performance have taken place to commence scoping with a phased rollout approach to support the project initiation process.

Patient Safety Partners (PSP)
Since the adoption of Patient Safety Incident Reporting Framework, the Trust has recruited 10 PSP's with a diverse background knowledge of our mental health and community services. We have created an induction process with a PSP Handbook; resourced with information that describes the role and function of this service and the support available to them. The PSP meet monthly as a team and are supported by the Lessons Team and Safety Division.

They regularly attend the Care Unit Quality and Safety meetings providing insights and feedback from the site visits they conduct on a monthly basis. The PSP have developed their own 'Safety Walkabouts' where they visit patients and hold interviews to capture their stories and experiences of

services and illicit any safety concerns from the patient perspective. Their findings form feedback to clinical and operational leads to identify opportunities for improvement. The PSP model has attracted regional and national recognition being nominated and shortlisted as finalists at the HSJ Patient Safety Awards 2024.

The PSP play an important role in the safety improvement plans, supporting PSIRF learning response methods and are currently undergoing foundation training in Quality Improvement methodology.

Physical Health
Physical health continues to be a priority for the Trust, with a monthly Physical Health Steering Group established and Chaired by a Deputy Director of Quality and Safety alongside a Multi-Disciplinary Team Task and Finish Group under Priority 2 of the Physical Health Framework. This work is supporting a holistic physical health assessment and reducing diagnostic overshadowing in our inpatient wards in line with with the NHS England guidance 2023/24, NICE guidance and NHS Long Term Plan commitment.

2.4 People and Culture – Andrew McMenemy, Executive Chief People Officer
National Workforce Report

Resident Doctors
From 18 September 2024 the British Medical Association (BMA) has announced that the term Junior Doctors will be replaced by the new term Resident Doctors following a survey and vote with their members which took place earlier this year.

Doctors in training-pay offer
On 17 September 2024, the BMA has announced that its doctors in training members have voted in favour of the government's offer. This ends the dispute between the BMA Resident Doctor Committee and government. The offer has been designed to reform the pay for resident doctors, and includes measures aimed at improving the experiences of resident doctors in England.

Pay Award
The pay award for agenda for change staff and VSM staff has now been confirmed and are planned to be provided to staff in October 2024.

Trust Workforce Performance

Staff in Post
The Trust is currently operating at 7% above planned workforce trajectories taking consideration of substantive, agency and bank workforce. This predominantly due to high levels of bank use mainly due to high numbers of unqualified nursing vacancies and requirement for enhanced observations. Unqualified nursing roles account for 62% of bank use in the Trust. Action plans are in place to reduce vacancy levels across all professional staffing groups and drive improvements in rostering.

Recruitment
The Trust has a vacancy rate of 15.1% against our target of 12%. Further consideration by staff group shows a vacancy rate for nursing at 22%, HCAs at 13% and AHPs at 17%. Time to hire averages out at 82 days from job approval to start date, inclusive of candidate notice period.

Staff Turnover & Retention
Staff turnover has increased slightly from July where it was 9.3% to 9.5% in August 2024. This is against a target of 12% and therefore demonstrates stability within the workforce. The Trust is expecting to start measuring turnover for those in the first 12 months of appointment where this tends to be higher. The new People Promise Manager role is expected to focus of hot spot areas including staff groups, care units/departments and specific departments.

Appraisal Compliance

The appraisal compliance within the Trust is currently at 71%. This is disappointing as the annual appraisal process demonstrates a supportive opportunity for all staff and enhances the supportive and compassionate culture we strive to have embedded. The team alongside HR Business Partners will work with local areas to enhance compliance and demonstrate the benefits of the staff appraisal process. The target date for all appraisals being complete was set as October 2024.

Mandatory Training compliance

The current compliance rate is 84.1% which demonstrates a flat line trajectory looking at the last 3 months. The reports for the organisation and Care units don't yet highlight the specific detail associated with staff group and subject matter to provide areas of risk. Therefore our priority is to improve overall compliance while understanding some specific risk areas based on compliance rates.

Staff Engagement

The national staff survey will be launched from the 1 October 2024 and this provides an opportunity to engage with all of our staff to seek their views regarding their experience working at EPUT. As senior leaders it's important to encourage participation and reassuring that the survey is anonymous and that we want to listen to the views of our staff to give us a better opportunity to make improvements.

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

Information Item | PS | 15

REFERENCES

Only PDFs are attached

Quality & Performance Scorecard 02.10.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

Report Title:	**Quality & Performance Scorecard**					
Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Janette Leonard, Director of ITT					
Report discussed previously at:	Finance and Performance Committee Clinical Governance & 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			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety			✓
	SR2 People (workforce)			✓
	SR3 Finance and Resources Infrastructure			
	SR4 Demand/ Capacity			✓
	SR5 Lampard Inquiry			
	SR6 Cyber Attack			
	SR7 Capital			✓
	SR8 Use of Resources			✓
	SR9 Digital & Data Strategy			
Does this report mitigate the Strategic risk(s)?	No			
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No			
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A			
Describe what measures will you use to monitor mitigation of the risk	N/A			
Are you requesting approval of financial / other resources within the paper?	No			
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When	
	Executive Director			
	Finance			
	Estates			
	Other			

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

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

Full Report

The full Power BI EPUT Quality & Performance Board Report can be found **HERE.**

Summary of Key Issues

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

Mental Health Inpatient Capacity -
The average length of stay for adult patients has reported consecutive increases over the last 3 months, with August reporting an average of 101 days against a target of <35. When monitoring this performance with assessment units included; we see an average length of stay positon of 74 days. There were 117 discharges (44 from assessment units), 36 of whom were long stays (60+ days).
Older adult average length of stay increased in the month to 137 days, however still remains outside the target of 74. There were 27 discharges, 16 of whom were long stays.
PICU average length of stay has increased slightly back to outside of target in August at 56 days, this is against a target of <50 days. There were 6 discharges, 3 of which were long stays, whilst August is reporting marginally outside of target, the variation of the average length of stay month to month is consistently marginal and shows no concerning trend.

Adult and Older Adult bed occupancy rates continue to be higher than their respective targets with little to no variation over past 3 months, whilst PICU occupancy remains comfortably within target. In August, adult occupancy maintained the 97% reported since June (target <93%) which is comparable with year to date performance.
Older adult occupancy also remains stable at 90%, against a target of <86. PICU occupancy increased to 64%, however this is within the 88% target whilst they continue to work with reduced beds.

Rates of patients who are clinically ready for discharge remains within target for PICU, Older Adult and Specialist Wards. However Adult wards have seen an increase, reporting outside of the target since April, with August at 7% against the target of 5%, before April the Adult wards typically reported 2% for the previous 12 months, and these past 5 months are the first time reporting outside for the past 2yrs.
Although subtle, there has been a small increase in the number of females awaiting discharge over the last 3 months, while the overall numbers waiting discharge on Adults wards is showing a reduction over the same period.

Inappropriate Out of Area Placements –
At the end of August there were 56 patients in an out of area bed, which is a third consecutive month of increase from a position of 37 in May. 22 patients were newly placed in an OOA bed during the month, which is representative of the average over the past 2yrs.
Efforts were made to repatriate and a total of 19 clients were successfully brought back to EPUT wards.

The Operational and Flow Teams continue to work to operating plan targets, however the August target of 14 patients in an OOA bed was not met. Work to reduce and eliminate the need for people to be placed outside of Essex is ongoing. The improving flow programme of work within EPUT is focused on ensuring inpatient assessment & treatment is offered where there is a clear purpose to admission with therapeutic benefit that can only be offered within hospital. Quality improvement work to the daily safer staffing, demand and capacity call has taken place, ensuring a renewed focus on exploring opportunities to return people place out of area into Essex.

MH Inpatients Follow Ups –
72 hour follow ups reduced in August to 84% from a high of 94% in July, however this remains above target (80%). There were 16 discharges not followed up within 72 hrs, of these; 4 were identified as out of area, 1 did not respond to attempts to contact, 1 had been sent to prison. 9 were breaches that were followed up within 7 days, 1 was followed up on day 8.

The patient who did not respond is of no fixed abode and has no GP currently. A phone call was attempted and a care co-ordinator did attend a home address without any answer to either. Patient had an assessment on 25th August with an outpatient appointment also made for 16th September.

Whilst 7 day follow ups has been superseded by 72hrs, we continue to represent its performance in the report. In August, the 7 day follow up performance reduced from 95%, to 93% (target 95%). There were 7 discharges not followed up within 7 days in August.

These indicators can now be monitored by the Operational Productivity team via a Power BI Report, this report is refreshed several times a day & has an interactive narrative function where breach reasons can be recorded.

NHS Talking Therapies (IAPT) –
North East Essex access rates continue to be the most challenged area, and witnessed a marked reduction to 446 patients accessing treatment in August, against a 844 target. This is attributed to seasonal variation.

The number of patients accessing treatment in Castle Point and Rochford reported below the target of 300 at 258 in August for the first time since December-22. Southend achieved the target of 367 reporting 368 in August. Performance against all areas continues to be monitored regularly through the Integrated Performance Report, The Accountability Frameworks, and Commissioner reporting.

Across other Talking Therapies KPIs; all areas consistently meet 100% for clients beginning treatment both within 6 weeks and 18 weeks. The percentage of clients moving to recovery also maintains consistent target attainment.

Temporary Staffing –
The Trusts performance for agency staffing continues to maintain the reducing trend of shifts being booked through agency, the number of agency shifts booked in August halved the number that was booked 12 months ago. Bank usage continues to operate at above planned levels.

The continued realisation of quality and operational benefits of the Time to Care project are key to help reducing temporary staffing and is the area of focused work being carried out by the HR Business Partners. In addition, regular discussions and monitoring of this performance takes place within the Accountability Frameworks.

Sickness Absence –
August has reported a reduction for the first time in four months (to 5.6%). Although marginal, the overall absence rate continues to exceed the benchmark of <5%.
Nationally, EPUT is reporting slightly higher than the England average however the most reported reason for absence across all areas remains to be anxiety/stress/depression/other psychiatric illness.

The care units with the highest sickness rates in August were; Specialist at 6.8%, North at 6.2%, with both Inpatient and Urgent Care and West at 6% each.

Trust Income & Expenditure
M5 results are YTD deficit of £9.4m, £3.1m adverse variance to plan due to high levels of patient demand and acuity within Inpatient Mental Health services leading to overspends in staffing and out of area placements. . The 'in month' deficit was £1.1m being a £1.6m improvement on the previous month including reductions in agency workforce costs and, with the exception of Inpatient services and associated medical costs all Care units are delivering within financial plans.

Efficiency Programmes
In order to deliver the 24/25 financial plan, the Trust has to deliver £28.6m of efficiencies equivalent to 5.2% of operating spend. The Month 5 YTD position is delivery of £6.1m. Mobilisation of the Time To Care project is supporting delivery of further reductions in temporary workforce costs with mitigating actions including, establishment, vacancy and non-pay controls.

Temporary Staffing

Temporary staffing spend YTD is £29.6m (£25.5m in Month 5). Overall temporary staffing costs reduced with agency expenditure reduced and a slight increase in bank expenditure. Temporary staffing usage continues to be an area of focus including enhanced controls and monitoring and continued deployment of the Time to Care project.

Capital Expenditure
YTD capital expenditure totals £5m.

Cash Balance
Cash balance as at end of M5 is £27.9m

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

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

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

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

Supporting Reports/ Appendices /or further reading
EPUT Quality & Performance Board Report **HERE.**

Executive Lead
Paul Scott **Chief Executive Officer**

7.2 COMMITTEE CHAIRS REPORT

Information Item | Chairs | 10

REFERENCES

Only PDFs are attached

Committee Chairs Report 02.10.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

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

Risk Assessment of Report				
Summary of risks highlighted in this report	N/A			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety			✓
	SR2 People (workforce)			✓
	SR3 Finance and Resources Infrastructure			✓
	SR4 Demand/ Capacity			✓
	SR5 Lampard Inquiry			✓
	SR6 Cyber Attack			✓
	SR7 Capital			✓
	SR8 Use of Resources			✓
	SR9 Digital and Data Strategy			✓
Does this report mitigate the Strategic risk(s)?	N/A			
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No			
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A			
Describe what measures will you use to monitor mitigation of the risk	N/A			
Are you requesting approval of financial / other resources within the paper?	No			
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When	
	Executive Director			
	Finance			
	Estates			
	Other			

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

Recommendations/Action Required

The Board of Directors is asked to note the report and assurance provided.

Summary of Key Points

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

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

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

- Assurance – any key assurances to be provided to the Board.

- Information – any issues previously identified which have now been resolved, including lessons learned.
- Alert – any issues / hotspots for escalation to the Board.
- Action – any issues where the Standing Committee is requesting action from the Board.

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

1. Finance & Performance Committee (Loy Lobo)
2. People, Equality & Culture Committee (Diane Leacock)
3. Quality Committee (Dr Mateen Jiwani)

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Committee Chairs Report

Executive/ Non-Executive Lead / Committee Lead:
Chairs of Board of Director Standing Committees.

NHS
Essex Partnership University
NHS Foundation Trust

Committee Chairs Report

Board of Directors Part 1

2 October 2024

EPUT

1. INTRODUCTION

Purpose of the report

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

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

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

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

2. FINANCE & PERFORMANCE COMMITTEE

Chair of the Committee: Loy Lobo, Non-Executive Director

Committee meeting held: Thursday 19 September 2024

Assurance

Performance Report

- The Committee received assurance on the Trust's performance during August 2024.
- Areas of performance discussed included: Children's Speech & Language; Mental Health Inpatient Capacity; Out of Area Placements; Mental Health Inpatient Follow Ups; NHS Talking Therapies (IAPT); Home Treatment Referrals; Lighthouse Paediatrics.
- Significant improvements have been achieved by the Lighthouse service to reduce patient waiting times. Waitlist for Children's Speech and Language also reduced following successful recruitment, but cover for future planned leave is currently being sought.

Financial Report Month 5 (SR8 and SR7)

- The Committee received an update on the Trust's Revenue, Capital and Cash position.
- Corporate teams are working closely to achieve the required targets by the end of the financial year.
- NHS Pay Awards have been agreed, and will be actioned in the coming months.

Information

Capital Planning & Programme Group Recommendation (SR3)

- The Committee approved proposed expenditure for environmental upgrades on Finchingfield, Galleywood, Hennage, Peter Bruff, Ardleigh and Gosfield Wards.

Draft Estates Strategy (SR3)

- The Committee gave their approval for the Draft Estates Strategy to be presented to the Board of Directors for signoff. This will be presented in a separate Agenda item.

BAF Risk Deep Dive – Demand and Capacity (SR4)

- The presentation also provided an update on Time to Care, highlighting the progress made with recruitment, and escalations around the required numbers of registered professionals sitting outside the model for PICU. Roadshows to clinical sites were scheduled to commence from 25 September 2024 to support the new operating model.
- **BAF SR6** noted that all actions are now complete and review of risk score (assessment to be undertaken).

Alert

No Alerts for the Board.

Action

BAF Risk Deep Dive – Demand and Capacity (SR4)

- The Committee received a Deep Dive presentation on Demand and Capacity with a focus on Patient Flow. The presentation included: system flow and why it is a priority; how the system is maturing; current demand levels; out of area challenges, increased senior clinical engagement; reporting benefits; reasons for delayed discharges; length of stay and its effect on capacity, and occupancy.
- The Committee discussed the need to strengthen medical consultant resources to increase discharge flow and reducing out-of-area placements.
- Action for Quality Committee – to review systems and process of oversight of safety for those patients awaiting an inpatient bed in this period of increased and sustained demand.

NHS
Essex Partnership University
NHS Foundation Trust

3. PEOPLE, EQUALITY & CULTURE COMMITTEE

Chair of the Committee: Diane Leacock, Non-Executive Director

Committee meeting held: Monday 2 September 2024

Assurance

Freedom to Speak Up
- Bullying and inappropriate behaviour cases have reduced, whilst worker safety cases have increased. Funding has been allocated to increase resource for the service.

Time to Care
- 143 WTE roles had been approved through the Establishment Control Panel. Implementation of the Inpatient & Urgent Care Operating Model underway.

Workforce Plan
- Bank usage and vacancy rates are currently above planned levels, however it is anticipated that Time to Care will help to increase permanent staffing and reduce temporary workforce.
- Sickness is above the KPI at 6% against a target of 5.3%, but is now reducing.
- All off framework staff usage ceased from 1 July 2024, in line with national guidance.
- Overall mandatory and essential training compliance are above target.
- There has been a downturn in appraisal and supervision performance, but this is expected to improve following the autumn appraisal window.

Education Strategy
- Apprenticeship utilisation as at the end of June 2024 was 32.51%. The team is investigating how this can be improved in future. Management development and succession planning are currently being reviewed. The People Strategy will be reviewed by the end of 2024.

Employee Relations Case Management
- The Committee received an update on employee relation formal procedure activity.
- The Trust's Disciplinary (Conduct) Policy and the Dignity Respect and Grievance Policy and has been reviewed and updated. A Conduct Concerns Panel will be established to deal with matters which could be considered a breach of the Trust's disciplinary rules.

Management of Change Annual Assurance Report 2023/24
- 14 programmes were implemented, and 153 staff had been consulted with, during this period.

Board Assurance Framework
- Risk SR2 has been broken down into three risks for improved focus relating to Organisational Development, Retention and Workforce Sustainability had been developed.
- Corporate risks is being developed.

Information

Student Experience
- An Anglia Ruskin University student provided the Committee with an account of their recent work placement at Basildon Urgent Care unit, noting that their experience has been positive.

Chief People Officer Emergent and Topical Issues
- The Staff Survey was launched in September 2024, and the target was to achieve a 50% response. A new Workforce Efficiency Group has been established.

Workforce Efficiencies Programme
- The governance structure has been revised, including the introduction of a new Workforce Efficiencies Group to be chaired by the Executive Director of People & Culture. PWC have been working with the Trust on an 'investigate and intervene' exercise.

Stakeholder Engagement
- The Trust has been working with Anglia Ruskin University to develop a stakeholder engagement strategic framework and operational group- with a planned future item for Board consideration.

National Staff Survey 2024
- The Staff Survey was launched in September 2024, and the target is to achieve a 50% response rate. A range of promotional materials have been produced to encourage participation. Information on actions taken as a result of previous surveys will be publicised. The Senior Leadership Group have been provided with support in their role of driving awareness and encouraging staff to participate.

People Promise Exemplar Programme
- The Trust has been added to Cohort 2 of this 12-month national programme funded by NHSE, which supports organisations in valuing and retaining employees, and improving staff experience. A Retention Strategy will be produced. In order to maximise the opportunity within the limited timescale available, the Trust will be focussing on three main projects: Flexible working improvements; On-boarding; and Retaining staff in hard to recruit roles.

Action

The FTSU Toolkit to be discussed at Board Seminar in September.

Annual Organisational Audit of Appraisal & Revalidation
- Committee members received a report providing assurance that the Trust is compliant with the *Medical Professional (Responsible Officers) Regulation 2010 (as amended in 2013) Act*.
- The report recommended that the Trust is compliant, and Committee members endorsed this recommendation to the Board.

Workforce Equality Standards & Actions
- The Committee received assurance on the Trust's performance relating to the Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES).
- Improvements to the provision of adequate reasonable adjustments consistently across the Trust is currently a priority.
- Reports of bullying and harassment against BME staff by patients is currently higher than the national average, and the team is working on plans to correct these behaviours.

Alert

No Alerts for the Board.

4. QUALITY COMMITTEE

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

Committee meeting held: Thursday 12 September 2024

Assurance

Quality Performance Report
- Learning around restraint and seclusion incidents was shared with the Committee.
- Collaborative work on suicide prevention has taken place.
- There has been a small increase in falls reported.

Safeguarding Thematic Report
- The Committee received a thematic review of the Trust's *Multi-Agency Public Protection Arrangements* (MAPPA) and *Multi-Agency Risk Assessment* (MARAC) arrangements.

Infection Prevention & Control Report
- The Committee received assurance that the Trust's infection prevention and control was in line with national guidance during April-June 2024.

Patient & Service User Experience Report
- A summary of patient and service user experience activity during April–June 2024 was presented to the Committee.
- Poor communication was identified as the greatest cause of complaints during the period.

Physical Health Annual Work Plan & Progress Report
- The Committee received an update on the programme of work to improve the physical health of the Trust's service users.

Emergency Preparedness, Resilience & Response Core Standards Self-Assessment 2024/25
- The Trust is meeting all the standards with the exception of one being partially compliant related to all Gold On call staff having attended training. The Committee were assured that would be resolved with training sessions now being available regionally.
- The next steps is for Trust's *Emergency Preparedness, Resilience & Response Core Standards Self-Assessment* to be presented to NHSE's Emergency Preparedness Team for critical feedback.

Information

Emergent Issues
- Action is being taken to resolve concerns reported to the CQC relating to care at The Lakes.
- There has been increasing internal and external pressure to improve flow through our inpatient units with an a focus on enabling those patients assessed as ready for discharge of patients as soon as possible. However, patient safety remains the Trust's first priority.

Patient Story
- The Committee received an account of a patient's experience as an inpatient at the Trust.
- There was discussion around allocating staff of a specific gender on request; providing holistic care; and provision of guidance for staff on interacting with patients on a personal level in addition to providing medical care.

Trust Response to the Greater Manchester Mental Health Report
- A proposed programme of work in response to the key findings of the Greater Manchester Mental Health Report was presented to the Committee for information. Assurance reports and updates will be provided to the Committee as work progresses.

Research & Innovation Strategy Delivery Update
- The Committee received an update on delivery of the Trust's Research and Innovation Strategies since their launch in January 2024.
- Significant progress has been made with Research, including recruitment to key posts; commencement of work with two multi-national pharmaceutical companies to run commercial treatment trials; and commencement of a six-month Lived Experience Advisory Panel pilot.
- The Innovation Strategy is still in its early stages, and Committee members welcome a further discussion about the Trust's ambitions, innovation and potential commercial plans.

Quality Impact Assessments (QIA) Procedure
- The Committee approved an updated QIA Procedure to support the Quality of Care Programme.

Action

CQC Assurance Report

- The CQC improvement plan continues with good progress, and an internal check and challenge exercise underway prior to submission to the Evidence Assurance Group for approval. The Committee received an update on the 12 items off track. *The Board will receive the usual report as a substantive item on the agenda*

Mental Health Act Annual Report 2023/24

- The Committee received assurance that the Trust had been compliant with the *Health Act 1983* and *Mental Capacity Act 2005* during the 2023/24 financial year. *The annual report to be presented to Board as an substantive item for approval.*
- A deep dive into mental health inequalities will be presented at a future meeting.

. **Safeguarding Annual Report 2023/24**

- The Committee received assurance relating to the Trust's care for vulnerable children, young people and adults during 2023/24, and approved presentation of the report to the Board of Directors. *The annual report to be presented to Board as an substantive item for approval.*

Health, Safety, Security & VAPR Annual Report

- The Committee received assurance that the Trust had been 100% compliant with the *Health & Safety at Work Act 1974* and *Management of Health & Safety at Work Regulations 1999* during the 2023/24 financial year. *The annual report to be presented to Board as an substantive item for approval.*

Alert

No Alerts for the Board.

7.3 CQC ASSURANCE REPORT

Information Item AS 5

REFERENCES

Only PDFs are attached

CQC Assurance Report 02.10.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

Report Title:	**CQC Assurance Report**					
Executive/ Non-Executive Lead / Committee Lead:	Ann Sheridan, Executive Chief Nurse					
Report Author(s):	Comfort Sithole, Head of Compliance and Emergency Planning.					
Report discussed previously at:	Quality Committee and Executive Operational Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with: 1. An update on CQC related activities that are being undertaken within the Trust. 2. An update and escalations as required on progress made against the Trust CQC improvement plan.	**Approval**	
	Discussion	✓
	Information	✓

3. Internal Assurance against the CQC Quality Statements 4. Details of CQC guidance/updates that have been received since the previous reporting in July 2024		

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note the contents of the report for assurance of oversight of progress against the CQC improvement plan.

Summary of Key Points

- EPUT continues to be fully registered with the Care Quality Commission.
- The Trust continues to focus on the implementation of the CQC improvement plan. Good progress continues to be made with the implementation of actions with 87% of actions reported completed by action owners and 27% having been agreed for closure through the Evidence Assurance Group.
- The Trust awaits the CQC inspection report of our Forensic / Secure Services at Brockfield House in March 2024.
- The pilot of the new joint quality visits framework continues with early feedback being positive.
- There were no CQC enquiries raised during this reporting period.

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

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

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

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	EPUT	Essex Partnership University Trust
ICB	Integrated Care Board	EAG	Evidence Assurance Group

Supporting Reports and/or Appendices

CQC Assurance Report
Appendix 1 - CQC Improvement Plan Update September 24

Executive/ Non-Executive Lead / Committee Lead:

Ann Sheridan

Ann Sheridan
Executive Chief Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Assurance Report

1. Purpose of the report

This report provides the Board of Directors with:

- An update on CQC related activities that are being undertaken within the Trust.
- An update and escalations as required on progress made against the Trust CQC action plan.
- Internal assurance of CQC Quality Statements.
- Details of CQC guidance / updates that have been received since the previous reporting in August 2024.

2. CQC Registration Requirements

2.1. Registration

EPUT continues to be fully registered with the Care Quality Commission.

3. CQC Inspections and Improvement Plans

3.1. Unannounced CQC Inspection Forensic / Secure Services

The CQC report following the unannounced inspection of our Forensic / Secure Services at Brockfield House in March 2024, is awaited.

3.2. CQC Improvement Plan

The Trust has continued to focus on implementation of the CQC improvement plan.

As at 11 September 2024:

- 68 (87%) of the Must do / Should do actions have been reported as completed by action owners. Of these, 21 (27%) have been closed following review at the Evidence Assurance Group.
- 334 sub-actions complete
- 12 sub-actions past timescale (Nb. Associated with 8 overall actions status) weekly monitoring is in place.

The EAG meeting held on the 23 September 2024 was chaired by the MSE ICB Deputy Director of Nursing with EPUT operational and corporate staff in attendance.

89 Assurance Metrics / Measures have been identified to help demonstrate that actions being taken in the CQC improvement plan will have sustained impact. As at 14 August 2024, 40% of these indicators have been developed and taken forward.

3.3. CQC Enquiries

There were no CQC enquiries raised during this reporting period.

4. Annual Programme 2024-25

4.1. CQC Assurance Programme

The Compliance Team have continued to take forward the development of the CQC Assurance Framework, with adaption of our internal processes due to change in the CQC approach under the new Single Assessment Framework and its supporting quality statements (replacing the Key Lines of Enquiry).

The pilot of the new joint quality visits framework continues with early feedback being positive. A full review is to be undertaken in October 2024 prior to any further amendments to the process.

4.2 Internal Assurance

The Trust annual compliance team assurance visit programme to promote and monitor adherence to the CQC quality statements for 2024-25 continues. In the period, the Compliance Team focused on the following Core Services:

- Community Health Inpatients
- Nursing Homes
- Children's Community Health Services

Following each visit, feedback was provided for each core service capturing the good practice and any areas for improvement. This is shared with the Service and Care Unit Leadership for review and implementation of change. These in turn are monitored through the Accountability Framework meetings.

Note: The recommendations are based on limited assurance testing gained through the internal Compliance Team reviews and applied across the service for shared learning and checks.

5. CQC Guidance / Updates

5.1 Observing and Improving Culture in mental health inpatient services

As part of the CQC's public commitment to respond to the closed cultures identified in some mental health inpatient settings, they are piloting a framework for Observing and Improving Culture at a small number of assessments in mental health services between August and December 2024.

The purpose of the framework, which was developed through extensive external engagement with clinicians, partners, providers and people with lived experience, is to support the identification of closed cultures through observing and speaking with people.

This work will be carried out as part of the wider CQC assessment in each service and by trained staff with a background in mental health inspection. The CQC will report on the findings within each service report as well as more broadly after completion of the programme.

5.2 Review into the operational effectiveness of the Care Quality Commission: interim report

Dr Penelope Dash was asked to carry out a review of the Care Quality Commission (CQC) in May 2024. Over the last 2 months she spoke to around 170 senior managers, caregivers and clinicians working in the health and care sector, along with over 40 senior managers and national professional advisors at CQC.

All shared considerable concerns about the functioning of the organisation, with a high degree of consistency in the comments made. At the same time all recognise the need for a strong, credible and effective regulator of health and social care services.

The interim report provides a high-level summary of the emerging findings in order to inform thinking around changes needed to start the process of improving CQC.

A more detailed report will be published in autumn 2024. There is an urgent need for a rapid turnaround of CQC - a process that has already started with the appointment of an interim chief executive in June 2024.

Review into the operational effectiveness of the Care Quality Commission: interim report - GOV.UK (www.gov.uk)

6.0 Recommendation

The Board of Directors is asked to:

1. Receive and note the contents of the report
2. Note the assurance on progress against the improvement plan

Report Prepared by:

Comfort Sithole
Head of Compliance and Emergency Planning

On behalf of

Ann Sheridan
Executive Chief Nurse

Appendix 1:

CQC Improvement Plan Update – 11 September '24

CONTENTS

Introduction

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

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

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

- Initial S29 plan (Willow and Galleywood Wards – Oct '22)
- Intra-inspection feedback of acute wards for adults and PICU (Nov '22)
- Internal report for 2 Adult Acute Wards (Jan '23)
- CQC report Acute Wards for Adults and PICU (published Apr '23)
- CQC report Core Services and Well Led (published July 23)
- CQC report Rawreth Court (published Nov '23)

Level of Assurance: Level 1

Key Messages

There are currently 78 'must do' / 'should do' actions being taken forward (Note: combination of some actions into one), with 348 sub-actions (as at 11 September 2024) associated with CQC activity.

Overview as of the 11 September 2024:

- 68 (87%) of the Must do / Should do actions have been completed.
- 21 (27%) have been closed following review at CQC Leads Meeting and Evidence Assurance Group.
- 334 sub-actions complete

12 sub-actions past timescale as at 11 September 2024 (Nb. Associated with 8 overall actions status) weekly monitoring is in place.

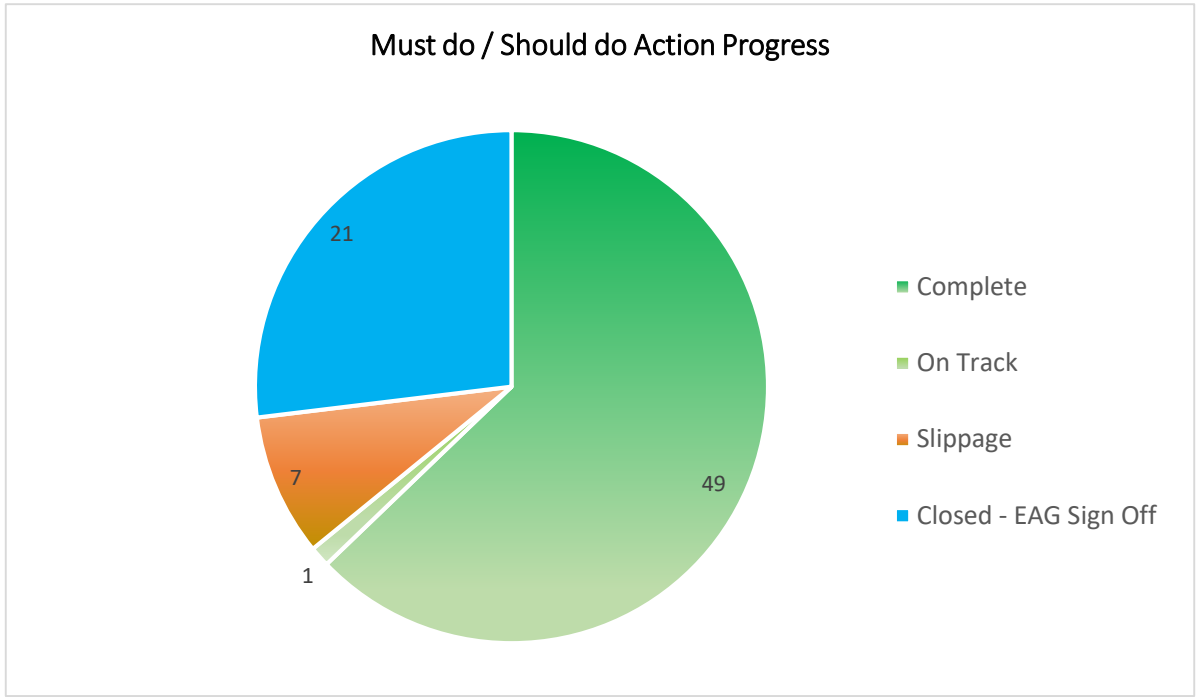
The CQC Action Leads meeting continues to hold action owners to account for delivery. The meeting is chaired by the Senior Director of Corporate Governance and attended by Executive Chief Nurse.

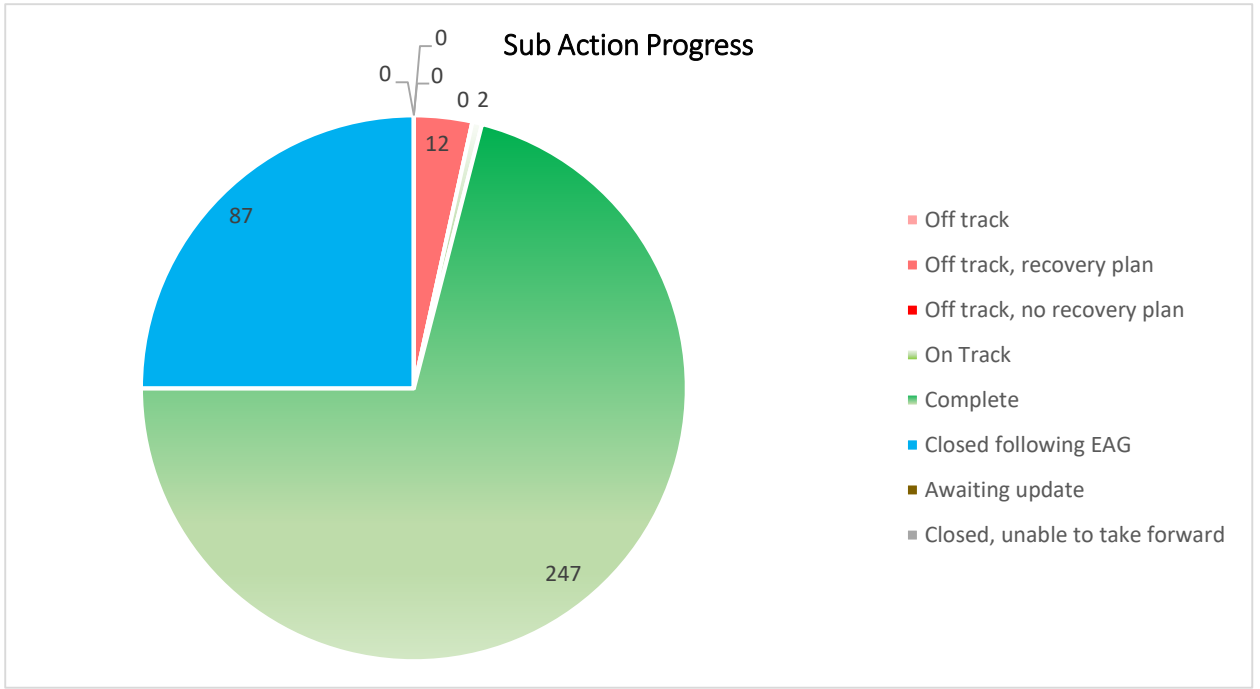
Action Progress Update

NHS Essex Partnership University NHS Foundation Trust

Summary of implementation status

- 78 Must do / Should do actions and 348 Sub-Actions identified as at 11 September 2024
- 21 (27%) have been closed following review at CQC Leads Meeting and Evidence Assurance Group (EAG).
- 68 (87%) of the Must do / Should do actions have been completed. (next step is for the evidence to be presented to the CQC Leads Meeting and EAG)
- 334 sub-actions complete
- 12 sub-actions past timescale as at 11 September 2024 (Nb. Associated with 8 overall actions) weekly monitoring is in place.





Summary of activities and highlights

NHS
Essex Partnership University
NHS Foundation Trust

Summary of key activities completed in the last month:

- M3 (Trust side) – Enhancement of Shared Care Record went live.
- M6 (Adult Acute & PICU) – New CCTV software passed cyber security processes and progressing plans, noting that this is to achieve the added benefit of being able to access footage remotely.

Actions Closed

4 Actions closed by EAG in the reporting period (21 closed in total)

47 must do/should do actions complete and ready for closure. These are being prepared to be taken through the evidence assurance processes with our ICB Colleagues

Summary of activities and highlights

NHS Essex Partnership University NHS Foundation Trust

Key Slippages (12 Sub-actions are past timescale)				
(M3.4.1, M3.5.1 and S19.2 impacted by the Paris upgrade delay)				
Must do / Should do Action	**Sub-Action past timescale**	**Current Position**	**Recovery Plan**	**Lead**
M3: The trust must ensure they improve the quality of their data, the effectiveness of their systems and the accuracy of the assurance they receive about the quality of care being delivered. M5: The trust must ensure that they have a robust and timely plan for the implementation of a consistent patient record in line with their current strategic aim. (4/11 actions complete / 2 on track)	M3.4.1 Complete Paris upgrade which will include waiting list management	Supplier (Civica) is actively supporting the trust for the upgrade of Paris following setbacks in the testing of the new version. Upgrade to undergo Dry Run and short spell of UAT.	Once achieve resolution of issue identified at testing, to repeat the upgrade – plan is for the end of October '24. **Weekly touchpoint to review.**	Jan Leonard
	M3.5.1 Enhancement of the Shared Care Record (SCR)	ICS Programme re-baselined project go live date 8th July technology go-live and 12 July service go-live. Testing continues. Data validation and UAT dates to be moved out post sign-off of technical testing. Shared care record went live 27/08/24 although reserved some time to meet actual commitment /requirement to be met.	Orion health/ Cerner (Suppliers) negotiations for resolution to share care record access between ICS's Impacted by the Paris upgrade delay. **Weekly touchpoint to review**	Jan Leonard
S19 The trust should ensure that care plans are easy to use and understand. (2/3 actions complete)	S19.2 New smart care plan to be launched later this year late Q3 (key principles of SMART, Simple and uncluttered, short and to the point, includes primary outcome measure and secondary outcome measure)	Care plan signed off at Project Board. System now being aligned with new care plan	Continue training in preparation for go live Impacted by the Paris upgrade delay. **Weekly touchpoint to review**	Tendai Ruwona

Summary of activities and highlights

NHS Essex Partnership University NHS Foundation Trust

Key Slippages (12 Sub-actions are past timescale)				
Must do / Should do Action	**Sub-Action past timescale**	**Current Position**	**Recovery Plan**	**Lead**
M6: M1 (April 2023) and M6 (May 2023) The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the trusts' policies and procedures for the recording and reporting of incidents	M6.5 Identify solution to current technical barriers which prevent wide access to closed-circuit television (CCTV) to enable use for training / learning	Work continues for remote access can be uploaded to current ward IT equipment. New software identified and has passed cyber security processes. Note: This is to achieve the added benefit of being able to access footage remotely.	New software identified and passed as Cyber Compliant. **Weekly touchpoint to review transition of implementation**	Tendai Ruwona
M8: The trust must ensure that staff do not fall asleep when undertaking patient observations. (Regulation 12 (2).	M8.6 Address Sleeping on duty action plan following further review	Full review of action plan undertaken with new actions being taken forward following a successful QI pilot of changes to duration of observations (to 30 minute cycles between 8pm – 6am) on Cherrydown Ward. Agreed to keep action open and as a consequence of our agreed approach to any extension beyond the originally stated date this is now included within the 'off track' list. The Trust continues to have in place robust HR procedures for any staff member found to be sleeping on duty.	Angela Wade (Director of Nursing) is now the lead for progressing new actions. **Weekly touchpoint to review**	Angela Wade

Summary of activities and highlights

NHS Essex Partnership University NHS Foundation Trust

Key Slippages (12 Sub-actions are past timescale)

Must do / Should do Action	Sub-Action past timescale	Current Position	Recovery Plan	CQC Lead
M32: The trust must ensure that all patients have fully completed discharge plans and that there are systems and processes in place to secure timely discharge for patients using the recovery and wellbeing part of the service as part of their recovery.	M32.1 Change care plans to prompt clinicians to set discharge date M32.2 Create clear identification for cases where there are factors that limits the patients from being discharged and extends length of time on caseload M32.3 Benchmark workforce establishment to understand resourcing and availability to complete discharge M32.4 Training needed to identify when and how to have goal setting and discharge conversations and also the tactical preparation for discharge planning. Connect this in with the work already on the safety improvement planning work.	Work continues to embed discharge and transfer planning. Care Unit Director to worked with teams to ensure discharge plans are clearly articulated and for the people who remain with the services for extended period legitimately (such as Depot injections, S117 after care, CTO etc) this is clearly documented within the record. Questions added to care note audit to test these are in place moving forward. Due to the small numbers of patient records the audit cycle has been extended to end December '24 to be able to evidence sustainability of the actions taken.	Initial Audit results collated and presented. A further audit cycle to be undertaken in November '24 **Timescale: December 2024**	Lynnbritt Gale
S22 The trust should ensure all wards follow its governance systems and processes to maintain patient safety, in particular for clinical equipment monitoring, assessment and management of patient risk, and medicines management (2/3 actions complete)	S22.3 Tendable data to be made available on safety dashboards to ease accessibility of data.	Explored how to use automation and funding. Contract reviewed and expanded. Technical ability to achieve the action has been confirmed through proof of concept, validation and sign off of the information to be mapped in progress.	To complete the validation and sign off of data to be mapped. **Weekly touchpoint to review**	Rebecca Pulford

Summary of activities and highlights

NHS
Essex Partnership University
NHS Foundation Trust

Key Slippages (12 Sub-actions are past timescale)

Must do / Should do Action	Sub-Action past timescale	Current Position	Recovery Plan	CQC Lead
S9: The trust should ensure that vacancy rates are reduced so that teams are adequately staffed. (3/4 actions complete)	S9.4 Reduction in vacancy rates	Vacancy rates have been analysed between Month 8 22/23 (49.96 wte) and Month 3 24/25 (57.90 wte) and whilst vacancy rates have increased, budgeted establishment has increased from 174.02 wte to 195.41 wte and staff in post has increased from 124.06 wte to 137.51 wte (improvement of 13.45 wte).	Next steps on our recovery are to analyse recruitment pipeline to address remaining vacancies. **Monthly touchpoint to review**	Cindy Weaver
RC10: Queries – Nursing Home admission criteria	RC10.3: To review home admission criteria	Review underway. Requires wider discussion with ICB partners	Ann Sheridan (Executive Nurse) is in discussions with ICB colleagues. **Touchpoint end September ’24**	Tendai Ruwona

Next steps

NHS
Essex Partnership University
NHS Foundation Trust

Areas of focus for the next month

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

7.4 WORKFORCE EQUALITY STANDARDS & ACTION PLAN 2024-25

Decision Item AM 5

REFERENCES

Only PDFs are attached

Workforce Equality Standards and Actions 24 25.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

Report Title:	**Workforce Equality Standards and Actions (2024 – 25)**					
Executive/ Non-Executive Lead / Committee Lead:	Andrew McMenemy, Executive Chief People Officer					
Report Author(s):	Lorraine Hammond-Di Rosa - Director of Employee Experience Gary Brisco - Equality Advisor					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides Board of Directors with a summary of key headlines and shares information associated to our obligations for the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans,	**Approval**	✓
	Discussion	
	Information	

The report also details activity within the Action Plans for WRES and WDES 2024/25 with the intention to be published on 31st October 2024.		

Recommendations/Action Required
The Board of Directors are asked to: • Note the updates and actions in the report. • Approve the proposed action plans for publication on 31 October 2024.

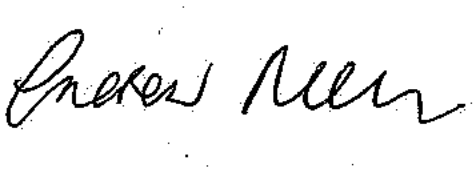
Summary of Key Points
Implementation of the Workforce Race Equality Standard (**WRES**) and the Workforce Disability Equality Standard (**WDES**) is a requirement for NHS Commissioners and NHS healthcare providers through the NHS Standard Contract. In 2024 EPUT demonstrated improvements in **six out of the nine WRES** indicators and **nine out of the ten WDES** Metrics. Whilst improvements have been made over the past year, there is still need for improve the experiences of minority staff within the trust as there is a disparity to their counterparts in both the WRES and WDES.

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

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

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

Acronyms/Terms Used in the Report			
WRES	Workforce Race Equality Standard	WDES	Workforce Disability Equality Standard
BME	Black, Asian and Minority Ethnicity	EMREN	Ethnic Minority and Race Equality Network
EIC	Equality and Inclusion Committee	PECC	People, Equality and Culture Committee

Supporting Reports and/or Appendices
Workforce Equality Standards (2024-25) Report Appendix A – WRES Action Plan 2024-25 Appendix B – WDES Action Plan 2024-25 Appendix C – WRES Action Plan 2023-24 (Summary of Progress) Appendix D – WDES Action Plan 2023-24 (Summary of Progress) **Further Reading:** Workforce Race Equality Standard Report (2024) Workforce Disability Equality Standard Report (2024)
Executive/ Non-Executive Lead / Committee Lead:
 **Andrew McMenemy** **Executive Chief People Officer**

WORKFORCE EQUALITY STANDARDS (2024 – 25)

1 PURPOSE AND INTRODUCTION

Implementation of the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) is a requirement for NHS Commissioners and NHS healthcare providers through the NHS Standard Contract.

The purpose of this report is to provide analysis and progress on the WRES indicators and WDES metrics, as well as identifying disparities and providing recommendations on how to advance the equality agenda. Data was taken directly from the most recent staff survey results (2023) and workforce data (2024).

The WRES and WDES are important tools in gauging the experience of Black, Asian and Minority Ethnicity (BME) staff and Disabled staff in comparison to the wider Trust, measuring factors such as discriminatory behaviour, likelihood of being appointed from shortlisting and career progression.

This data was presented to key stakeholders in our staff networks and wider Trust, with actions developed to improve the *metrics (WDES)* and *indicators (WRES*) that have declined or continue to show inequality. This report lists our improvements from the previous year as well as setting new actions for 2024-25 for approval.

2 PERFORMANCE AND PRIORITIES

In 2024, EPUT saw improvements in six out of the nine WRES indicators and nine out of the ten WDES Metrics, a full breakdown and analysis of these are available in the WRES and WDES reports for 2024.

Appendix C and D show current progress and impact on each of these previous action plans developed in October 2023. Key highlights *(with the corresponding indicator / metric alongside them*) include:

- A higher percentage of staff declaring themselves as having a disability in the Trust in comparison to previous years (via ESR). **(WDES 1)**
- A reduction in the percentage of disabled staff saying that they have felt pressure from their manager to come to work. Now lower than the national average. **(WDES 6)**
- An increase in disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work. Higher than the national average. **(WDES 8)**
- Improvements in the likelihood of BME staff accessing non-mandatory training and career progression. (**WRES 2)**
- Reduction in BME staff members reporting bullying, harassment and abuse from colleagues, which was lower than the national average and near-equal to the experiences of white counterparts. **(WRES 6)**

There is still need for improvement in the following areas:

- Declaration of disability and long-term conditions for all staff, in particular those undergoing formal capability assessments, as many staff are recorded as “unknown”. **(WDES 3)**
- Reports of bullying, harassment and abuse against disabled staff members from both patients and colleagues remain higher than their non-disabled counterparts. **(WDES 4)**
- The relative likelihood of BME staff appointed from shortlisting decreased, as more white staff were appointed from shortlisting during this period. **(WRES 2)**

- A disproportionate amount of BME staff entered the formal disciplinary process during this period, being nearly twice as likely in comparison to their white counterparts. **(WRES 3)**
- Reports of harassment, bullying and abuse against BME staff members from patients, relatives or the public is higher than the national average, the results of our previous WRES and the experience of their white counterparts**. (WRES 5)**
- Reports from staff of discrimination from their manager or other colleagues is still twice as high for BME staff members in comparison to white counterparts. **(WRES 8)**

These were identified as priorities for improvement following presentations to the Ethnic Minority and Race Equality (EMREN) and Disability and Mental Health Networks. New actions have been developed (**Appendix A and B**) for 2024 – 25 to improve in these areas.

5 ACTION REQUIRED

The Trust has developed Action Plans for both WRES/WDES (**Appendix A and B**) designed to reduce disparities and provide recommendations on how to advance the agenda for race and disability equality. Activity will be monitored on a monthly basis with key leads reporting to the Equality and Inclusion Committee.

The Trust has set out recommendations on the support required from its leadership teams to improve the experiences for BME and disabled staff within the Trust.

- **Hold leaders accountable:** EDI is everyone's responsibility. Holding leaders accountable for ensuring they have SMART EDI objectives within their appraisals, ensuring that EDI is a regular conversation in 121 supervision and team meetings, which helps leaders, recognise their role in creating inclusive culture.
- **Supporting staff networks and events:** As Executive Sponsors, attend network meetings and events 75% of the year to support the network Chairs, proactively encouraging members of their teams, in particular senior leadership team, to engage and join networks events supporting staff sharing their lived experiences with challenges at work.
- **Zero tolerance approach to violence and discrimination:** Encourage the use of zero-tolerance letters and behaviour contracts to patients, carers and families who are violent or abusive to our staff. Senior leaders should also be held accountable for reducing discriminatory behaviour within their care units with support from key stakeholders within the trust.
- **Increase communication and awareness:** Proactively increase communication and awareness around the behaviours framework and tools for senior leaders within team meetings and other opportunities when they arise.
- **Cultural awareness and safety:** Champion resources within the organisation to promote inclusive behaviours, improve psychological safety and better support minority staff. E.g. understanding their role in providing reasonable adjustments to their teams, as well as identifying appropriate support for staff who are repeat victims of discriminatory, bullying, harassment or abusive behaviours at work.
- **Policies and procedures:** Ensure that Senior Leadership Teams are regularly reminded of Code of Conduct and Dignity and Respect policies, practices and procedures and regularly cascading to the team.
- **Supporting staff:** Attending 'hot spot' areas where high levels of discriminatory incidents occur to engage and listen to the lived experiences of staff.

These are in line with the objectives set for Board members under the NHS EDI Improvement Plan High Impact Action 1 (**Appendix E**) and our People and Education Strategy.

6 NEXT STEPS

The Board of Directors are asked to:

- Note the updates and actions in the report
- Approve the proposed action plans for publication on 31 October 2024

Report prepared by:

Gary Brisco | Equality Advisor

Lorraine Hammond-Di Rosa | Director of Employee Experience

On behalf of:

Andrew McMenemy | Executive Chief People Officer

APPENDIX A - WORKFORCE RACE EQUALITY STANDARD ACTION PLAN 2024 – 25

WRES indicators – 1, 2, 3, 5, 6, 8
People Promise Themes – *We are Compassionate and Inclusive, We are Safe and Healthy*
NHS EDI High Impact Actions – 1, 2, 4, 6

Priority Area	Actions	Lead	Target / Measures
APPOINTMENT FROM SHORTLISTING Improve likelihood of BME staff being appointed from shortlisting relative to their white counterparts.	• Continue to implement and promote Inclusion Ambassador (IA) Program to support Interview panels (8a+). (Ongoing) • Develop additional resources (guidance documents, post interview survey) for IA's to be part of the full interview process (as well as protected time from substantive role.) (January 2025) • Increase number of IA's by 25% - Recruitment team to work with EMREN Network, marketing and communications to develop a recruitment campaign. (August 2025)	*Associate Director Resourcing* *Marketing and Comms Leads* *Equality Advisor*	**WRES Indicator 1:** Increase of BME Staff % in WRES 2025 **WRES Indicator 2:** Relative Likelihood at 1, Parity between BME staff and White counterparts
FORMAL DISCIPLINARY PROCESS Reduce number of BME Staff Members undergoing the Formal Disciplinary procedure.	• Continue to implement *"Fair and Just Culture"* in EPUT and adopt an informal resolution approach where possible. (Ongoing) • Hold cultural awareness sessions as well as targeting areas with high rates cultural challenges for staff. (Ongoing) • Triangulate reports (including ER, F2SU, DATIX and HRBP reports) to identify areas for action and improvement. (April 2025)	*Equality Advisor* *Employee Relations* *Director of Employee Experience*	**WRES Indicator 3:** Relative Likelihood at 1, Parity between BME staff and White counterparts
BULLYING AND HARASSMENT FROM SERVICE USERS Reduce reports of bullying and harassment from patients, carers and members of the public from BME Staff.	• Take learning from EPUT Pilot Programme to develop interventions for wider use in EPUT teams across the Trust. (Ongoing) • Progress actions related to the Sexual safety charter (in line with NHS England timeline). (October 2024) • Co-ordinate support visits to 'hot spot' areas to engage with staff as a result of repeat violent/racial and discriminatory abuse from staff/patients/carers or families (including Here for You, VAPR, Employee Experience, HRBP's and Senior Leaders) (September 2024). • Develop a new communication campaign to reduce abuse from patients/ visitors (Winter 2024) • Holding regular 'big conversations' with senior leaders and safe spaces for staff networks (Winter 2024) • Hold regular engagement and feedback sessions on HR processes (October 2024) • To implement a concerns panel to check and challenge whether referrals need to enter formal processes (October 2024) • Launch the new Equality Impact Assessment (EIA) digital form and guidance and improve competency around the process (October 2024)	*Director of Employee Experience* *OD Team* *Equality Advisor*	**WRES Indicator 5** Below 30% for BME Staff on WRES 2025

WRES indicators – 1, 2, 3, 5, 6, 8 **People Promise Themes –** *We are Compassionate and Inclusive, We are Safe and Healthy* **NHS EDI High Impact Actions –** 1, 2, 4, 6			
Priority Area	**Actions**	**Lead**	**Target / Measures**
DISCRIMINATORY BEHAVIOUR Reduce reports of discriminatory behaviour from managers, team leaders or other colleagues from BME Staff.	• Continue to implement and promote the Behavioural Framework in EPUT. (Ongoing). • Develop bespoke Cultural Awareness and Safety for areas identified as having high levels of discriminatory behaviour (April 2025). • Introduce a diversity dashboard to look at representation across different staff groups and to consider intersections such as ethnicity and gender together (April 2025).	*Director Employee Experience* *OD Team* *Equality Advisor*	**WRES Indicator 6** Below 20% for BME Staff on WRES 2025 **WRES Indicator 8** Below 10% for BME Staff on WRES 2025

APPENDIX B - WORKFORCE DISABILITY EQUALITY STANDARD (ACTION PLAN 2024 – 25)

WDES Metrics – 1, 4a, 4aii, 4aiii, 4b, 6, 8
People Promise Themes - *We are Compassionate and Inclusive, We are Safe and Healthy, We are a Team*
High Impact Actions – 1, 4, 6,

Priority Area	Action	Lead	Target / Measures
DECLARATION OF DISABILITIES Improve declaration of disability and long-term conditions for all staff in EPUT, in particular those undergoing formal capability assessments to ensure they are tracked.	• Celebrate and promote national awareness campaigns and key dates for disability and long term conditions via Trust Comms Channels (Ongoing). • Review Intranet resources to provide online information on Access to Work, Reasonable Adjustments and Invisible Disabilities to support staff. (December 2024). • Develop standalone sessions with all networks to promote awareness of different forms of disability and neurodiversity (intersectional approach) (April 2025)	*Comms Team* *OD Team* *Equality Advisor*	**WDES Metric 1:** Increase of up to 5% in overall staff declaration of disability via ESR. **WDES Metric 3:** Relative Likelihood at 1
BULLYING AND HARASSMENT FROM SERVICE USERS Reduce disabled staff reports of bullying and harassment from patients, carers and members of the public.	• Take learning from violence and discrimination pilot to develop interventions for wider use in EPUT teams across the Trust. (February 2025). • Targeted visits to "hot spot" areas by both support teams (Here for You, VAPR, Employee Experience, HRBP's) and Senior Leaders to show support and drive improvements. (Ongoing) • Develop resources for staff to challenge discriminatory requests from patients and carers - additions to policies and guidance for staff. (August 2025)	*Director Employee Experience* *VAPR Lead* *Employee Relations Lead* *Equality Advisor*	**WDES Metric 4ai:** Below 20% for Disabled Staff on WDES 2025 **WDES Metric 4b:** Above 65% for Disabled Staff on WDES 2025
BULLYING AND HARASSMENT FROM STAFF Reduce disabled staff reports of bullying, pressure and harassment from colleagues and managers and ensure managers are providing appropriate support and reasonable adjustments to employees.	• Create guidance for all line managers to ensure they are aware of the legal requirements to provide reasonable adjustments and the process for delivering them. (April 2025) • Survey staff members following implementation of reasonable adjustments to gather feedback and identify potential areas of difficulty as part of the process via online survey in reasonable adjustments passport. (April 2025) • Investigate a central budget or support resource for reasonable adjustments (September 2025) • Ensure managers and teams from "hot spot" areas undertake disability awareness, and neurodiversity training (see above) in response to reports of discriminatory behaviour. (Ongoing) • Triangulate sickness absence records with a focus on disability as an indicator of efficacy of flexible working. (August 2025)	*OD Team* *Equality Advisor*	**WDES Metric 4aiii:** Below 20% for Disabled Staff on WDES 2025 **WDES Metric 6:** Above 20% for Disabled Staff on WDES 2025 **WDES Metric 8:** Above 85% for Disabled Staff on WDES 2025

WORKFORCE RACE EQUALITY STANDARD ACTION PLAN

Summary of 2023 - 2024 Progress (WRES data in colour, taken from 2024 WRES Report)

OBJECTIVE	2023 - 24 ACTION PLAN	PROGRESS AND WRES 2024 DATA	LINKED WRES INDICATOR(S) and HIA(S)
Implement a plan to widen recruitment opportunities within local communities and to be measured in terms of representative from people from a BME background, this should include career pathways into the NHS such as apprenticeship programmes and graduate management training schemes. Increase representation of colleagues with an ethnic minority background at all levels. Improved data monitoring of diversity within EPUT. As well as representation across senior Trust pay-bands.	1. Year-on-year improvement in BME representation leading to parity. 2. Year-on- year improvement in representation of senior leadership (Band 8a and above). 3. Working in partnership with the Integrated Care System (ICS) to focus on equality and inclusive practices for colleagues from a BME background. 4. Increase the pool of Inclusion Ambassadors to ensure that shortlists and panels are diverse and include members who are representatives of groups currently under-represented at that level within an organisation. Ensure there is an independent member of every interview panel who understands these issues and is able to challenge other panel members. 5. Conduct regular stakeholder sessions to review the recruitment process, to ensure the interview questions are reflective of the Trusts values and behaviours framework (Values Based Questions). Review the wording and images of all job adverts to ensure it includes positive messaging on anti-racism and the Trust's commitment to race equality.	1. **WRES Indicator 1:** 2.8% (247) Increase in BME Staff, Higher than NHS Average 2. **WRES Indicator 2:** Additional +6 staff at Band 8+ in EPUT ○ Increase in BME Board Members and Executive Board Members in EPUT. 3. Sharing of good practice and collaboration in ICS Anti-Racism strategies and programs. • EPUT has encouraged our workforce to be part of Herts and West Essex Inclusive Career Development Program. • Reciprocal Mentoring provided by HWE ICS in collaboration with EPUT • De-Bias Toolkit developed in collaboration with HWE ICS and used as part of EPUT Interview process. 4. Inclusion Ambassador Program currently in development in EPUT, further work required to establish a formal cohort accessible for all interview panels above 8a. This is currently taking place with the Equality Advisor and Recruitment Team and expected to launch before October 31. 5. Ongoing link between recruitment team and EMREN stakeholders still in development. • New job description and person specification template to promote inclusive recruitment. • Value Based Questions asked of staff reflect the Trust Behavioural Framework • De-Bias Toolkit integrated into recruitment process to help mitigate bias and promote inclusive behaviours on interview panels. • **WRES Indicator 2:** Higher amount of BME Staff shortlisted in comparison to previous WRES • **WRES Indicator 2:** Lower amount of BME staff appointed from shortlisting. In comparison to previous WRES • **WRES Indicator 2:** Increase in Relative likelihood of white staff being appointed in comparison to previous WRES	**Indicator 1** Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce. **Indicator 2** Relative likelihood of white staff being appointed from shortlisting compared to BME staff. **Indicator 9** Percentage difference between the organisations' Board Executive membership and its overall workforce. **High Impact Action 2** Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

OBJECTIVE	2023 - 24 ACTION PLAN	PROGRESS AND WRES 2024 DATA	LINKED WRES INDICATOR(S) and HIA(S)
Embed the 'fair and just culture'. Develop staff toolkit for conversations about race / staff affected by racial discrimination. Provide cultural intelligence training to build awareness, to build a better understanding of diversity, bias, how to challenge discrimination and micro aggressions.	1. Role model a culture of listening and respect across the organisation. Seek opportunities to gather different people together and draw out diverse opinions. 2. Provide resources, tools and training to staff to enable an effective reporting process for bullying, harassment and abuse. 3. Employee Relation leads and HRBPs are aligned to their care groups to ensure a consistent approach to conflict, employee relation cases to reduce any bias. 4. Reduction of staff entering formal capability process in comparison to their white counterparts. 5. Ensure that cultural awareness training sessions are available for staff, to raise awareness and to provide resources to increase staff confidence when working in a diverse workforce.	1. Introduction of EPUT Behavioural Framework highlights Inclusive anti-racist stance of the Trust and the importance of this in Trust culture. Toolkit developed in collaboration with EPUT staff across the Trust. 2. Introduction of EPUT Pilot Program in July 2024 to introduce interventions designed to enable effective reporting, support and intervention for staff experiencing bullying, harassment or abuse. Currently taking place across five EPUT wards. • F2SU Lead regularly attends EMREN • Employee Experience Managers and HRBPs support EPUT staff in reporting bullying, harassment and abuse. • No Space for Abuse Campaign in EPUT promotes an anti-racist Trust with zero tolerance for discriminatory behaviour. 3. HRBP's and Employee Experience Managers currently aligned to EPUT Care Groups. Implementation of a 'fair and just culture' to ensure best practice in supporting staff experience. 4. **WRES Indicator 3:** 61% increase in staff entering formal disciplinary process (13 to 34) • Increase in relative likelihood in comparison to white staff. 5. MDP training now contains cultural awareness training as standard for EPUT managers, • Updated EDI Staff Induction and Toolkit cover the importance of Culture and Cultural Awareness in the workplace. • Active Bystander Approach to discriminatory behaviour in EPUT. Encouraging staff to challenge discrimination. • Additional learning tools and resources, videos and reading lists available to staff covering key concepts in race equality and allyship. • Cultural awareness resources being developed with EMREN and Faith and Spirituality Network for delivery in mid 2024. **Additional information:** • **WRES Indicator 5**: 1% increase in Staff Survey Score, Higher than National Average. • **WRES Indicator 6**: 4.2% Reduction in Staff Survey Score, Lower than National Average. • **WRES Indicator 8**: 1.2% Reduction in Staff Survey Score, Lower than National Average.	**Indicator 3** Relative likelihood of BME staff entering the formal disciplinary process compared to white staff. **Indicator 5** Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last twelve months. **Indicator 6** Percentage of BME staff experiencing harassment, bullying or abuse from staff in last twelve months. **Indicator 8** Percentage of BME staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months. **High Impact Action 6** Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

OBJECTIVE	2023 - 24 ACTION PLAN	PROGRESS AND WRES 2024 DATA	LINKED WRES INDICATOR(S) and HIA(S)
Embed a fair and inclusive recruitment and talent management process. Take positive action on recruitment and career progression ensuring that staff from BME communities are being nominated for career development.	1. Create a comprehensive on-boarding process, which is monitored utilising data captured from various sources including staff survey, cohort feedback and exit interviews. 2. Ensure effective appraisals provide developmental feedback regarding performance and progression. 3. Gather data on patterns of appraisal ratings and interview feedback collected against protective characteristics and other categories. 4. Managers to emphasise the importance of development opportunities such as experience in performing different roles, acting up, secondments, involvement in project teams and shadowing. 5. Enhance the exit interview process, ensuring data is collected on protected characteristics. 6. Develop and embed a mentoring "partnerships" for senior BME staff.	1. On-Boarding in place for international and domestic recruited BME staff. o EPUT International candidates receive a welcome pack, the content includes guidance relating to Visa UK employment requirements, accommodation, registrations for Banks, GP, Dentists and information relating to the Trust and locations. 2. Appraisal process includes PEN plan to identify high performers in the organisation for career progression and development. 3. Initial reporting on career progression and development submitted to PECC in October 2023 following WRES Action Plan. • August 2024 data: shows 15% of *"Very High Performers"* are BME staff. • August 2024 data: shows BME Staff make up 26% of all staff accessing non-mandatory training and CPD in the Trust. • August 2024 data: 45 BME graduates from our RISE Program, 166 in Management Development and 92 in Leadership Development. 4. EPUT managers are encouraged to discuss stretch goals, secondments and other opportunities as part of staff appraisals, as well as identifying what additional training or support would be beneficial to the employee's career development. These programmes are monitored and reported within the PEN. • The OD team are planning to do another BME career lounge in November 2024. • BME staff members encouraged to participate in the RISE program by OD Team and Trust messaging, the OD have delivered sessions on the RISE programme regarding development 5. Exit interview involves conversation with leaver to identify reasons for leaving, but at present this is conducted by managers and protected characteristic data is not available. Retention currently awaiting access to Laserfiche to interrogate data and themes. 6. EPUT takes part in HWE Reciprocal Mentoring program with support from the ICS, but at present, this program does not have mentoring partnerships. Mentoring and support is provided to RISE attendees as part of their professional development. **Additional information:** • **WRES Indicator 4**: Relative Likelihood of White Staff accessing NMD and CPD close to 1 (Parity) • 178% increase in BME staff accessing CPD and non-mandatory training from previous year (From 146 to 406) • **WRES Indicator 7**: 0.6% increase in Staff Survey Score, Higher than National Average.	**Indicator 4** Relative likelihood of white staff accessing non-mandatory training and career progression and development (CPD) in comparison to BME staff. **Indicator 7** Percentage of BME staff believing that the Trust provides equal opportunities for career progression or promotion. **High Impact Action 5** Implement a comprehensive induction, on boarding and development programme for internationally recruited staff.

WORKFORCE DISABILITY EQUALITY STANDARD ACTION PLAN

Summary of 2023 - 2024 Progress (WDES data in colour, taken from 2024 WDES Report)

OBJECTIVE	2023-24 ACTION PLAN	PROGRESS AND WDES DATA	LINKED WDES METRIC(S) and HIA(S)
Implement a plan to widen recruitment opportunities within local communities and to be measured in terms of social mobility, which include career pathways into the NHS such as apprenticeship programmes and graduate management training schemes. Increase visibility and awareness for colleagues with a long-term condition or disability.	1. Year-on-year improvement in disability representation leading to parity. 2. Year-on- year improvement in representation of senior leadership (Band 8C and above). 3. Increase declarations of disability by 10% within the organisation through increased communications and a targeted campaign 4. Working in partnership with the ICS to focus on equality and inclusive practices for those with disabilities and long-term conditions. 5. Developing Disability Inclusion Ambassadors to ensure that shortlists and panels are diverse and especially includes members who are representatives of groups currently under-represented at that level within an organisation. (Band 8a and above) 6. Provide a psychologically safe environment for staff to feel confident in identifying with a long term health condition or disability	1. **WDES Metric 1:** Increase of 1% to 7.56% of workforce (104 staff members) • Higher than national average benchmark (4.9%) • Overall increase from 404 to 518 staff members 2. Two additional staff members with disabilities and long-term conditions in Band 8c+ in comparison to previous year. **WDES Metric 10:** Smaller percentage different between EPUT Board voting membership and organisations overall workforce. More representation at senior levels. 3. EDI Portlet provided by ESR as well as regular messaging through staff EDI induction and Intranet, ESR target of additional 10% not reached, but improvements in WDES Metric 1 4. EPUT recognised as Disability Confident Leader, and this good practice has been shared with the ICS as well as examples of our Reasonable Adjustments passport and offer for adjustments when someone first joins the organisation. 5. Inclusion Ambassador Program currently in development in EPUT, further work required to establish a formal cohort accessible for all interview panels above 8a. This is currently taking place with the Equality Advisor and Recruitment Team. • **WDES Metric 2:** Improvement in relative likelihood of non-disabled staff being appointed from shortlisting in comparison to disabled staff. 6. EPUT is working in partnership with FSTU Guardian, D&MH Staff Network as well as Employee Experience Managers and HRBPS. Staff have multiple options to provide feedback when speaking up and seeking guidance for disability and long-term conditions. • Support also available via line managers (who are now trained to better support staff with disabilities and long-term conditions), EDI Hub and dedicated intranet resources for staff feeling pressured to come into work or with concerns about reasonable adjustments / access to work.	**Metric 1** Percentage of disabled staff in National NHS pay-bands compared with the percentage of staff in the overall workforce **Metric 2** Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts **Metric 10** Percentage difference between the organisation's Board voting membership and its organisation's overall workforce **High Impact Action 2** Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

OBJECTIVE	2023-24 ACTION PLAN	PROGRESS AND WDES DATA	LINKED WDES METRIC(S) and HIA(S)
Embed the 'fair and just culture'.	1. Role model a culture of listening and respect across the organisation. Seek opportunities to gather different people together and draw out diverse opinions. 2. Provide resources, tools and training to staff to enable an effective reporting process for bullying, harassment and abuse. 3. Employee relation leads are responsible for their care groups to ensure a consistent approach to employee relation cases and reduce any bias, build awareness for reasonable adjustments. 4. Reduction of staff entering formal capability process by 5% in comparison to their non-disabled counterparts. 5. Making disability training sessions available for all staff, to raise awareness and provide resources.	1. Implementation of a 'fair and just culture' to ensure best practice in supporting staff experience. • Staff Disability and Mental Health Network meeting on a Bi-Monthly basis to encourage staff to share feedback. • EDI function in contact with Freedom to Speak Up function to gather feedback and respond to staff concerns. • Introduction of EPUT Behavioural Framework highlights Inclusive stance of the Trust and the importance of this in Trust culture. • Toolkit developed in collaboration with EPUT staff across the Trust. • Improved Equality and Inclusion guidance for supporting staff with disabilities as part of CP24 Equality and Inclusion. 2. No Space for Abuse campaign in EPUT promotes active bystander approach to challenging discrimination; this is reflected in our management training and all staff induction. Additional resources available via EDI Training Hub. 3. Employee Experience Team works in conjunction with HRBP's to provide guidance and support. awareness building for reasonable adjustments, working in conjunction with Equality Advisor and accessing the D&MH Network for lived experience guidance. 4. **WDES Metric 3:** Relative likelihood ratio is at zero, with only two staff members with disabilities entering formal capability processes in comparison to zero staff members without disabilities. Lower than national average (2.17). • Figure below 5%, additional review of data collected by employee relations team in these instances required to ensure this is representative of the Trust. To be delivered in 2024-25 action plan. 5. MDP core training for EPUT Managers contains guidance on reasonable adjustments, and resources, tutorial videos and guidance available for managers and employees completing a reasonable adjustments passport. Also part of Trust mandatory induction to raise awareness and increase staff confidence. **WDES Metric 4a:** Significant improvements in reports of bullying, harassment and abuse against staff with disabilities from: • Patients/service users, their relatives or other members of the public (reduction from previous year, lower than national average benchmark) • Managers (reduction from previous year) • Other colleagues (reduction from previous year) **WDES Metric 4b:** Increase in reports of staff raising incidents of bullying, harassment and abuse: • Significant improvements for both disabled and non-disabled staff.	**Metric 3** Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. **Metric 4** a) Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: I. Patients/Service users, their relatives or other members of the public ii. Managers iii. Other colleagues b) Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. **High impact action 6:** Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

OBJECTIVE	2023-24 ACTION PLAN	PROGRESS AND WDES DATA	LINKED WDES METRIC(S) and HIA(S)
Take positive action on recruitment, career progression and staff recognition, ensuring staff are aware of opportunities available.	1. Provide managers with support for having effective appraisals and providing developmental feedback from performance and interviews. 2. Gather data on patterns of appraisal rating and interview feedback. 3. Implementing a comprehensive data and evaluation process, to develop a talent management programme 4. Managers to emphasise the importance of development opportunities such as experience in performing different roles, acting up, secondments, involvement in project teams and shadowing. 5. Improve exit interview process, revise questionnaire and collate data on protected characteristics.	1. MDP core training for EPUT Managers contains guidance on reasonable adjustments, and resources, tutorial videos and guidance available for managers and employees completing a reasonable adjustments passport. Also part of Trust mandatory induction to raise awareness and increase staff confidence requesting adjustments. 2. Data collected by Organisational Development Team, managers and employees encouraged to share feedback of experiences when applying for reasonable adjustments to share examples of good / bad practice. 3. Organisational Development team provides tools for appraisals of staff to identify "High Performers" and reports on this cohort. High Performers as part of EPUT's "PEN Plan" are then encouraged to undertake stretch goals, secondments or other career development opportunities. 4. All candidates as part of their appraisal are offered the chance to discuss progression and development in their careers, as well as non-mandatory training opportunities provided in and outside of the Trust (for example, the management development program or Edward Jenner courses). During this appraisal, staff are also able to request a review of their reasonable adjustments passport as part of the appraisal process. 5. Exit interview involves conversation with leaver to identify reasons for leaving, but at present this is conducted by managers and protected characteristic data is not available. Retention currently awaiting access to Laserfiche to interrogate data and themes. **WDES Metric 5:** Improvement in percentage of disabled staff believing that the Trust provides equal opportunities for career progression or promotion. • Increase of 4.5% (higher than national average benchmark). **WDES Metric 7:** Improvement in percentage of disabled staff saying that they are satisfied with the extent to which their organisation values their work. • Increase of 4.9% (higher than national average benchmark). **WDES Metric 10:** Significant improvement between EPUT's board voting membership and overall workforce, improved representation (6.7 / 7.6%)	**Metric 5** Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion. **Metric 7** Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. **Metric 10** Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board. **High impact action 2** Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

OBJECTIVE	2023-24 ACTION PLAN	PROGRESS AND WDES DATA	LINKED WDES METRIC(S) and HIA(S)
Embed a psychological safe environment for staff to express themselves without fear of negative consequences.	1. Employee Relations team, Disability and Mental Health Network to monitor reported incidences when staff felt pressured to come into work. 2. The Trust will monitor staff requests for reasonable adjustments and ensure they are implemented effectively. 3. Embed a Health and Wellbeing team to hold awareness and drop in sessions, which offer staff support and resources.	1. Whilst summaries of incidents are not provided to the Disability and Mental Health Network by the Employee Relations Team, lived experience is collected via feedback from attendees sharing their own lived experiences. This feedback is also shared with the Employee Relations Team. **WDES Metric 6:** Reduction in percentage of disabled saying that they have felt pressure from their manager to come to work. • Lower than national average benchmark 2. A request was raised by the D&MH Network for the consideration of a centralised reasonable adjustments budget, function and facilitator in the Trust to ensure consistency and to provide guidance to teams. • Whilst this was not achievable during this period, we as a Trust can provide guidance to teams to promote best practice in requesting and granting reasonable adjustments. • At present, the employee's supervisor supports the implementation of reasonable adjustments and Access to Work requests, but this data is not shared with the employee relations team or D&MH Network **WDES Metric 8:** Increase in percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. • 2.5% increase from previous year • Higher than national average benchmark 3. A member of The Employee Experience Team acting as EPUT's Wellbeing lead attended the EPUT Disability and Mental Health Network sessions throughout this period to gain feedback, and helped to develop a linked Neurodiversity group as part of this work. The Employee Experience Team, as well as supporting health and wellbeing within our workforce have provided this function. **WDES Metric 9:** Improvement in Staff Engagement score for disabled staff in comparison to previous year. • Similar to Staff Engagement score for non-disabled staff (6.9 dis, 7.3 non-dis). • Both higher than national average benchmark	**Metric 6** Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. **Metric 8** Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. **Metric 9** The staff engagement score for disabled staff, compared to non-disabled staff. **High impact action 4:** Develop and implement an improvement plan to address health inequalities within the workforce.

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 BOARD ASSURANCE FRAMEWORK

Decision Item | PS | 10

REFERENCES

Only PDFs are attached

Board Assurance Framework Report.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report

2 Note the reduction in risk scores for CRR96 – Loggists

3 Request any further information or action

Summary of Key Issues

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

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

The Board is asked to note:

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

  Note there are a number of risks being reassessed following significant actions being achieved and following Executive review these will be reported through the Board assurance committees for oversight.

  SR2 People – has been removed from the reporting period and following approval by the Executive and socialisation with the People Equality and Culture Committee the three new risks will be included in the report going forward. These being SR10 – Organisational Development; SR11 – Staff Retention; and SR12 Workforce Sustainability.

- Section 2 – Risks that have changed in risk score

  CRR96 Loggists - Trained loggists continue to increase (21 in place which is assessed to meet the threshold for delivery of a 24/7 response following declaration of an incident. The trained loggists within the Corporate Governance Team are available to cover out of hours if required). The action is now closed and risk assessment reviewed for closure. We will continue a programme of Loggist training as both a refresher and to continue to bolster our numbers. The risk is now considered to have been diminished and will be monitored as BAU through the EPRR programme

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

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

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

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

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

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

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

Supporting Reports/ Appendices /or further reading

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

Lead

Denver Greenhalgh
Senior Director of Corporate Governance

NHS
Essex Partnership University
NHS Foundation Trust

Board Assurance Framework

2 October 2024

Denver Greenhalgh
Senior Director of Corporate Governance

EPUT

Risk Dashboard

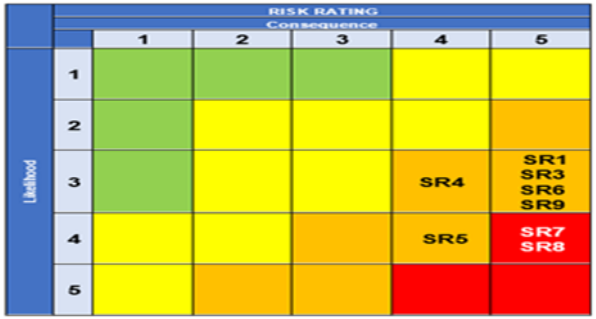
August 2024

EPUT

Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
8	Pending 3	0	1-SR2

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



% Risks with Controls Identified	% Risks with Assurance Identified	Actions Overdue	Risk Reviewed by Risk Owner
100%	100%	4	8

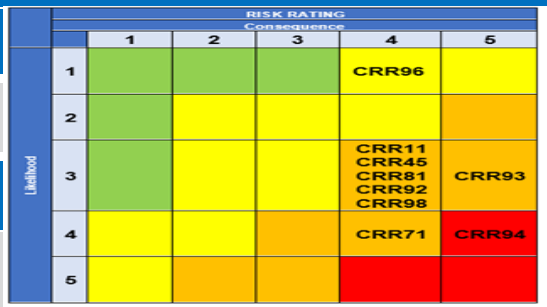
ID	SO	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
SR2	2	People	MR		Closed	Closed	National challenge for recruitment and retention	Risk is in process of being replaced by 3 new risks. These are to be reviewed by the Executive Team and then presented at the People Equality and Culture Committee (30 October '24). R10 - Organisational Development R11 - Staff Retention R12 - Workforce Sustainability These will feature in the next BAF report to the Board in December '24.
SR5	1	Lampard Inquiry	NL	Regulatory Reputation	5x4=20	16 16 16	Government led public inquiry in to Mental Health services in Essex	Governance has been established to oversee the Trust response (Lampard Oversight Committee chaired by NED. 6 actions have been achieved in the reporting period with the agreement with HPFT now in place for the support of families. Protocols in place to support staff (current and former). Engagement meetings have been and continue to held with staff groups across the Trust. The first phase of the Lampard Inquiry is due to sit in September '24. Review of risk score in progress as a consequence of actions being achieved and confidence in ability to respond to Rule 9 Activity .
SR7	All	Capital	TS	Safety, Experience, Regulatory, Service Delivery, Reputation	5x4=20	20 20 20	Need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	Continuing to horizon scan to maximise opportunities both regional and national to source capital investment. Electronic Patient Record Full Business Case approved by Board and approved by NHSE.
SR8	All	Use of Resources	TS	Safety, Compliance, Service Delivery, Experience, Reputation	5x4=20	20 20 20	The need to effectively and efficiently manage its use of resources in order to meet its financial control total targets and its statutory financial duty	Continue to focus on financial management and efficiency at AF meetings. New actions (7-11) to address recommendations from the Investigate and Intervention Programme activity.
SR4	All	Demand and Capacity	AG	Safety, Experience, Regulatory, Service Delivery, Reputation	5x4=20	15 15 15	Long-term plan. White Paper. Transformation and innovation. National increase in demand. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	The New Operating Model has been approved by the Board and implementation of the plan will begin in September' 24. This will be achieved in a phased approach to ensure embedding (including training programmes) by the end of March '25.
SR1	1	Safety	AS	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	Rising demand for services; Government MH Recovery Action Plan; Covid-19; Challenges in CAMHS & complexities; Systemic workforce issues in the NHS	Quality of Care Strategy and associated governance are now in place. Delivery of the Patient Safety Incident Response Plan 2023-25 and the Safety Improvement Plans continues. Further work added to this action to enhance some aspects of Datix system to improved reporting functionality of the incident management module within the care units. We have established the process and care units are making good progress in reviewing incidents on Datix. Ongoing until Jan 25 with touch point reviews. Note RAG rated amber as action extended. This risk is being re-assessed following the transition to the Quality of Care Strategy and associated governance.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
SR3	All	Infrastructure	TS	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	Capacity and adaptability of support service infrastructure including Estates & Facilities, Finance, Procurement & Business Development/ Contracting to support frontline services.	Draft Estates Strategy socialised via Finance & Performance Committee September 2024. Strategy to be presented to Board meeting for approval October 24. Trust have evaluated and submitted the ERIC return for 2023-24 in August 2024. Data to be published in December 2024 Premises Assurance Model data to be submitted September 2024.
SR6	All	Cyber Attack	ZT	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	All of the high-risk security remediation activities identified by the penetration test within EPUTs control have been completed. There are outstanding medium and low risk actions identified by the pen test that are tracked on the local cyber risk/action log and are progress reported as part of the routine cyber assurance report to F&P. All actions to mitigate the risk to its target score of 12 have been completed. A reassessment is being undertaken to assess if target score has been met.
SR9	1	Digital and Data Strategy	ZT	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	The risk of not being a digitally and data enabled. Resulting in poor and/or limited implementation of systems and technologies, with reduced quality and safety of care and lack of data intelligence to inform change / transformation.	The Digital transformation plan is undergoing further review to ensure it reflects the Trust efficency targets and prioritises areas of greatest need for lifetime of the strategy. Target operating model approved May '24 with implementation commencing July '24 and will be fully implemented by the end of the 2024/25 year. Action timeline amended to align with the programme of work. New service desk management system is progressing.

Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
7	0	0	1 - CRR96

Risk Score Increase	Risk Score Decrease	Risk Score No Change	On Risk Register >12 months
0	0	7	7



% Risks with Controls Identified	% Risks with Assurance Identified	Extended Actions	Risk Reviewed by Risk Owner
100%	100%	5	100%

ID	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR94	Engagement & Supportive Observation	AS	Safety Regulatory	5x4=20	20 20 20	CQC found observation learning not embedded	Safewards interventions seek to reduce rates of behaviours that threaten patient safety or the safety of others (violence, suicide, self-harm, absconding etc.) and seeks to minimise harmful outcomes (e.g. PRN medication, special observations, seclusion, etc.) Baseline planned to be complete over next quarter of safe wards implementation. Learning events are scheduled in diaries with all inpatients teams to review safewards implementation and will support skills and knowledge of Safe Wards interventions (linking with international lead for safewards who has agreed to support our continued implementation). Programme of work being tracked via Reducing Restrictive Practice Group and reporting to the Safety of Care Group (chaired by the Executive Chief Nurse). Risk assessment re-visited given the majority of actions now complete and assessing the evidence to support a reduction based on likelihood reducing.
CRR98	Pharmacy Resource	FB	Safety	4x4=16	12 12 12	Continuous state of business continuity plan	Recruitment campaign remains ongoing and continuing to see recruitment with clear pipeline running throughout 2024. 24.3 current vacancies (including the 9 WTE Time to Care provision) To note due to our successes over the past two years and the demand for pharmacists and technicians being high we have experienced leavers to promotions or posts closer to home for the individuals. Hence the recruitment campaign will continue on an ongoing basis.
CRR11	Suicide Prevention	MK	Safety	4x3=12	12 12 12	Implementation of suicide prevention strategy	STORM (Effective self-harm and suicide prevention) now in place. Next steps following approval of theSuicide Prevention Framework is to work with our Lived Experience Ambassadors and our communities to take forward actions. Oversight of this programme of work is through the new Effectiveness of Care Group chaired by the Executive Medical Director.
CRR45	Mandatory Training	MR	Safety Regulatory	4x3=12	12 12 12	Training frequencies extended over Covid-19 pandemic leaving need for recovery	Transition complete back to annual update, current TASI compliance is 91% Progress with new starters to complete suite of mandatory training, including additional training added, compulsory booking and communications strategy. All bank staff compulsory booked to attend by the end of May '24. Any 'did not attends' will be picked up in arranged training prior to target date of Sept '24. 1071 (59%) trained for TASI (Bank)
CRR77	Medical Devices	AS	Safety Financial Service Delivery	4x4=16	16 16 16	Number of missing medical devices compared to Trust inventory	Medical Devices Training Policy and Medical Devices Policy have been reviewed and are now operational across the clinical services. Continure to explore working in partnership with MSEFT for the provision for quality assurance programme. In process of procuring new devices to support the programme. Delay in obtaining costings from MSEFT - now expected October '24 (extended timelines as a consequence). Tender for medical devices management contract is complete - now progressing through contract award through F&P Committee and Board.
CRR81	Ligature	AG/TS	Safety Regulatory Reputation	5x3=15	12 12 12	Patient safety incidents	Ligature policy including new environmental standards and inspection SOP has been updated with new process and following consultation has been approved.New audit tool development and in use. New capture to distnguish actions which are maintenance requirements has been put in place. Roll out of new training programme commenced in May 2024 (face to face sessions) Additional training dates being added to continue delivery through to March'25 (action timeline extended to close at point when majoirty if staff have been trained. Drills established in all inpatient areas from Sept'24 OLM provision review being finalised to launch Sept'24

ID	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR92	Addressing Inequalities	MR	Experience	4x3=12	12 12 12	Staff Experience	Designing a OD and Engagement Strategy whch will include an 'always-on' approach to continue to embed the sexual safety charter across the Trust and adopt a zero tolerance approach to unwanted and poor behaviours from staff. A pilot on 5 inpatient wards focussed on reducing racial abuse and violence from our patients to staff. Evalution and learning from the pilot will form part of a the culture strategy to roll out to the rest of the Trust. (January '25)
CRR93	Continuous Learning	FB	Safety Regulatory	5x315	15 15 15	HSE and CQC findings highlighting learning not fully embedded across all Trust services	All actions are complete and the risk reviewed has been completed and the Director of Safety is due to meet with Executive Leads for Quality of Care to confirm the Trust direction.
CRR96	Loggists	NL	Regulatory	4x1=4	Closed	Major incident management	Trained loggists continue to increased (21 in place which is assessed to meet the threshold for delivery of a 24/7 response following declaration of an incident. The trained loggists within the Corporate Governance Team are available to cover out of hours if required). The action is now closed and risk assessment being reviewed for closure. We will continue a programme of Loggist training as both a refresher and to continue to bolster our numbers. Assessed the impact of the new loggists on the risk score and confirmed 24/7 access to loggist should this be needed - risk is now considered to have been diminished and will be monitored as BAU through the EPRR porgramme

Strategic Risk Register

August 2024

EPUT

SR1- Safety (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L3 =15*	*C5 x L2 = 10*	**Note:** Action 5 previously removed as integral part of action 1**.** Previous reported completed actions 2,3,4 and 6 and have been removed from the report. This risk is being re-assessed following the transition to the Quality of Care Strategy and associated governance.

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

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

	Actions (to modify risks)	By When	By Who	Gap	Update
1	Deliver the Patient Safety Incident Response Plan	Mar '25	MA	Control	The Patient Safety Incident Response Plan (PSIRP) 2023-25 has been approved and is live on EPUT website. The undertaking of thematic analysis of the key areas to inform Safety Improvement Plans is in progress. With a Safety Improvement Plan Oversight Group has been established and reporting monthly into the Safety of Care Group chaired by the Executive Nurse to oversee their development and programmes of work.
7	Ensure good governance controls for monitoring to progress towards action closures and achievement of additional controls	Extended Jan '25	NJ	Assurance	PSIRF Oversight Groups established. Further work added to this action to enhance some aspects of Datix system to improved reporting functionality of the incident management module within the care units. We have established the process and care units are making good progress in reviewing incidents on Datix. Ongoing until Jan 25 with touch point reviews. Note RAG rated amber as action extended.

SR3- Finance and Resources Infrastructure (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x L3 = 15	*C5 x L3 =15*	*C5 x L2 = 10*	**Note:** Previous reported completed actions 1, 3, 4 and have been removed from the report. **Note:** Re-assessment of risk on completion of Estates Strategy. **Note:** New actions 5 and 6 associated with assurance through ERIC and Premises Assurance Model assessments.

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

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

	Actions (to modify risks)	By When	By Who	Gap	Update
2	Develop Estates Strategy & Development Plan (as informed by the 6-facet survey)	Extended November 24	MM	Roadmap	Phase 1 - current status complete. Internal delivery and steering groups in place. External support in place. Draft socialised via Finance & Performance Committee September 2024. Strategy to be presented to Board meeting for approval October 24, extended action to November 24. RAG rated green as extension agreed by Board of Directors.
5	Review ERIC data submission against Peer groups and determine efficiencies	Jan-25	MM	Control	Trust have evaluated and submitted the ERIC return for 2023-24 in August 2024. Data to be published in December 2024
6	Develop action plan for Premises Assurance Model (PAM) outstanding tasks	Dec-24	MM	Control	PAM data to be submitted September 2024.

SR4- Demand and Capacity (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previous reported completed actions 1, 2, 3, 4, 4.1,4.2, 4.3, 4.4, 4.5, 4.8 and 5 have been removed from the report.
C5x 4L = 20	*C5 x L3 =15*	*C5 x L3 = 15*	

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

Actions (to modify risks)		By When	By Who	Gap	Update
4.6	Reducing variations across wards	Complete	LW	Control	The New Operating Model has been approved by the Board and implementation of the plan will begin in September' 24. This will be achieved in a phased approach to ensure embedding (including training programmes) by the end of March '25. (see new action below)
6	New Action: Demand and Capacity module to be procured and fully implement	Oct '24	JL	Control	Demand and capacity module is complete and in proof of concept phase Procurement underway to licence product for use in “live” Next steps following procurement will be to bring into live
7	Conclude new risk share arrangement for Out of Area bed capacity with ICB leads.	Oct '24	AG	Control	Discussions are ongoing with ICB colleagues to review and renew the risk share arrangements across our three systems.
8	**New Action:** Implementation of new operating model	Mar-25	SB	Control	New action to implement the new Operational Model for Inpatient Services.

SR5 - Lampard Inquiry (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C4 x L4 =16*	*C4 x L3= 12*	**Note:** Previous reported complete actions 1, 2 and 4 have been removed from the Board report. **Note**: Review of risk score in progress as a consequence of actions being achieved and confidence in ability to respond to Rule 9 Activity .

Executive Responsible Office: Executive Director Major Projects Board Committee: Audit Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Project Team Support from external consultants with experience of inquires.	Establishment Expanded to meet increased ask	EOC and Board oversight	
Internal methodology for working with inquiry	In place	In place and used for reporting Project Group Oversight	As above
Inquiry Terms of Reference MOU and Information Sharing Protocol	In draft		
Learning Log	Log in place	Reporting ET / Audit Committee and Auditors	
Exchange portal in place to safely transfer information to the inquiry	Data protection impact assessment	Reporting in place	
Learning from Deep Dives	Deep dive into sample of deaths in scope over 20 year period Deep dive in 13 prevention of future death notices		
Audit on Learning from Independent Inquiry		Assurance checks completed and presented to ET - approved ongoing assurance through Care Unit Accountability Frameworks	IA - opinion moderate for design and effectiveness
Inquiry Team (Resource with skills and capacity to meet the needs of EPUT response to the Inquiry).	Executive SRO (Nigel Leonard) Project Director Browne Jacobson Essex Chambers	Trust Board of Directors	Internal audit
Financial Resource (To meet the needs of the EPUT response to the Inquiry)	Financial Allocation, budget held by Project Director	Finance reports, approved by Finance and Performance Committee, Audit Committee and Board	External audit of provision for the Inquiry.
Inquiry Response Governance	Inquiry Team Chaired by SRO Inquiry Project Team Multi-Disciplinary Working Group Project Plan Schedule of work agreed with Legal Advisors / Counsel	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal audit.

Learning Log (this is learning noted by the Project Team during searches not in relation to themes from specific incidents. Historic learning of past events within the Inquiry is led by the Quality Committee)	Inquiry Project Team Multi-Disciplinary Working Group	Executive Operational Sub Committee	Internal audit.
Support for staff	Resources from GW. Project Working Group	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal audit.
Support for families	Report from HPT to Project Working Group	Lampard Inquiry Oversight Committee (Board Committee) Trust Board of Directors	Internal audit.
Communications Plan	Multi-disciplinary Project Working Group Multi-disciplinary Communications Group	Lampard Inquiry Oversight Committee, BOD	Internal audit.

Actions (to modify risks)		By When	By Who	Gap	Update
3	EPUT should assure itself that its information processes and systems are fit for purpose, and controls around data input and records management to be reviewed across the Trust to minimise risks associated with information recording and management going forward.	Complete	GB	Control / Assurance	Update: Forms part of the Records Management Accreditation process which was achieved in June 2023 for Mobius. SystmOne, EMIS, Theseus, IAPTUS and Excelicare all are all working in line with the required standards. Extra resources are being secured to ensure Paris meets the standards. Records management for the areas identified is part of the Care Units Accountability Frameworks. Transfer of historic records to Restore completed and cataloguing of records being finalise
5	New Action: Track the use of historical learning themes through the Quality Senate and the outcomes.	Mar '25	AW	Assurance	Quality Senate is due to operational from April '24 in line with the launch of the Quality of Care Strategy.
6	New Action: Management Development Programme module in place	Complete	GW	None	First session taking place on 25 April 2025. Completed.
7	New Action: Support re-secured for families	Complete	GB	Contract not in place	Agreement with HPFT in place and contract signed.
8	New Action: Protocols in place for support for current and former staff	Complete	GW	Ensuring compliance with GDPR	Protocols in place. DPIA approved and signed off.
9	New Action: Schedule meetings for Care Units and Wards in place	Complete	GW	None	Schedule in place and attending Care Unit meetings and completing staff engagement visits.
10	New Action: Completion of the initial work schedule agreed with legal team and Counsel	Complete	GW/GB	None	Initial work schedule completed.

11	New Action: Review Data A -Extraction of data from incidents resulting in SI/PSIRF investigations. B - Review of board and committee papers from 2000 to 2023. C - Cataloguing of information and running patient searches D - Learning themes from SI/PSIRF reports, including PFDs, to establish what action has been taken and what may be outstanding E - Review of thematic reviews F - Completion of Rule9(1) request	Sept '24 Ongoing for Rule 9 Requests	GW/GB	A – None. B- Gaps in Board papers identified. Committee papers being looked at. C - None D - Some reports cannot be located for the period. E - Some reports cannot be located for the period. F- Further extension to 11 July	B-E Working progressing in all areas. F - This is a final date and if missed the Trust may face a S21 notice. Mitigated by increasing the number of staff trained and available to roster to over 90.
12	New Action: Info system procured and in place	Nov-24	GB/AW	Awaiting decision from the Lampard Inquiry on the system to be used for disclosure	Procurement discussions underway. Budget identified. DPIA being completed

SR6- Cyber Security (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L3 =15*	*C4 x L3= 12*	**Note:** Previous reported completed actions 1, 2, 3 and 4 have been removed from the report. **Note:** All actions to mitigate the risk to its target score of 12 have been completed. A reassessment is being undertaken to assess if target score has been met.

Executive Responsible Office: Executive Director Strategy Transformation and Digital Board Committee: F&P Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place	Substantive post holder (Aug '23)	IGSSC	NHS Digital Data Security Protection Toolkit (DSPT) Cyber Essentials Accreditation
Range of policies and frameworks in place	Virtual and site audits Compliance with mandatory training – Cyber Assurance Framework	IGSSC; BDO internal audit May 22 – overall Moderate Confidence level Medium	As above MSE ICS IG & Cyber Levelling Up Project (annual) BDO Audit actions completed
Investment in prioritisation of projects to ensure support for operating systems and licenses	Prioritisation of digital capital allocation	CPPG – with priority decisions made at DSG	
IG & Cyber risk log	Risk working group reporting into IGSSC – owing and tracking actions from audits and assessments	IGSSC and Digital Strategy Group	DSPT Internal Audit June 2024 provide Substantial assurance opinion.
Business Continuity Plans and National Cyber Team processes	Business Continuity and Disaster Plan in place	Successfully managed Cyber incident	Annual Testing as part of DSPT NHS Digital Data Security Centre, Penetration Testing, Cyber Essentials+
CareCert notifications from NHS Digital	Monitored and acted upon within 24 hours of their announcement	Reported to IGSSC	NHS Digital
Cyber Essentials Accreditation	Certification achieved	Monitor controls through IGSSC	Accreditation certified
MSE ICS DSPT & Cyber Maturity Baseline	Completed	Audit Committee	DSPT Internal Audit June 2024 provide Substantial assurance opinion.

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
5	Systems that are running unsupported software identified by the latest penetration test and internal cyber audit require upgrade or replacement.	Complete	AW	Control	All of the high-risk security remediation activities identified by the penetration test within EPUTs control have been completed. There are outstanding medium and low risk actions identified by the pen test that are tracked on the local cyber risk/action log and are progress reported as part of the routine cyber assurance report to F&P.

SR7- Capital (At a Glance)

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

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

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

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

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: F&P	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team in place	Decision making group in place and making recommendations to ET, FPC and BOD	
Purchasing / tendering policies	Policy Register		Internal Audit
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2023/24	Capital Project Group forecasting	Capital Resource reporting to Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£0.4m resources secured 2024/25 YTD	Capital Resource reporting to Finance & Performance Committee	
ICS representation re: financial allocations and MH/Community Services	EPR convergence business case developed with additional capital resources identified	ECFO or Deputy Attendance at ICS Meetings; CEO or Deputy membership of ICB;	
Prioritised capital plan to maximise the use of available capital resources	Capital Plan 2024/25 in place		
EPR Programme	Progress published June 23 outlining programme structure and governance principles and timelines	EPR Joint Oversight Committee EPR Programme Board Convergence and Delivery Board EPR FBC approved by Board	FBC approved NHSE

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
1	Horizon scan to maximize opportunities both regional and national to source capital investment	Ongoing	JD	Control	Currently over committed the programme which is planned to be covered by system resources. We have been successful to date in securing an additional 0.4 million pounds following mental health applications.
3	Track key strategic investments i.e. EPR to be monitored for impact on Capital Programme	Mar '25	JD	Control	Electronic Patient Record Full Business Case approved by Board and approved by NHSE.

SR8- Use of Resources (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previous reported completed action 1,3,4, and 5 has been removed from the report.
C5x 4L = 20	*C5 x L4 =20*	*C5 x L3 =15*	

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: F&P	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team Establishment	Use of Resources Assessment	Use of Resources NHSE Assessment
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place Scheme of Delegation in place Accountability Framework in place	Financial Management KPIs Audit Committee F&PC Accountability Framework	IA Key Financial Systems – Budget Management (Sep '22) Substantial opinion and Costing (March 2023). Reasonable opinion Core Financial Assurance (excluding payroll)(2023/24)
Estates & Digital Team (Response to new resource bids)	Team in place		
Deliver efficiency savings and targets 23/24		Finance Report	
Finance reporting	Finance Reports AF Reports	EA of Accounts	NOF3 Rating
Budget setting	To complete mid year financial review. Key risk and opportunities assessments performed	Accountability framework reporting; Finance reporting to F&PC; National HFMA Checklist Audit	Annual VFM through external auditors identified no significant weaknesses
Operational Plan 2024/25			
Forecast Outturn and risk/ opportunities assessments 24/25			

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
2	Deliver Financial Efficiency Target	31 Mar '25	TS	Control	Action rolled forward for 2024/25. £28.6m (5.2%) by 31 March 2025 - schemes identified but with high risk of full delivery. Deficit is £9.4m to date. £3.1m off track . The investigation report from PWC identifies gaps in the efficiency programme of all organisations.
6	New Action - Deliver Financial plan for 24/25	Mar '25	TS	Control	Continued enhanced controls, efficiency and productivity improvement and transformation/restructure activities.
7	Investigate & Intervention Programme Activity: Rostering and scheduling with Total Mobile and Health Trust Europe.	Mar '25	AM	Control	New actions as part of the Investigate & Intervention Programme.
8	Investigate & Intervention Programme Activity: Estates commercials review i.e. leases, PFI, PropCo and Valuation options.	Mar '25	TS	Control	New actions as part of the Investigate & Intervention Programme.
9	Investigate & Intervention Programme Activity: Out of Area Placements (scope provided to PwC and Regional Colleagues)	Mar '25	AG	Control	New actions as part of the Investigate & Intervention Programme. At the end of August '24 there were 56 patients in an out of area bed, which is a third consecutive month of increase from a position of 37 in May '24. Work to reduce and eliminate the need for people to be placed outside of Essex is ongoing.

10	Investigate & Intervention Programme Activity: VAT advice relating to a single contract (details provided to PwC)	Mar '25	TS	Control	New actions as part of the Investigate & Intervention Programme.
11	Investigate & Intervention Programme Activity: Property Top-Up Insurance (details provided to PwC).	Mar '25	DG	Control	New actions as part of the Investigate & Intervention Programme.

SR9- Digital and Data Strategy (At a Glance)

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

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

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previously reported complete action 2,3, 6,7 and 8 have been removed from the report.
C5x 3L = 15	*C5 x L3 =15*	*C5 x L2 =10*	

Executive Responsible Office: Executive Director of Strategy, Transformation and Digital
Board Committee: F&P

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

	Actions (to modify risks)	By When	By Who	Gap	Update
1	Digital Transformation programme Plan	Extension Sept '24	JL	Road Map	The Digital transformation plan is undergoing further review to ensure it reflects the Trust efficiency targets and prioritises areas of greatest need for lifetime of the strategy.
4	Digital target operating model implementation	Mar '25	AW	Control	Target operating model approved May '24 with implementation commencing July '24 and will be fully implemented by the end of the 2024/25 year. Action timeline amended to align with the programme of work.

SR9 (Continued)

Actions (to modify risks)		By When	By Who	Gap	Update
9	Implementation of the new service desk management system.	Extended Nov '24	AW	Control	Capital bid approved at CPPG, procurement complete, development of the system for EPUT's needs underway, delay in timescales to agree design and configuration with revised launch timescale of beginning of Nov '24.

Corporate Risk Register August 2024

EPUT

CRR94 - Observation and Engagement

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L4 = 20*	*C5 x L2= 10*	**Note 1**: Previous reported completed actions 1-11 have been removed from the report. **Note 2**: Risk assessment re-visited given the majority of actions now complete and assessing the evidence to support a reduction based on likelihood reducing.

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

Controls Assurance

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

	Actions (to modify risks)	By When	By Who	Gap	Update
12	Thematic review into incidents across all units	Complete	LJ	Assurance	Review completed and linked to work programme of the Reducing Restrictive Practice Group and the Ligature Risk Reduction Group,
13	Monitor Safe Wards Interventions	Extended Dec '24	LJ	Assurance	Baseline planned to be complete over next quarter of safe wards implementation. Learning events are scheduled in diaries with all inpatients teams to review safewards implementation and will support skills and knowledge of Safe Wards interventions (linking with international lead for safewards who has agreed to support our continued implementation). Programme of work being tracked via Reducing Restrictive Practice Group and reporting to the Safety of Care Group (chaired by the Executive Chief Nurse).

CRR11 - Suicide Prevention

Risk Description: If EPUT fails to implement and embed its Suicide Prevention Strategy into Trust services, then it may not track and monitor progress against the ten key parameters for safer mental health services resulting in not taking the correct action to minimise unexpected deaths and an increase in numbers.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4x 4L = 16	*C4 x L3 = 12*	*C4 x L2= 8*	**Note:** CRR34 Suicide Prevention Training has been amalgamated into this risk as part of delivery of overall Suicide Prevention Framework, with CRR34 being closed on the risk register (this action was closed at the August Board meeting and has been removed from the report. **Note:** Previous reported completed actions 1, 2, 3 and 4 have removed from the report for CRR11.

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

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
5	Review approach to ligature risk management training (through the introduction of effective self-harm and suicide prevention training).	Complete	GW	Control	STORM (Effective self-harm and suicide prevention) now in place.
6	Implementation of the Suicide Prevention Framework (as aligned to the Quality of Care Strategy	Dec '26	GW	Control	Next steps following approval of the framework (action 1) is to work with our Lived Experience Ambassadors and our communities to take forward actions. Oversight of this programme of work is through the new Effectiveness of Care Group chaired by the Executive Medical Director.

CRR45: Mandatory Training

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previously reported completed actions 1, 2 and 3 have been removed from the report.
C4 x L4= 16	*C4 x L3 = 12*	*C4 x L2 = 8*	

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

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
4	New Action: Monitor transition of TASI training back to yearly update arrangements and that all new starters have successfully completed the full suite of mandatory training.	Mar '25	PT	Assurance	Monitoring through Accountability Framework meetings. Transition complete back to annual update, current TASI compliance is 91% Progress with new starters to complete suite of mandatory training, including additional training added, compulsory booking and communications strategy.
5	Provide TASI training to bank who have joined EPUT temporary workforce.	Sept '24	PT	Control	All bank staff compulsory booked to attend by the end of May '24. Any 'did not attends' will be picked up in arranged training prior to target date of Sept '24. 1071 (59%) trained for TASI (Bank)

CRR71: Medical Devices

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4 = 16	*C4 x L4 = 16*	*C4 x L2 = 8*	**Note:** Previous reported completed actions 1,2, and 6-8 have been removed from the report. **Note:** A reassessment of the risk is underway to assess the impact of the improved asset register function and service records with potential to reduce the risk score.

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

Controls Assurance

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

	Actions (to modify risks)	By When	By Who	Gap	Update
1a	Implement the solutions from the outcomes of the deep dive	Extended See timelines below	NA	Control	Management actions concluding. Remaining action associated with actions detailed below.
4	Medical Device Management training ensuring staff know that they have a responsibility to ensure pieces of kit are calibrated	Complete	NA	Control	Responsibilities of staff groups on training will be stated in new Medical Devices Training Policy (CLP88) approved and now operational.
5	Introduce point of care testing quality assurance process to avoid use of equipment that is not calibrated or serviced	Extended Dec '24	NA	Control	Exploring working in partnership with MSEFT for the provision for quality assurance programme. In process of procuring new devices to support the programme. Delay in obtaining costings from MSEFT - now expected October '24 (extended timelines as a consequence).
9	Tender contract for medical devices programme.	Sept '24	NA	Control	Tender for contract complete - now progressing through contract award through F&P Committee and Board.
10	To enhance the Medical Devices Policy with detail of risk assessment for equipment marked as 'end of life' to support continued use in a clinical area.	Complete	AB	Control	CLP17 Medical Devices Policy has been reviewed and approved and now operational.

Actions (to modify risks)		By When	By Who	Gap	Update
11	To deliver management actions from the IA of medical devices management at ward / service level (2023/24)	Jan '25	NA	Control	Management actions being progressed and on track.

CRR81: Ligature

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

Initial Risk Score C4 x L4 = 16	*Current Risk Score* C4 x L3 = 12	*Target Score* C4 x L2 = 8	**Note:** Previous reported completed actions 1 - 6 have been removed from the report.

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

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
7	Implement new environmental standards with new way of recording maintenance breaches only on 3i	Complete	SP	Control	Ligature policy including new environmental standards and inspection SOP has been updated with new process and following consultation has been approved. New audit tool development and in use. New capture to distinguish actions which are maintenance requirements has been put in place.

8	Roll out new ligature training	Extended Mar '25	Project Group	Control	Roll out of new training programme commenced in May 2024 (face to face sessions) Additional training dates being added to continue delivery through to March'25 (action timeline extended to close at point when majority if staff have been trained. Drills established in all inpatient areas from Sept'24 OLM provision review being finalised to launch Sept'24

CRR92: Addressing Inequalities

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previous reported completed actions 1, 2, 3 and 6 have been removed from the Board report.
C5 x L4 = 20	*C4 x L3 = 12*	*C3 x L2 = 6*	

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

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Employee Experience Team including Director	Established and 6 Employee Experience Managers in post. Working with VAPR and safety teams		
Equality and Inclusion Policies	Policy and Procedures in place	Governance - Equality & Inclusion Sub-Committee and reporting to PECC	HIA4: Addressing Inequalities Staff Survey Results Increase of 0.86% for "My organisation takes positive action on health and well-being." (Staff Survey Q11a) Decrease of 4.16% for "How often, if at all, do you feel burnt out because of your work?" (Staff Survey Q12b) Decrease of 1.79% for "In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?" (Staff Survey Q11b) Decrease of 0.86% for "During the last 12 months have you felt unwell as a result of work related stress?" (Staff Survey Q11c) Decrease of 2.87% for "In the last three months have you ever come to work despite not feeling well enough to perform your duties? (Staff Survey Q11d)
Range of equality networks and staff engagement methods	Networks Established Executive Sponsors		
Training (inc. RISE Programme)	Workshops on micro-incivilities completed RISE Programme in place HIA2: Evaluation RISE 28.95% of participants achieved their goals completely, 89.47% of participants reported that the programme had a significant personal impact 27% have been promoted	RISE (3 cohorts completed with positive staff feedback)	
WRES and WDES / Gender Pay Gap	WRES and WDES plans in place Executive Sponsorship of plans		HIA3: For Pay Gap below the national average of 14.9% and has shown improvement from 2017 to 2023
EDI Culture	Ongoing programme in place to Nov 24 Supporting staff affected by discriminatory behaviour, abuse and bullying		HAI6: Eliminate Violence, Bullying and Harrassment Staff Survey: Decrease of 0.75% for "In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from Managers?" (Staff Survey Q14b) Decrease of 2.07% for In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues? (Staff Survey Q14c) "On what grounds have you experienced
Behaviours Framework	Behaviour Framework in place		

EDI Framework RAG system		Framework developed			
Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
4	Improve the environment of psychological and physical safety for staff. Address racial abuse and sexual safety at EPUT.	Mar '25	LH	Control	Designing a OD and Engagement Strategy which will include an 'always-on' approach to continue to embed the sexual safety charter across the Trust and adopt a zero tolerance approach to unwanted and poor behaviours from staff. A pilot on 5 inpatient wards focussed on reducing racial abuse and violence from our patients to staff. Evaluation and learning from the pilot will form part of a the culture strategy to roll out to the rest of the Trust. (January '25)
5	Implement the EDI framework as part of NHS England EDI plan (including new Leadership Behaviour Toolkit)	Extended Dec '25 To align with NHS England EDI Improvement Plan	LH	Control	Executive EDI objectives have been set and agreed through Remuneration and Nominations Committee. The Leadership Behaviour Toolkit continues to be socialised and will be further strengthened through the OD and Engagement Strategy. With a plan to include a targeted approach for leaders and a timeline with monthly activity to engage all staff around behaviours including discrimination, code of conduct, policies, and behaviours in meetings

CRR93: Continuous Learning

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L3 = 15	*C5 x L3 = 15*	*C5 x L2 = 10*	**Note:** Previous reported completed actions1,- 6 have been removed from the report. **Note:** This risk is currently static ant 15, note next steps below.

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

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

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
7	Assessment of the current Risk	August '24	MA	Assurance	Risk reviewed has been completed and the Director of Safety is due to meet with Executive Leads for Quality of Care to confirm the Trust direction.

CRR96: Loggists

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

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4 = 16	*C4 x L1 = 4*	*C4 x L1 = 4*	**Note:** Previous reported completed actions 1-2 have been removed from the report. **Note**: Assessed the impact of the new loggists on the risk score and confirmed 24/7 access to loggist should this be needed - risk is now considered to have been diminished and will be monitored as BAU through the EPRR programme.

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

Controls Assurance

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

	Actions (to modify risks)	By When	By Who	Gap	Update
3	Deliver Loggist training as per training needs analysis for new entrants on the Loggist register	Completed	NJ	Control	Trained loggists continue to increased (21 in place which is assessed to meet the threshold for delivery of a 24/7 response following declaration of an incident. The trained loggists within the Corporate Governance Team are available to cover out of hours if required). The action is now closed and risk assessment being reviewed for closure. We will continue a programme of Loggist training as both a refresher and to continue to bolster our numbers.

CRR98: Pharmacy Resource

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

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Following a review of business continuity plan as a consequence of new starters in February '24 , the likelihood score driving the change from a 4 (likely) to a 3 (possible) with a revised risk score of 12.
C4 x L4 = 16	*C4 x L3 = 12*	*C4 x L2 = 8*	

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

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
1	Continue with recruitment campaign	Ongoing	HS	Control	Recruitment campaign remains ongoing and continuing to see recruitment with clear pipeline running throughout 2024. 24.3 current vacancies (including the 9 WTE Time to Care provision) To note due to our successes over the past two years and the demand for pharmacists and technicians being high we have experienced leavers to promotions or posts closer to home for the individuals. Hence the recruitment campaign will continue on an ongoing basis.

Risk Movement and Milestones

Strategic Risk Movement – two year period (July 22 – Aug 24)

Risk ID	Initial Score	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Au 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	
SR1 Safety	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15 ↔	15 ↔	**15 ↔**
SR2 People	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20 ↔	C	**C**
SR3 Infrastructure	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15 ↔	15 ↔	**15 ↔**
SR4 Demand	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15 ↔	15 ↔	**15 ↔**
SR5 Inquiry	20	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	16↓	16↔	16↔	16 ↔	16 ↔	**16 ↔**
SR6 Cyber	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15 ↔	15 ↔	**15 ↔**
SR7 Capital	20			New	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20 ↔	20 ↔	**20 ↔**
SR8 Resources	15			New	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20 ↔	20 ↔	**15 ↔**
SR9 Digital	20																			New	20↔	15↓	15↔	15↔	15↔	15 ↔	15 ↔	**15 ↔**

Risk Movement and Milestones

Corporate Risk Movement and Milestones – two year period (July 22– Aug 24)

Risk ID	Initial Score	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	July 24	Aug 24	
CRR11	16	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	**12↔**
CRR34	9	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	close							
CRR45	12	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	**12↔**
CRR77	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	**16↔**
CRR81	12	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	**12↔**
CRR92	20	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	**12↔**
CRR93	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	**15↔**
CRR94	16	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	**20↔**
CRR95	20			15	15↔	15↔	15↔	15↔	12↓	12↓	Close																		
CRR96	16						New	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	**16↔**
CRR98	20							New	20	20	20	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	12↓	12↔	12↔	12↔	12↔	12↔	4	**4**
CRR99	16						New	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	08↓	8↔	8↔	8↔	Close	

8.2 HEALTH & SAFETY AND VAPR ANNUAL REPORT

Decision Item | DG / TS | 5

REFERENCES

Only PDFs are attached

Health & Safety Annual Report 02.10.2024 FINAL.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

Report Title:	**Health & Safety and VAPR Annual Report**					
Executive/ Non-Executive Lead / Committee Lead:	Denver Greenhalgh, Senior Director of Corporate Governance and Affairs Trevor Smith, Executive Chief Finance Officer					
Report Author(s):	Adam Mack, Head of Corporate Health & Safety and Violence, Abuse, Prevention Reduction (VAPR). Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Quality Committee September 2024					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
The purpose of this report is to present the Annual Health, Safety and Security Report 2023-24. It is a requirement to produce an annual H&S report which is presented to the Trust Board of Directors.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and approve the report noting the prior review and recommendation to the Board from the Quality Committee.

Summary of Key Points

The annual report provides an update on the activity of the Health, Safety and Security team from 1 April 2023 – 31 March 2024 and provides assurance that there are satisfactory arrangements in place for managing Health, Safety and Security across the organisation.

Prior to its submission to the Board, this report was presented and discussed at the Quality Committee.

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

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

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

Acronyms/Terms Used in the Report			
LRRG	Ligature Risk Reduction Group	CAS	Central Alerting System
HSE	Health and Safety Executive	NHSE&I	NHS England and Improvement
LWD	Lone Worker Device	BWC	Body Worn Camera
GWPRA	General Workplace Risk Assessment	DSE	Display Screen Equipment
V&A	Violence and Aggression	CCG	Clinical Commissioning Group
H&S	Health and Safety	CQC	Care Quality Commission
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations		

Supporting Reports and/or Appendices
Health & Safety and VAPR Annual Report 2023-24

Executive/ Non-Executive Lead / Committee Lead:

Denver Greenhalgh
Senior Director of Corporate Governance and Affairs

Trevor Smith, Executive Chief Finance Officer

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

HEALTH & SAFTEY AND VAPR ANNUAL REPORT 2023/2024

EPUT

CONTENTS

Report Prepared By:
Adam Mack, Head of Corporate H&S and VAPR
On behalf of:
Nicola Jones, Director of Risk and Compliance

1.0 SUMMARY

This 'Health & Safety and VAPR Annual Report' covers the period 01 April 2023 to 31 March 2024. The purpose of this report is to provide assurance on compliance with legislation and policies within the Trust. It provides an update on all health and safety activity in 2023/24 with details of any changes to policy and procedures. A forward plan for the Health & Safety and Violence Abuse Prevention and Reduction (VAPR) team for 2024/25 is included. The report provides assurance that there are satisfactory arrangements in place for the management of health, safety and security risks across EPUT.

2.0 INTRODUCTION

Health and Safety is a key priority for the Trust as any implications on staff health, safety or wellbeing has a direct impact on the ability to deliver high quality and compassionate patient care.

EPUT adopts the Plan, Do, Check, Act approach (PDCA) which is an iterative four step management method to validate, control and achieve continuous improvement of processes. This is pivotal to the management of health and safety within the workplace, as outlined in the guidance issued by the Health & Safety Executive (HSE), known as the HSG65 model.

Plan

At the planning stage of self-assessment against the Standards and Policies. Develop our aims, strategies and policies to work towards or sustain compliance of the standards and, general considerations to be made where the Trust currently are and, where we would want to be in line with legislation and guidance.

Do

Once the planning stage of the cycle has been completed, the Trust will move on to the second 'Do' stage. This stage concerns ensuring robust and transparent processes and practices for sharing and communicating risks along with their mitigation controls.

Check

The check stage is when EPUT considers how successful any implemented interventions have been, which can be audited via a strengths, weaknesses, opportunities, threats (SWOT) methodology.

Act

There is a requirement for providers to reflect and appraise their overall performance. This stage is concerned with testing and measuring performance against the overall Health & Safety Policy and Procedures and the VAPR Strategy and Policy.

This report outlines key developments and work that has been undertaken during the reporting period and reflects the Trust's adherence to its Health & Safety Policy Statement and Board of Directors Statement of Intent which, requires those

responsible for health and safety within Trust premises and whilst undertaking Trust activities to:

- Comply with and implement health and safety legislation and arrangements
- Implement health and safety arrangements
- Comply with monitoring and reporting mechanisms appropriate to internal and external key stakeholders and statutory bodies
- Develop partnership working and to ensure health and safety arrangements are maintained for all

The report further provides an overview of the key developments and the work undertaken to reflect NHS England Violence, Abuse, Prevention and Reduction (VAPR) Standards (August 2022).

The report provides an opportunity to consider work planned, and the objectives for the year ahead.

The Trust's Statement and Policy on Health and Safety (RM01) reviewed in year demonstrates a clear organisational structure for the management of health and safety. It demonstrates how the Board of Directors discharges its statutory obligations and ensures the identification of control measures to suitably reduce health, safety, security and ligature risks so far as is reasonably practicable and as required by the:

- Health and Safety at Work Act 1974
- Management of Health and Safety at Work Regulations 1992
- Workplace (Health, Safety and Welfare) Regulations 1992

3.0 OVERVIEW

Overview of Legal Compliance

The table below outlines the main health & safety legislation and identifies the reactive and proactive work that the Trust has carried out in both health & safety and VAPR.

Legislation	Description of Actions/Compliance	
Health & Safety at Work Act 1974	• Health & Safety Policy published. • Violence & Abuse, Prevention and Reduction Policy published. • Competent persons in place to guide and provide advice. • Health, Safety & Security Committee (HSSC) meet monthly, including bi-monthly H&S and VAPR reporting.	

Legislation	Description of Actions/Compliance	
Management of Health & Safety at Work Regulations 1999	• Health & Safety and VAPR annual report. • General Work Place Risk Assessment (GWPRA) training for staff (delivered bi-monthly). • Intranet online training material.	
Display Screen Equipment Regulations 1992	• DSE self-assessment tool available online, including occupational health referral process.	
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)	• Suspected RIDDOR incidents are investigated and if found to meet the threshold, reported to the HSE. • Findings are shared with management of the respective reporting teams.	
Health & Safety Information for Employees Regulations (Amendment) 2009, Health & Safety Consultation with Employees Regulations 1996 and Safety Representatives and Safety Committees Regulations 1977 and Fire Safety Act 2001	• Terms of reference have been reviewed for the Health, Safety and Security Committee. • Health & Safety Policy has been updated. • Health, Safety and Security Committee meetings are attended by Managers and Trust Competent Persons. • Reports on Audits, Action Plan progress, KPIs and Risk Register. • H&S advice and guidance is displayed in wards/offices where appropriate (including H&S poster). • H&S Trade union representatives in place. • Fire Safety Officer in post.	
Control of Substances Hazardous to Health 2002, Electricity at Work Regulations 1989, Workplace (Health Safety & Welfare) Regulations 1992, Provision and Use of Work Equipment Regulations 1998, Lifting Operations and Lifting Equipment Regulations 1998, The Control of Noise at Work Regulations 2005, Control of Asbestos Regulations 2012 and Personal Protective Equipment at Work Regulations 1992	• Regulations are monitored and required changes are delivered and managed through the Health, Safety and Security Committee specialist groups. • Subject matter experts are in place to provide advice and guidance on specialist matters. • Premises assurance compliance reviews undertaken on an annual basis by estates team. • Health and Safety advisors involved with subject matter groups to monitor and advise where appropriate.	

Health & Safety and VAPR Objectives

Objectives for the Corporate H&S and VAPR team are set annually in partnership with the Health Safety and Security Committee. The objectives for 2023/24 were focused on the following key work streams:

	Objective	What was achieved	
1	To ensure, as far as reasonably practicable that EPUT is compliant with all relevant H&S legislation.	See legal compliance table above.	
2	To review and update the Health & Safety policy (RM01).	The Health & Safety policy RM01 (version 7) was updated and published across the Trust on the 18 March 2024. There were no amendments or changes required.	
3	To create the Violence Abuse Prevention and Reduction policy (CPG84).	Version 1 of the Violence Abuse Prevention and Reduction policy (CPG84) was published across the Trust in August 2023. This policy will replaces the previous Trust Security policy (RM09).	
4	To undertake a comprehensive Health & Safety and Ligature audit program across the Trust, to ensure safe working environments for both staff and patients.	45 annual (12-month) ligature inspections, 45 bi-annual (6 month) ligature inspections and 108 health & safety inspections have taken place between in the period. The total number of sites requiring ligature audits is 45 and for the period the total number of sites requiring health & safety audits was 108, therefore the program was 100% complete.	
5	Review of the Trust environmental ligature inspection policy and tool.	Updates were made to the existing tool, to ensure clear distinction between general maintenance and breaches and to further enhance environment standards. This process monitored as part of continuous improvement via the monthly Ligature Risk Reduction Group (LRRG).	
6	Improving the method for monitoring compliance with the General Workplace Risk Assessments (GWPRA) process.	A comprehensive central General Workplace Risk Assessments (GWPRA) register was created, identifying which departments have risk assessments and when these are due for renewal.	
7	Retender the lone worker device contract and enhancing processes for the return of devices no longer in use.	The existing contract was renewed for 12 months. Recall of existing devices not in use continues, enabling better distribution in required areas.	

	Objective	What was achieved	
8	Provide more readily available information and advice via redesigned intranet pages.	As a consequence of staff capacity (vacancies) not been achievable. There is existing data and information available online, including established routes for staff to seek H&S or VAPR advice if required. Updating the intranet page will be an objective for 2024/2025.	
9	Implementation of and work towards, continued delivery against the Violence, Prevention, Reduction Strategy (VPRS).	The Violence, Prevention, Reduction Strategy (VPRS) was developed in 2021 by NHS England and every Trust is required to achieve continued compliance with this standard. EPUT have implemented this standard and continue to work towards achieving full adherence. . As of April 2024 the Trust have achieved 60.7% with work ongoing.	
10	Make effective changes to the DATIX system for more comprehensive reporting or VAPR related incidents, in order to better quantify data obtained to identify patterns or trends.	This action forms part of the Violence, Prevention and Reduction Strategy (VPRS). As a consequence of staff capacity (absence) not achieved and will be an objective for 2024/2025.	
11	Continue to support staff engaged in violent or abusive incidents within the work place, including the facilitating the creation and distribution of Trust warning letters.	The H&S/VAPR team continues to provide liaison support for staff between the Trust and law enforcement organisations. Working closely with Police forces to tackle any issues or concerns staff may have. Including creating and distrusting Trust warning letters, which are sent to patients or other persons who have engaged staff in either violent or abuse related incidents.	
12	Continue to provide training to staff and managers on the General Workplace Risk Assessments (GWPRA) process, as part of the Management Development Program (MDP).	The learning and development department within the Trust offers a Management Development Program (MDP), which provides training to managers of the correct process for undergoing a General Workplace Risk Assessments (GWPRA). This is delivered by members of the H&S/VAPR team and is undertaken on a pre-scheduled basis.	

4.0 GOVERNANCE

Core Elements of Managing Health and Safety

Day-to-day management of health and safety is undertaken by the Health & Safety/VAPR team, in cooperation with care unit, locality managers and all staff according to their level of responsibility. Effective risk management is completed, monitored and reviewed by the team, to understand what is currently being done to resolve issues and if any changes are required.

The Trust Health Safety and Security Committee (HSSC) has responsibility for developing and monitoring effective systems and processes, which include the following:

- Maintain and improve the quality (safety, experience and effectiveness) of Trust services.
- Ensure the Trust remains compliant with all regulatory or legislative requirements. Including the Trust's constitution, policies and procedures.
- Identify, manage and escalate risks and issues.
- Provide assurance that systems are in place internally and externally to manage risks.
- Ensure governance structures of the Trust are appropriate and effective.
- Co-ordinate the implementation and management of health, safety and security and non-clinical risk management across the Trust. The Committee has wide representation from both operational, support services, as well as receiving assurance and escalation from the local level Health and Safety/Quality sub-groups where required.

EPUT has a legal duty to have suitable arrangements in place, in which to manage health and safety.

This is process is undertaken via the following:

- The Trust's Directorate of Risk and Compliance who provides Leadership and management
- A trained/skilled workforce which is available via the Health & Safety/VAPR Team, consisting of subject matter experts who possess the appropriate training and qualifications, in accordance with their role.
- Fostering a safety culture, which provides a safe and secure working environment. Employees are involved in health and safety and security developments through staff representation at the Health Safety & Security Committee (HSSC), which drives Trust policy and procedure.
- Relationships built by the Health & Safety and VAPR Team including thorough

H&S inspections, Ligature inspections and General Workplace Risk Assessments (GWPRA), which are underpinned by the Trust risk profile which is managed through the Risk Management Assurance Framework.

The Trust's Statement and Policy on Health and Safety (RM01) demonstrates a clear structure for the management of Health and Safety and how the Board of Directors fulfils its statutory obligations to ensure that the identification of control measures to suitably reduce health, safety, security and ligature risks so far as is reasonably practicable is in place as required.

Examples of the legislation include:

- Health and Safety at Work Act 1974
- Workplace (Health, Safety, and Welfare) Regulations 1992
- Management of Health and Safety at Work Regulations 1999
- Provision of Use of Work Equipment Regulations 1998
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
- Manual Handling Operations Regulations 1992
- Personal Protective Equipment at Work Regulations 1992
- Health & Safety (Display Screen Equipment) Regulations 1992

Competent Health & Safety Advice:

EPUT is required to fulfil statutory Health & Safety requirements including but not limited to the Health & Safety at Work Act 1974. As an illustration:

- Section 7 of the Management of Health & Safety at Work Regulations 1999, requires the Trust to have access to competent health and safety advice. This ensures the identification of control measures are in place not only to identify potential issues, but also to suitably reduce health, safety, security and ligature risks so far as is reasonably practicable. This is achieved via suitable trained members of the Health & Safety/VAPR team, who (as part of their role) ensure that there is a continuous access to competent health and safety advice throughout the year.

The Health Safety and Security Committee co-ordinates the implementation and management of health, safety and security and non-clinical risk management across EPUT, which has wide representation from both operational and support services with a representative invited from each area. It receives assurance on health, safety and security at a local level from the Health and Safety/Quality sub-groups and oversees improvement plans.

As illustrated in the Health and Safety at Work Act 1974 (HASWA 74), it is the responsibility of every employee within an organisation to take reasonable care for the health and safety or themselves and others within that place of work.

The H&S/VAPR team leads the management of health and safety. However, all staff within the Trust remain responsible for fostering a safe working culture by way of maintaining safe working and professional standards; adhering to policies and risk assessments, engaging with the Trust regarding safety matters, ensuring the completion of mandatory training (as required within their role), working to a level of competency and following safe systems of work.

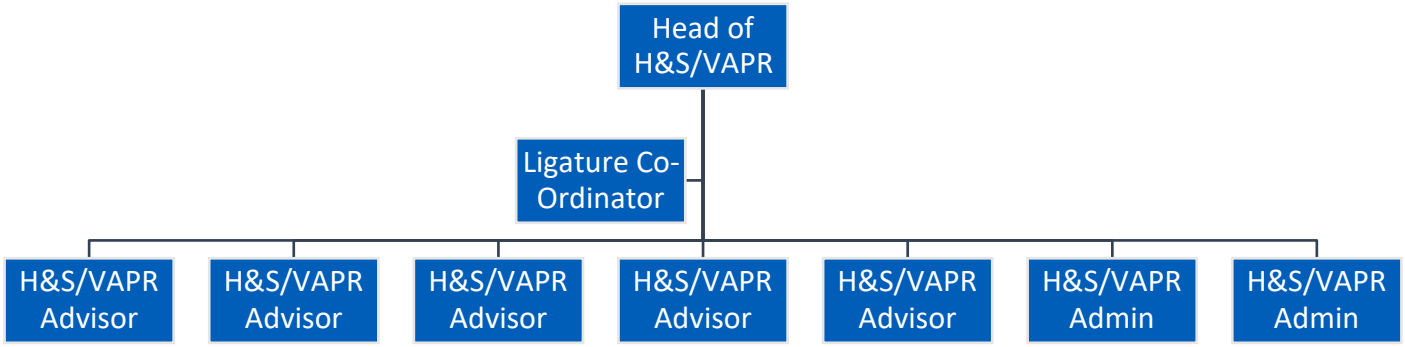
There is a clear structure for the prevention and reduction of violence and abuse against Trust staff, via Multi-Agency Resolution meetings, The Health Safety and Security Committee and External Risk Management Board, Integrated Care Board and Quality Committees and External Essex Crisis Concordat.

Health & Safety (H&S) / Violence Abuse Prevention & Reduction (VAPR) Team

The Health & Safety VAPR Team are part of the wider Risk and Compliance Directorate. The team is responsible for providing expert advice and guidance, as well as being responsible for overseeing Health, Safety and Security requirements.

Due to staffing vacancies, the business continuity plan was enacted, as at March 2024, a recruitment program is underway with a view to enable the team to return to business as usual within 3 months.

The team structure is as follows:



During 2023/24, members of the team have supported/assisted on projects with the Estates and Facilities Team, Ligature Risk Reduction Group members, Patient Safety Advisor and the Capital Projects team to ensure a safe and therapeutic environment, which is safe for patients and staff.

The Team continues to maintain professional development and training, for example:

- Therapeutic and Safe Interventions De-escalation (TASI) training completed for all H&S/VAPR Advisors.
- Intranet pages maintained with existing information and guidance for all staff. Plans to update and redesign this resource is a priority for 2024/25.
- Restructured the team to align and support care units and a new Head of Health and Safety/VAPR recruited and commenced in post.
- A robust system in place for ensuring H&S inspections are undertaken for each of our premises every 24 months (or sooner, if required).
- A robust system in place for delivering both 6 and 12 monthly ligature assessments.

- Supported the completion of General Workplace Risk Assessments with additional training delivered via the Management Development Program (MDP).
- Continue to support the use of Body Worn Cameras within clinical environments, to help deter instances of violence and aggression towards staff.
- Ensuring that new staff within the H&S/VAPR team complete the NEBOSH General Certificate in Occupational Health & Safety. Those staff who remain in advisor posts either have completed or are in the process or completing this qualification at the time of this report. Recruitment for vacancies that move in to 2024/2025 will include individuals who possess required qualifications for their role.
- Mental Health First Aider Instructor course
- Level 7 – Violence Prevention Reduction Public Health
- VPR Level 3 Strategic Specialists

H&S Policies and Procedures

As outlined above, the Trust's Health and Safety Policy and Statement (RM01) sets out the structure for managing Health and Safety and how the Board of Directors discharges its statutory obligations.

To achieve the Management of Health and Safety at Work Regulations (1999) to control health and safety risks, EPUT has the following in place required to meet the legal requirements:

- Health and Safety Policy.
- General Workplace Risk Assessment and a Risk Management Assurance Framework as the documents outlining processes for the assessment of the risks to employees, contractors, service users, partners, and any other people who could be affected by activities. These include the requirements to record the significant findings in writing and provides templates for 'suitable and sufficient' risk assessments. Including arrangements for the effective planning, organisation, control, monitoring and review of the preventive and protective measures that come from risk assessment.
- A Health and Safety Team providing competent health and safety advice.
- General Workplace Risk Assessments and risk registers providing employees with information about the risks in the workplace and how they are protected.
- Instruction and training during the induction process for new employees, in how to recognise risks and implement measures to mitigate these hazards.
- Supervision Policy and Procedure, which ensures there is adequate and

appropriate supervision in place.

- Local Quality and Safety Groups providing a focus for consulting with employees about their risks at work and current preventive and protective measures.

Ward to Board

The Trust Health Safety and Security reporting has continued through the governance structure as outlined in Fig 1 below. The Trust Risk Management Framework is used to escalate risks when appropriate:

5.0 CONTINUOUS LEARNING

Risk Management System

The Risk Management system (DATIX) continues to develop to enhance its functionality. EPUT uses DATIX for a range of functions including incident reporting, alerts issued through the Department of Health Central Alerts System (CAS), ligature actions and Claims, Complaints and PALs.

The DATIX dashboard module continues to be utilised by both clinical and support staff 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.

In January 2024, the National Reporting and Learning System (NRLS) was replaced with the new Learning from Patient Safety Events system (LFPSE). Incidents that are reported as affecting patients are automatically uploaded to LFPSE at the time of submission prior to any management sign off or review, as opposed to the manual upload previously required for the NRLS after review/sign off. The DATIX system was upgraded to facilitate this change and staff communications in preparation for the launch date, which occurred on the 15 January 2024. Further to this, the training

package has been updated to include this new reporting process.

The LFPSE go live in 2022 was delayed, due to national interfacing software issues that required rectifying. The Trust launched live with the new system on 15 January 2024.

Health and Safety Incidents

H&S and Security related incidents are reported via the DATIX system, with oversight by the Trust Health, Safety and Security Committee.

The H&S and VAPR Team reviews all H&S and VAPR incidents to ensure appropriate actions are taken and identify any lessons learnt. There were 575 health and safety related incidents reported in 2023/24 (an increase of 21% when compared to 2022/23).

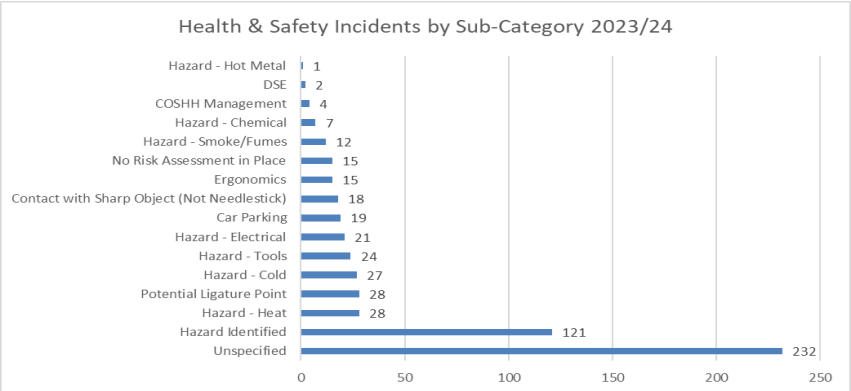
The increase is seen mainly in the categories marked as 'unspecified', which accounts for **232** incidents. These incidents were not reviewed for re-coding within the 2023/24 period. However, this piece of work will be undertaken as part of the 2024/25 period.

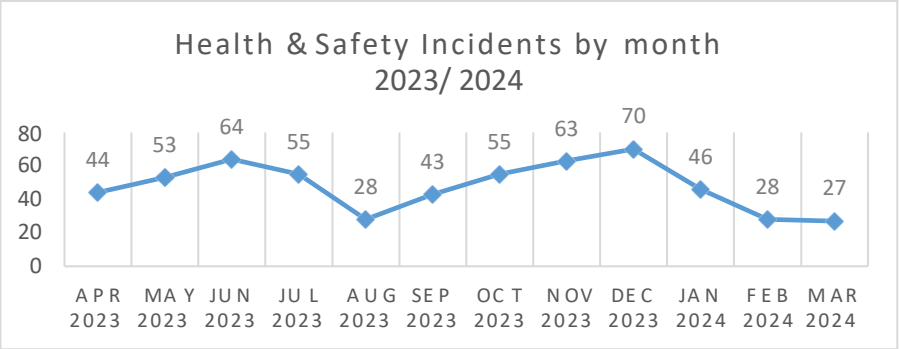
It is understood that the incorrect categorization has occurred at the initial stages of completing the DATIX report, by the original user. The reason for this is believed to be due to users either not searching for the required category correctly, or clicking on the wrong option by mistake. Both of which are believed to be due to human error.

A review was carried out of the category choice '**unspecified'** and was found not to be required, as there were suitable alternatives that should be used in its place. Therefore, in January 2024, this option was **removed** from the available choices, thus eliminating further miss-categorization of DATIX incidents.

The **232** incidents that were categorized as 'unspecified' are in the process of being reviewed and re-allocated correctly.

The tables below details health and safety incident data and trends and themes during the financial year;





Needle and Sharp Related Injuries

There were a reported 55 incidents of needle and sharp related injuries across the Trust within the reporting period. This compares to 63 incidents reported during 2022/23.

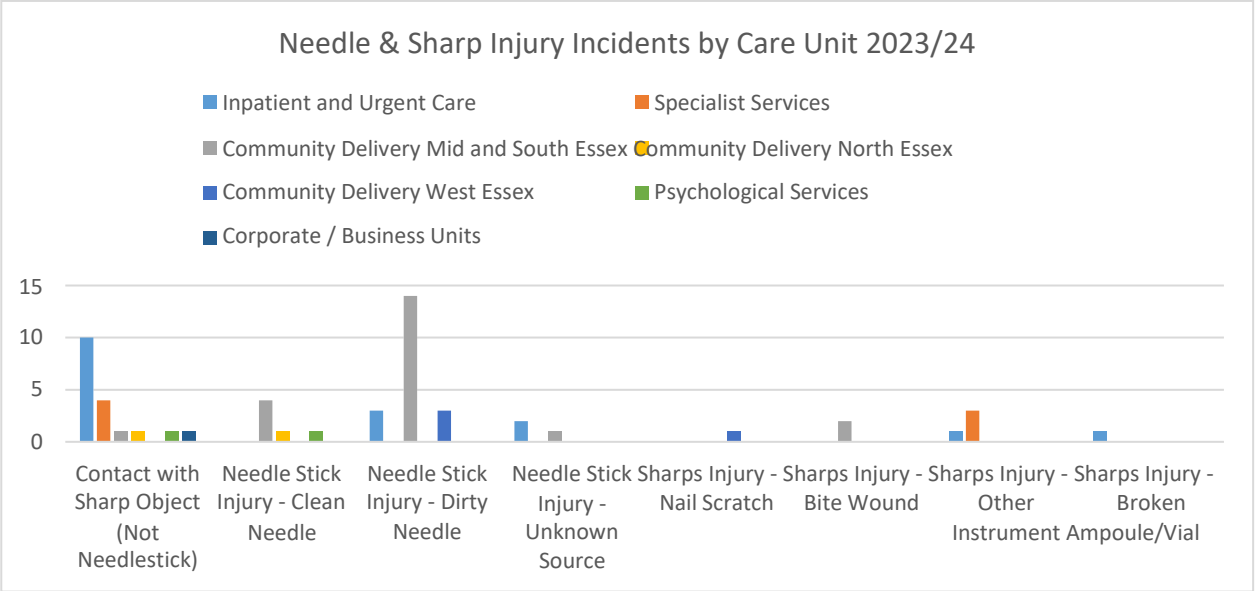
Under the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, all organisations are required by law to ensure that the risks from sharp injuries are adequately assessed and appropriate control measures are in place.

Needle and sharp injuries are monitored by the Trust Infection Prevention and Control Team and support provided to staff via Occupational Health. It continues to be the responsibility of all staff to report any blood or bodily fluid contamination injuries to the occupational health provider immediately, using the specialist helpline. This service is available 24hrs a day, 7 days a week.

Measures to avoid occupational exposure to blood borne viruses including prevention of sharps injuries must include; the safe handling and disposal of sharps. This includes the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for staff. This is a requirement of the 'Code of Practice on the prevention & control of infections' and 'Sharps Instruments in Healthcare Regulations 2013'.

In the event of a sharps related injury, a DATIX report is required and an investigator will be assigned (clinical manager) to undertake an investigation into the incident to obtain a clear understanding of the circumstances, what led to this incident and any changes that be required as part of future learning. A review of any existing General Work Place Risk Assessment (GWPRA) is be undertaken by the investigator to ensure that any mitigation factors have been followed in accordance with the assessment. If it has and the incident has still occurred they will offer support by the H&S/VAPR team to help identify why this has occurred and include further mitigating factors to prevent future incidents. If the process has not been followed, then a review of the actions taken by the injured party (including their reasoning as to why they took those actions) will be reviewed by the department undertaking the investigation.

The H&S/VAPR team report sharps related injuries to the Health, Safety and Security Committee (HSSC), who have oversight of the incident and discuss any actions taken by the respective departments involved within that forum, to ensure that suitable actions are being taken in line with legislative requirements.

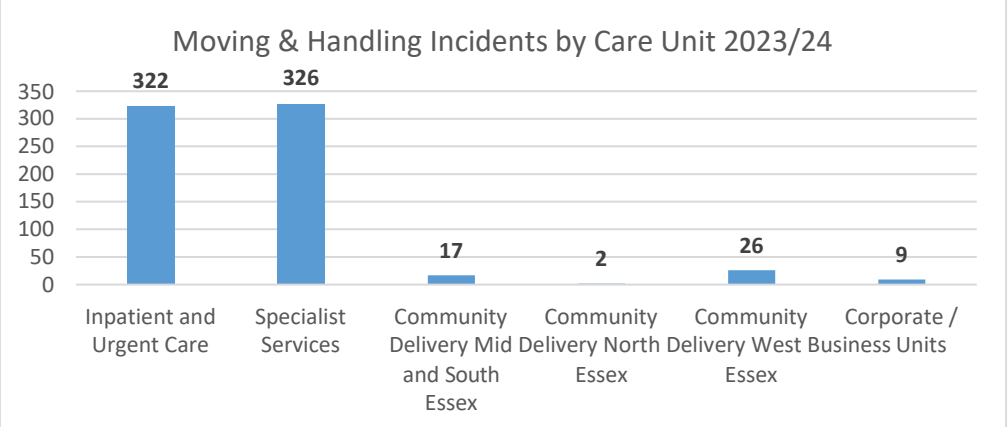


Moving and Handling Injuries

There were 702 incidents relating to moving and handling within the reporting period, compared to 2245 during 2022/23, which is an overall reduction of moving and handling incidents by 68.7%.

The majority of overall incidents that have occurred in 2023/24, have been within 'inpatient and urgent care' settings (45.9%) and 'specialist services' settings (46.4%), which accounts for 92.3% of all the moving and handling incidents during 2023/24. This decrease is in part due to incidents involving restraint previously being copied by the DATIX team under the Moving & Handling category, to reflect the patient safety aspect for NRLS (National Reporting Learning System) reporting purposes. This process was discontinued during 2023/24 following the transition to LFPSE (Learning from Patient Safety Events) which accounts for the significant reduction in incidents year on year.

The data reflects that the majority of patient restraint related incidents occur within a clincial inpatient setting, which is supported by Therapeutic and Safe Interventions De-escalation (TASID) training, which provides front line clinical staff with suitable and sufficient training to deal with volatile patients safely.

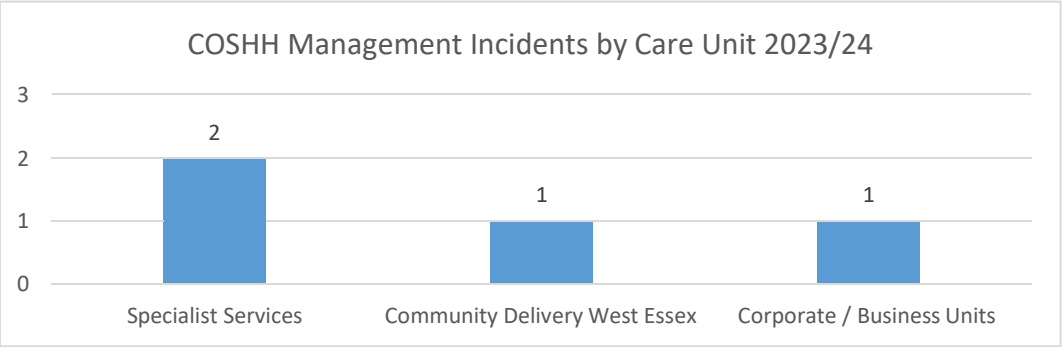


Control of Substances Hazardous to Health (COSHH)

As per the Control of Substances Hazardous to Health Regulations 2002, both employers and employees have a responsibility manage the health risks associated with the handling of hazardous substances within the work place.

During 2023/24, there were 4 COSHH Management related incidents within the reporting period. This compares to 18 incidents recorded during 2022/23, which is a decrease of 77.7%.

The findings of COSHH management related incidents are reported to the Health, Safety and Security Committee (HSSC). The 4 incidents reported during 2023/24 have all related to hazardous chemical related materials being left unattended; however, none of these have resulted in a patient or member of staff receiving any related injuries. The outcomes have resulted in further staff training to resolve the issues.



Safety Alerts

The DATIX team reviews Safety Alerts issued via the Central Alerting System (CAS) and creates an internal alert on the DATIX Safety Alert module. The Trust has nominated Central Alert System Liaison Officer (CASLO), whose role is to review and respond to the alert via the DATIX system, advising if relevant to any Trust services or if any action is required.

This process includes input from specialist leads, such as Pharmacy and the Medical Devices Safety Officer (MDSO) where appropriate.

Alerts relevant to EPUT are cascaded for action across the Trust and responses provided as required via DATIX within specified timescales. These are added to the Trust intranet page for all staff to review as required.

Once the actions are complete or the alert is assessed as not being relevant to EPUT services, the alert will be signed off as complete on the CAS online portal by the CASLO. Where assessed appropriate alerts are added to the Trust Risk Register.

The Trust responded to all relevant alerts issued during **2023/24.**

Below is the list of alerts received in the period.

Reference	Alert Title	Originated By	Issue Date	Status	Response
NatPSA/2024/003/DHSC_MVA	Shortage of salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials.	National Patient Safety Alert - DHSC	26/02/2024	Issued	Action Completed
NatPSA/2024/001/DHSC	Shortage of GLP-1 receptor agonists (GLP-1 RA) update.	National Patient Safety Alert - DHSC	03/01/2024	Issued	Action Completed
NatPSA/2023/016/DHSC	Potential for inappropriate dosing of insulin when switching insulin degludec (Tresiba) products.	National Patient Safety Alert - DHSC	08/12/2023	Issued	Action Completed
NatPSA/2023/015/UKHSA	Potential contamination of some carbomer-containing lubricating eye products.	National Patient Safety Alert - UKHSA	07/12/2023	Issued	Action Completed
NatPSA/2023/011/DHSC	Shortage of methylphenidate prolonged-release capsules and tablets, lisdexamfetamine capsules.	National Patient Safety Alert - DHSC	27/09/2023	Issued	Action Completed
NatPSA/2023/010/MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death.	National Patient Safety Alert - MHRA	31/08/2023	Issued	Action Completed
NatPSA/2023/009/OHID	Potent synthetic opioids implicated in heroin overdoses and deaths.	National Patient Safety Alert - Office for Health Improvement and Disparities	26/07/2023	Issued	Action Completed
NatPSA/2023/008/DHSC	Shortage of GLP-1 receptor agonists.	National Patient Safety Alert - DHSC	18/07/2023	Issued	Action Completed
NatPSA/2023/007/MHRA	Potential risk of underdosing with calcium gluconate in severe hyperkalaemia.	National Patient Safety Alert - MHRA	27/06/2023	Issued	Action Completed
NatPSA/2023/006/DHSC	Shortage of pyridostigmine 60mg tablets.	National Patient Safety Alert - DHSC	24/05/2023	Issued	Action Completed
NatPSA/2023/004/MHRA	Recall of Emerade 500 micrograms and Emerade 300 micrograms auto-injectors.	National Patient Safety Alert - MHRA	09/05/2023	Issued	Action Completed

6.0 ENHANCING ENVIRONMENTS

The Health & Safety team have supported the Capital Projects programme through the provision of expert advice and support with refurbishment and improvement works within EPUT ensuring health and safety is at the forefront of any works including:

- Refurbishment of Woodlea Clinic
- Oxygen Cylinder relocation at the Lakes
- Refurbishment of Hadleigh Unit
- Refurbishment of Brockfield

7.0 CULTURE

The Trust has continued to deliver a programme of H&S/VAPR training including:

- Management Development Programme – General Workplace Risk Assessment Module
- Live learning sessions for General Workplace Risk Assessments
- Body Worn Camera training and ad-hoc support
- Fit for work (Mandatory)

The Management Development Programme has continued throughout the reporting period with 617 staff enrolled in the programme. During this reporting period, the H&S/VAPR team delivered 11 sessions to train managers in 'how' to undertake a General Work Place Risk Assessment (GWPRA).

As part of the Trust culture of learning the H&S Team have continued to collaborate with the Compliance Team by visiting all MH inpatient wards 6 months post-annual ligature inspection to provide coaching on ligature management and awareness; this is evidential to empowering staff to manage their ligature risks and share learning and good practice.

The H&S/VAPR team have continued to engage with staff holding 320 drop in clinics and regular attendance for supporting with Body Worn Cameras, Lone Worker Devices and to support with violence and aggression incidents.

8.0 INNOVATION

The Trust has reviewed its progress against the Violence Prevention Reduction Standards (VPRS), which consists of 56 key performance indicators (KPI's), of which the Trust fully meets 33 indicators. This review included the development of a comprehensive plan outlining the requirements of all 56 indicators, detailing what work has been undertaken and next steps.

The use of body worn cameras has continued within ward settings, capturing visual and audible recording of any criminal activity, which may be used as evidence for external criminal investigations where required.

At the end of the 2023/24 period, the H&S/VAPR team reviewed the Environmental Ligature Policy and working tool, making improvements, which have included adding a fluidity to the renewal date of any inspections, to provide a contingency to avoid missing rigid deadlines. In 2024/25, the working tool will be translated into an automated reporting tool online for ligature inspections, using the audit software called Tenable.

In 2023/24, the two teams were restructured to develop all individuals to be dual trained in both H&S and VAPR (in line with the organisational change policy). This provided for clearer business partnering with the care units and offered greater access to support and advice. For 2024/25, the service is transitioning to this new structure with staff being support through appropriate training programmes and mentoring.

9.0 CORE ACTIVITIES

Ligature Inspections

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 Chief Operating Officer and Deputy CEO (Chair), Director of Mental Health (Deputy Chair), Director of Compliance & Risk, Estates representatives, the Ligature coordinator and Senior Leads from Clinical Services.

The Trust also has an Estates Group that have an agreed risk stratification and prioritisation program 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.
- Ligature awareness eLearning program.
- Risk Stratification.
- Related ligature safety alert(s) compliance.

LRRG make recommendations for patient safety work and agree standards in line with policy.

The Health and Safety Team hold the responsibility for facilitation of the annual environmental ligature inspection program covering all Mental Health inpatient wards. A multidisciplinary team made up of H&S Advisor, Estates and the ward manager or Charge Nurse undertake each Ligature Risk Assessment. The purpose of having this approach is to ensure that all factors are considered, not only from the H&S perspective, but also from an Estates point of view. This is to ensure that any potential issues that fall outside of the ligature process can be rectified. For example, fire or water safety issues, electrical faults, gas risks, ventilation issues etc., to ensure that they are in line with measures outlined within the Health Technical Memorandum (HTM).

Additional considerations include any discovery of asbestos related materials, correct working practices of sub-contractors whilst at the site, as well as the safety of the patients during this work.

As part of the ligature inspections, the teams experience some of the more challenging behavior of patients towards staff and the negative effects it can have on staff morale. In these circumstances, advice is given regarding next potential steps from a VAPR perspective, as well the benefits of occupational health referrals.

An outcome report is shared with all parties for agreement and includes action identification, monitored to completion by the Ligature Risk Reduction Group (LRRG). Closing of actions within set timescales has been an area of focus in 2023/24 with joint work between the Health and Safety and Estates teams to improve process.

In addition to annual visits a program of follow-up support visits (6 months after inspection) have been undertaken. The support visit is led by a senior clinical lead and focuses on both clinical and non-clinical ligature risks.

There have been 46 full annual ligature inspections completed between 1 April 2023 and 31 March 2024 with all relevant six monthly reviews completed in line with the inspection schedule program.

The Trust continues to regularly review and develop agreed risk reduced environmental standards based on both internal and national learning, including national Safety Alerts. The standards inform the Ligature Risk Assessment Inspections, investment and patient safety improvement program and are overseen by the Ligature Risk Reduction Group.

In addition to the above, the Trusts ligature risk assessment tool has been reviewed in year with improvements and recommendations approved by both HSSC and LRRG. 38 sixed-ligature points were identified through the risk assessment process in the reporting period and proactively managed.

General Workplace Risk Assessments (GWPRA)

All services are asked to undertake a General Workplace Risk Assessment (GWRA), which is updated regularly or as new risks are identified. The Health & Safety/VAPR Team continues to support staff with the completion of their GWRA and these have been included in an exemplar Risk Assessment document.

Health and Safety Inspections

The procedure and process for conducting Health and Safety is included in the Health and Safety Policy. Health and Safety inspections are conducted every 24 months; there is no longer a tiered system as there is no legislative timeframe/requirement for H&S inspections to be conducted every 12 months and the H&S team has authority to enter any premise without restriction.

The team have completed 108 Health and Safety inspections between 01 April 2023 and 31 March 2024completing all the required inspections during this period, in line with Trust policy.

VAPR Clinics / Visits

The Violence and Abuse Prevention and Reduction Team (VAPR) implemented an increased program of visits with a commitment to engage with staff from both inpatient and community teams and ensure awareness of the support the team offer.

The team completed 320 visits across the Trust to offer support and guidance to staff in the event that they are a victim of violence and aggression, with these clinics being supported by Essex Police and our TASI training team.

Violence Prevention Reduction Standard (VPRS)

NHS England's Violence Prevention & Reduction Standard (VPRS) were introduced in January 2021. The Trust has continued to work towards achieving these standards fully.

The standard is made up of 56 key performance indicators (KPI's), of which the Trust meets 33 indicators. As of April 2024, the Trusts overall achievement sits at 58.9%. Plans are in place to achieve 90% within 2024 by achieving the following:

- Approval of a revised VAPR Strategy
- Developing incident-reporting capture through Datix to reflect types of incidents related to VPRS.

Within the Essex Partnership University Trust, the 'board level (director)' designated to manage the Violence Prevention & Reduction work stream is identified as: The Executive Chief Finance and Resource Officer).

The following is a breakdown of the Trust's achievement within each of the individual areas:

PLAN	DO
There are 14 areas within the 'PLAN' section of the standards, of which the Trust has achieved in 10	*There are 11 areas within the ''DO' section of the standards, of which the Trust has achieved in 7*

CHECK	ACT
There are 12 areas within the ''CHECK' section of the standards, of which the Trust has achieved in 4	*There are 19 areas within the 'ACT section of the standards, of which the Trust has achieved in 12*

Body Worn Cameras

Body worn cameras (BWCs) are used in mental health wards, Health Based Place of Safety suites (HBPoS), mental health liaison teams, and the Mental Health Urgent Care Department. As of the end of 2023/24, a total of 252 BWC's are in use, compared with the 214 the previous year.

During the period there have been 2758 DATIX incidents with related BWC footage saved, compared to 1321 incidents from the previous 2022/23 year.

DATIX shows the types of incidents that staff utilized BWC's for varies, however the highest use for the cameras relate to incidents of self-harm, physical assault, anti-social behavior, clinical care, abscond, damage to property and racial abuse.

Body Worn Camera's used by staff in situational conflicts, continue to enhance preventative measures and support any potential criminal actions that can be pursued.

Lone Worker Devices

The VAPR team currently maintain the lone worker device management. Devices are allocated to individual staff members in the community, staff members who have been subjected to threats or those who have a raised risk to their personal safety. To date the Trust have 1750 registered devices, which is an increase on the last reporting period (1688).

The Trust commenced a contract with the current LWD provider in 2019 for a 1000 devices for a period of three years. The contract being extended for a further two years due to a successful joint working partnership. In September 2022, an additional number of devices were purchased which would run concurrently with the other contract. The LWD contract expires on the 30 June 2024, this was renewed with the existing vendor for 12 months. During which time the Trust will explore what alternative solutions are available and it is meets the needs of the organisation.

During the reporting period, there have been 3 emergency 'red alert' calls. The red alerts were as detailed below:

- On 6 January 2024, whereby a staff member was escorting patient on leave who became aggressive and absconded, police contacted and dispatched to ward.

- On the 31 January 2024, whereby a staff member activated device for self-harm incident on arrival at patients home, ambulance called who advised contact with police due to self-harm with knife. Police contacted and established no threat or danger to staff member. Arrangements made

with the family to attend to take patient to hospital due to ETA for ambulance.

- On the 14 February 2024, whereby a staff member requested police assistance due to a missing patient. Police attended.

None of the above incidents resulted in harm.

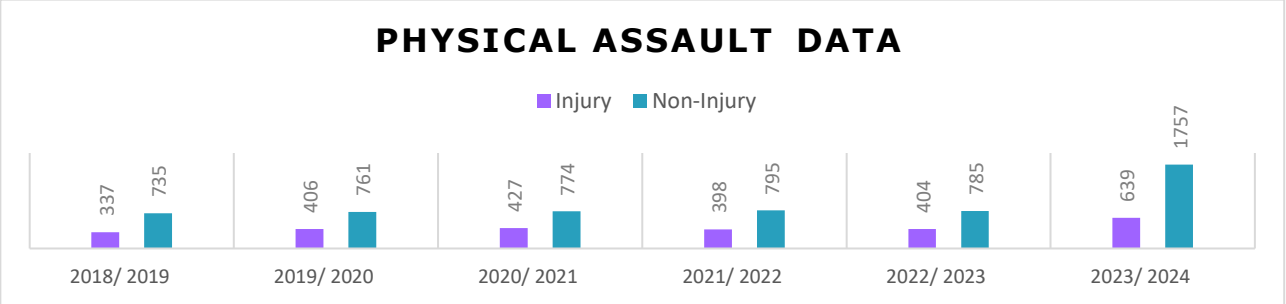
During the reporting period, the number of devices not in use has increased with new reporting established to ensure Care Units are aware of how many devices they have allocated not in use. All devices no longer required are returned to the VAPR Team for reallocated.

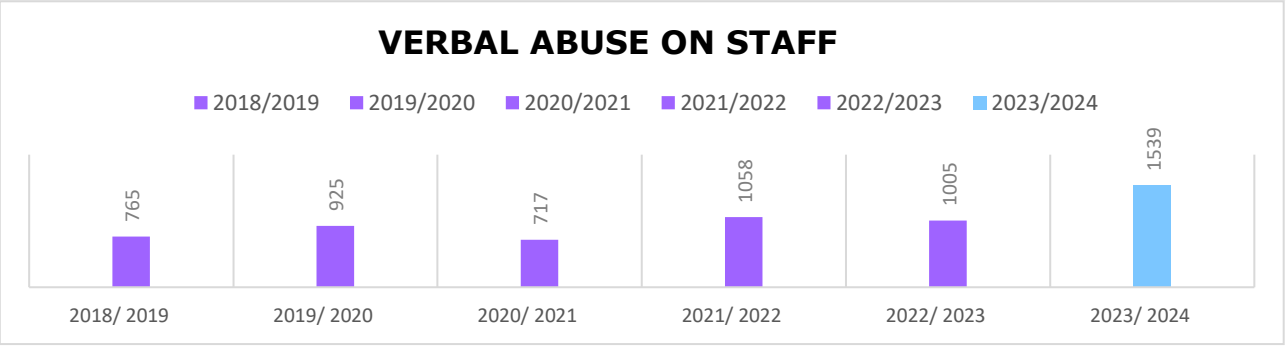
Assaults on Staff

The VAPR Team monitor incidents of assaults on staff and seek to support staff following such incidents. The Health Safety and Security Committee has oversight of this activity.

The graphs below gives figures for physical assault data, both for injury and non-injury incidents, over the last 6 years. The graph shows the reported spike in non-injury assaults in the last reporting year. The causes for this relate to various impact factors, however the 'non-injury' data also includes the following figures of verbal and racial abuse towards staff from patients:

- 1539 reports of verbal abuse towards staff
- 384 reports of racial abuse towards staff



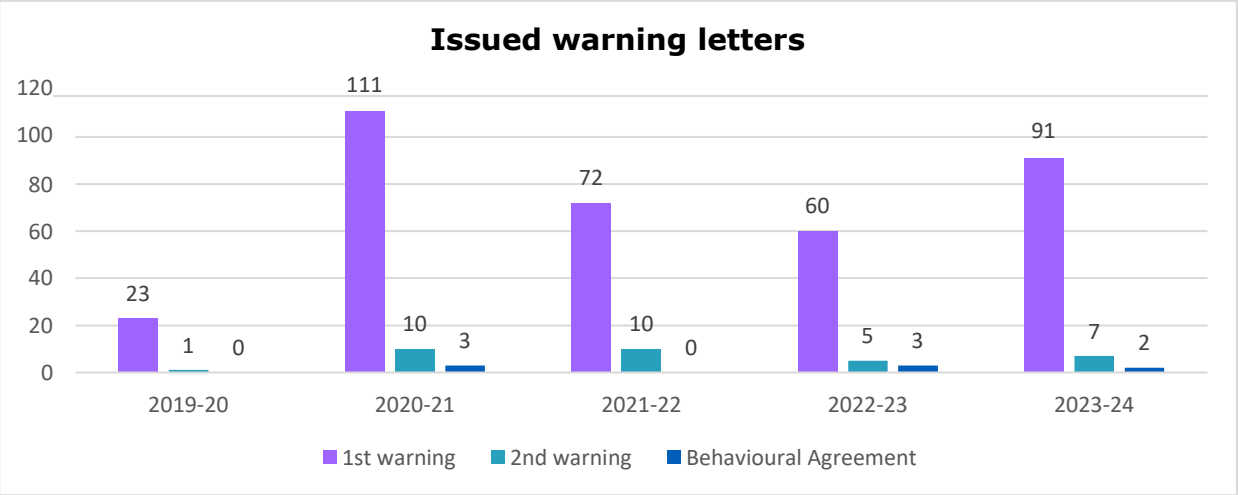


The graph below details the number of warning letters (previously known as zero tolerance letters) over the last 5 years. There are three types of letter issued: first warning, second warning and a behavioral agreement.

It is believed that the increased figures since 2020/21 are due to the promotion of the letters as an option to hold people to account for violence and abuse against staff.

The warning letters are requested by the ward/team affected following submitting a DATIX incident report. The above figures show that a larger amount of first warning letters are issued than any other, which could give an indication that the letters do serve a purpose in supporting our staff and holding the persons responsible to account.

The chart below shows the number of warning letters/behavioral contracts issued in 2023/24.



Police Engagement

The VAPR team have been liaising with various departments within Essex Police over the period. Excellent working relationships are being forged with the local single points of contact within the North, Mid, West and South of Essex. Steps are being made to work with Bedfordshire Police to undertake the same work in the area. Each of these areas have a dedicated Inspector and Police Constable to advise and assist EPUT with police matters/investigations.

The VAPR team chair monthly meetings for EPUT and Essex Police Management to discuss concerns of issues raised on a local level to problem solve, identify, and mitigate risks at a lower more immediate level.

In addition, present at the local meetings is a representative from the Police control room, this is to allow police or EPUT staff to raise any concerns about emergency or non-emergency calls in regards to EPUT sites.

At the beginning of 2023, Essex Police have committed officers to a newly formed mental health strategic department. The purpose of this team is to

- Bridge the gap between the Police and partner agencies regarding mental health Policies and procedures in order to ensure they are collaborative and fit for purpose.
- They aim to assist in highlighting and identifying high harm and high-risk individuals in order to ensure that all partner agencies and relevant stakeholders have a working plan in place in order to identify, monitor and prevent/reduce risk.
- They assist with training regarding mental health matters to ensure officers, staff and ourselves are kept up to date with the latest updates in law, policy and notable news events that may highlight learning points for us all in ongoing development.
- They research and identify best practice from other Police Forces and NHS Trusts around the UK to learn, share and implement in order to continually enhance our service delivery.
- They collate data regarding Section 136/135 detentions before forwarding to the Home Office as part of the required reporting process for National Statistics purposes.
- They reduce the volume and time spent on s136 detentions, through diversion, data tracking and escalation to improve the service to those in crisis.
- They collate data on behalf of the Coroner regarding sudden deaths reported as suspected suicides to identify trends, areas of concern and learning to aid in prevention purposes and to share with our partners.
- They aim to reduce the level of violence within health care settings through the nationally recognised Operation Cavell, through training, communication and dip sampling of investigations.
- Improve information sharing between agencies.
- Understand the victim and suspect experience for those suffering mental health through the criminal justice system.
- Identify projects to research and implement ensuring we are providing best practice and a professional service from Essex Police to service users, partners and relevant stakeholders.

10.0 RIDDOR

The legislative requirement to report any injuries, diseases or dangerous occurrences that meet the reporting criteria, is set under **The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).**

This process ensures that the Trust remains legally compliant by reporting any incident that falls within the parameters of the RIDDOR framework to the Health and Safety Executive (HSE). Reportable incidents can involve both patients and/or staff, depending on the circumstances.

If an incident is believed to be reportable under the RIDDOR criteria, the current process requires that a DATIX incident be created outlining the circumstances of what took place, including why this is believed to meet the RIDDOR criteria. Once this is achieved, the H&S/VAPR team will undertake an investigation to confirm if this meets the RIDDOR criteria. If it does, then they will report this directly to the Health Safety Executive (HSE) and update the DATIX report with the required reference number.

During this reporting period, there have been 40 reported incidents that have met the RIDDOR criteria; each of these has been reported to the HSE. A breakdown of these incidents are listed in the table below.

	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total
Major Injury (Fracture, Amputation, Loss of Sight etc.)	0	0	0	0	0	1	0	0	1	0	1	2	5
Staff off Sick for 7 Days or More	2	2	4	2	6	1	2	3	1	2	1	0	26
Staff off Sick for 3 Days or More	0	0	0	0	0	0	0	0	0	0	0	1	1
Disease/Infection	0	0	0	0	0	0	0	0	5	2	0	0	7
Exposed to, or in contact with, a harmful substance	0	0	0	0	0	0	0	0	1	0	0	0	1
Total	2	2	4	2	6	2	2	3	8	4	2	3	40

11.0 INDEPENDENT ASSURANCE

EPUT recognises the requirement for the effective management of health and safety and part of the effective management is assessing if we are doing what is required, to maintain and manage legislative compliance.

The Trust's internal auditors, carry out annual internal audits to test policy compliance at ward level, this tests adherence to policies at service level. The Audit Committee monitors recommendations and follow up actions.

Glossary of Terms

VAPR	Violence, Abuse, Prevention and Reduction
SWOT	Strengths, Weaknesses, Opportunities and Threats
PDCA	Plan, Do, Check, Act process
BWC	Body Worn Camera
PICU	Psychiatric Intensive Care Unit
GDPR	General Data Protection Regulation
LWD	Lone Worker Device
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulation
WRES	Workforce Race Equality Standard
WDES	Workforce Disability Equality Standard

Essex Partnership University NHS Foundation Trust

Trust Head Office
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Tel: 0300 123 0808

8.3 SAFEGUARDING ANNUAL REPORT 2023-2024

Decision Item | AS | 5

REFERENCES

Only PDFs are attached

Safeguarding Annual Report 02.10.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

Report Title:	**Safeguarding Annual Report 2023-2024**					
Executive/ Non-Executive Lead / Committee Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Tendayi Musundire, Deputy Director of Nursing for Safeguarding & MHA					
Report discussed previously at:	MHA & Safeguarding Sub-Committee, Safety of Care Group and Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	Note: within year CRR99 featured in the Corporate Risk Register within the Board Assurance Framework.		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with assurance that safeguarding of children, young people and adults is considered to be core business and is a shared responsibility with the need for effective joint working between partner agencies and professionals and outlines how the Safeguarding service is performing and promoting best practice.	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report, the improvements made during 2023/24 and the quality improvement priority areas for implementation during 2024/25.

2. Approve the report and agree publication.

Summary of Key Points

- 2023/24 has seen a continuation of the strengthening and improvement of the arrangements in place within the Trust to safeguard our most vulnerable patients.
- Safeguarding training meets the national standards as identified in the Intercollegiate Guidance 2019 (children) and the RCN Intercollegiate Guidance 2018 (Adults).
- The report provides a breakdown of activity by the safeguarding team during 2023/2024.

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			
MARAC	Multi-Agency Risk Assessment Conferences	ICB	Integrated Care Board
MAPPA	Multi-Agency Public Protection Arrangements	SU	Service User
MHA	Mental Health Act	MDT	Multi-Disciplinary Team
LADO	Local Authority Designated Officer	SAR	Safeguarding Adult Review
SAB	Safeguarding Adults Board	DHR	Domestic Homicide Review
CMHT	Community Mental Health Team	LAC	Looked After Children
RHA	Review Health Assessments	MCA	Mental Capacity Act
DoLs	Deprivation of Liberty Safeguards	LPS	Liberty Protection Safeguards
DA	Domestic Abuse	CSPR	Child Safeguarding Practice Review
EHCP	Education, Health Care Plan	HEF	Health Executive Forum
ICS	Integrated Care System	MACE	Missing and Child Exploitation in Essex
SEND	Special Educational Needs	SET	Southend, Essex and Thurrock

SETDAB	Southend, Essex and Thurrock Domestic Abuse Board	STP	Sustainability and Transformation Plan

Supporting Reports and/or Appendices

Attached report

Executive/ Non-Executive Lead / Committee Lead:

Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

SAFEGUARDING ANNUAL REPORT 2023-2024

REPORT CONTENTS

Foreword by Ann Sheridan, Executive Nurse

I'm pleased to share the 2023/2024 Safeguarding Annual Report for Essex Partnership University NHS Foundation Trust (EPUT), my first as the Trust's Executive Nurse.

This report is an opportunity to reflect on our safeguarding work over the last year and to look ahead to the priorities we have set ourselves for the coming year.

Safeguarding children and adults is at the heart of every service we provide – colleagues are committed to the safeguarding agenda and strive continuously to ensure people are protected from harm. Safeguarding is everyone's responsibility and it is vital that we continue to provide clinical and strategic support, advice and training to colleagues working across all areas of the organisation. Our Safeguarding Champions act as a conduit of information between the Safeguarding and clinical teams, providing specialist oversight and raising awareness of best practice.

During the year, we held our first ever safeguarding conference, attended by over 120 colleagues from within the Trust and from NHS England and local and regional partners. At the conference, we launched our sexual safety reporting flowchart and phone line, having recently become a signatory of the new NHS Sexual Safety Charter as part of our ongoing commitment to staff and patient safety. Other innovations during the year included our new domestic abuse support package for our staff and having our commitment to breaking the cycle of domestic abuse recognised by the countywide Alpha Vesta community partnership scheme. Partnership working continues to be incredibly valuable - the importance of working together with partners across all sectors to help keep people safe cannot be emphasised enough.

Looking ahead to the coming year, safety remains our absolute priority and safeguarding will always play a key role in helping us provide safe, high quality care. By delivering and maintaining the highest possible standards, we can ensure we do this for everyone who needs our help. I hope the information included in this report demonstrates the commitment of colleagues both within the Safeguarding team and across the Trust to do just that.

Local Authority Safeguarding Boards

Feedback

Southend Safeguarding Partnership (SSP)

"reported last year that Essex Partnership University NHS Foundation Trust (EPUT) is an active core member of the Partnership, and nothing has changed. EPUT continue to Chair the SSP Performance, Audit, Quality and Assurance Subgroup and are now one of the longest standing chairs.

The support offered to SSP and its Partners throughout the year includes actively engaging in all case reviews, audits, self-assessments, consultations, and presenting at the Annual Conference, and providing input to all Partners during the National Safeguarding Awareness Week. EPUT is one of the strongest members of the SSP and they continue to be represented at all meetings and respond to all requests for support."

Essex Safeguarding Adults Board

"Essex Partnership University Trust (EPUT) continued to be a valued member of the Essex Safeguarding Adults Board (ESAB) throughout 2023/2024, regularly attending and contributing to main Board meetings and several Sub-Committee meetings, such as the Safeguarding Adult Review Committee (SAR) and the Southend, Essex and Thurrock Multi-Agency Safeguarding Adult Policy and Procedure Group. Alongside this EPUT's Deputy Director of Nursing for Safeguarding and Mental Health Act, has taken on the role of Chair for our newly reconvened Prevention and Awareness Sub- Committee, with the first meeting taking place in March 2024 where both Terms of Reference and the Delivery Plan were set out.

The ESAB Independent Chair has requested regular updates from EPUT, in relation to their Patient Safety strategies; planning; implementation, quality assurance processes and outcomes from change programmes – in order to seek assurance and accountability from EPUT. The Chair has also arranged for an onsite visit to be made to a number of EPUT's mental health units, where she will meet with both patients in receipt of mental health care; EPUT's Senior Management Team and their operational staff.

EPUT have continued to share assurance issues, with candour and transparency and ESAB wish to acknowledge the effort that EPUT has been undertaken, to share their improvement journey. We, as a partnership Board continue to support EPUT in its ongoing endeavours to improve organisational and cultural change, recognising that there is still yet more to be done, in the belief that despite challenge: 'together we achieve more."

What is the role of the safeguarding team?

Safeguarding Structure

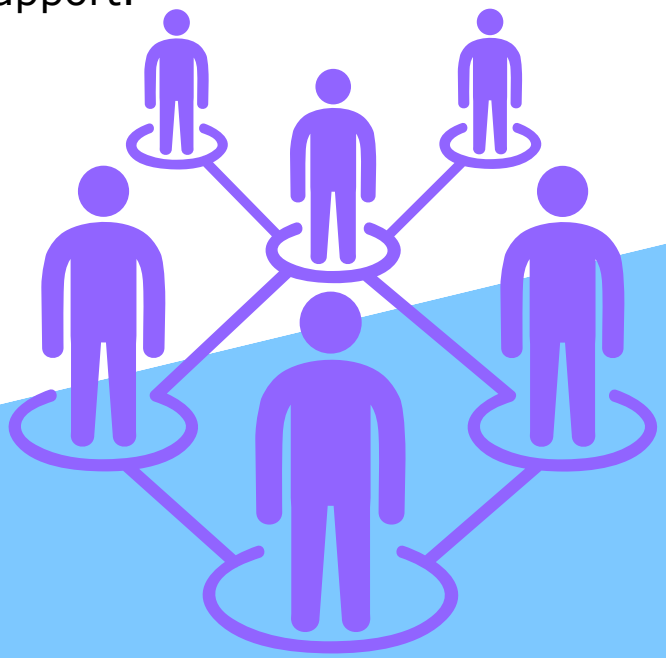
Within Essex Partnership University Trust (EPUT), the Executive Nurse is responsible for the delivery of the Safeguarding Service which includes the Mental Capacity & Deprivation of Liberty service, Domestic Abuse, MARAC, MAPPA, PREVENT and the Looked after Children service.

The Safeguarding Service is led by the Deputy Director of Nursing for Safeguarding & Mental Health Act covering Mental Health and Community Services across the organisation.

The team has adopted a "Whole Family" philosophy and are providing an integrated approach to safeguarding provision, which is facilitated by joint meetings and peer support.

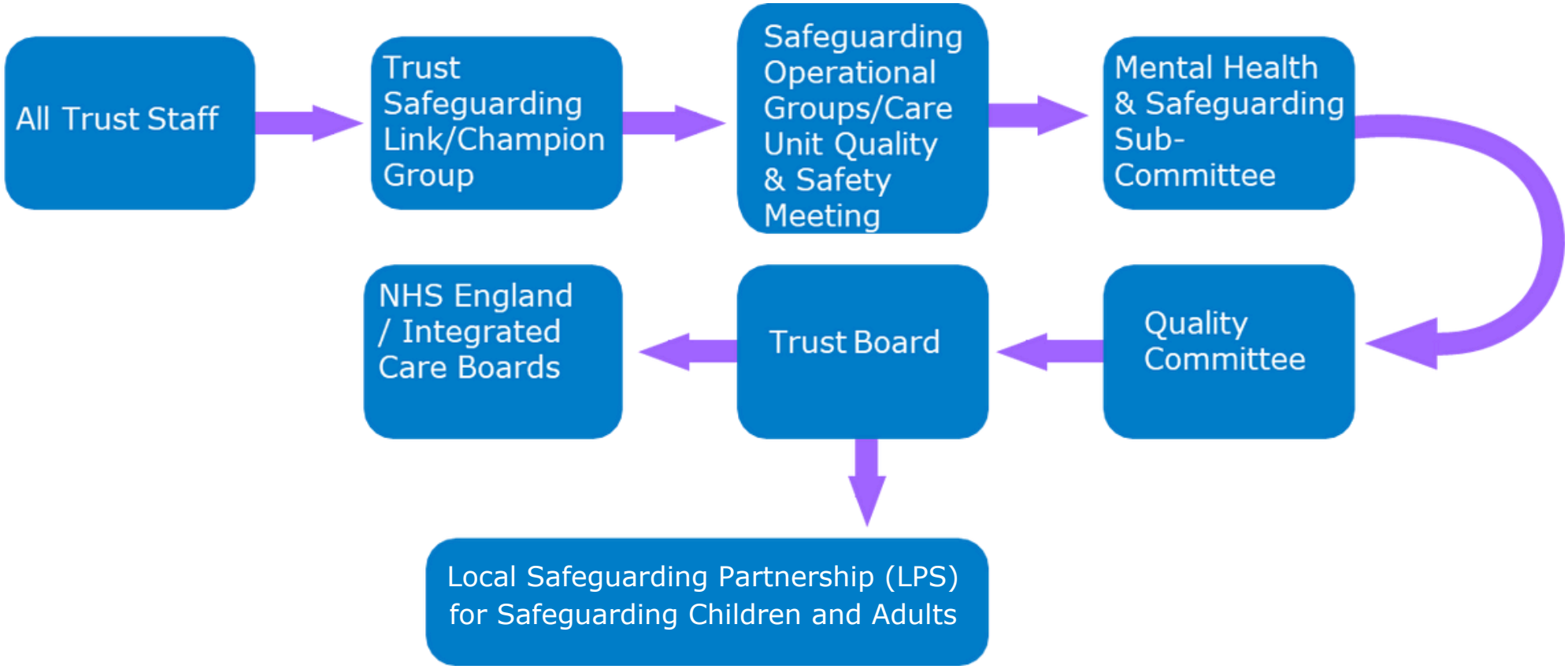
The team consists of a variety of professionals such as Registered General and Mental Health Nurses, Health Visitors, Social Workers, Midwives and an Occupational Therapist, all of whom bring additional expertise to the service.

The Integrated adults and children's safeguarding team operate a duty system between the hours of 9-5 Monday to Friday across EPUT.



Safeguarding Service 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 Service provides regular reports for the Local Authority, Integrated Care group (ICB) and NHS England.

Business Support

The Business Support Safeguarding Team provide secretarial and administrative support to the Safeguarding Service. They administer the 'Duty Line', a single point of access number & email which feeds into the team. Business Support receive a high workflow of enquires as to whether the adult/child is open to our secondary Mental Health Service from:

- Social Workers
- Police
- Social Care Teams
- LA Business Support Teams

Following triage from the duty clinician, Business Support administer the safeguarding enquiry or case management process where further action or progression are required to be communicated. Business Support administer the booking function that supports provision of mandatory, informal and group safeguarding supervision for practitioners within EPUT.

The Administrators also support the child death review process by notifying safeguarding clinicians of the receipt of a child death notification within Essex in the organisation, so that they can identify the relevant practitioners that have been involved in the child's care.

Business Support receive, disseminate and manage the Safeguarding Children inbox. This includes information received or requested from:

- Domestic abuse notifications
- Child Protection Minutes and Invitations
- Children's Social Care
- LADO
- National Crime Agency
- Essex Police
- Prevent Enquiries
- MARAC
- Safeguarding adult Reviews (SAR)
- Domestic Homicide Reviews (DHR)

The Team produce a monthly Safeguarding newsletter, covering clinical topics identified by the Safeguarding Team and administrate the Safeguarding Champions events.

Business support has been under review and restructure to ensure that administrative functions are robust and effective in delivering on safeguarding priorities and this is expected to be in place from April 2024.

Supervision

There are a variety of models used within EPUT for safeguarding supervision, these include; individual, group, peer, as well as pre & post case conference supervision. The safeguarding clinical specialists within the Safeguarding Team are trained to offer supervision across the Trust. They receive supervision internally from the named professionals for the clinical skill mix team and the named safeguarding children's nurse receive their supervision externally for themselves through arrangements with the designate professionals.

Supervision enables both the supervisor and the supervisee to reflect, scrutinise and evaluate cases where safeguarding concerns have occurred. The process of safeguarding supervision is both educative and supportive whilst facilitating the supervisee to explore their feelings about the work and the family. Staff will be encouraged to use professional curiosity when discussing their cases and will bring cases for escalation. As a 'Whole Family' organisation, we offer formal supervision to both Adult and Children's Services. The frequency of supervision is mapped to the roles that staff undertake within the organisation. Supervision covers safeguarding concerns in regard to both children and adults safeguarding.

Children's Services are expected to comply with a mandatory safeguarding supervision framework which is monitored closely for compliance. Adult Services access supervision sessions through their link safeguarding clinical specialist, for children or adult concerns as required, if duty advice is not considered sufficient to meet the need of a case. The model offered is a flexible one, with most of the supervision contact taking place via Microsoft Teams or face to face within a community base or inpatient setting.

The Safeguarding Team also offer joint supervision where practitioners across services are working with the same family. This is actively encouraged in the Trust to support the building of knowledge and skills in practice and the organisation's active ethos of 'Whole Family', both adult and children concerns can be considered, and a plan agreed and documented.

Benefits of Supervision

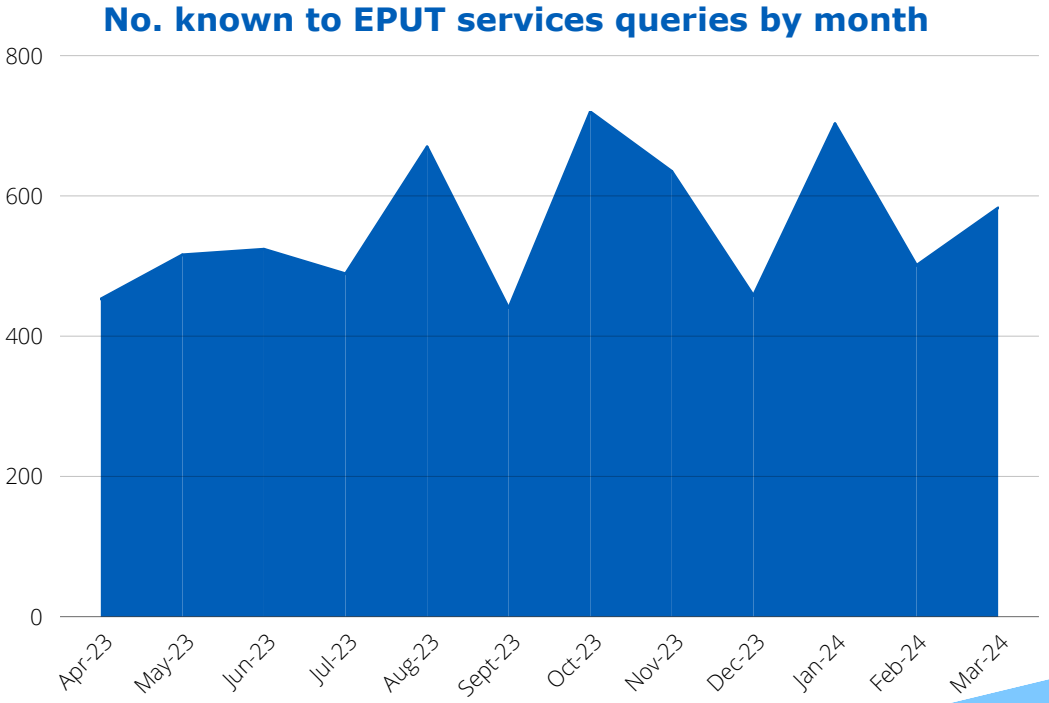
The benefits of supervision are well documented, and the model adopted by the Safeguarding Team covers the four areas below:

- Management (ensuring competent and accountable performance/practice)
- Engagement/mediation (engaging the individual with the organisation)
- Development (continuing professional development)
- Support (supportive/restorative function)

Initial involvement queries from partner agencies

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Number of queries	453	516	524	489	670	440	720	635	458	703	501	583
Average no. per day	24	26	24	23	29	21	33	29	22	31	24	28
Month on month change	-7.8%	+8.2%	-7.7%	-2.2%	+25.1%	-28.1%	+56.2%	-11.8%	-24.4%	+53.5%	-28.7%	+16.4%

Business support receive an average of 26 Known to service queries per day from both the local Authority and Police.



Duty System

DUTY CONSULTATIONS
1686 advice calls taken by duty line

The service has a safeguarding duty system operating between the hours of 9-5 Monday to Friday. The duty system has proved invaluable, providing a reflective space to discuss and clarify adult or children safeguarding concerns and to provide support to practitioners on next steps. Safeguarding specialists provide advice to operational teams in cases where the safeguarding threshold has not been met, but operational teams require guidance on forward actions to manage emerging risks.

The service operates a single point of access for all safeguarding matters, which has streamlined processes and supports timely access to specialist safeguarding support.

Core duty functions are:

- Where a person is open to EPUT, triage the concern and confirm if it meets criteria for a Section 42 Safeguarding enquiry or an Alert, sharing the relevant information with the team(s) supporting that person.
- Assist practitioners to decide whether a safeguarding children referral is required under section 17/47 to Children's Social Care.
- Provide advice and support to clinical staff regarding escalation of a safeguarding children/adult case.
- Provide advice to Trust staff and agree a plan for any safeguarding concerns/queries.
- To discuss/explore issues that may be preventing staff from raising a safeguarding concern or delay conducting a safeguarding enquiry.
- Review completed Mental Capacity Assessment forms and discuss any issues with all Trust staff.
- Deal with complex safeguarding child/adult issues from both local authorities, police and EPUT staff.
- Providing relevant information about specific individuals for Multi-Agency Risk Assessment Conferences (MARAC) and Multi-Agency Public Protection Arrangements (MAPPA) processes as requested.
- Supporting learning by providing a reflective space where practitioners can explore a situation, & gain an understanding as to why the issue may or may not present as a safeguarding concern, and identify forward actions to manage risk.
- Provide a point of contact for advice to partner agencies. Promoting multi-agency working. Maintaining links with key staff/ teams within other agencies to support this approach.

Themes from Duty System

Safeguarding activity remains high with a total of 1686 calls reported in 2023/24.

EPUT services have been advised of 206, S.17 enquiries and 81, S.47 enquiries for children and young people under the care of EPUT service users during the reporting period.

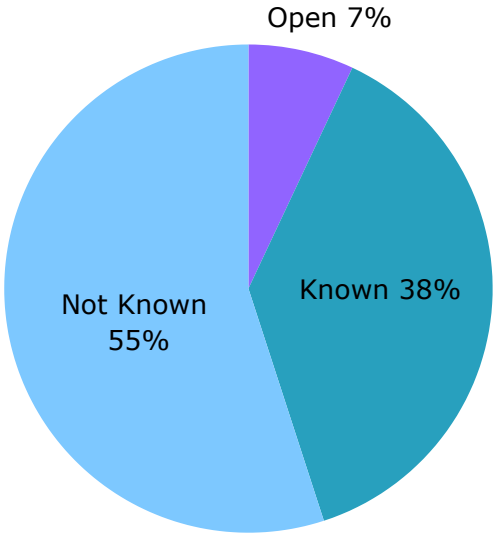
This highlights the need for practitioners to adopt a Whole Family Approach when working with families to de-escalate potential harm and support positive outcomes for children and young people.

Key themes reported through duty:

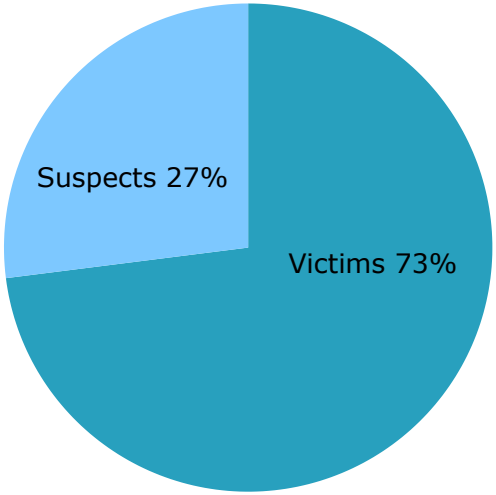
- Concern for risk taking behaviour where the service user has capacity (using illicit substances/sexually disinhibited behaviour).
- Advice on historical sexual/physical abuse cases where victim does not wish to take any action but others may be at risk.
- Escalation in cases where staff are concerned at the outcome of a referral or cases closed where the level of risk posed to child/adult remains high, requiring specialist advice and support to challenge.
- Increased case discussions for people who have comorbidities or dual diagnosis.
- Escalation in self-neglect cases where there is capacity and patient is declining support.
- Increased contact from staff who are experiencing domestic abuse.
- Management of perpetrators of domestic abuse.
- Support with progression of ongoing enquiries where the lead investigator has hit a barrier and needs advice on how to progress the case to conclusion.

MARAC

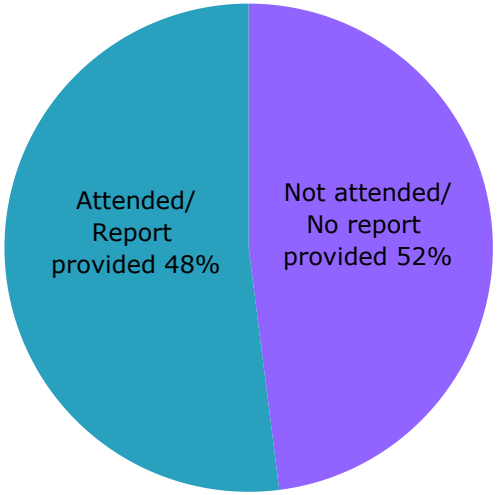
Essex MARAC
April 2023 - March 2024



Essex MARAC open to EPUT
April 2023 - March 2024



Essex MARAC meeting attended/report provided
April 2023 - March 2024

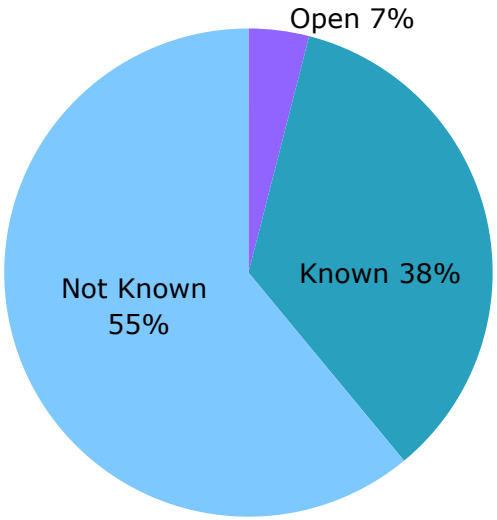


In 2023 – 2024, there were 267 services users open to EPUT who were known to MARAC, compared to 345 in 2022-2023.

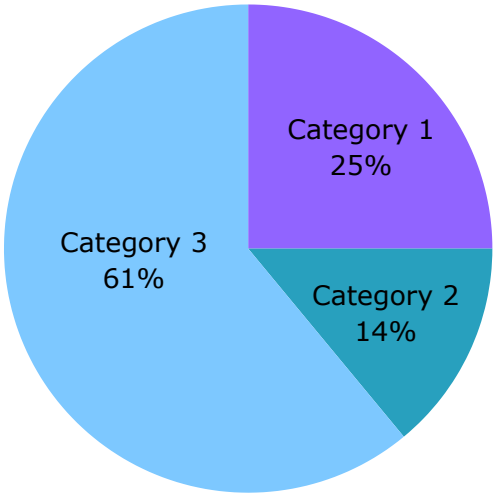
In 2023 – 2024, there was a 47% decrease in clinical teams providing a report or attending the MARAC meeting for services users who were open to EPUT at the time of the meeting, compared to 2022-2023.

MAPPA

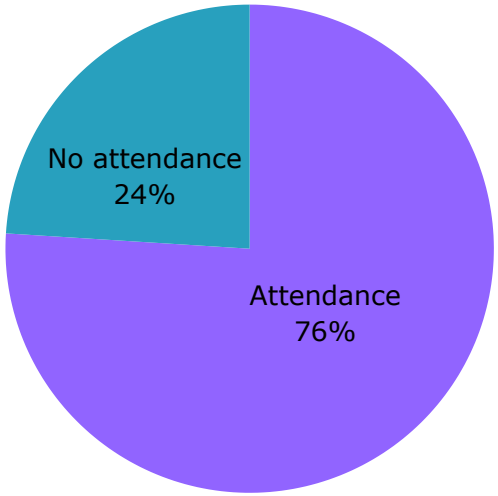
MAPPA Initial requests for information sharing April 2023 - March 2024



MAPPA open to EPUT cases heard April 2023 - March 2024



MAPPA EPUT clinical team attendance/report provided April 2023 - March 2024



During 2023–2024, the Safeguarding Team received 679 MAPPA Initial Requests for Information Sharing, of which 48% were received in Q4.

Comparing data between Q4 2022-2023 and 2023-2024, there was an increase of 146% for these requests.

For the MAPPA meetings that were held 2023-2024, 53% of offenders were known to EPUT, with 16% being open to a team at the time of the meeting. For those that were open, 61% were registered as a Category 3 other dangerous offender.

In Q4 2023–2024, there was a 41% increase in clinical teams attending the MAPPA meeting for service users who were open to EPUT at the time of the meeting, compared to the same time period in 2022-2023.

Key Safeguarding Facts

April to March	2021-22	2022-23	2023-24
Mandatory 1:1	478	433	269
Group (no. of participants)	254	503	395
Additional	216	158	12
Total	948	1094	-

The data continues to show the number of practitioner supervisions. Staff are positively engaging with Safeguarding Supervision in adherence with Intercollegiate guidelines.

The number of mandatory safeguarding supervisions has reduced following the transfer of Children's, Young People and Families Public Health Services to Southend City Council.

Benefits of Supervision

The benefits of supervision are well documented, and the model adopted by the Safeguarding Team covers the four areas below:

- Management (ensuring competent and accountable performance/practice)
- Engagement/mediation (engaging the individual with the organisation)
- Development (continuing professional development)
- Support (supportive/restorative function)

Supervision

Paediatric Liaison Health Visitor

"I find it really useful to talk about our role and how safeguarding is an important part of liaison.
Although we do not carry a caseload our supervision is still relevant and is a good time to discuss how we manage issues that arise with children attending ED."

South East Perinatal

"Marie escalated someone I discussed in supervision where baby was on CP and reduced down and I was the only professional who disagreed with this decision and also one from supervision Marie supported me with that decision."

Specialist School Nurse

"The safeguarding team have always been accommodating. I have been able to express my concerns and then together, have discussed it in detail and come up with a suitable plan. The team are all very friendly and approachable."

Paediatric Liaison Health Visitor

"I have found safeguarding supervision extremely helpful as it is a safe space to discuss cases that we are unsure on how to manage and gain advice from yourselves and other colleagues . It is also great to hear about other peoples experiences so that we are equipped with the knowledge should we every see ourselves in the same situation."

Prevent

- A representative from EPUT Safeguarding team attends monthly Prevent Channel Panels as a core member for Essex & Southend and Thurrock. In total, 13 service users known to EPUT were presented at Panel.
- The Safeguarding Prevent lead responds to queries from the Prevent Police in addition to the routine information requests in preparation for Channel Panels.
- Safeguarding Prevent lead and administration team will ensure that any known Prevent information is shared with the clinical teams to inform robust risk assessment.
- Safeguarding Team Duty clinician or Prevent Lead will triage all Prevent referrals raised by EPUT staff and forward these onto the Prevent police team if appropriate.
- In Q4 23/24, Extreme Right wing referrals were the most suitable for progression by Prevent police.
- For 23-24, there has been five EPUT Prevent referrals. There has been a decline in The Eastern Region in referrals from Health, Education remain the highest referrer.
- The Internet has become increasingly prominent in radicalisation pathways and offending over time for convicted extremists in England and Wales.
- Mental health issues, Neurodivergence and personality disorder/ difficulties alongside depression and personality disorder/ difficulties have been recorded in a Study published by the HM Prison and Probation Service (2022) as the most common types of disorders for those who have primarily been radicalised online.
- All EPUT Staff will need to complete HM Government Prevent Duty Training Modules 1 & 2 Prevent awareness & Prevent referrals.

Domestic Abuse

- The Trust is committed in supporting employees who are experiencing domestic abuse (DA), around their health, safety and wellbeing; supporting them to remain productive and efficient at work. In realising this commitment the organisation's Employee Experience Team and Safeguarding Team have developed a staff support pathway, to enable employees to access support both internally and externally via a number of specialist organisations.
- The staff support pathway is informed by the Domestic Abuse Toolkit which has been developed in partnership with Alpha Vesta, a specialist domestic abuse consultancy. This toolkit aims to create awareness about domestic abuse and demonstrates the support any employee can access if they are experiencing it.
- Domestic abuse is a complex issue that requires effective partnership working to ensure wrap around support to individuals at the time that they need it. The Safeguarding Service, in partnership with SETDAB, are currently delivering a pilot project funded by Standing Together Against Domestic Abuse (STADA), which provides a Mental Health Domestic Abuse Practitioner from Next Chapter, to support staff and service users across the North and Mid Essex Localities. The aim of the project is to support learning and understanding of domestic abuse within the organisation and to increase access to specialist domestic abuse services for service users, their families and staff. In Q4, Next Chapter received 42 referrals from EPUT Staff, representing a 30% increase on the same quarter last year which could be attributed to the increased awareness of services due to the project.
- In collaboration with Alpha Vesta, the Safeguarding Team, has over the past year, been delivering Domestic abuse awareness training and Line managers training to increase awareness when supporting service users or colleagues experiencing domestic abuse. Since June 2023, 1135 staff members have accessed this training with more training planned for the remainder of the year. In quarter 4, over 252 practitioner have attended additional training on MAPPA/MARAC and Coercive control delivered jointly with partner agencies.

Challenges and Innovations

Challenges

- Poor representation at Mental Health Act and Safeguarding Sub Committee impacts the governance of the group due to not being quorate, which compromises the delivery of safeguarding arrangements. The Executive Nurse sent emails to the members of the Sub Committee, highlighting the importance of attending the Sub Committee. This had a positive effect and the attendance improved.

- Increase in both levels of complexity and safeguarding activity requiring specialist oversight from Safeguarding Team within operational teams to support timely, robust and rigorous safeguarding enquiries. The safeguarding team successfully recruited a clinical practitioner for safeguarding which was essential in supporting operational teams. We have also increased our presence in operational teams and are offering safeguarding clinics and drop in sessions.

- Raising awareness within the organisation regarding the application of the Mental Capacity Act (2005). We have given bespoke training sessions on the Mental Capacity Act (2005). The Mental Capacity Act (2005) has also featured in the Safeguarding Newsletter.

- Responding and being involved with a high volume of Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Practice Reviews across the SET Area. The Safeguarding team are working collaboratively with operational teams with regards to EPUT involvement in all reviews. We are sharing responsibility in regards to involvement and reviews.

- An increase in both the non-attendance or provision of a report to update the MARAC and to inform risk management & safety planning, when a patient who is open to EPUT is being discussed. However, there has been a significant increase of 41% in representation by staff with MAPPA. EPUT have delivered awareness sessions with regards to MARAC and MAPPA involvement. Our MARAC MAPPA co-ordinator also delivers bespoke sessions to the various teams.

Challenges and Innovations

Innovations and Achievements

- Continue to work Alpha Vesta, a specialist domestic abuse consultancy, a review has taken place of the Domestic Abuse Toolkit. Training for frontline managers in supporting staff who are experiencing domestic abuse (DA) was delivered in June and in total 114 managers and advisors from HR, Employee Experience and the Safeguarding Team attended. This training is designed to provide an awareness of domestic abuse and to assist managers in supporting colleagues who maybe experiencing DA through risk assessment, workplace adaptation and access to internal and external forms of support.
- Commencement of the Mental Health Domestic Abuse Practitioner Pilot, in partnership with Next Chapter delivered within Mid and North Essex. Early data already shows an increase in the number of EPUT service users being referred and supported to access specialist domestic abuse services (29 in January to 37 as of end of February '24). Next Chapter are also offering short term interventions to service users and a programme of training to clinical staff.
- Restructure of business support functions to improve efficiency and effectiveness.
- Successful recruitment to all vacant posts.
- The team have worked with the transformation team to support best practice in safeguarding record keeping through the integration of safeguarding processes into the patient record, with the incorporation of S.42 SET Safeguarding forms into Electronic Patient Records – Paris.
- Review of all children's and adults safeguarding policies and procedures.
- Delivery of a programme of safeguarding champions events on key themes.
- Contribution to the ECOL learning matters events and newsletter.
- Delivery of bespoke training packages in response to operational teams training needs.
- Successful disaggregation of delegated safeguarding responsibility under S.75 with Southend City Council.

Forward Plan Review 2023/24

Objectives 2023/24	Success Criteria
Completion of the Safeguarding Audit Programme for 23/24 to provide assurance on the quality of safeguarding practice within the organisation and to inform service improvement	EPUT has engaged in the following partnership audits: • Multi Agency Targeted Audit – Essex • Multi Agency Case Audit • ICB Safeguarding Audit • Joint assurance visits with system leaders fro Safeguarding Partnerships
Integration of MHA and Safeguarding Functions	The Named Professional for Quality and Governance has worked jointly with the MHA Team to support reporting and governance processes, this work is ongoing. A review of current resource allocation for both teams to support and complement statutory processes is also ongoing.
Review and submission of the Section 11	This was completed and was subject to peer review process with a successful ratification by the Local Safeguarding Partnership Boards. Under the Children Act 2004 and the Education Act 2002, EPUT is required to undertake an audit of its statutory responsibilities regarding the safeguarding of children and the promotion of their welfare within the community as described within section 11 (s11) of the Children Act.
Domestic Abuse	The Domestic Abuse Training Framework to support both clinical teams and line managers in their practice to support service users and staff who maybe experiencing domestic abuse has been delivered through out the year. To date 1135 staff members have attended this training. The Trust, in partnership with Next Chapter, are delivering a Mental Health Domestic Abuse Practitioner pilot within NE and Mid Essex to support service users experiencing Domestic Abuse.

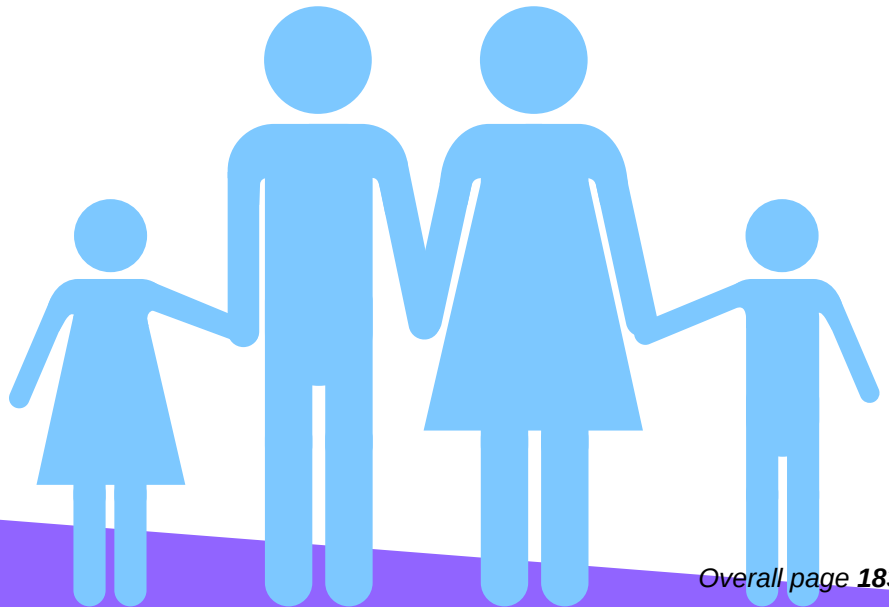
Objectives 2023/24	Success Criteria
Whole Family.	This piece of work is on going. The team is represented at the SET Whole Family Approach Working Group to identify key principles and resources to support best practice. Whole Family has also been a theme presented to the Trust Learning Collaborative Partnership.
The Trust will implement the new Liberty Protection Safeguards (LPS) effectively with sufficient resourcing to support its implementation.	This remains on hold following the publication of the letter from Department of Health, on 16th of December 2021, stating a delay in the implementation of LPS. This remains on hold until further government direction is received.
Align the Safeguarding service to the new Sustainability and Transformation Plans (STP) and Integrated Care Systems (ICS) systems and processes.	We have actively engaged in the provider collaborative for the Mid and South Essex ICS. The Health Executive Forum was regularly updated of the actions of the provider collaborative.
Implementation of the Trusts Safeguarding Strategic Framework.	The Annual Report provides evidence that demonstrates delivery of the objectives in the strategic framework.
Creation of Looked After Children (LAC) team EPUT dashboard to enable service analysis of lac population/cohort.	This piece of work was initially halted but has now been reallocated within the Performance Team and is being progressed to completion.
Development and implementation of outcomes of LAC Service Business Case undertaken subject to agreement and contract variation.	This is under development with the creation of new job descriptions and a review of current teams alongside the recruitment of additional resource as a result of the increase in funding. The first objective on the business case addition to the success criteria, is for the ICB to provide a contract variation and the appropriate financial resource to implement the agreed business case .

Partnership Working

The Trust is actively represented on all the Local Authority Safeguarding Children and Adult Partnerships by Executive Directors, Directors and the Deputy Director for Safeguarding within the areas where the Trust provides care. 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 in. The Partners seek help and expertise from the Trust in developing strategies/protocols which include aspects of mental health etc.

One Local Authority has co-commissioned with the ICB and the EPUT Safeguarding Children team to support the Southend Children, Young People and Families Public Health Services. 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, Learning and Development, Performance, Audit, Quality and Assurance, Case Review, Policy Development etc.

These are attended by members of EPUT Safeguarding Team who actively participate in achieving the aims of the business plans of the individual Safeguarding Partnerships.



Communications

Safeguarding Champions

Safeguarding Champions act as conduit of information between the Safeguarding Team and their clinical area by raising awareness of safeguarding practice and initiatives and supporting the identification of team learning needs.

The following Champions events have been held during the reporting period to support this function and are open to Safeguarding Champions and EPUT Practitioners to support best practice in safeguarding.

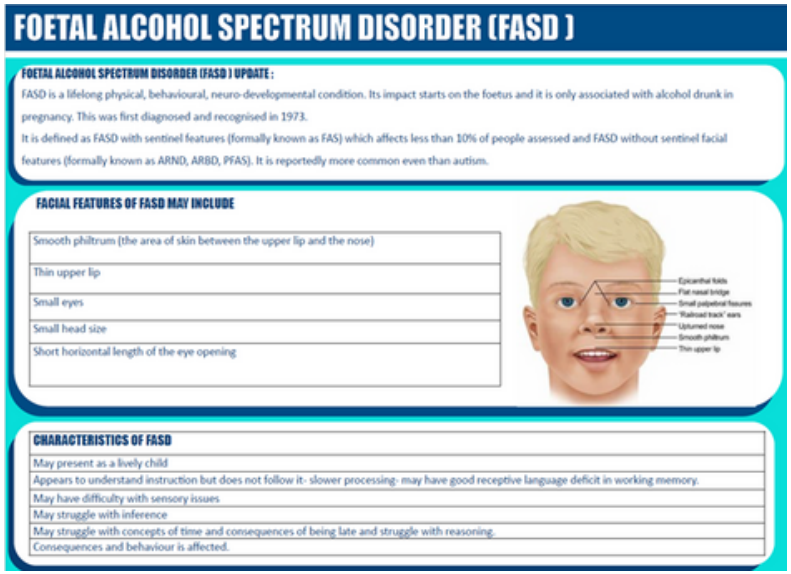
April 23- Family Group Conference attended by 93 staff members.

July 23- Re Think Advocacy attended by 73 staff members.

August 23- MARAC, MAPPA & Essex Mental Health Prevention Team attended by 110 staff members.

March 24- Suicide and Domestic Abuse attended by 111 staff members.

Communications



FOETAL ALCOHOL SPECTRUM DISORDER (FASD)

FOETAL ALCOHOL SPECTRUM DISORDER (FASD) UPDATE :

FASD is a lifelong physical, behavioural, neuro-developmental condition. Its impact starts on the foetus and it is only associated with alcohol drunk in pregnancy. This was first diagnosed and recognised in 1973.

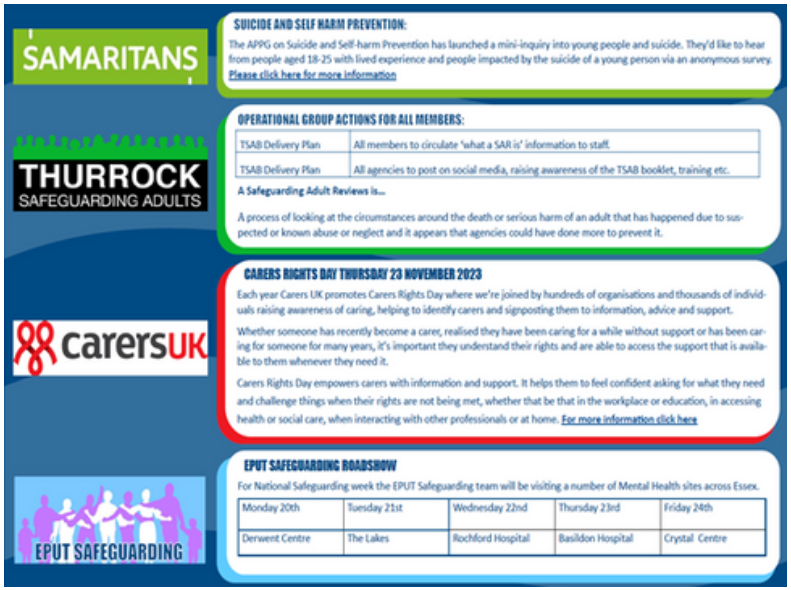
It is defined as FASD with sentinel features (formally known as FAS) which affects less than 10% of people assessed and FASD without sentinel facial features (formally known as ARND, ARBD, PFAS). It is reportedly more common even than autism.

FACIAL FEATURES OF FASD MAY INCLUDE

Smooth philtrum (the area of skin between the upper lip and the nose)
Thin upper lip
Small eyes
Small head size
Short horizontal length of the eye opening

CHARACTERISTICS OF FASD

May present as a lively child
Appears to understand instruction but does not follow it- slower processing- may have good receptive language deficit in working memory.
May have difficulty with sensory issues
May struggle with inference
May struggle with concepts of time and consequences of being late and struggle with reasoning.
Consequences and behaviour is affected.



SAMARITANS

SUICIDE AND SELF HARM PREVENTION:

The APPG on Suicide and Self-harm Prevention has launched a mini-inquiry into young people and suicide. They'd like to hear from people aged 18-25 with lived experience and people impacted by the suicide of a young person via an anonymous survey.
Please click here for more information

THURROCK SAFEGUARDING ADULTS

OPERATIONAL GROUP ACTIONS FOR ALL MEMBERS:

TSAB Delivery Plan	All members to circulate 'what a SAR is' information to staff.
TSAB Delivery Plan	All agencies to post on social media, raising awareness of the TSAB booklet, training etc.

A Safeguarding Adult Reviews is...

A process of looking at the circumstances around the death or serious harm of an adult that has happened due to suspected or known abuse or neglect and it appears that agencies could have done more to prevent it.

carersUK

CARERS RIGHTS DAY THURSDAY 23 NOVEMBER 2023

Each year Carers UK promotes Carers Rights Day where we're joined by hundreds of organisations and thousands of individuals raising awareness of caring, helping to identify carers and signposting them to information, advice and support.

Whether someone has recently become a carer, realised they have been caring for a while without support or has been caring for someone for many years, it's important they understand their rights and are able to access the support that is available to them whenever they need it.

Carers Rights Day empowers carers with information and support. It helps them to feel confident asking for what they need and challenge things when their rights are not being met, whether that be that in the workplace or education, in accessing health or social care, when interacting with other professionals or at home. For more information click here

EPUT SAFEGUARDING

EPUT SAFEGUARDING ROADSHOW

For National Safeguarding week the EPUT Safeguarding team will be visiting a number of Mental Health sites across Essex.

Monday 20th	Tuesday 21st	Wednesday 22nd	Thursday 23rd	Friday 24th
Derwent Centre	The Lakes	Rochford Hospital	Basildon Hospital	Crystal Centre

Safeguarding Newsletter

The newsletter is published on a monthly basis and is circulated to all Safeguarding Champions and Operational Leads for wider distribution within the organisation.

Topics reported over the past year include:

- Themes from Safeguarding Reviews
- Escalation
- Mental Capacity Act
- Learning from Domestic Homicide Review 'Kimmi'
- Hidden Harms- Abuse and Older People
- The Hardest day of the year- Age UK
- Foetal Alcohol Spectrum Disorder
- Male Domestic Abuse
- NSPCC Learning
- ESCB Development Opportunities
- Southend Safeguarding Update
- DHR Briefing Beth
- DASH Training
- Survivors of Domestic Abuse fund
- The Change Hub
- Child Accident Prevention Trust
- National Children and young Peoples Mental Health

Communications

Alpha Vesta Community Advocate Scheme
EPUT Safeguarding are proud to announce that we have been presented a certificate of recognition to recognise our commitment to "Breaking the Cycle of Domestic Abuse"

The Alpha Vesta Community Advocate Scheme is funded by the Police, Fire, and Crime Commissioner for Essex. Its purpose is to recognise those Essex Employers and Organisations that have demonstrated their continued commitment in raising awareness and building understanding of domestic abuse within their community. It is through this scheme that the EPUT Safeguarding Team, and therefore EPUT, has been recognised as an Employer/Organisation that has demonstrated the important role an Employer and Workplace has in 'breaking the cycle of domestic abuse.

Since the scheme was fully launched in April 2023, businesses and organisations throughout the county have actively engaged with our services to provide their staff with awareness programs, training sessions, and policy, procedure, and guidance development. These valuable partnerships collectively contribute towards our vision and mission of engaging, educating, and empowering communities and workforces. Many of our Community Advocates also provide us with their ongoing valuable time, expertise, and skills which we are immensely grateful for.

Our Community Advocates are awarded a certificate and the use of the Community Advocate badge as a symbol that represents an Employer or Organisation that is invested in supporting their people.

The following events were held in September:

- Domestic Abuse Basic Awareness, attended by 68 staff members.
- Line Managers Training: Supporting Staff Experiencing Domestic Abuse, attended by 84 staff members.
- The impact of Domestic Abuse on Children and Young people, attended by over 200 staff members.

The following events were held in October:

- Domestic Abuse Basic Awareness, attended by 68 staff members.

The following events were held in March:

- Domestic Abuse Basic Awareness and Staff Toolkit, attended by 137 staff members.
- Impact of Domestic Abuse on Children and young people training, attended by 115 staff attended.
- Domestic Abuse Line Manager training, attended by 56 staff attended.

Communications

Sexual Safety Conference

The Trust held its first Sexual Safety Conference on the 20th February 2024 attended by 120 delegates from EPUT, NHSE, ICB and partner agencies. The event was well received with key note speakers specialising in sexual trauma and lived experience. At the conference the Trust launched its sexual safety reporting flowchart and phone line.

The event follows the Trust becoming a signatory of the new NHS Sexual Safety Charter as part of our ongoing commitment to staff and patient safety. Presenters included Tendayi Musundire, Director of Safeguarding, who spoke about the work of the Trust's Sexual Safety Committee and Zoe Lodrick, a psychotherapist with more than 20 years' experience in providing counselling and psychotherapy to people who have experienced rape or sexual assault. They were joined by Kate Lorrimer, Deputy Head of Quality Transformation at NHS England, who shared learning from lived experience and the national sexual safety collaborative.

Since the launch of the sexual Safety Intranet page we have had the following views:

February: 380 Views
March: 339 Views

Safeguarding Adult Reviews

Safeguarding Adults Reviews (SARs) are a statutory requirement for Safeguarding Adults Boards (SABs).

Safeguarding adult practice can be improved by identifying what is helping and what is hindering safeguarding work, in order to tackle barriers to good practice and protect adults from harm.

In 2023/24, the organisation has contributed to 16 SAR's, 7 of which have been commissioned during 2023 to 2024. Of these reviews 4 are combined reviews, bringing together the SAR requirements with a Domestic Homicide Review(DHR).

Learning from all Safeguarding Adult Reviews has featured further in this report under Key Themes from wider learning.

Domestic Homicide Reviews

Domestic Homicide Review (DHR) is a multiagency review into the circumstances around a death of someone following domestic abuse. The purpose is to establish what can be learned from the death regarding the way in which local professionals and organisations work individually and together to safeguard victims.

During 2023, the organisation has contributed to 11 DHR's, five of which have been commissioned during the report period. Off these reviews, three have also been joint Safeguarding Adults Reviews.

The Trust has been contributed to two DHR's that have been published during the report period:

- 'Bob'
- 'Kimmi' Joint DHR/SAR

Key Themes

- Improved understanding of carers assessments and support for carers particularly those coming to terms with a close relative diagnosed with dementia.
- Carers Stress and the understanding of and provision of support to prevent it potentially manifesting in other forms of abuse.
- Raising and investigating of safeguarding concerns appropriately.
- Risks around the lawful possession of firearms.
- The importance of routine enquiry and professional curiosity.
- How layers of intersectionality can impact on men being identified as victims of abuse and the impact of unconscious bias on females being identified as possible aggressors.
- Generational attitudes and barriers to persons being able to accept support.
- Knowledge linked to domestic abuse and mental health and how they work in partnership.
- The complexities of abusive relationships where there is violence by both parties with an addiction to alcohol.

Learning from Children's Safeguarding Practice Reviews

Key Themes

During 2023, the organisation has been involved in two CSPR's.

- Staff are aware of access to specialist neurodiversity pathways and support services (including services to prevent escalation of behaviours that challenge such as Positive Behaviour Support), Autism Act 2009 and Equalities Act 2010.
- Children with complex needs should have clear risk management plans that are shared across the network.
- Escalation processes are known by all staff and there is shared analysis across agencies to support practitioners undertaking Mental Capacity Assessments.
- Staff are aware how to access legal advice in respect of conflicting legal/guidance encounters.
- Staff to have an awareness of the impact of the new substance misuse strategy.
- Staff to ensure they discuss safe storage of medication and where there are children in the home, consideration of a home visit.

Key Themes from Wider Learning

The Safeguarding Team as a member of the Learning Collaborative Partnership provides specialist expertise to support the Trust's Culture of Learning in the identification of lessons from good practice, safeguarding investigations and reviews.

The Safeguarding Team has contributed to the Learning Matters Monthly Event on safeguarding and the five key messages and Lessons Identified Newsletter.

Key Messages Identified

Referral to Police
Where a safeguarding concern had been raised with social care, the referrer should not assume that social care or other organisations will contact the Police. Early involvement of the police is vital to support any criminal investigation. Delays in reporting can delay the safeguarding of the victim, delay the apprehension of the offender, result in the loss of evidence and risk the commission of further offences against other victims.

Whole Family
A greater awareness that a 'Whole Family 'approach is adopted in the assessment of service users particularly within Older Adult Mental Health Inpatient Units. Staff need to ensure that wider family and community support are investigated to inform assessment of need and risk.

Key Themes from Wider Learning

Trauma Informed Care
The need to be cognisant of a patients previous history and take this into account when planning an assessment ensuring a trauma informed approach is adopted. For service users who have a prior history of sexual abuse and/or exploitation it is important for practitioners to take these factors into account when undertaking assessment and planning of care to include:- The most appropriate person to conduct the assessment and also the need for a chaperone.

Domestic Abuse
The need for patient records to be reviewed for evidence of alerts for domestic abuse and that this is considered in the assessment of risk. The service user must be provided the opportunity to raise concerns alone and in private, even if a service user is accompanied by a relative who is not their partner or spouse, regardless of gender, staff must consider that this person could be related to the abuser or could be the abuser themselves.

Escalation
Problem resolution must be seen as an integral part of co-operation and joint working to safeguard adults and children/young people. The Safeguarding Team can assist practitioners with the escalation process as per the resolution of professional disagreement within SET Safeguarding & Child Protection Procedures and Safeguarding Adults Guidelines.

Looked After Children

- The Looked After Children's Service (LAC) adhere to the provision of service detailed within the Statutory Guidance- Promoting the Health and Well-Being of Looked After Children(2015,DFE).
- The service offer is to address the health needs of all Looked After Children and young people placed in the South East locality, regardless of which authority placed them there. Additionally, the team is responsible for co-ordinating and monitoring the health needs of all children and young people who are looked after and placed by the South East locality elsewhere in the country.
- The EPUT LAC Service provides support to front line 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 young people who are not in education and have no universal services practitioners caring for them.
- The service raises awareness of the needs of LAC by providing up-to-date, accessible, informative and appropriate training, on health-related topics to both EPUT staff and Foster Carers. Provision of evidenced-based training supports the development of practitioner's clinical skills in undertaking robust Review Health Assessments (RHAs), which support a holistic review of the health and developmental needs of the child or young person.
- The LAC Team continue to work in partnership with statutory agencies to promote the overall outcomes for LAC under the duty of the Corporate Parenting Responsibilities. The specialist nurses remain 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 as reviewing the pathways for transition to adult services for Care Leavers as they move to independent living.
- The statutory frameworks that support quality and assurance within the LAC Service include peer reviews, training, attendance at professional meetings, attendance at the East of England LAC Forum, and quarterly supervision.

Local picture 'LAC'

The current LAC caseload held by the service within the South East Locality is 743, which is broken down by area as:

CPR 82	SOUTHEND 302	73 CARE LEAVERS
Under 18 years of age children	Under 18 years of age children	18 to 19 years old

The total number of children in care in The United kingdom as of 31st March 2023 is an estimated 83,840 compared to 82,170 in March 2022. Increase of 2%.

The number of unaccompanied migrant children in the UK remains above pre-pandemic levels of 2019 . As of 31st March 2023 the number increased to 7,290, increase of 29% on March 2022.

Source children looked after in England including adoptions 16/11/23.

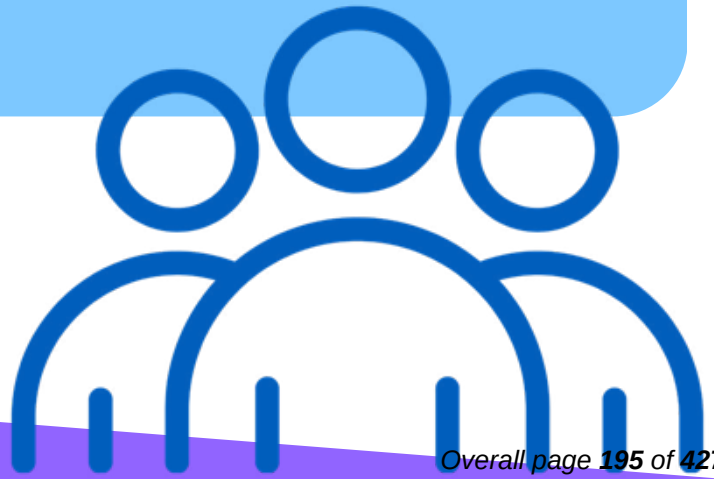
Dental

During the Covid 19 pandemic the percentage of CLA having had their teeth checked by a dentist fell to 40%; this improved to 70% last year and in 2023 is 76%, however this is still below the pre-pandemic level of 86%.

Source https://explore-education-statistics.service.gov.uk Nov 2023.

Key Themes from looked after children

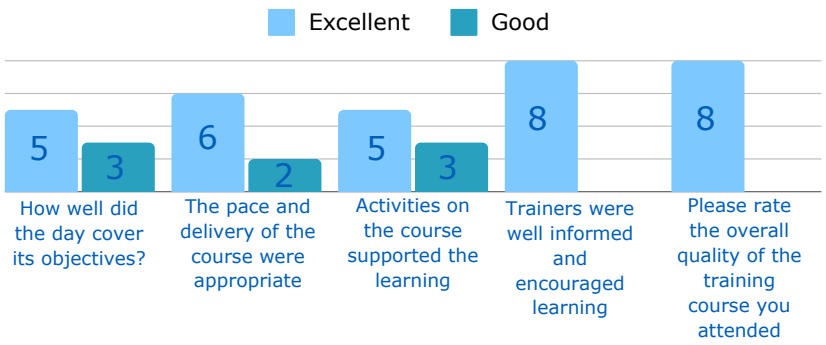
- Increase of county lines, injuries and criminal activity. There are now more effective disruption plans in place lead by social care which has resulted in effective multi partnership engagement rather than moving the problem on. Unfortunately some young people continue to be at risk and are now in the penal institutions or still within the gangs.
- A need for a planned and coordinated transition to adult service especially for those Care Leavers with increased vulnerabilities. This area has seen an increase in activity following the extension of provision to Care Leavers aged 21-25, particularly for children with EHCP or SEND needs. NICE (2021) also include in this group young people who identify as LGBTQ+.
- An increase in Looked After Children attendances at A&E for complex mental health needs. Lack of tier four beds to meet demand, resulting in some YP being placed in bespoke or unregulated placements due to the high need. This is now subject to a formal escalation process that is being trialled with the Designate Nurses at the ICB.
- An increase in unaccompanied migrant children who during their journey may have been subject to modern day slavery, trafficking, enforced separation from family by traffickers, abuse at the camps as well as trauma.
- An increase in missing episodes, strategy meetings to co-ordinate partnership working.
- Proactive working to increase Strengths and Difficulties Questionnaire returns.



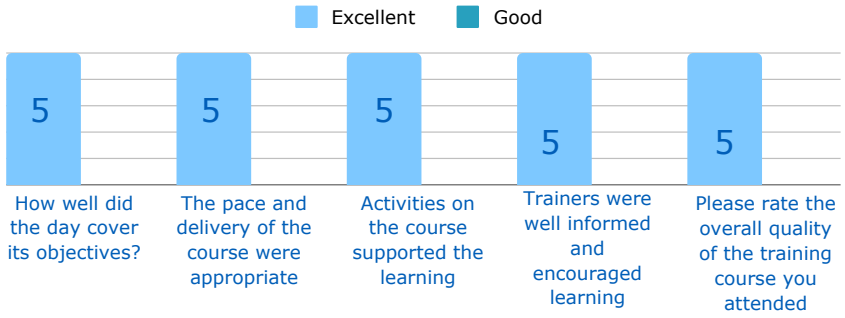
Looked After Children

Children looked after in England including adoptions, Reporting year 2023 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)

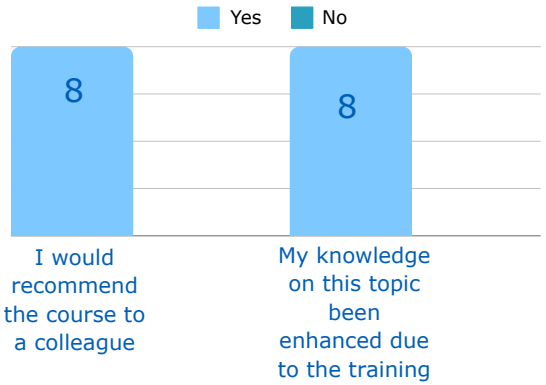
LAC Training June 2023



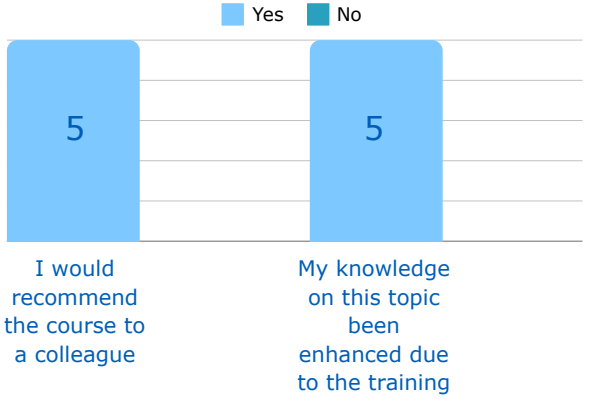
LAC Training October 2023



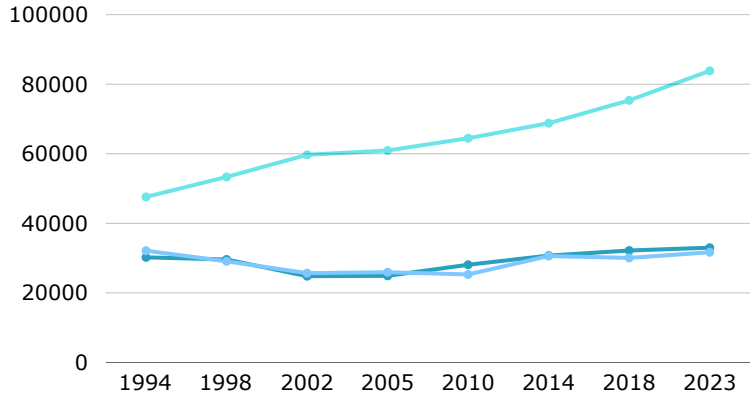
LAC Training June 2023



LAC Training October 2023



The number of CLA in England continue to rise



Key Safeguarding Facts Training - update

Safeguarding training is mandatory for all staff within the Trust; all staff undertake level 1 and 2 training (including basic awareness of Prevent, MCA and DoLS) during their induction. Level 3, 4, MCA and DoLs, and safeguarding investigations training is dependent on individual's roles and responsibilities.

Our training is in line with Safeguarding Adult and Children Partnership Boards and intercollegiate guidance for both adults and children. Assurance that training has been undertaken is provided via the online training tracker, which prompts staff to undertake refresher training. In addition, the safeguarding team attend regular team meetings.

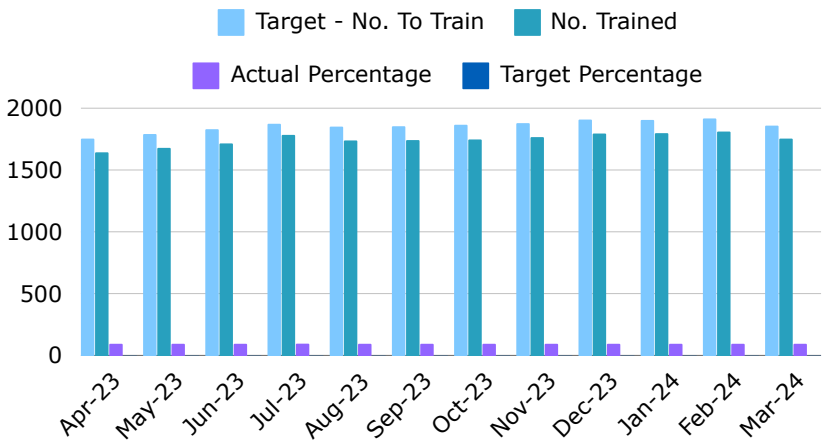
Competency of staff is demonstrated through planned and live supervision. If it is felt that staff require more support or training this will be identified and provided.

The Safeguarding Team also offers additional training to teams where there are identified concerns regarding MCA / DoLS documentation or safeguarding practices. The safeguarding training explores different scenarios through a case study approach incorporating lessons learned and key themes from safeguarding adult reviews.

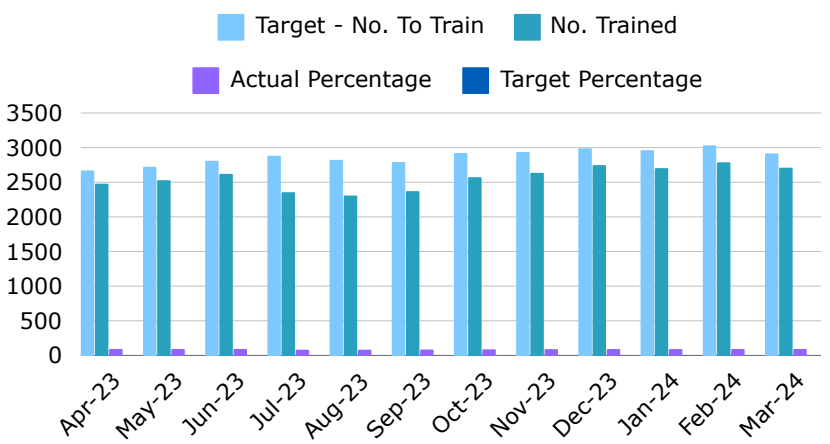
The LAC Team have developed a Level 3 Looked after Children's Training. This ensures that the key LAC drivers are embedded into best practice when completing Review Health Assessments (RHAs) in order to be able to provide a holistic review of the health and development of Looked After Children.

Safeguarding Training Graphs

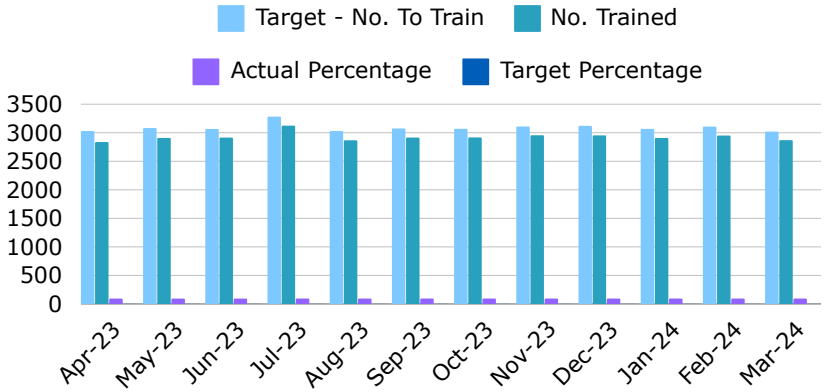
Safeguarding Level 1



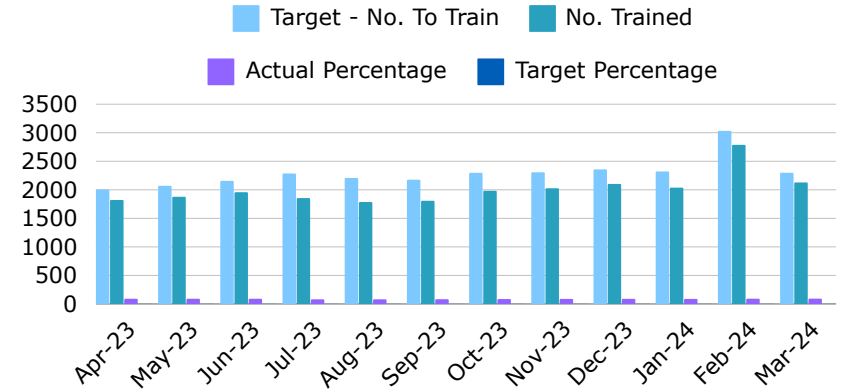
Safeguarding Adults Level 3



Safeguarding Level 2



Safeguarding Children Level 3



Key Safeguarding Facts

Training Feedback

"The training was packed full of very interesting information that I was not aware of. The trainer was very articulate, and knowledgeable, and answered questions in a very professional way. The room setting was very good because it provided me with the opportunity to hear other people's opinions. Also listening to people's experiences and cases they are dealing with helped me to understand the topics better. Thank you so much for the great training."

"I really enjoyed today's session and was really informative. I would like to appreciate the presenters who did their job very nicely. I found their communication very powerful and a suitable environment to learn more regarding safeguarding. The videos and presentation was really useful as it addressed all categories of children which include child who is not yet born. The group discussion was another plus point, it helped us to think about the situation and what action do we need to take etc. The explanation regarding the laws and legislation like mental capacity act was too useful. Overall, I really liked this session and grateful for EPUT who gave me this opportunity."

Key Safeguarding Facts

Feedback 3 months post-training

"This course was done in a timely, informative and efficient approach. The information was grouped in chunks for easy understanding. The examples and illustrations given were accurate and useful. Group work also gave room for discussions with everyone participating bringing in their ideas making learning more easy and quite understandable. Environment was conducive and the topics were distributed amongst different tutors for diversity. Thank you."

"It is great to have this course every couple of years, especially for those who do not work directly within children services as sometimes your focus can unknowingly be solely on supporting the adult that you divert past the fact there are others involved in the dynamics of the crisis. This reminds us what we need to look out for and ensure that we safeguard all and not just the one presented as a concern or in need during a crisis."

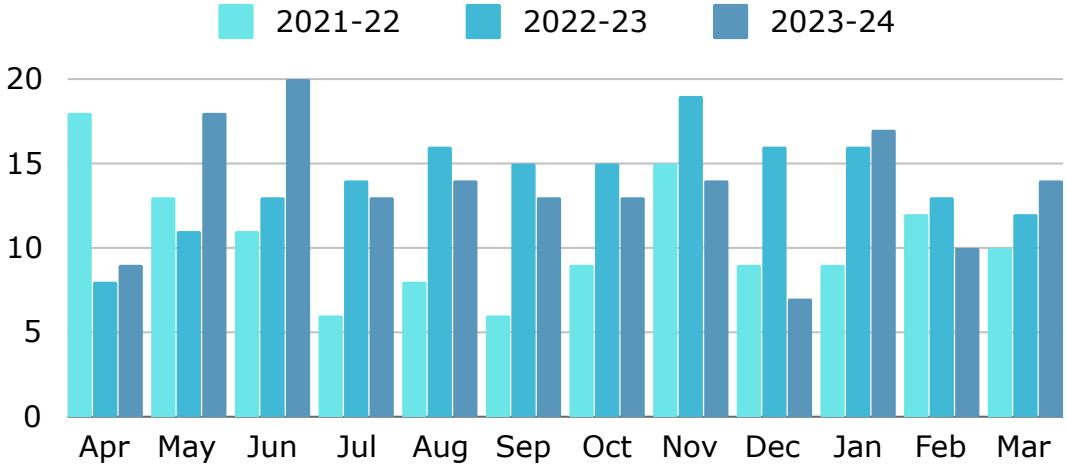
Key Safeguarding Facts

Safeguarding Children

Figure 9: Trust Safeguarding Children Referrals Raised

	'23									'24			
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
No. of Children Referrals	9	18	20	13	14	13	13	14	7	17	10	14	162

Figure 10: Number of Safeguarding Children Referrals (April to March)



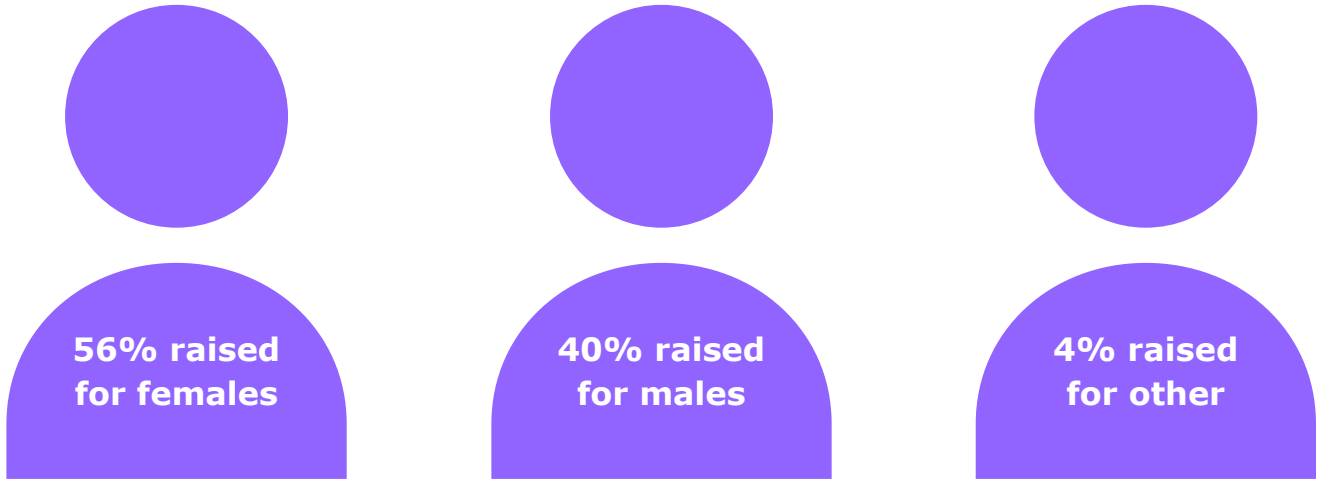
EPUT continues to provide specialist paediatric services within Essex. EPUT additionally provides Tier 4 adolescent inpatient services, Together with Baby, Perinatal Mental Health Service and Mother and Baby inpatient mental health provision in Essex. Children's service practitioners within EPUT receive mandated safeguarding supervision.

Key Safeguarding Facts

Safeguarding Adults

3168 Safeguarding Concerns received,
-7% from previous year

57% Progressed to Section 42 Enquiry



Safeguarding Adults

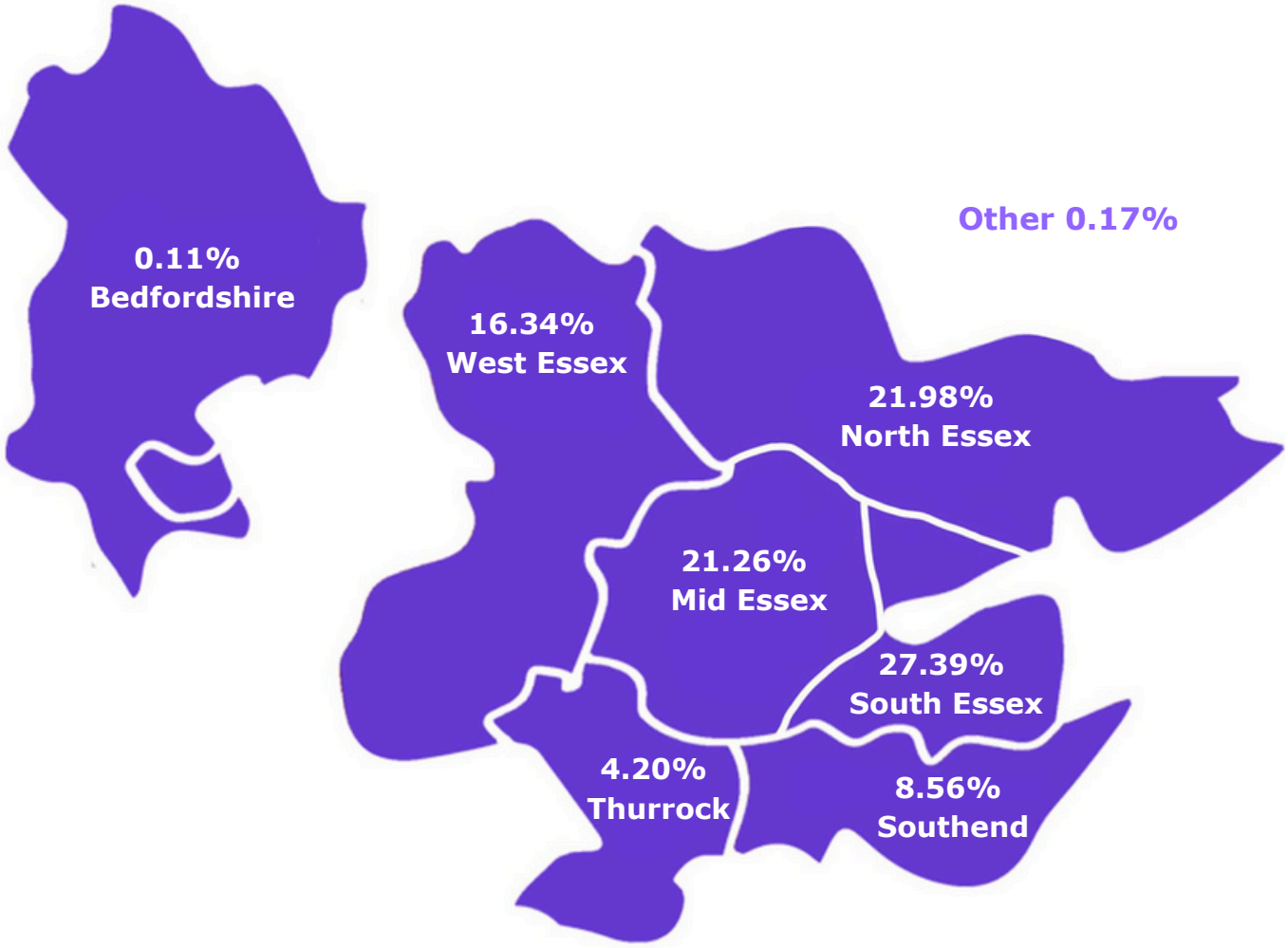
Person Alleged to have cased harm (top 10)

Self	**36%**
Not determined	**17%**
Partner	12%
Other EPUT Service User	8%
Adult Child	6%
Ex-partner	4%
Other	4%
EPUT Staff Member	4%
Residential Care Staff	4%
Parent	3%

Source of referral

EPUT Mental Health	**51%**
Police	**12%**
Ambulance Service	7%
EPUT Community Health	6%
Residential Care Home	6%
Local Council	5%
Acute / General Hospital	5%
Family	3%
Supported Housing	2%
GP Surgery	2%

Safeguarding Adults



Self Neglect	20.9%
Physical	16.5%
Psychological	15.8%
Financial	14.3%
Neglect	8.4%
Domestic Abuse	8%
Sexual	7%
Not Determined	4.7%
Organisational	2.7%
Discriminatory	0.7%
Modern Slavery	0.5%
Radicalization	0.4%

Safeguarding Conclusion

Safeguarding Referral Outcome

Substantiated	34.43%
Unsubstantiated	21.22%
Partly Substantiated	14.96%
Inconclusive/Not Determined	16.17%
Investigation Ceased at individuals Request	13.22%

Is the vulnerable adult satisfied with the outcome?

Yes	41.52%
Not applicable/Known	55.93%
No	2.55%

Risk Level

Risk Reduced	48.95%
Risk Removed	32.93%
Risk Remains	18.12%

Safeguarding Priorities 2024-25

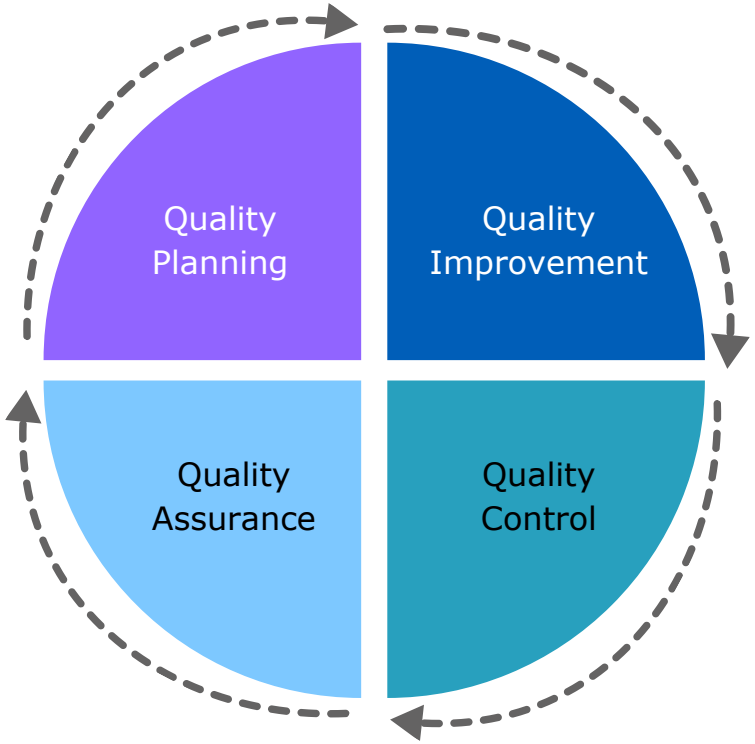
The Safeguarding Service has identified 4 key quality improvement strategies to strengthen and support the effectiveness of safeguarding delivery and functions within the organisation.

Theses are the 4 key areas that we will be working on in 2024-5 are:

- Domestic Abuse
- S.42 Enquiries
- Children
- Learning and Awareness of Safeguarding Agenda

These priorities were based on the priorities set in the year ending 2024, priorities identified Local safeguarding partnerships, areas of development identified from within the service and learning from Trust External auditors.

This is in line with the Trust Quality of Care Strategy to ensure the three components of quality - Safety, Effectiveness and Experience – collectively underpin how care is designed and delivered.



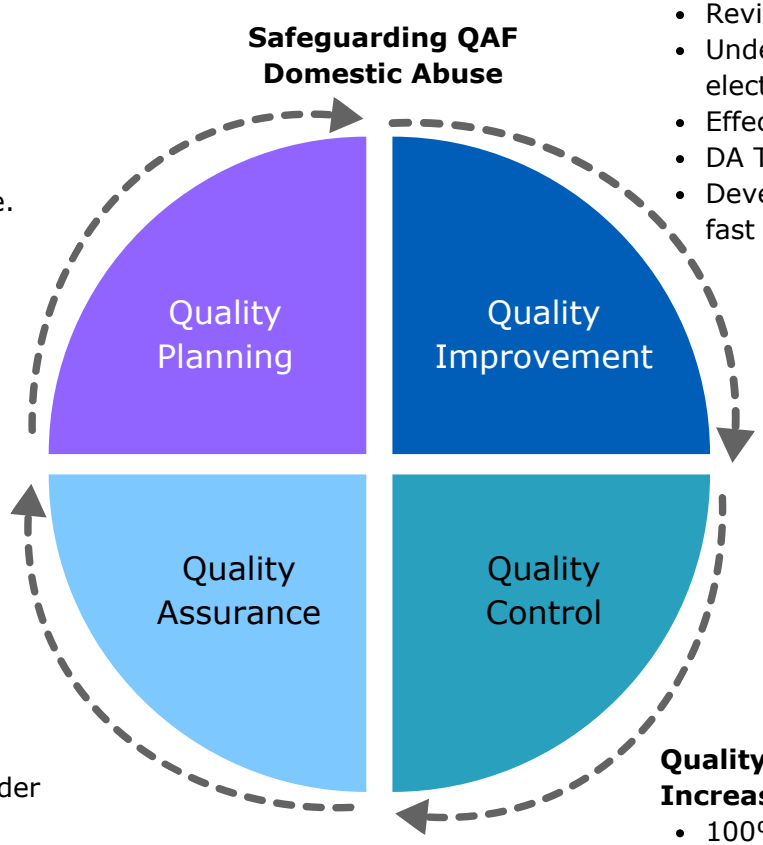
Safeguarding Priorities - Domestic Abuse

Quality Planning

- Emerging themes identified from:
- Staff disclosures though duty system and F2SU.
- Cases reported to Safeguarding Duty Line.
- Learning from Domestic Homicide Reviews.
- Review of current policy guidance.
- Domestic Abuse Act 2021 and Statutory Guidance.

Quality Assurance

- EPUT patient record systems should support the documentation of routine enquiry for DA and the timely extraction of data to support service delivery.
- Record keeping audits to identify compliance to NICE standards.
- Training Compliance adult and children's in line with safeguarding training framework.
- Monthly performance reports to Quality and Safety Meetings.
- Bi-monthly performance reporting to MHA & Safeguarding Sub Committee.
- Monthly performance report to commissioners under S.75 agreement.
- Monthly safeguarding performance reports to Quality and Safety Meetings.
- Quarterly report to Safety of Care Group.
- Mental Health Act & Safeguarding Sub Committee.



Quality Improvement

- Review of clinical DA policy guidance.
- Undertake a review of the DA reporting process on electronic patient records for all initial assessments.
- Effective utilisation of Staff Toolkit for Domestic Abuse
- DA Training framework
- Development of a domestic abuse page on intranet with fast exit buttons.
- Next Chapter MHDAP Pilot to support access for service users and staff to specialist DA services and training for practitioners within Mid and North Localities.
- Safeguarding Champions events: Thematic topics identified through learning.
- Dissemination of key learning through ECOL.
- Commissioning of DASH training.
- Domestic abuse notification feed from police for children, YP and pregnant women.
- Learning from Domestic Homicide Reviews.

Quality Control

Increased safeguarding referral

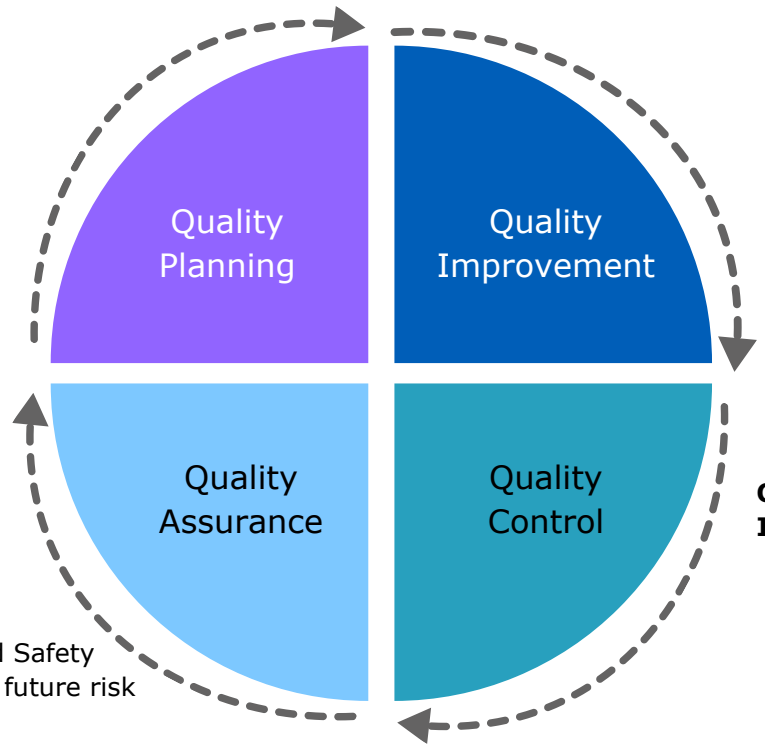
- 100% of staff DA cases should be managed as per DA Staff Tool Kit.
- 80% EPUT practitioner attendance to MARAC for service users presented who are open to EPUT services.
- 8 Domestic abuse related training events per annum.
- 85% of service users to be asked routinely if experiencing DA as per NICE Guidelines at initial assessment.
- All DHR action plans to be completed within the SET time scales.

Safeguarding Priorities - S.42 Enquiries

Quality Planning

- EPUT under Section 75 of the Care Act (2014) has delegated responsibility to undertake/lead S.42 Adult Safeguarding Enquiries for service users open to the Mental Health Services within Essex.
- Since the pandemic , there has been a significant increase in the number of safeguarding concerns raised. This has provided challenge for operational teams to undertake enquiries within the recommended times frames as identified under the Southend, Essex and Thurrock (SET) Guidance.
- The complexity of some of the concerns requires operational teams to commit significant amount of resources to address the investigation.
- The Trust has a considerable number of safeguarding enquiries that are open outside of the identified SET guidelines, this has been put on both the Trust and ECC S75 Budget, Performance and Learning risk register. This is also identified as an issue across the wider system.

Safeguarding QAF
S.42 Enquiries



Quality Assurance

- Assurance from Senior Leaders through Quality and Safety
- Meetings on actions to address backlog and reduce future risk going forward.
- Monthly performance reports to Quality and Safety Meetings.
- Bi-monthly performance reporting to MHA & Safeguarding Sub Committee.
- Monthly performance report to commissioners under S.75 agreement.
- Monthly safeguarding performance reports to Quality and Safety Meetings
- Quarterly report to Safety of Care Group.
- Reporting of learning through ECOL via LOSC and LCP.
- Collaborative partner quality visits.
- The Trust engages with system safeguarding assurance visits from the ICB and Local Safeguarding Partnership Boards and Local Authority (as part of S.75 Agreement) to identify how safeguarding is embedded within the Trust and review safeguarding assurances in practice.

Quality Improvement

- Policy and procedure on a pageto support quick access to key points.
- Agreement of a improvement plan with the individual care units.
- Review of the current caseload report format as presented to Care Unit & Quality and Safety meetings.
- Remedial action plan in place to address historical open safeguarding enquiries, resourced through bank provision.
- Review of Datix reporting mechanism to capture 'justifiable delays'.
- Clear allocation process for EPUT safeguarding lead to be agreed.
- Analysis and reporting of rationale for justifiable delays for safeguarding enquiries.

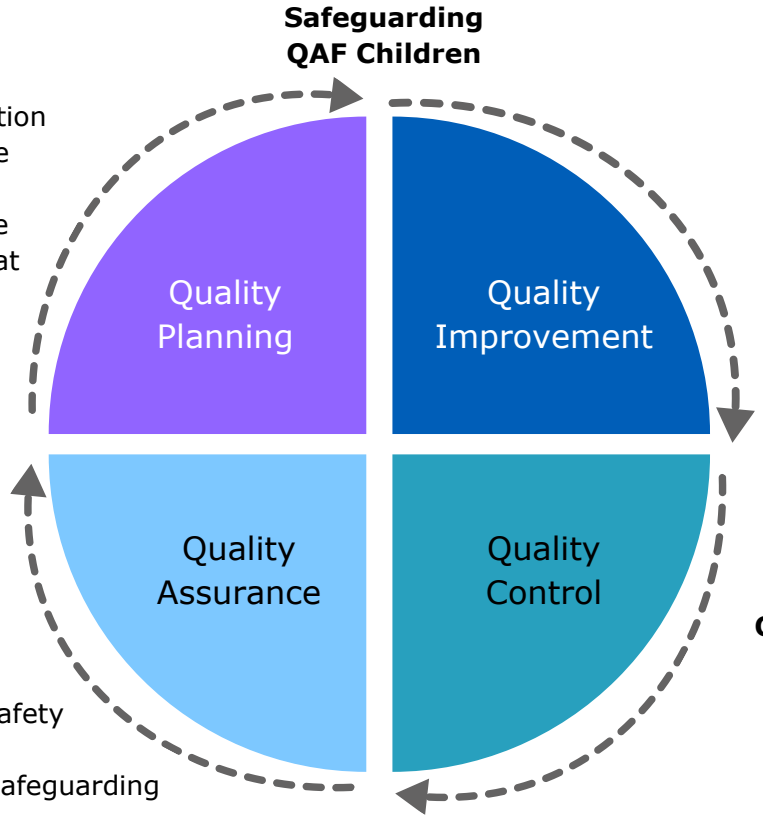
Quality Control
Increased safeguarding referral

- A quantitative analysis to be undertaken into open safeguarding enquiries per care unit, to identify resource implications an allocate provision.
- 70% of S.42 enquiries completed within 3 months of referral by year end.
- 80% of cases that have not been completed within the SET 3 month timeline have a justifiable delay for all new S.42 enquiries opened after the 1/5/24.
- 100% Datix Risk Management completed for all S.42 Safeguarding enquiries by year end.
- Q4 data to report 100% of safeguarding enquiries demonstrate making safeguarding personal.
- Safeguarding compliance audit- 100 % of Staff interviewed demonstrate knowledge of the S.42 enquiry process, timelines & duty to safeguard adults as per SET Safeguarding adults guidance.

Safeguarding Priorities - Children's Safeguarding

Quality Planning

- Low referral numbers for children and young people for either Child in Need or Child Protection reported despite high numbers of adult service users requiring safeguarding.
- The organisation works with families who have complex needs and there is an expectation that practitioners utilise a holistic approach to the assessment of need and risk.
- Learning from Safeguarding Adult, Child & Domestic Homicide Reviews.



Quality Improvement

- Undertake a bench marking exercise to inform a clearer understanding of current practice and training needs within adults services.
- Review of the Datix reporting process for Children's Safeguarding referrals.
- Review of safeguarding children's L3 training.
- Inclusion of Whole Family approach in the agenda for the hybrid model of training delivered to locality teams.
- Contribution to the SET Whole Family Approach working group to ensure EPUT embedded in system wide processes.
- Request comparable data from relevant partner agencies and statistical neighbours.
- Awareness raising through ECOL.
- Develop closer working relationship with Single Point of Access Children's Social Care Essex.

Quality Assurance

- Monthly performance reports to Quality and Safety Meetings.
- Bi-monthly performance reporting to MHA & Safeguarding Sub Committee.
- Monthly performance report to commissioners under S.75 agreement.
- Monthly safeguarding performance reports to Quality and Safety Meetings.
- Bi Monthly report to Safety of Care Group.
- Reporting of learning through ECOL via LOSC and LCP.
- Bi Annual Section 11 Audit to SET Safeguarding Partnership.

Quality Control

- Attendance and compliance with safeguarding mandated training framework to be monitored and to ensure 90% and above attendance.
- Training compliance currently identified at 95%.
- Qualitative review of user experience of training to identify key themes to inform learning.
- Practitioners working with children, young people and their families will attend quarterly safeguarding face to face supervision – 95% compliance.
- 90% contribution either by attendance or report to Initial and review Child protection conferences.

Safeguarding Priorities - Learning & Awareness

Quality Planning

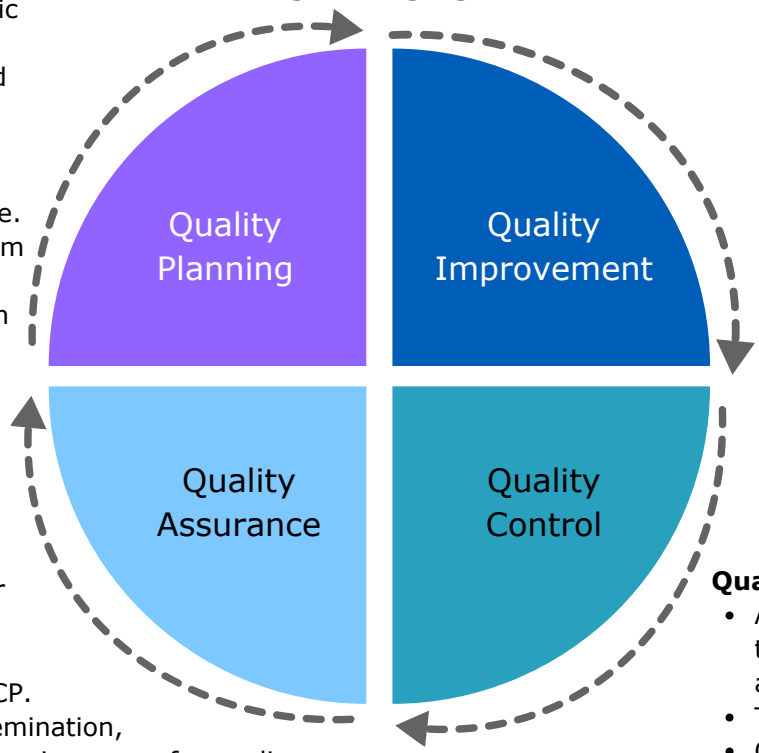
Emerging themes identified from:

- Learning from Safeguarding Adult, Child and Domestic Homicide reviews.
- Statutory requirements (Intercollegiate Guidance and SET).
- Supervision & cases reported to Safeguarding Duty Line.
- Any changes in statutory legislation and LSP guidance.
- Identification of early learning through incidences from the point of receipt of a safeguarding concern.
- Greater collaborative working and visibility working in partnership with care units.

Quality Assurance

- Monthly performance reports to Quality and Safety Meetings.
- Bi-monthly performance reporting toMHA & Safeguarding Sub Committee.
- Monthly performance report to commissioners under S.75 agreement.
- Quarterly report to Safety of Care Group.
- Reporting of learning through ECOL via LOSC and LCP.
- Care units will be held to account in regards to dissemination, implementation and planning of early learning from reviews or safeguarding incidences, monitored through the Quality and safety meetings.
- Safeguarding Compliance Audit.
- Collaborative partner quality visits.
- The Trust engages with system safeguarding assurance visits from the ICB and Local Safeguarding Partnership Boards and Local Authority (as part of S.75 Agreement) to identify how safeguarding is embedded within the Trust and review safeguarding assurances in practice.

Safeguarding QAF Learning & Awareness Safeguarding Agenda



Quality Improvement

- Annual review of Safeguarding policies and procedures.
- Annual review of mandated training within adults and children L1,2 & 3.
- Targets and time frames as identified by KPI's.
- Review of CLPG 37 Appendix 2: Safeguarding Supervision to include guidance for adults.
- Safeguarding staff events delivered in partnership with external agencies to support identified learning themes.
- Dissemination of key learning through ECOL-5 key messages, Lessons identified newsletter & Learning matters.
- Access to L4 safeguarding training for Clinical Safeguarding Specialists.
- Provision of a hybrid model of training with a focus on localised delivery informed by locality themes.
- Safeguarding Champions events delivered within localities by Clinical Safeguarding Specialists.
- Training and awareness to be made available in different modes to include bespoke targeted training to team - bite size learning, videos and interviews to support different learning styles.
- Routine support visits by Clinical Safeguarding Specialist to clinical teams.

Quality Control

- Attendance and compliance with safeguarding mandated training framework to be monitored and to ensure 90% and above attendance.
- Training compliance currently identified at 95%.
- Qualitative review of user experience of training to identify key themes to inform learning.
- All practitioners working with children, young people and their families will attend quarterly safeguarding face to face supervision – 95% compliance.
- Delivery of 4 safeguarding staff events in partnership with external agencies in line with emerging themes and learning identified from reviews per year.
- Minimum of 6 safeguarding News letters per year.
- 75% attendance by safeguarding champions to Locality Champions Events.

Glossary of Terms

CCG	Clinical Commissioning Group
CPR	Castle Point Rayleigh Rochford
DA	Domestic Abuse
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
ECOL	EPUT Culture of Learning
EHCP	Education, Health Care Plan
HEF	Health Executive Forum
ICB	Integrated Care Board
ICS	Integrated Care System
LAC	Looked After Child
LADO	Local Authority Designated Officer
LPS	Liberty Protection Safeguards
MACE Group	Missing and Child Exploitation in Essex Group
MAPPA	Multiagency Public Protection Arrangements
MARAC	Multiagency Risk Assessment Conference
MCA	Mental Capacity Act
MHA	Mental Health Act
MSE	Mid and South Essex
RHA	Review Health Assessment
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review
SEND	Special Educational Needs
SET	Southend, Essex and Thurrock
SETDAB	Southend, Essex and Thurrock Domestic Abuse Board
SPOC	Single Point of Contact

8.4 MENTAL HEALTH ACT ANNUAL REPORT 2023-2024

Decision Item | AS | 5

REFERENCES

Only PDFs are attached

MHA Annual Report 02.10.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

Report Title:	**Mental Health Act Annual Report 2023/24**					
Executive/ Non-Executive Lead / Committee Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Debbie Radley, Mental Health Act Senior Manager on behalf of Tendayi Musundire, Deputy Director for Nursing Safeguarding & MHA					
Report discussed previously at:	Safety of Care Group and Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	None		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report is designed to provide assurance to the Board of Directors that risks that may affect the achievement of the organisations' objectives and impact on quality are being managed effectively and to provide assurance that the Group is discharging its terms of reference and delegated responsibilities effectively.	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the content of the report.
2. Approve the report and publication.

Summary of Key Points
This is the seventh Annual Report prepared on behalf of EPUT's Mental Health Act & Safeguarding Sub-Committee. It sets out the framework within which the Committee operates, provides an overview of its activities in 2023/24 and the outcomes of its deliberations, and looks ahead to developments and challenges anticipated in 2024/25. The Mental Health Act & Safeguarding Sub-Committee ensures the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005. This report reviews the operation of the Mental Health Act for the year 1st April, 2023 to 31st March, 2024. It will provide an overview of the work undertaken in the administration of the Mental Health Act 1983. The Mental Health Act Office continues to monitor Mental Health Act activity across the Trust, including the number and type of detention (i.e. Section 5(4), Section 5(2) etc.) and instances of detained patient's absence without leave (AWOL). The Mental Health Act Office also monitors detentions by ethnicity. Whilst there is some fluctuation in data, it remains consistent with previous years and in the expected range. The CQC carried out twenty three Mental Health Act focused inspections during the period April 2023 – March 2024. Overall, the feedback from the CQC reviews was positive with a small number of points of learning/themes identified and addressed. Following these inspections, the CQC also commented on a number of good practices. The target compliance figure of 85% (this threshold is set out nationally via core skills framework and NHS England) for Mental Health Act mandatory training, covering both registered and un- registered staff, was met for the period April 2023 – March 2024. The Mental Health Act office continues to provide Mental Health Act administration support to several local acute care partners for patients detained to them under a Service Level Agreement. As part of the agreement the Mental Health Act office also provides training to our acute care colleagues which helps ensure those individuals detained under the Act are in receipt of their rights as a detained patient. Going forwards, work will continue to address and streamline the functions of the Mental Health Act Administration, ensuring compliance under the Mental Health Act. The Mental Health Act team remains committed to providing a quality, supportive function to EPUT clinicians to ensure that those individuals detained under the Act are in receipt of their rights as a detained patient.

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			
MHA	Mental Health Act	SPC	Statistical Process Control
CQC	Care Quality Commission	NMC	Nursing & Midwifery Council
IMHA	Independent Mental Health Advocate	MSE	Mid & South Essex NHS Foundation Trust
MH	Mental Health	PAH	The Princess Alexandra Hospital
CAMHS	Child and Adolescent Mental Health Services	ESNEFT	East Suffolk and North Essex NHS Foundation Trust, Colchester Hospital
AMHP	Approved Mental Health Professionals	SLA	Service Level Agreement
AHM	Associate Hospital Manager		

Supporting Reports and/or Appendices

Mental Health Act Annual Report 2023/24

Executive/ Non-Executive Lead / Committee Lead:

Ann Sheridan

Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

Mental Health Annual Report 2023-24

EPUT

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (EPUT)

MENTAL HEALTH ACT ANNUAL REPORT 2023-24

CONTENTS

Table of contents

FOREWORD

I am delighted to introduce this year's Mental Health Act Administration Annual Report (2023/24) which sets out our performance in relation to the Mental Health Act and highlights our plans and priorities for the coming year.

Providing high quality, safe and compassionate care remains our priority as we continue on our journey of transformation and improvement. Over the last 12 months we have taken great strides towards achieving our vision 'to be the leading health and wellbeing service in the provision of mental health and community care."

Central to this is our new Quality of Care Framework. Launched earlier this year, it builds on the improvements already achieved through our three-year Safety First, Safety Always strategy and sets out our new guiding principles for delivering great care and putting people at the heart of everything we do. The framework is shaped by what our staff, people with lived experience and partners have told us quality of care means to them and focuses on safety, effectiveness and people's experiences as the three foundations for delivering consistent and reliable care.

We are focused on providing the best inpatient care, building a stable and skilled workforce to provide that care, and safe and therapeutic environments in which to do so. In 2023, we welcome more than 1,700 permanent new colleagues and continue to make improvements to our wards following a £20 million investment. Widespread changes have been made across wards to reduce the risk of self-harm and create the best environment for care and recovery. Oxevision remote monitoring technology is now in use across 23 of our inpatient ward.

2023/24 has been a busy year and one in which we have made great progress in helping people in mental health crisis get the right care at the right time. Our Mental Health Urgent Care Department in Basildon has supported more than 2,000 people since it opened in spring 2023 and joint response vehicles in partnership with the East of England Ambulance Service Trust are reducing admissions to emergency departments.

All that we have achieved is testament to the hard work and dedication of our staff and I would like to take this opportunity to thank everyone at the Trust as well as our system partners for their continued support.

#WhatWeDoTogetherMatters

Ann Sheridan, Executive Nurse

EXECUTIVE SUMMARY

This is the seven Annual Report prepared on behalf of EPUT's Mental Health Act & Safeguarding Sub-Committee. It sets out the framework within which the Sub Committee operates, provides an overview of its activities in 2023/2024 and the outcomes of its deliberations, and looks ahead to developments and challenges anticipated in 2024/2025.

The Board recognises that high standards of governance throughout the Trust are essential for the delivery of the identified strategic objectives, the safety of its services, the quality of service user and carer experience, and the long-term protection of stakeholder interests. Good governance emanates from the Board but pervades the entire organisation, being reflected in its operating practices, policies and procedures.

The Mental Health Act & Safeguarding Sub-Committee ensures the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005.

This report reviews the operation of the Mental Health Act for the year 1st April, 2023 to 31st March 2024. It provides an overview of the work undertaken in the administration of the Mental Health Act 1983 (as amended by the Mental Health Act 2007).

The Mental Health Act Office continues to monitor Mental Health Act activity across the Trust, including the number and type of detentions (i.e. Section 5(4), Section 5(2) etc.) and instances of detained patients' absent without leave. The Mental Health Act Office also monitors detentions by ethnicity. Whilst there is some fluctuation in data, it remains consistent with previous years.

The CQC carried out twenty three Mental Health Act inspections during the period 1st April 2023 – 31st March 2024. Overall, the feedback from the CQC reviews was positive with a small number of points of learning/themes identified and addressed.

The Trust's Target Compliance figure of 85% for Mental Health Act mandatory training, covering both registered and un-registered staff, was met for the period 1st April 2023 – 31st March 2024.

The Mental Health Act Office continues to provide Mental Health Act administration support under a service level agreement to several local acute care partners. As part of the agreement, the Mental Health Act Office also provides training to our acute care colleagues which helps ensure those individuals detained under the Act are in receipt of their rights as a detained patient.

Work will continue going forward in continuing to address and streamline the functions of the Mental Health Act Administration, ensuring compliance under the Mental Health Act.

The Mental Health Act Team remains committed to providing a quality, supportive function to EPUT clinicians to ensure that we work collectively to ensure that those individuals detained under the Act are in receipt of their rights as a detained patient. The Trust will continue to support the key functions of the Associate Hospital Managers in considering patient's requests for discharge from detention under certain sections of the Mental Health Act in accordance with section 23 of the Act including Community Treatment Orders and review detentions following renewal of such sections or following the barring by a Responsible Clinician of an application for discharge by the patient's nearest relative.

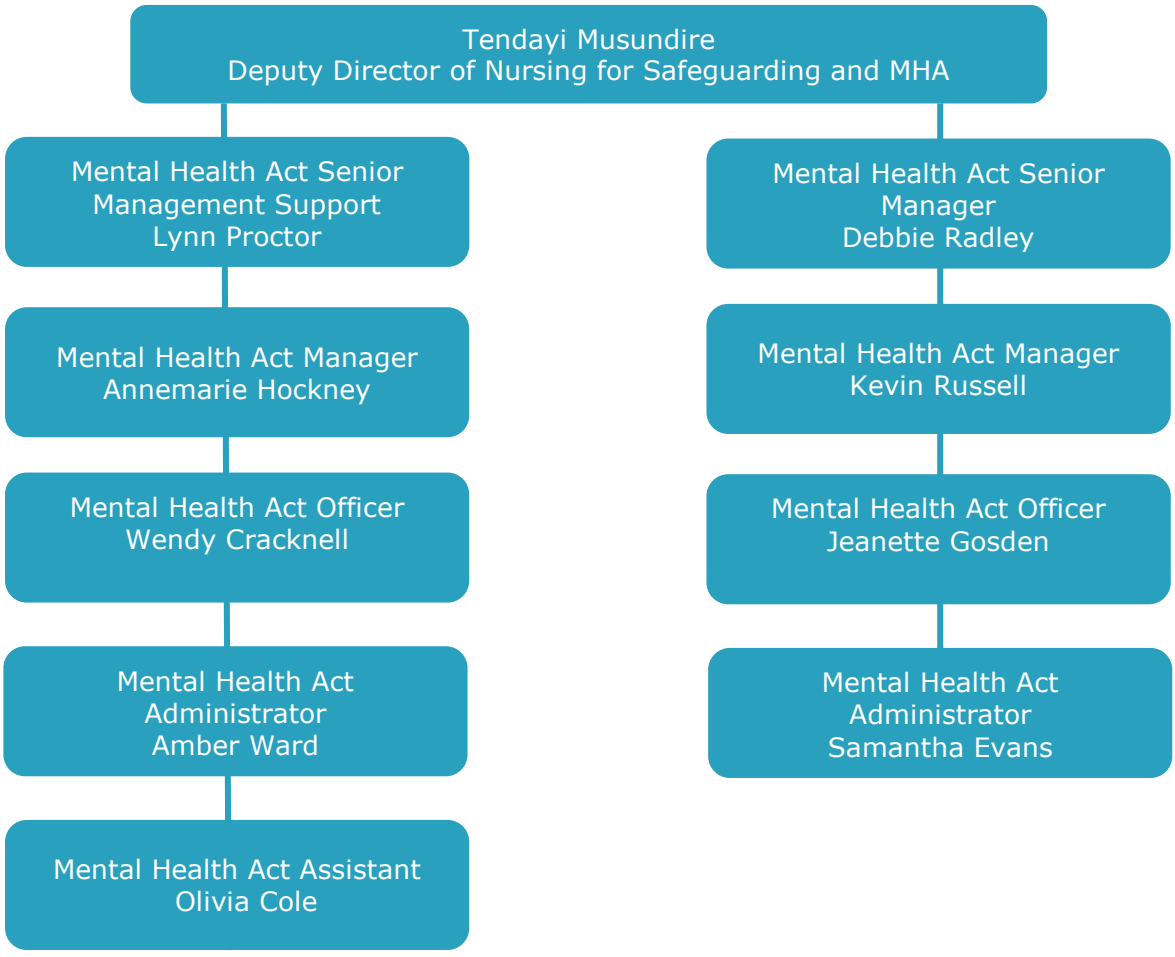
EPUT GOVERNANCE

Mental Health Act Team

Within Essex Partnership University NHS Foundation Trust (EPUT), the Executive Nurse is responsible for the delivery of the Mental Health Act Administration service.
The Mental Health Act Team is led by the Deputy Director for Safeguarding and Mental Health Act.

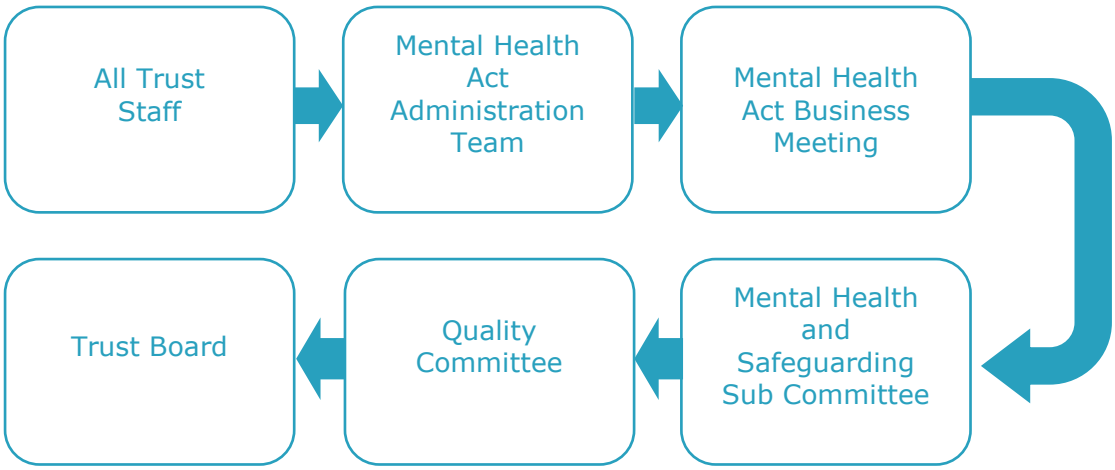
The Mental Health Act Team operation an admiration service between 8:30am and 5pm, Monday to Friday, excluding bank holidays.

Mental Health Act Team Structure



Mental Health Act Administration Service Pathway

The diagram below demonstrates the reporting pathway for the Mental Health Act Administration Service within the Trust.



The Trust has robust reporting systems in place which ensures the Trust Board and associated committees are updated regularly on Mental Health Act activity, trend analysis and quality issues.

Mental Health Act Training in EPUT

Mental Health Act Training is an online training module and is mandatory to both registered and un-registered staff. Compliance with training requirements is monitored monthly and where compliance falls below the target, this is escalated to the Mental Health Act Business Meeting and Mental Health Act & Safeguarding Sub Committee. The Trust compliance figure is 85%.

Training needs are highlighted through results from ongoing Mental Health Act Audits, Mental Health Act Care Quality Commission visits and requests from Ward Managers to address team or individual needs. Where training needs are identified the Mental Health Act Office provided bespoke training either via Microsoft Teams, or supported one to one telephone discussions.

	Overall Competence		
	Total Target	Trained	
		No	%
Mental Health Act All Registered Staff	2140	1974	92%
Mental Health Act All Non-Registered Staff	1358	1329	98%

Data provided by EPUT Workforce Department

Mental Health Act Training Delivered by Mental Health Act Team

The MHA team have devised a rolling programme of MHA training which can be accessed by all members of staff within the Trust on a monthly basis. These monthly sessions provide an opportunity for learning as well as sharing current CQC themes arising from MHA focussed CQC visits.

The table below identifies the number of staff trained by group.

Staff Group	Numbers
EPUT staff	153
EPUT International Nurses	49
Service Level Agreement - Acute Hospital staff	130
Total	332

Data supplied by MHA team

Mental Health Act Team Development

As an organisation, EPUT supports development of its workforce and supports staff to offer the best possible care to our patients and service users.

Members of the Mental Health Act Team have continued to enhance their knowledge of the Mental Health Act by receiving regular distributions regarding changes to the Mental Health Act through Mental Health Law Online, the Care Quality Commission, The London Mental Health Network and the Law Society. This knowledge enhances the skills within the team and helps to ensure the team can support clinicians to continue to provide high quality care within the legal framework of the Act.

In order to continue in supporting the development of staff within the MHA team two MHA administrators will be attending the online Mental Health Act administrator courses hosted by Peter Edwards Law Company. These courses are specifically developed for MHA administrators to get together, learn and share skills using an evidenced based approach to fulfil statutory and non-statutory duties as MHA administrators on behalf of Hospital Managers.

The senior MHA management team have recently introduced "focused" MHA training to members of the MHA team as part of the bi-monthly MHA team meetings to support their knowledge and learning. In addition and to support the development and knowledge of the band 6 MHA Managers in the team, three monthly practice development forums are now arranged with the senior managers in the team where discussions and views regarding recent case law, high court judgements and day to day anomalies within the MHA administration are discussed.

Senior Managers in the Mental Health Act Team regularly review the career pathways of the team during annual appraisals.

DETENTIONS UNDER THE MENTAL HEALTH ACT 2023 -2024

Data Source

As there are currently two clinical systems being used for the administration of the Mental Health Act in the Trust – Mobius in the Basildon/Rochford/ Thurrock area and Paris in the Chelmsford/Colchester/Harlow Area, this report provides details for both systems, which are provided by the Trust's Information and Performance Team.

People may come into hospital under a detention order or they may have been admitted informally then assessed and detained. It is possible for one person to have been subject to numerous detention orders for example; Section 5(4), Section 5(2), Section 2 and Section 3. It is each of these individual sections that make up the detention figures.

EPUT Mental Health Act Detention Activity Data

Mental Health Act Activity (number of detentions) is monitored on a monthly basis in order to identify emerging trends and any anomalies and presented at the Mental Health Act Business Meeting and Mental Health Act & Safeguarding Sub-Committee. Any anomalies and emerging trends identified are further investigated to understand the context and circumstances; and remedial action taken as appropriate.

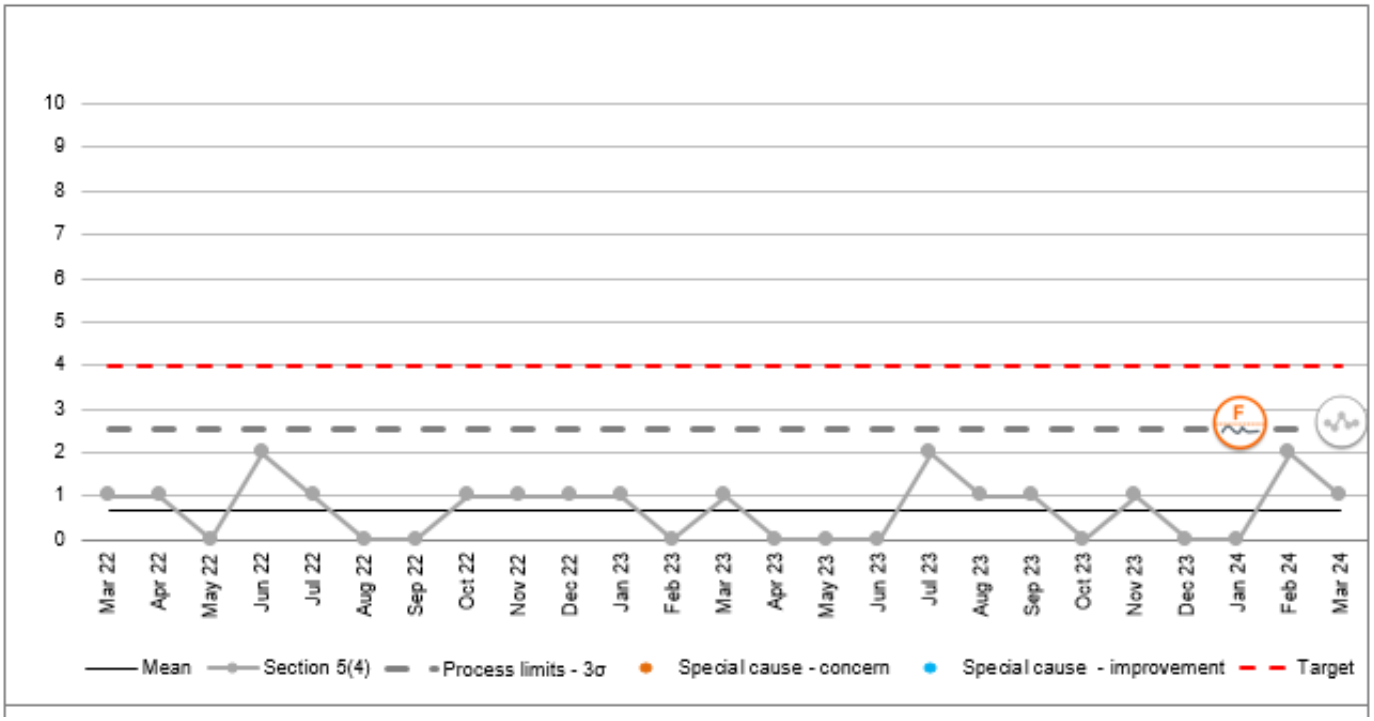
The below SPC Charts provides an overview of Mental Health Act Activity. Whilst there is some fluctuation in the use of some of the detentions it is consistent with previous years.

Section 5(4)

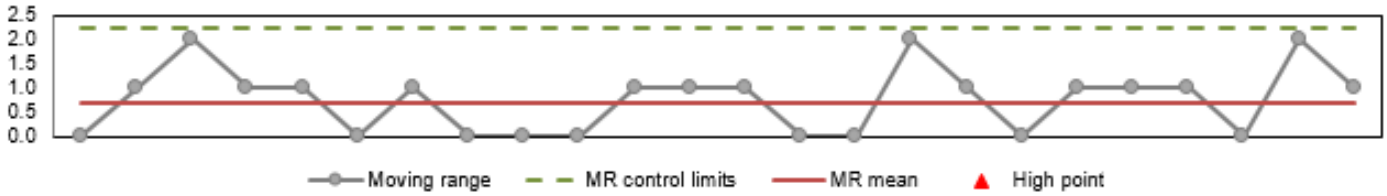
A Section 5(4) allows a nurse of the 'prescribed class' to detain an in-patient who is already receiving treatment for mental disorder. The definition of 'prescribed class' is any nurse registered in sub-parts 1 or 2 of the register maintained by the Nursing & Midwifery Council (NMC) whose entry on the register indicates that their field of practice is either mental health or learning disability.

A Section 5(4) lasts for up to six hours or until the doctor attends to assess the patient to ascertain if the patient requires further detention. The use of Section 5(4) whilst fluctuates remains low and within single figures.

From the 1st April 2023 to the 31st March 2024 section 5(4) was implemented eight times.



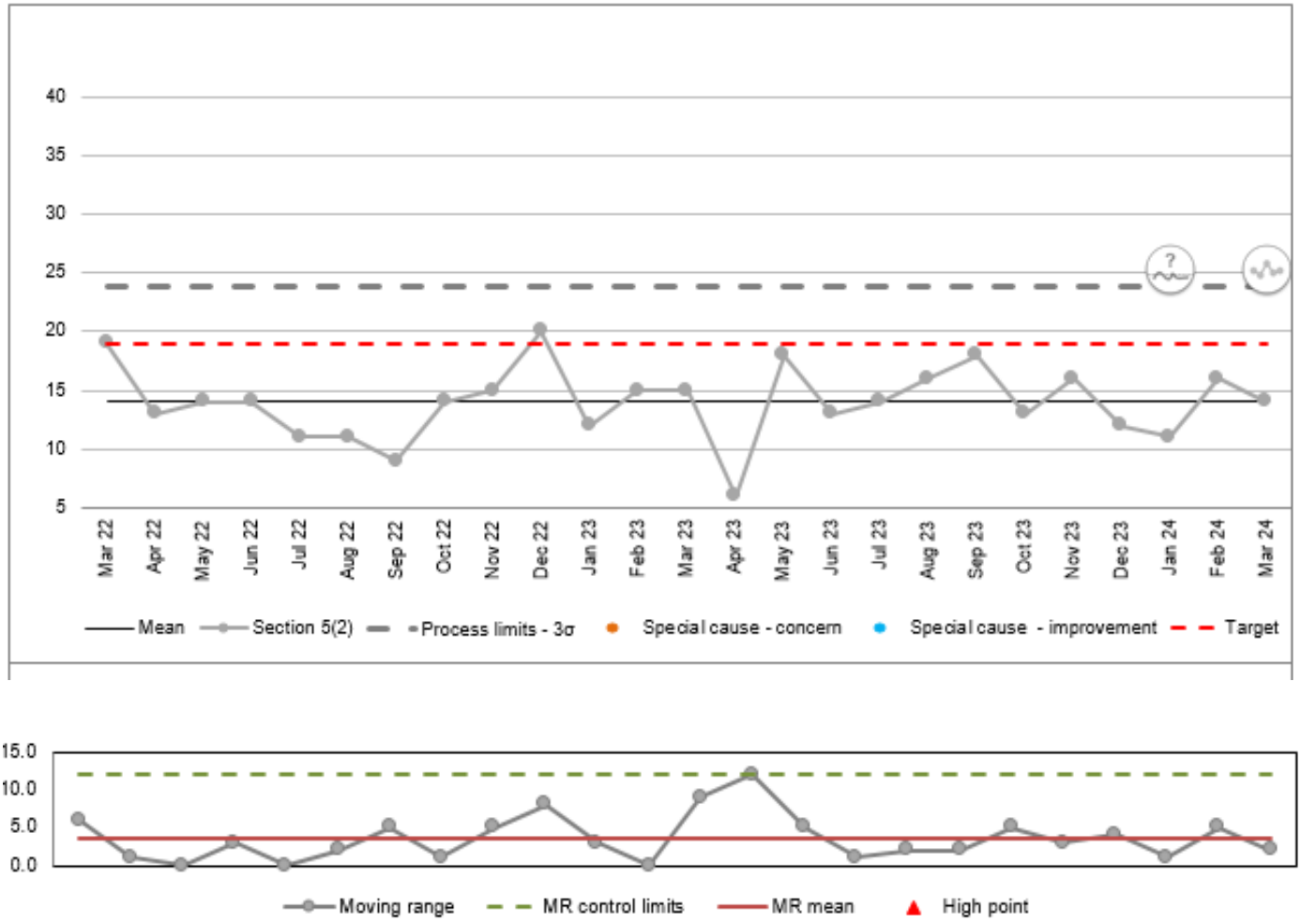
Data provided by EPUT Information Department



Section 5(2)

Section 5(2) is a holding section of an informal or voluntary patient on a mental health ward in order for assessment to be arranged under the Mental Health Act 1983 The purpose of a Section 5(2) is to prevent the person from discharging themselves before there is time to arrange an Mental Health Act assessment for a Section 2 or Section 3. The usage of a 5(2) can therefore fluctuate from month to month demonstrated as common variation.

From the 1st April 2023 to the 31st March 2024 section 5(2) was implemented one hundred and sixty seven times

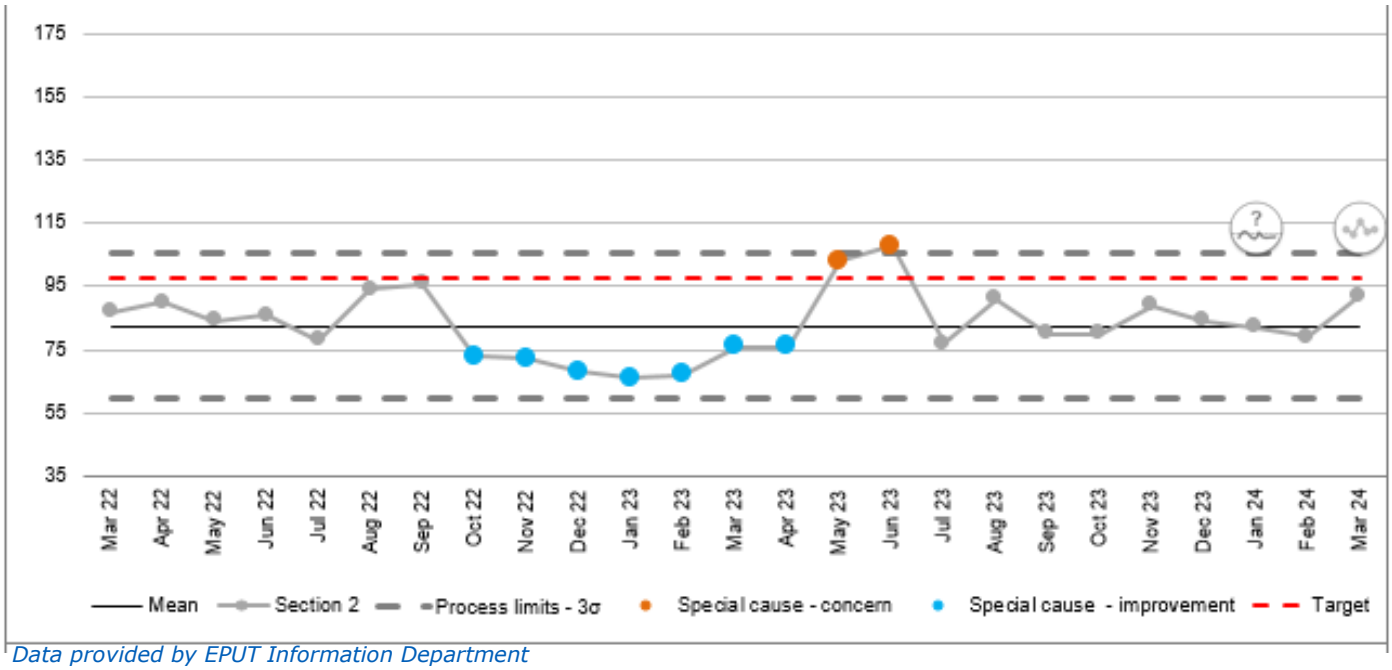


Data provided by EPUT Information Department

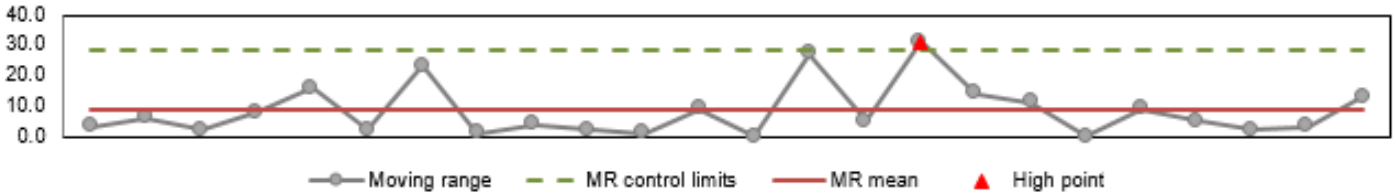
Section 2

Section 2 allows for the compulsory admission and detention for assessment of someone with a mental disorder. The mental disorder must be of a nature or degree which warrants the detention of the person in hospital and that they ought to be detained in the interests of their own health, safety or with a view to the protection of other persons. The Section 2 is for detention up to 28 days and cannot be renewed

From the 1st April 2023 to the 31st March 2024 section 2 was implemented one thousand and eighty two times.



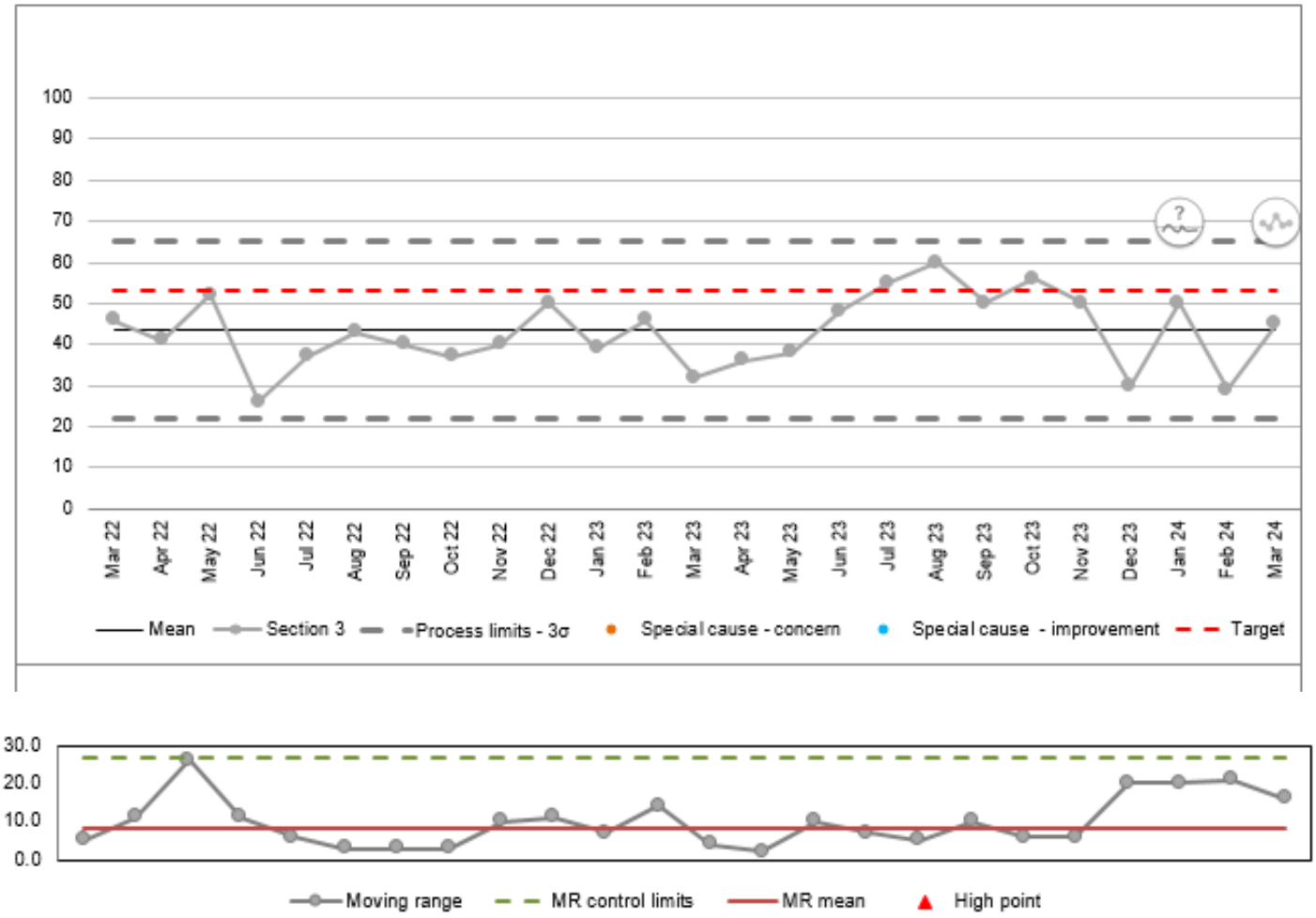
Data provided by EPUT Information Department



Section 3

Section 3 allows for a person to be admitted to hospital for treatment if their mental disorder is of a nature or degree which warrants the detention of the person in hospital and that they ought to be detained in the interests of their own health, safety or with a view to the protection of other persons. The Section 3 is for detention for up to six months, this can be renewed if the criteria is still met for a further six months and then yearly after that.

From the 1st April 2023 to the 31st March 2024 section 3 was implemented six hundred and thirty seven times.



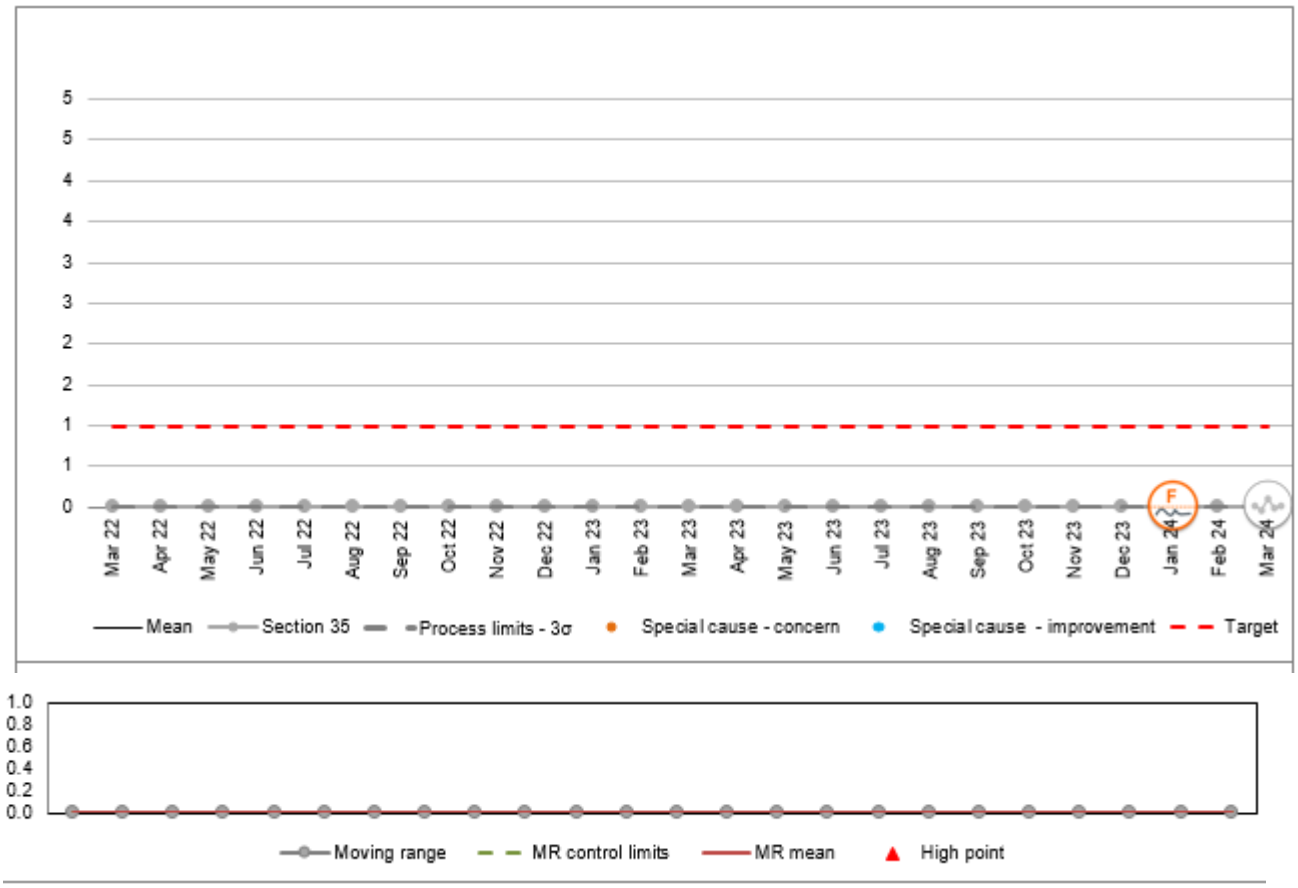
Data provided by EPUT Information Department

PART III OF THE MENTAL HEALTH ACT – FORENSIC SECTIONS

Section 35

Section 35 is a remand to hospital for assessment for up to 28 days, it can be renewed for a further 28 day period, for up to 12 weeks.

From the 1st April 2023 to the 31st March 2024 section 35 was not used.

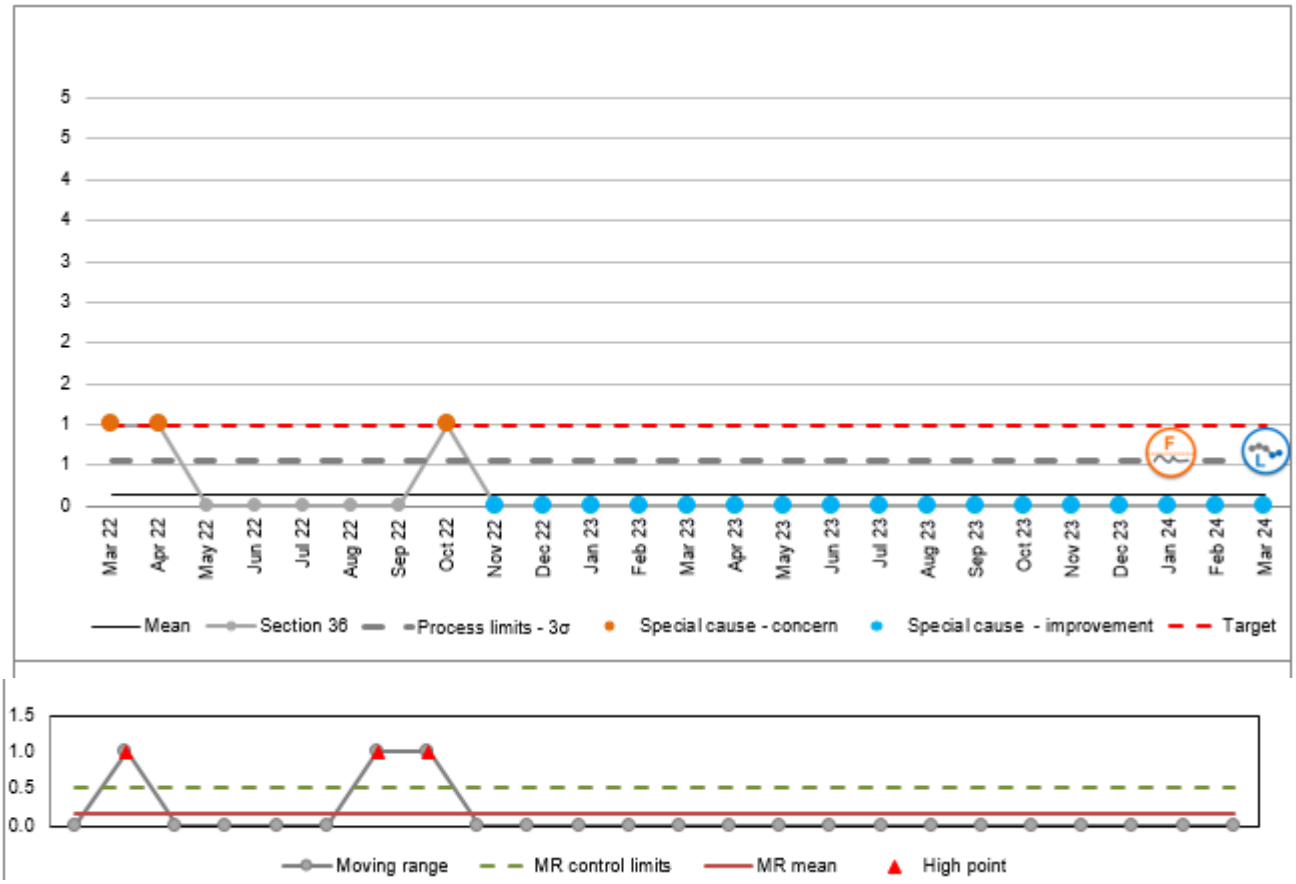


Data provided by EPUT Information Department

Section 36

Section 36 is a remand to hospital for treatment for up to 28 days, it can be renewed for a further 28 day period, for up to 12 weeks.

From the 1st April 2023 to the 31st March 2024 section 36 was not used.

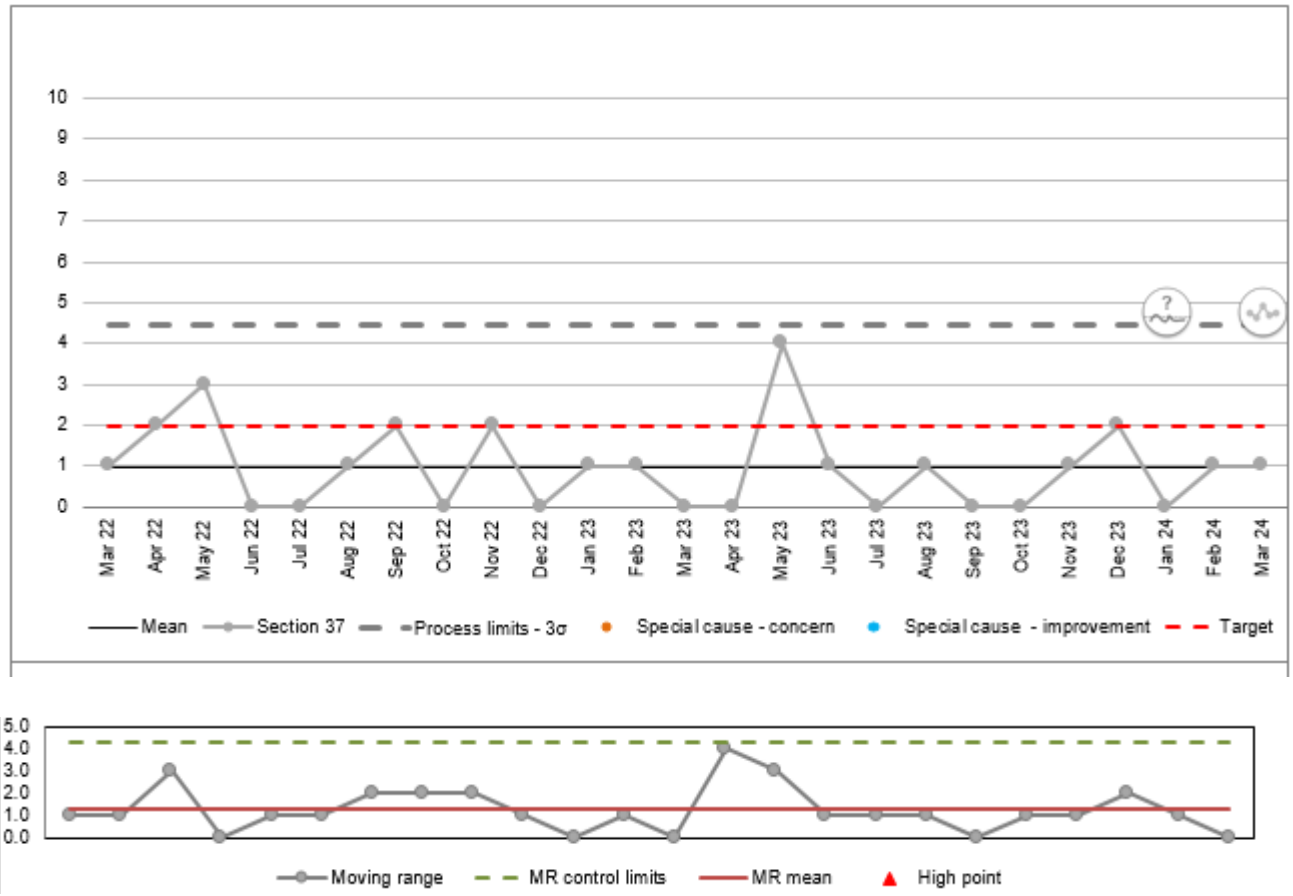


Data provided by EPUT Information Department

Section 37

Section 37 is a Hospital Order for the admission of an offender to hospital who is suffering from a mental disorder. Section 37 is for up to six months, renewable at six months and then yearly.

From the 1st April 2023 to the 31st March 2024 section 37 was implemented eleven times.

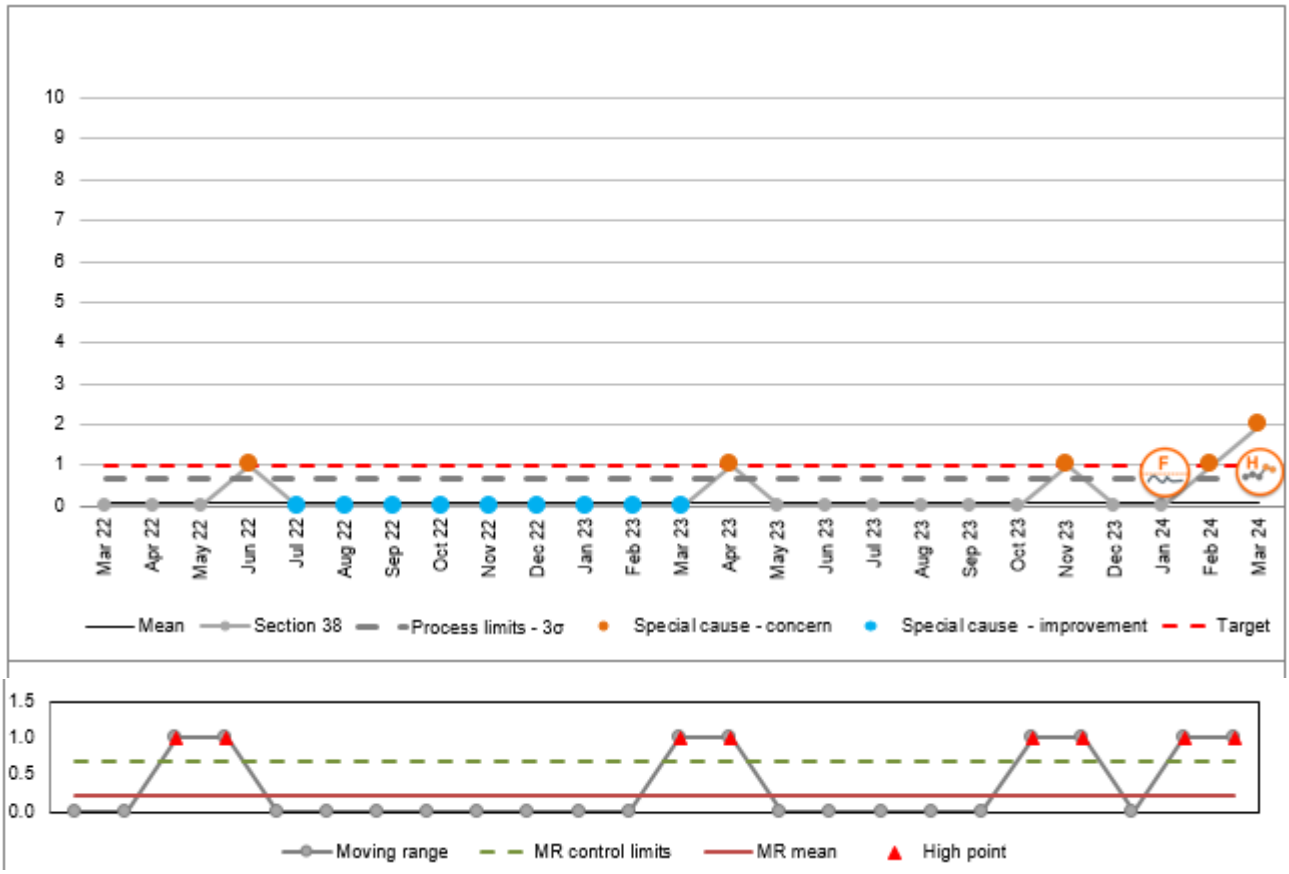


Data provided by EPUT Information Department

Section 38

Section 38 is an interim hospital order to assess an un-sentenced prisoner and is for up to 12 weeks.

From the 1st April 2023 to the 31st March 2024 section 38 was implemented six times.

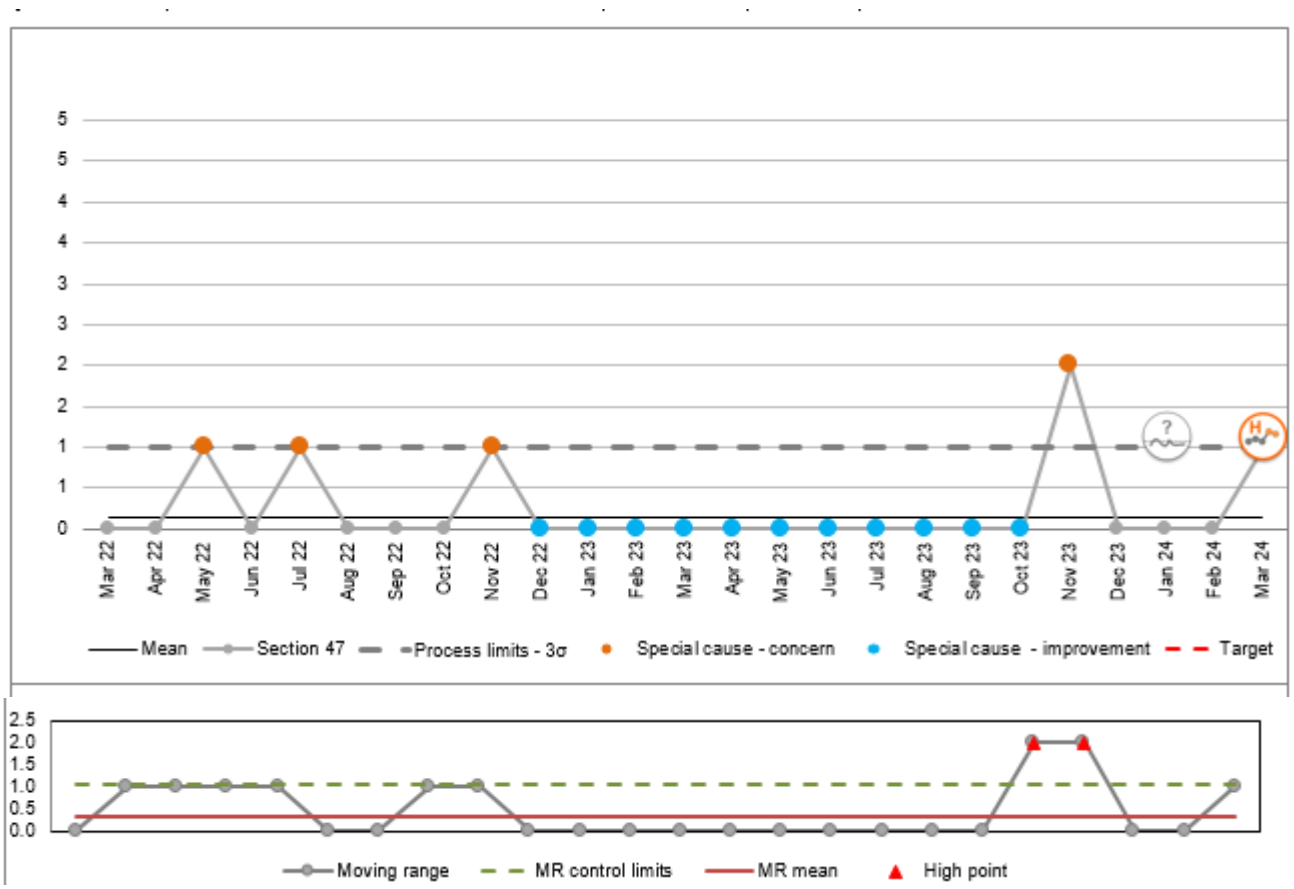


Data provided by EPUT Information Department

Section 47

Section 47 is the transfer of a sentenced prison to hospital who is suffering from a mental disorder. A Section 47 is for up to six months, renewable at six months and then yearly.

From the 1st April 2023 to the 31st March 2024 section 47 was used five times.

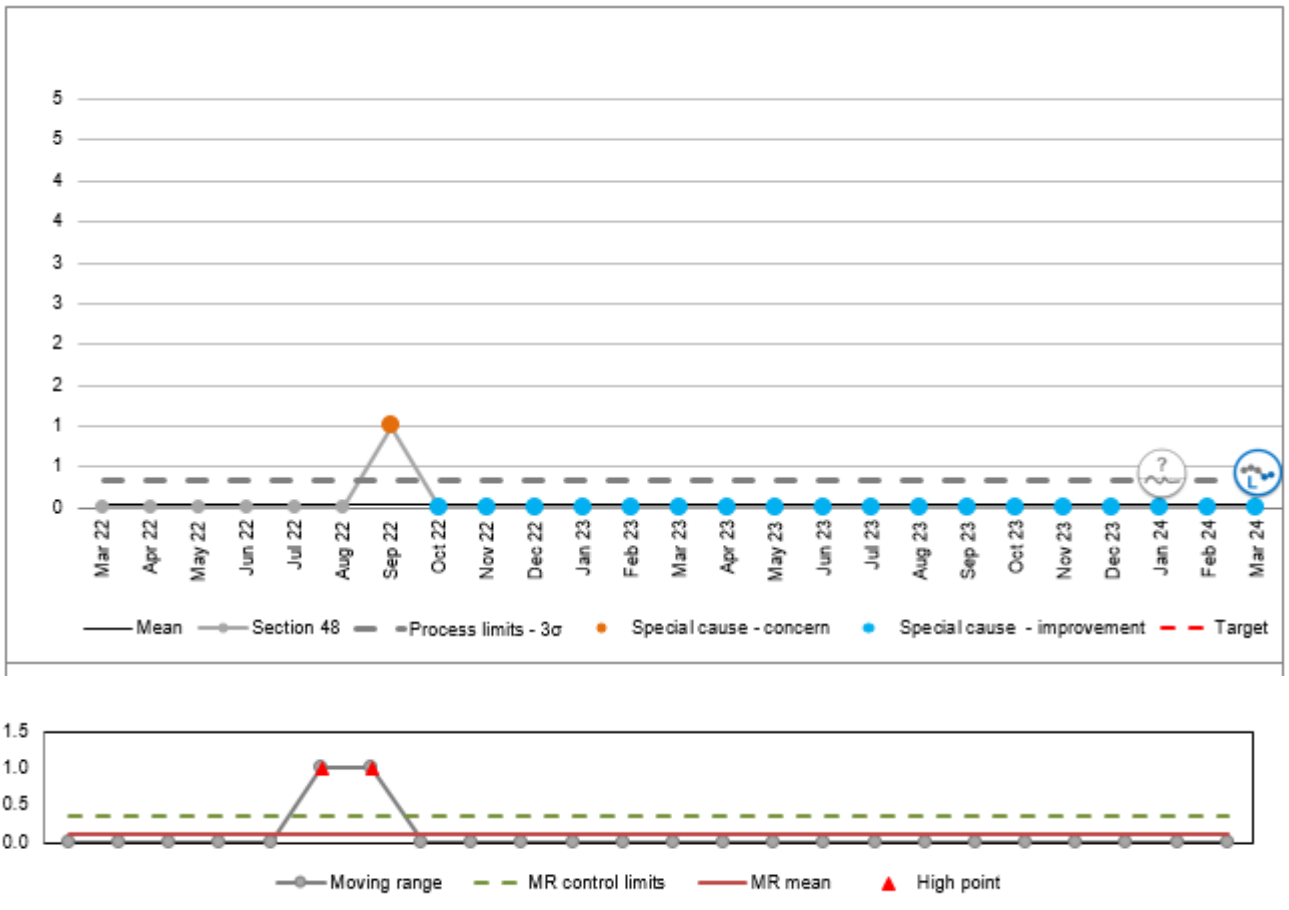


Data provided by EPUT Information Department

Section 48

Section 48 is the transfer of an un-sentenced prisoner in need of urgent treatment. The section has no limit of time.

From the 1st April 2023 to the 31st March 2024 section 48 was used 4 times



Data provided by EPUT Information Department

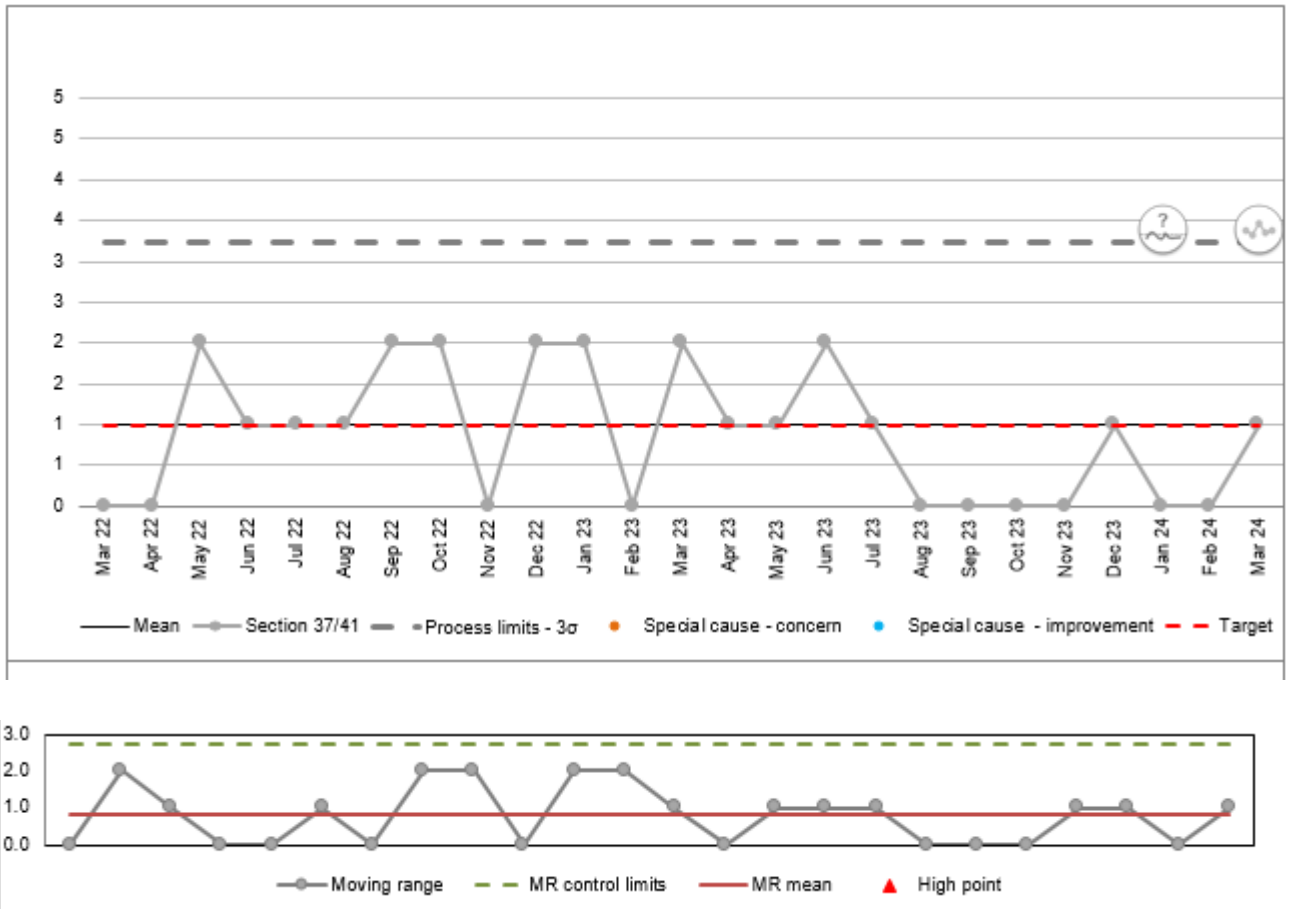
Restricted Patients

A restricted patient cannot be discharged by the RC, they can only be granted section 17 leave or transferred to another hospital or discharged with the permission of the Secretary of State.

Section 37/41

Section 37/41 is a Hospital Order with restrictions. The Section has no limit of time.

From the 1st April 2023 to the 31st March 2024 section 37/41 was used seven times.

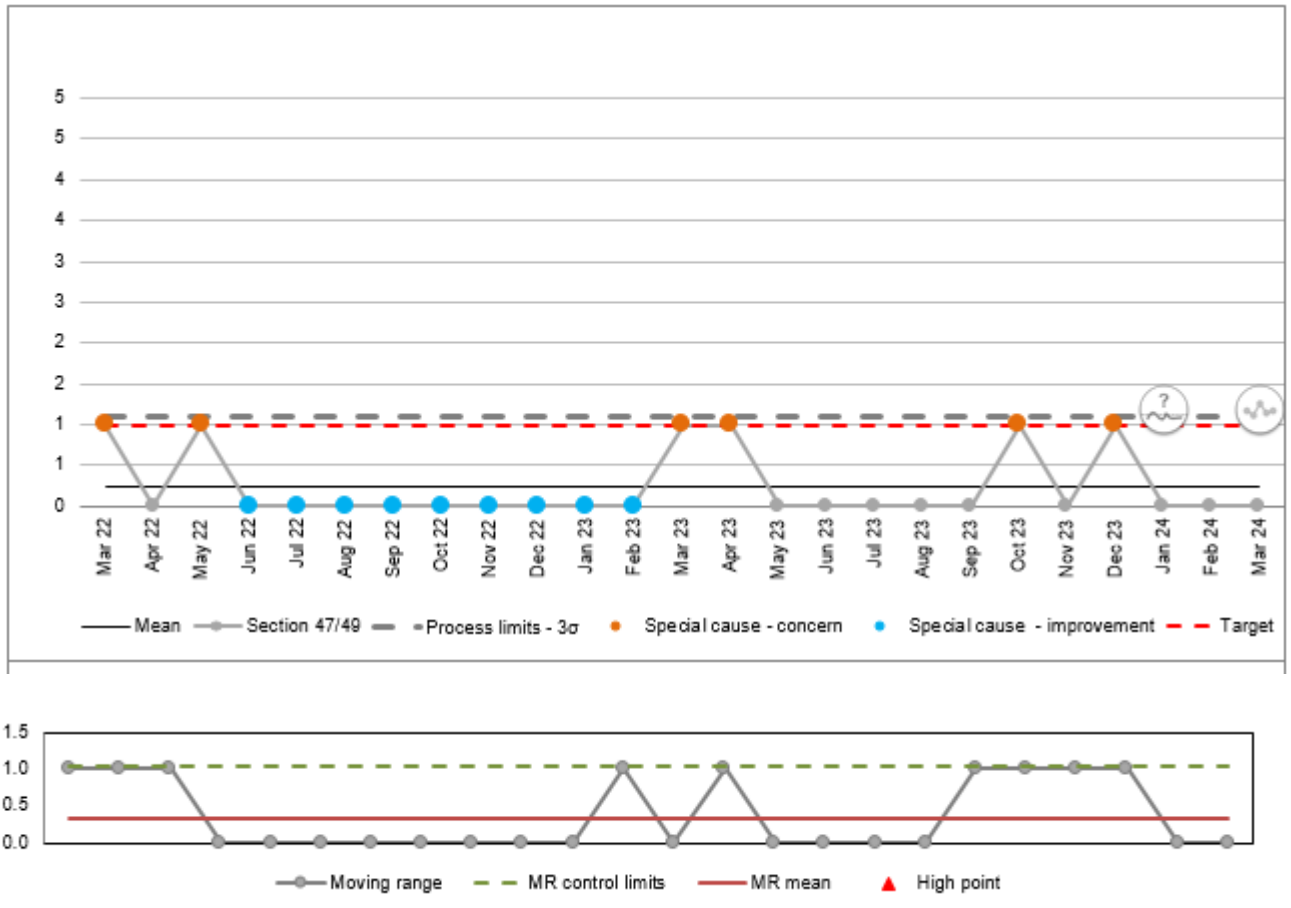


Data provided by EPUT Information Department

Section 47/49

Section 47/49 is the transfer of a sentenced prison to hospital who is suffering from a mental disorder with restrictions.

From the 1st April 2023 to the 31st March 2024 section 47/49 was used three times.

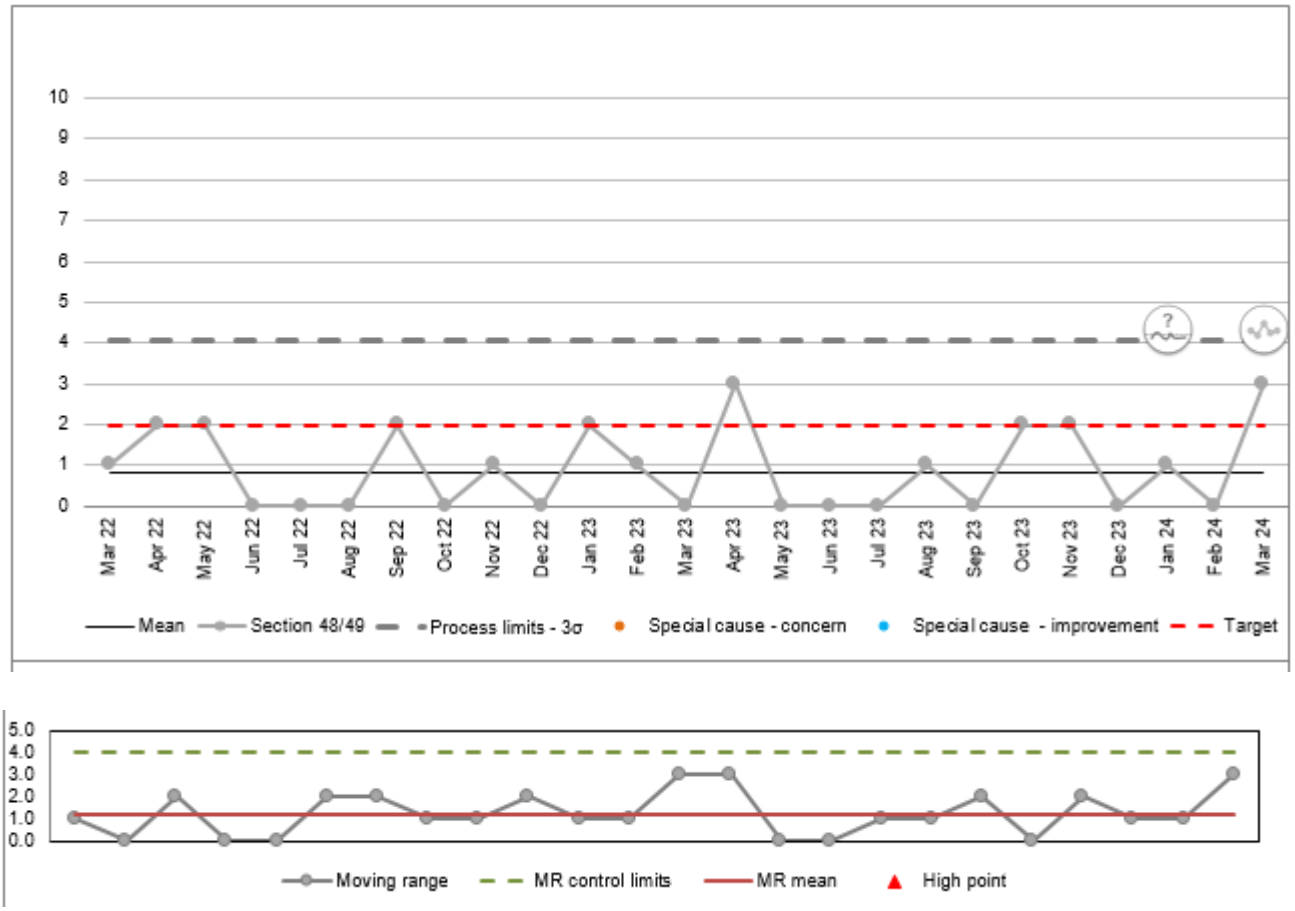


Data provided by EPUT Information Department

Section 48/49

Section 48/49 is the transfer of an un-sentenced prisoner in need of treatment.

From the 1st April 2023 to the 31st March 2024 section 48/49 was used eleven times.



Data provided by EPUT Information Department

Absence without Leave

Section 18 of the Mental Health Act authorises the return of a detained patient to hospital who absented themselves without authorised leave.

A detained patient's responsible clinician is the only person that can grant section 17 leave of absence.

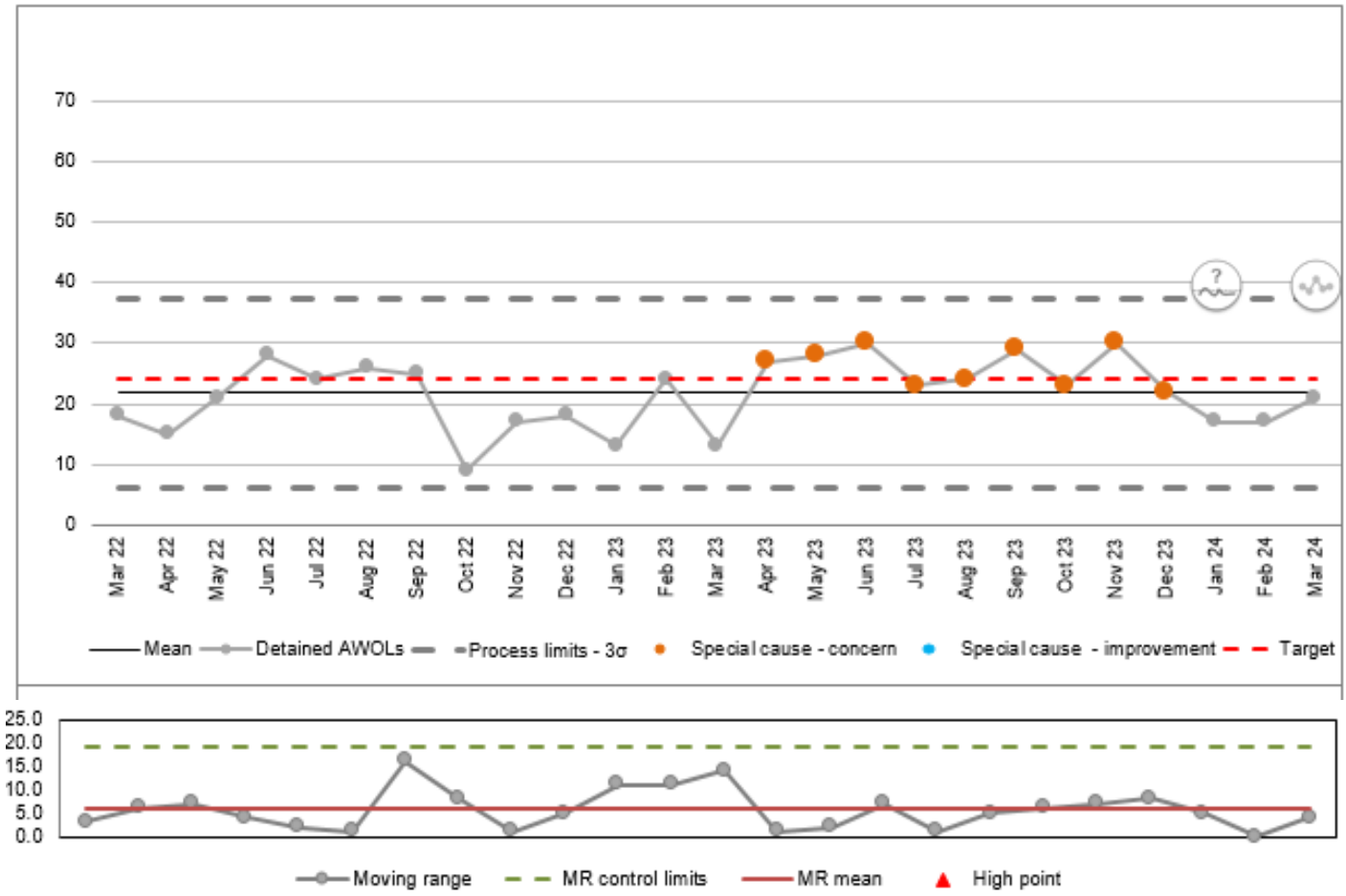
There are three factors that describe absence without leave (AWOL)

- Absenting themselves from hospital
- Absenting themselves from escorted leave
- Failure to return from section 17 leave at the appointed time

Prior to any agreed episodes of leave this is always discussed with the patient and or carer (where appropriate). The granting of leave is always based on current and historic presentations alongside observed mental state assessments.

A number of measures have been introduced to try and reduce the number of incidents of AWOLS.

These include improving communication between Multi-disciplinary team members (MDT), in particular reporting on patient's presentation or any untoward events. In addition the MDT fully review the risk when reintroducing leave following suspension, as well as improving staff skills in being able to complete pre leave risk assessments. Staff are supported in enhancing their learning and knowledge around the procedure to manage AWOLs.



Data provided by EPUT Information Department

National data – Mental Health Act statistics – Annual Figures 1st April 2022 to 31st March 2023 Published 25th January 2024

In 2022/23 there were 51,312 recorded detentions under the Mental Health Act, however the overall national total will be higher as not all providers submitted data and some submitted incomplete data. Trend comparisons are also affected by changes in data quality. For the providers that submitted good quality detentions data in each of the last six years it is estimated that there was a decrease in detentions of 7.7% from last year (EPUT figures for 2023/2024 evidence that there has been a 4% decrease in detentions over the last year against the national picture of 7%). Comparisons can still be made between groups of people using populations based rates even though the rates shown are based on incomplete data. Known detention rates were higher for males (83.7 per 100,000 population) than females (82.9 per 100,000 population). Amongst adults, detention rates tend to decline with age. Known detention rates for the 18 to 34 age group (135.9 detentions per 100,000 population) where around 59% higher than those age 65+ (85.4 per 100,000 population).

Detention Rates by Ethnicity

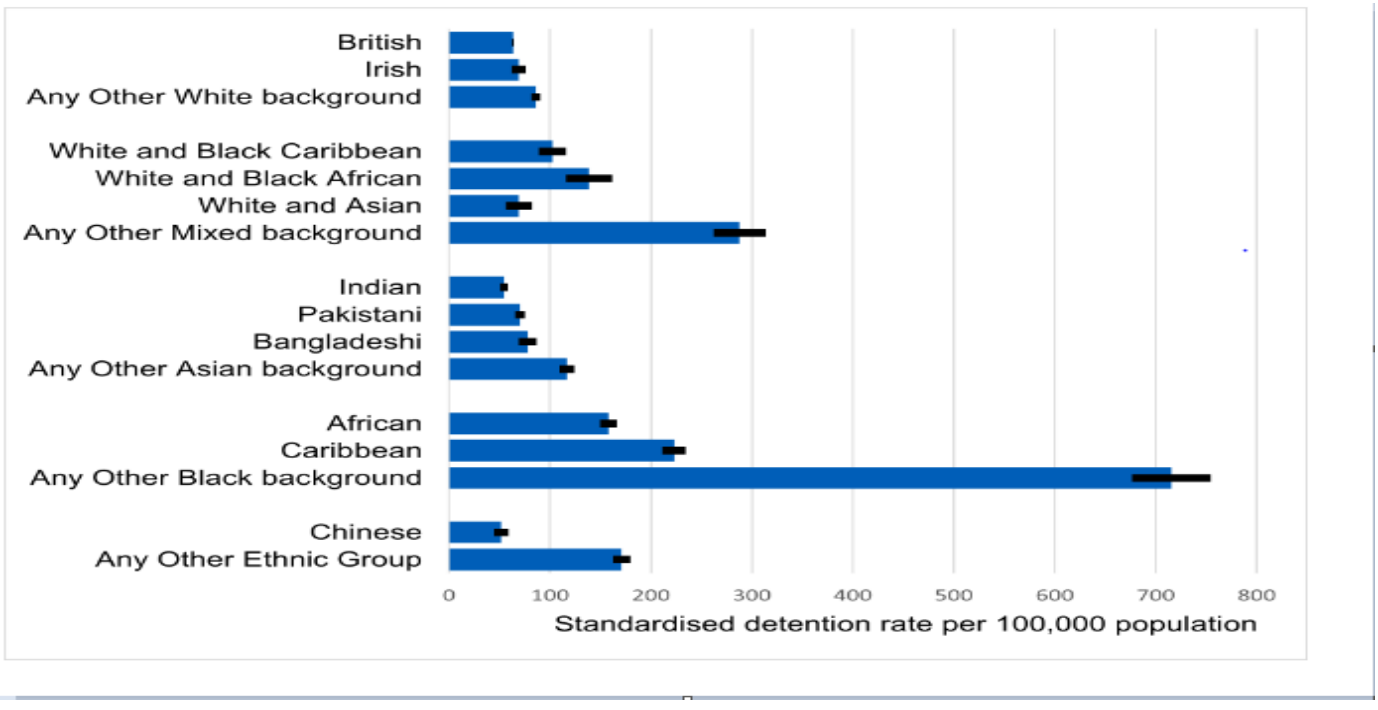
Detention rates by lower ethnic group

A more detailed breakdown of the five broad ethnicity groupings shows that the detention rate was highest for those with 'Any Other Black Background', which forms part of the 'Black or British' group. At 715.4 detentions per 100,000 people, this was over eleven times the rate for the White British group (63.4 detentions per 100,000 people) in 2022-23. The 'Any Other Mixed Background' had the second highest rate of detention (288.0 detentions per 100,000 population) followed by the Caribbean group at 222.8 detentions per 100,000 population.

Detention rates by higher ethnic group

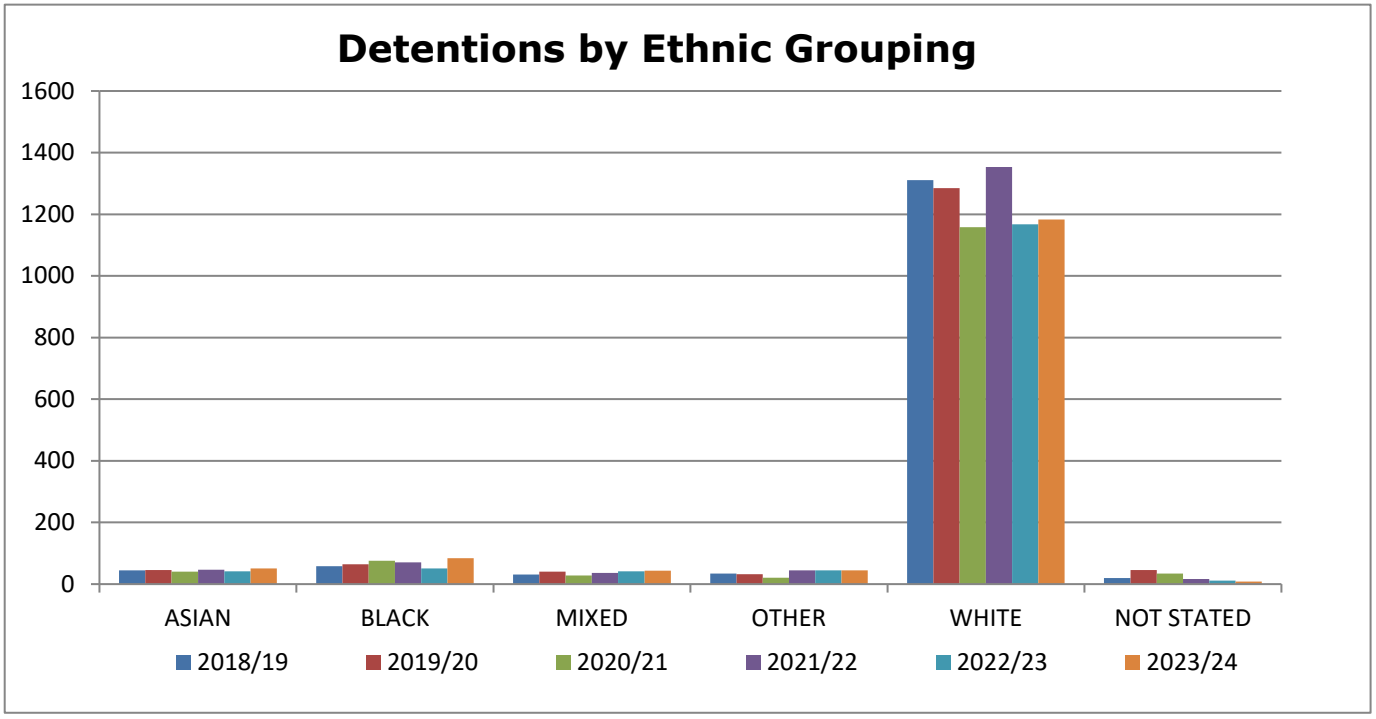
The White ethnic group is the largest in England, so we would expect this group to have the greatest number of detentions, even if there are missing data. But we can compare detentions for different groups of people (e.g. by age, gender and ethnicity) by expressing them as rates per 100,000 population. This is valid as long as there is no bias caused by the missing data.

National Data – Mental Health Act Statistics – Annual Figures. Published January 2024. Standardised detention rate per 100,000 population for the UK.



EPUT Detention Rates by Ethnicity

The table below details the ethnic grouping of detained patients in receipt of care from EPUT. Although the data indicates a slight increase in the detentions of black individuals and a slight increase in the detention of white individuals, the data, as in previous years, remains relatively stable and appears to be consistent with the demographic profile of EPUT's geographical area.



Data provided by EPUT Information Department

SERVICE LEVEL AGREEMENTS WITH OTHER PROVIDERS

The Trust continues to have in place Service Level Agreements with Princess Alexandra Hospital, Harlow, East Suffolk and North Essex NHS Foundation Trust who are responsible for services in Colchester General Hospital and Mid & South Essex NHS Foundation Trust who are responsible for services in Broomfield Hospital, Basildon General Hospital and Southend General Hospital. The Service Level Agreements provide Mental Health Act Administration expertise and support with patients detained to an acute hospital under the Mental Health Act.

Two service level agreements are currently in the process of being renewed for another year by Princess Alexandra Hospital (PAH) in Harlow and Mid & South Essex NHS Foundation Trust (MSE) for hospital in Basildon, Broomfield and Southend. The service level agreement with East Suffolk and North Essex NHS Foundation Trust (ESNEFT) is due for renewal in October 2024.

A vital part of the Service Level Agreement is the provision of Mental Health Act training to our acute care colleagues, all of which helps ensure those individuals detained under the Act are in receipt of their rights as a detained patient.

FEEDBACK

The support from EPUT MHA administration has been central to ensuring that we have met responsibilities in accordance with the MHA. The team are extremely proactive in their communication when notified of a person being detained in hospital and support staff from across the wards to ensure that paperwork is completed for scrutiny and are efficient in following up. I am very appreciative of how accessible and welcoming of contact the team (you) have been when I have had a query and patience that is demonstrated when support is required around MHA matters. The offer and facilitation of teaching has been great and positive feedback has been given in relation to this.
Tara Brown, Senior Lead for Safeguarding and Complex Health, East Suffolk and North Essex NHS Foundation Trust

- We are able to access expert advise
- We have had support when there have been appeals which is not something that we had been able to manager well previously
- We have access to specialist training which keeps out patients safer
- With the implementation of the "Right care Right person" we have been able to understand the implications and work together to implement and keep our patients safe

Denise Townsend, Deputy Chief Nursing Officer and Group Governance Director, Mid and South Essex NHS Foundation Trust

Since I have been in post (March 2023), I have been co-facilitating with the MHA Administrator on the MHA training. This is currently being delivered every 3 weeks. Previously it was fortnightly, however this was proving to be ineffective as attendance was very low. Attendance is now improving.
The content of the training was reviewed around 6 months ago to reflect the needs of the acute hospitals. Changes include showing the relevant forms to attendees as they were unfamiliar with them and they are now "talked through" what information should be included in the paperwork and who should be completing it.
In terms of content, it is pitched appropriately as the majority of attendees tend to be nurses and allied professionals. The session is delivered at a good pace and the facilitator explains every aspect clearly.
Wendy Hill, Mental Health Lead Nurse, Prevent Lead & Safeguarding Group, Mid and South Essex NHS Foundation Trust

CARE QUALITY COMMISSION

Care Quality Commission - Monitoring the Mental Health Act in 2022/2023 Report

The CQC's Monitoring the Mental Health Act in 2022/2023 Report was published on the 24th March 2024. The report is based on the findings from 860 monitoring visits carried out during 2022/2023. This involved speaking with 4515 patients (3410 in private interviews and 1105 in more informal situations) and 1200 carers. The CQC also spoke with advocates and ward staff. In addition the CQC carried out a series of interviews with people who have lived experience of being detained under the MHA or of caring for someone who have been detained.

The key points identified by the CQC were:

- Workforce retention and staffing shortages remain one of the greatest challenges for the mental health sector, affecting the quality of care and the safety of both patients and staff.
- Longstanding inequalities in mental health care persist. More work is needed to address the over-representation of black people detained under the MHA and to prevent prolonged detention in hospital for people who need specialist support.
- Despite additional investment, rising demand and a lack of community support means that children and young people face long waits for mental health support, and a lack of specialist beds means they continue to be cared for in inappropriate environments.
- We expect care to be person centered and are committed to helping services promote positive cultures. While we have seen improvements in some areas, there is still significant work to be done to reduce restrictive practices.
- It is promising that people, including staff, are aware of the drivers that can lead to a closed culture developing. But we are still concerned that too many abusive and closed cultures persist in mental health services.

https://www.cqc.org.uk/publications/monitoring-mental-health-act/2022-2023

Care Quality Commission MHA Focused Visits

The Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. They do this by looking across the whole patient pathway experience from admission to discharge.

The Mental Health Act Office provides a supportive process for the wards to help co-ordinate the visit. In the main during the last year, visits from the CQC have been unannounced. The Mental Health Act Office provide support to the ward staff for any responses that may be required to the CQC, during or following their visit. To date this has proved very successful.

CQC Mental Health Act Reviewers undertook the following:

1. Identify services that require monitoring based on emerging concerns and their previous contacts with the service;

The CQC have given formal provider action statements and monitoring reports detailing the outcome of the visit indicating any points where they would expect action to be taken. The Care Quality Commission made the following visits to the Trust from the 1st April, 2023 to the 31st March, 2024:

9th May, 2023	Rainbow Unit
25th July, 2023	Grangewaters Ward
16th August, 2023	Forest Ward
16th August, 2023	Lagoon Ward
17th August, 2023	Dune Ward
17th August, 2023	Causeway Ward
24th August, 2023	Finchingfield Ward
14th September, 2023	Gosfield Ward
26th September, 2023	Kitwood Ward
28th September, 2023	Galleywood Ward
24th October, 2023	Peter Bruff Ward
8th November, 2023	Henneage Ward
13th November, 2023	Ardleigh Ward
28th November, 2023	Longview Ward
6th December, 2023	Stort Ward
7th December, 2023	Chelmer Ward
12th December, 2023	Byron Court
10th January, 2024	Cedar Ward
16th January, 2024	Roding Ward
30th January, 2024	Edward House

5th March, 2024	Gloucester Ward
13th March, 2024	Cherrydown Ward
19th March, 2024	Christopher Unit

Overall the feedback from the CQC reviews was positive however, a number of themes were identified. The general themes identified have been shared both at the Mental Health Act Business meeting, Safe Care Group and the Mental Health Act & Safeguarding Sub Committee and action taken to mitigate against recurrence. It was pleasing to note that in addition to areas for improvement a number of positive general comments from patients, relatives, carers and IMHAs were provided to the CQC reviewers during their visits

Some of the themes identified were as follows:-

- IMHA Services
  - Lack of information around the ward
  - Lack of referring detained patients that have no capacity
  - Access to IMHA services
- Section 132 Rights
  - No evidence of rights being given
  - Delay in giving rights
- Capacity to Consent to Treatment Assessments
  - No evidence in the ward review electronic form, that capacity to consent to treatment had been assessed
- Food
  - Portion sizes too small
- Care plans
  - No evidence of patient involvement
  - patients not being given copies of their care plans
- Consent to Treatment
  - Treatment forms (T2/3 & Sec 62) not attached to the medication chart

Observations from the CQC:-

The young people knew that the hospital had a duty to inform patients of their rights as required by section 132 of the MHA. Their rights were provided in written form and verbally by staff. IMHA services were offered to the young people and requests for an IMHA to visit were made. **(*Longview Ward - CAMHS*)**

Our last visit to Rainbow Ward was on 27 November 2018. Since this visit, we found the following improvements: Staff provided patients with a copy of their section 17 leave authorisation. **(*Rainbow Unit – Specialist Service*)**

In the 3 records we reviewed, it was recorded that patients had been given information about their rights under section 132 and staff had noted the patients' level of understanding. None of the patients had understood the information. The records showed that the information was repeated monthly. We saw a copy of the easy read information given to patients. **(*Byron Court – Learning Disability Service*)**

Patients were involved in decisions about their care and treatment as far as was possible given the acuity of the mental health of some patients, especially at the time of their admission. The views of relatives and carers were considered. **(*Edward House – Secure Services*)**

Information was displayed about a community hub that provided information and access to organisations offering information on benefits, voluntary work, employment, drug and alcohol dependency support. **(*Cedar Ward – Adult Acute*)**

We reviewed all relevant T2 and T3 treatment certificates which were all present with medication charts. **(*Cedar Ward – Adult Acute*)**

Our last visit to Cedar Ward was on 2 August 2021. Since that visit we found the following improvements. The hospital had a duty to inform patients of their rights as required by section 132 of the MHA. These rights were provided in a timely way and recorded regularly. **(*Cedar Ward – Adult Acute*)**

Patients reported that they felt safe on the ward. **(*Cedar Ward – Adult Acute*)**

Our last visit to Roding Ward was on 28 November 2018. Since that visit we found the following improvements. Medications were listed on medication charts and were authorised on T2 authorisation certificates. Old section 17 leave forms were struck out when out of date and not in use any longer. **(*Roding Ward – Elderly Services*)**

Our last visit to Gloucester Ward was on 6 August 2019. Since that visit we found the following improvements. From the records we found that medication was authorised a certificate of second opinion (T3 form). Physical health checks were recorded and there was evidence of carer involvement and discharge planning found in records. **(*Gloucester Ward – Elderly Services*)**

Staff were trained in safeguarding and understood

the hospital policy for reporting safeguarding concerns. Information about safeguarding was displayed on the noticeboard. **(*Grangewaters Ward – MH Assessment Unit*)**

There was good evidence that the duties of the hospital managers were being correctly carried out, including the processing of applications to the Mental Health
Tribunal and arranging hospital managers' hearings. **(*Grangewaters Ward – MH Assessment Unit*)**

Discussion with patients:-

All young people we spoke with felt safe on the ward. They said that staff were approachable and they knew who their key nurse was. One young person said "my key nurse is really good." Young people felt they had enough 1-to-1 time with their key nurse. If key nurses were not available, then other staff gave 1-to-1 time. ***(Longview Ward - CAMHS*)**

One young person said there was not as much to do at the weekend. ***(Longview Ward - CAMHS)***

One patient told us they found the ward recovery focused and that they had seen the improvement in their wellbeing since being on the ward. Staff were respectful and approachable. They knew who their daily named nurse was, and they could talk and have regular 1-to-1 time with nursing staff. **(*Rainbow Mother and Baby Unit – Specialist Services*)**

The responsible clinician was approachable and made time to discuss care and treatment. Their treatment plan including medication was explained, including the advantages, risks and side effects. **(*Rainbow Mother and Baby Unit – Specialist Services*)**

Patients said that staff treated them well. They said that they could talk to staff and felt heard by them. **(*Forest Ward – Secure Services*)**

One patient said that he found it difficult on the ward at times but that he found the dialectical behavioral therapy (DBT) and substance misuse therapy helpful. **(*Forest Ward – Secure Services*)**

None of the patients with whom we spoke said they liked the food. One patient said that the food portions on the ward "were tiny". **(*Forest Ward – Secure Services*)**

Patients with whom we spoke with were happy with their experience of the ward.
One patient told us the treatment they received had "helped a lot". The ward manager was described as relaxed. All patients we spoke with said they felt safe on the ward. **(*Edward House – Secure Services*)**

Patients spoke about what they did with their time on the ward. One patient spoke highly of the OT technical instructor and explained that they went out of their way to provide extra gym sessions and that they really cared about the patients. **(*Edward House – Secure Services*)**

Patients we spoke with were happy with their experience on the ward. Staff were "absolutely lovely". One patient told us "this has been the best care I have ever had." **(*Edward House – Secure Services*)**

One patient explained their admission was "not good". In addition, they had experienced a homophobic attack on the ward from another patient. However, this incident had been addressed in a timely way. **(*Edward House – Secure Services*)**

We spoke to 5 patients in private. All patients we spoke with were happy with the staff support, "the ward manager goes over and above to help." "The staff have kept me alive and really supported me not to die." **(*Galleywood Ward – Adult Acute*)**

Patients we spoke with who were detained confirmed they had been informed of their rights. Two patients spoke about appealing their detentions. Two patients spoke about using the IMHA for information and support. **(*Cedar Ward - Adult Acute*)**

All of the patients we spoke with felt the staff were very good. **(*Gloucester Ward – Elderly Services*)**

Patients we spoke with had not seen an advocate. One patient said they had not received information about their legal position and rights under the MHA or had these explained to them. **(*Gloucester Ward – Elderly Services*)**

Most patients we spoke with told us that they were treated with respect and dignity and that they felt safe on the ward. We observed caring and supportive interactions between patients and staff. The patients told us that they were able to keep in contact with families and friends. They also said that there were no issues with arranging visits by their relatives. **(*Grangewaters Ward –*

***MH Assessment Unit*)**

They said that the atmosphere on the ward was mostly quiet but could be noisy and busy at times. **(*Grangewaters Ward – MH Assessment Unit*)**

Patients reported that most staff were "amazing" and "go that extra mile". **(*Peter Bruff – MH Assessment Unit*)**

One patient said the food was good. Another said the food was "horrendous" with sandwiches every day and hot food made with potatoes a lot. **(*Peter Bruff – MH Assessment Unit*)**

Discussion with carers:-

Carers told us that they could not fault the staff on the ward. They were kind, supportive, and lovely people. Staff listened and were accommodating. The team gave them hope about moving their relative forward. **(*Longview Ward - CAMHS*)**

Carers said that "communication is brilliant." Carers could ring the ward at any time and receive a response. **(*Longview Ward - CAMHS*)**

Carers were positive about the care and treatment their relative received. We were told that staff were helpful, approachable and listened to them. We heard that staff took time to understand the individual needs of the patients, asking carers for advice if they did not understand a particular behaviour or its meaning. Carers were invited to attend ward reviews and discharge planning meetings, with arrangements made for them to join remotely if they could not attend in person. A carer described the staff as "marvelous" and that "they do a great job". We heard that, in their opinion,
Byron Court was better than other similar units their relatives had been admitted to in the past. One carer specifically mentioned the responsible clinician who they described as "very professional" and "streets ahead" of other clinicians they had met previously. **(*Byron Court – Learning Disability Service*)**

We spoke with one carer of a patient from this ward. They spoke positively about the staff and the communication they received. Visiting their relative had been good. Staff had tried to arrange visiting at Christmas time and other important occasions like the patient's birthday. This had meant a lot to the carer and the patient. On admission the carer had been asked what the patient's likes and dislikes were. They had also been consulted on where the patient could move on to. The carer felt the patient was very settled on the ward and the staff went 'above and beyond' to support their relative. **(*Edward House – Secure Services*)**

Carers told us that "staff are very nice" and "staff are impressive and lovely." **(*Forest Ward – Secure Services*)**

One carer said that the doctors and nurses kept them regularly updated. One carer spoke about attending the carers' forum and that this was useful. **(*Forest Ward – Secure Services*)**

Carers found visiting easy and accessible. Carers told us that their relatives were happy on the ward, for example, one said "I am pleased overall with the care". **(*Galleywood Ward – Adult Acute*)**

Carers told us that staff were welcoming and friendly. Generally, they were lovely and listened. Carers said staff tried hard and the health care assistants were very good. **(*Cedar Ward – Adult Acute*)**

The carers we spoke with said that the staff were lovely. The ward was very good and worked well for patients. Both carers we spoke with said they were very grateful for the service their relative received from the ward.
Staff were approachable and explained things well. The matron was also approachable and happy to discuss issues and share knowledge. **(*Gloucester Ward – Elderly Services*)**

Staff were good and helpful at visiting times. A slot was booked off the ward for the visit. They were not kept waiting for visits. **(*Peter Bruff – MH Assessment Unit*)**

Discussions with the IMHAs

Referrals were made to the IMHA service regularly and support was provided at ward rounds and care programme approach meetings. Private space was always found for the advocate and they were made to feel welcome. Staff knew what an IMHA was and what support they provided. **(Longview Ward – CAMHS)**

The IMHA service was provided by Rethink. We heard that they had worked at
Byron Court for the past 8 years. Staff referred all detained patients to the service and they supported patients to appeal to the First Tier Tribunal – Mental Health and the Hospital Managers. Staff were in regular contact with the IMHA who was invited to attend the weekly

reviews and all other meetings. The IMHA met with any new ward staff to inform them of the support the IMHA service could offer to patients. We were told that the MHA administration team was a helpful point of contact for the IMHA. The IMHA expressed no concerns about the service.
Rethink also provided the independent mental capacity advocate (IMCA) service and a general advocacy service for any informal patients. **(*Byron Court – Learning Disability Service)***

The IMHA was from the local authority funded by Essex service Rethink. The IMHA agreed she was able to perform her role as per the Code of Practice. Private rooms were found for interviews and communication around ward round times was good.
A majority of staff knew the IMHA role and what it was for. Referrals were sent frequently. The IMHA visited the ward once every two weeks or when a referral was made. (***Edward House- Secure Services*)**

The IMHA told us that they were able to perform their role on the ward. **(*Galleywood – Adult Acute)***

They said that the ward had a routine of patient reviews that worked well for patients and the IMHA. Staff knew what the role was and used the service well. The referral system was embedded. The IMHA did not provide a drop in or attend community meetings. They came to the ward every Monday and Friday for most of the day.

(*Cedar Ward – Adult Acute*)

The ward was very good at communicating with the IMHA. They had a good working relationship with the matron and the interim ward manager and was made to feel welcome on the ward. The IMHA was found a private room to meet with patients. The staff made referrals in a timely way. The IMHA confirmed referrals for patients who lacked capacity were made. They also confirmed they worked in a non-instructed way with these patients. (***Roding Ward – Elderly Services***)

The IMHA from Rethink told us the ward staff were professional, helpful, and polite.
They were always provided with an alarm. Staff would brief the IMHA about any patients with risks. (***Gloucester Ward – Elderly Services***)

EPUT Guidelines for completing CQC Provider Action Statements

In order to provide staff with robust support in the completion of a CQC provider action statements, guidelines were developed in March 2024 which were reflective of the most common identified themes from CQC MHA focused visits from 1st April 2023. These guidelines will be updated on a regular basis by the MHA office to include any new themes going forward.
Additional one to one support is provided to staff in regards to the completion of the provider action statement by the MHA team senior manager.

AUDITS 2023/2024

Audits are undertaken annually, bi-annually and monthly to monitor EPUT's compliance with the Mental Health Act and to ensure that patients are legally detained and their rights protected

Associate Hospital Manager Audit

The Independent Chair of the Associate Hospital Managers, in conjunction with the Mental Health Act Office, undertake two audits a year; a decision form audit and a full panel audit.

Decision Form Audit

This audit involves scrutinising a number of decision forms (12 in total) to ensure that the forms gave sufficient evidence to justify the decision to discharge or not, the patients' detention under the Mental Health Act. The decision form audit took place during November 2023. The 12 decision forms audited were dated between the periods December 2022 to January 2024. In the vast majority of cases, forms were completed in line with expectations. The following observations were made at the conclusion of the Decision Form Audit:-

- There were at least two decision forms that could be considered exemplars. However some of the decision forms were lacking in some evidence not being recorded and/or conclusions not being drawn with limited reference to evidence which may have been gleaned but not recorded.
- Reference to capacity and insight was not always reported in detail and yet these aspects could sometimes directly affect compliance with medication and other treatments.
- Appropriate treatment can cover medication, occupational therapy and psychology however reference to section17 leave is often not always referred to as an important part of the therapeutic programme.
- Some of the decision forms would have benefited from a more detailed narrative to evidence that the criteria for continued detention had been met.

Full Panel Audit

The purpose of the Full Panel Audit is to reflect on what has occurred within hearings in order to learn lessons and improve practice and procedures within EPUT. The audit team will seek to ensure that the process of the hearing complied with the principles of clinical governance and that the rights of the patient were considered and, where appropriate, protected.

This includes ensuring that reports were received in a timely fashion and were of an appropriate standard, that the Associate Hospital Manager Decision Form from the hearing was clear and comprehensive and also to discuss and identify any best practice points for clinicians, administrators and Associate Hospital Managers

The full panel audit took place on 21st November, 2023. The Audit team looked at the case of a patient who was detained on Section 3. The Responsible Clinician Report, Social Circumstances Report and the Nursing Report were reviewed as part of the audit process.

It was evident during this audit that there were elements of the reports that did not provide sufficient detail for the AHMs to provide robust detail in their responses to the questions raised within the reports. With this in mind the guidance notes and revised report formats that were piloted previously will now include the necessary guidance to report authors to enable them to provide the relevant evidence.

A report identifying the themes and recommendations was presented to the Mental Health Act & Safeguarding Sub- Committee in January, 2024. An action plan has been devised to address the themes identified by the audit and developed in conjunction with the Associate Hospital Manager Chair and Vice Chair. The action plan was shared at a quarterly Associate Hospital Manager Meeting in March 2024 to ensure the dissemination of learning of all the points raised through the Associate Hospital Manager audit to Associate Hospital Manager colleagues as well as Responsible Clinicians and their colleagues.

Tendable Report

A monthly audit is undertaken at ward level by ward managers or nominated person, to ensure the ward's individual compliance with the Mental Health Act. Tendable, the audit tool designed to assist health and care professionals to own patient safety and conduct quicker and more efficient quality audits, is used to facilitate this audit and has proved effective in helping monitor compliance.

Audits are undertaken on a monthly basis, the results of which are produced and viewed through an Inspection Summary. The Inspection Summary is made up of various components containing previously agreed questions that are required to be asked of individual wards regarding compliance.

The Mental Health Act office review the Inspection Summary each month. Based on the findings of these audits, specific support training is offered to the ward and, where applicable, individual clinicians.

The results of the Mental Health Act Tendable audits are a standing agenda item at the Mental Health Act Bi-Monthly Business Meeting as well as the Mental Health Act & Safeguarding Sub Committee. Any emerging themes and points of learning are discussed, escalated if necessary and any remedial action taken, for example, bespoke training, review of online training and review of policies and procedures.

Mental Health Act Documentation Audit

When someone is detained under a section of the Mental Health Act certain section documentation is required in regard to the admission of and continued detention and, treatment under the Act

The role of the MHA administration team is to scrutinise documents for accuracy and completeness and to check that they do not reveal any failure to comply with the procedural requirements of the Act in respect of applications for detention.
The MHA office have developed processes and procedures to aid compliance with the Mental Health Act, the Mental Health Act Code of Practice and guidelines issued by the Care Quality Commission.

The aims of the audit were to provide assurance that the Trust is compliant with the legal requirements of the MHA which could lead to patient safety risks and reputational damage due to inaccurate completion and retention of appropriate section papers, as well as provide assurance that patients detained under the MHA with the Trust were detained lawfully and being treated within the parameters of section 58 of the MHA.

The audit demonstrated that the MHA office team on the whole operate a good sound system of MHA administration processes and procedures. However, it was identified that there were a few instances of non-compliance with processes and procedures which were addressed through learning and training.

Associate hospital managers

Section 145 of the Mental Health Act gives the designated Hospital Managers various powers and duties. In an NHS Trust or NHS Foundation Trust, the Hospital Managers will be the Trust or Foundation Trust as a body. In practice many duties within the Act for which Hospital Managers are responsible will be delegated.

Delegation is authorised within the Mental Health Act Regulations and in the case of discharge powers, under section 23 of the Act. Many of the functions will usually be delegated to Mental Health Act administration office. Organisations may delegate the section 23 role to a group of people referred to as "Associate Hospital Managers". Hospital Managers retain overall responsibility for any delegated duties. Associate Hospital Managers are lay individuals who work on a voluntary basis and they receive a small remuneration for their time

The key function of the Associate Hospital Managers is to consider patients' requests for discharge from detention under certain sections of the Mental Health Act in accordance with section 23 of that Act, (including from Community Treatment Orders) and reviewing detention following renewal of such sections or following the barring by the Responsible Clinician of an application for discharge by the patient's nearest relative.

The Trust currently has twenty Associate Hospital Managers who undertake Hospital Manager hearings, and to ensure that their Mental Health Act knowledge remains current, they participate in regular relevant learning sessions.

Three Associate Hospital Managers resigned during 2023/2024. Reasons for resignations include work/life balance and other commitments. The Mental Health Act office, in conjunction with the Independent Chair and Vice Chair, regularly review the number of Associate Hospital Managers to ensure there is sufficient capacity to facilitate hearings in a timely manner. Currently the MHA office are in the process of recruiting a number of new AHMs who are expected to be in post by autumn 2024.

The Associate Hospital Managers meet three times per year to discuss business pertaining to

their role. Guest speakers are invited to provide an overview of their specialist area and expertise in regards to their individual roles within the organisation which underpins the knowledge and expertise of the AHMs.

Associate Hospital Manager Review of Performance

The Mental Health Act Code of Practice requires Trusts to complete an evaluation of satisfactory performance for each Associate Hospital Manager prior to the renewal of their agreement. Each Associate Hospital Manager's two-year agreement includes a number of elements that they must fulfil to ensure renewal, of which the performance review is a primary element. These reviews are used to determine learning requirements, both specific to the individual as well as learning in general.

As reported in last year's MHA Annual Report all AHM reviews were concluded to a satisfactory standard. A new schedule of reviews has been devised to meet the conditions of the renewal of AHM agreements on 1st November 2024.

The Trust would like to acknowledge the hard work and commitment of all the past and current Associate Hospital Managers during 2023/2024.

Lancashire and South Cumbria Judgement

Recently the Trust were informed of a Judgement that may have had an effect on the current AHM agreement that the Trust has in place with the AHMs. The Judgement referred to an employment Tribunal in the case of *Lancashire and South Cumbria NHS Foundation Trust and Miss R Moon* where the employment tribunal found in favour of Miss Moon with regard to her "worker" status as an AHM in line with her "honorary" contract. Following this judgement, along with discussions with senior manages from the Trust's HR department, they were confident that the current agreement which is in place did not constitute the meaning of an" honorary" contract. A review of the agreement is currently being undertaken and will be shared with the Trust's solicitors, following which, confirmation of assurance is expect that the AHMs are not of "worker" status within the Trust.

Associate Hospital Managers Meetings and Supportive Learning

The AHMs have met three times during the last year and at the conclusion of each meeting have received presentations from:-

- Nicola Greenhalgh, Deputy Chief Pharmacist, Inpatients, Specialist and Secure Services
- Debbie Radley, Mental Health Act Senior Manager, Forensic Sections
- Debbie Payne, Named Professional Quality and Governance, Safeguarding

Face to Face Hearings

Following the reintroduction of face to face hearings by the Mental Health Review Tribunal and subsequent requests from patient's legal representatives, face to face hearings were reintroduced in October 2023 for Hospital Manager appeals and contested renewal hearings.

Understanding the Role of an AHM with the Trust's Governors

Phil Barlow, Independent AHM Chair will be making a short presentation to the governors in May 2024 to provide an overview of the role of an AHM within the Trust.

Non-Executive Directors undertaking an AHM Role

Recently an independent report titled *Rapid review into data on mental health inpatient settings: final report and recommendations* was published on the 28/06/2023.

The purpose of the review was to consider the way that data and evidence relating to mental health inpatient settings and pathways was collected, processed and used to identify risks early, and mitigate them to protect the safety of patients.

There were thirteen recommendations in the report and in recommendation five a number of points where identified, one of which was that every board should provide Mental Health Act training so that at least half their Non-Executive Directors are trained as Associate Hospital Managers under the Mental Health Act. These Non-Executive Directors should participate in hearings to best understand the clinical care provided, the challenges, and the views of patients, families and clinical teams for the patients. Following the publication, the Trust facilitated a presentation and training outlining the details of the review and recommendations to the Non-Executive Directors.

Derbyshire health care judgement

The High Court handed down its judgement in the *Derbyshire Health Care NHS Trust v Secretary of State for Health and Social and other (2023) EWHC 3182 (Admin) (the Derbyshire Judgement)* on the 13th December, 2023.

This case considered certain provisions of the Mental Health Act that were not addressed in the Devonshire Judgement in regards to the renewal of a section or the extension of a community treatment order, in that both the renewal and the extension process requires that the Responsible Clinician must "examine" the patient face to face.

As a reminder on the 19th May 2020, the government issued guidance regarding the process/guidance for remote assessments in light of COVID-19 restrictions. Devon Partnership NHS Trust subsequently challenged this.

The challenge was in regards to the phrases 'personally seen' and 'personally examined' in sections 11(5) and 12(1) of the Mental Health Act which require the physical attendance of the person in question on the patient, prior to an application being made for detention under section 2, section 3 or section 4, or guardianship under section 7. This meant that it was not sufficient or lawful for a patient to be seen or examined remotely using video technology.

On 22nd January 2021, the Divisional Court handed down a judgement that briefly stated that remote assessments were unlawful. This judgement was in relation to assessments for sections 2, 3, 4 and 7. The judgement did not mention assessments for renewal purposes or extending a community treatment order, however, following a call on the 26th January 2021 with the Trust Solicitors, it was confirmed that this should also include any renewals of Mental Health Act sections, and extensions of community treatment orders.

In light of the Devonshire Judgement the Mental Health Act Team undertook a review of all those patients who had been detained or had had their section/CTO renewed since March 2020 (approx. 2000+ records) to determine whether the required assessments were remote or face-to-face. The AMHP should have recorded this on their report if any of the medical recommendations or their assessment were done virtually and the reasons for this. Where these assessments were undertaken remotely, the section would be deemed invalid and the patient would require reassessment. In light of this, the team reviewed those patients who were still currently detained as priority. Once identified, all the individual patients were contacted in writing advising of the situation.

Following the Derbyshire judgement and the work previously undertaken by the MHA team, as a result of the Devonshire Judgement no further actions were required.

INNOVATIONS AND ACHIEVMENTS

MHA Training

To promote continuing knowledge and understanding of the MHA a rolling MHA Training programme has been introduced to capture staff from all disciplines to enhance their working knowledge of the MHA. Following discussions with Matrons it was agreed that the training will be delivered on the third Thursday of every month. The up take on the training has been fruitful and the feedback from staff has been complimentary.

SLA bespoke package

To promote partnership working, a MHA training package has been devised and tailored to reflect the needs of the acute hospitals who have a Service Level Agreement with the Trust. In the case of one of our acute hospitals colleagues have had a training package which has been specifically personalised to meet their individual needs in regards to "walking through" the relevant MHA section papers that they were unfamiliar with, and making them aware what must be included in the paperwork and who should be completing this. It is our intention to share this package with our other acute colleagues.

NEDS - AHM Training package

Following an independent report titled *Rapid review into data on mental health inpatient settings: final report and recommendations published on the 28/06/2023* (as previously mentioned earlier in this report)

There were thirteen recommendations in the report and in recommendation five a number of points where identified, one of which was that every board should provide Mental Health Act training so that at least half their Non-Executive Drectors are trained as Associate Hospital Managers under the Mental Health Act. As a result of this recommendation a bespoke training package was devised by the MHA team outlining the recommendation and included a comprehensive overview of the role of the AHM.

MHA Documentation Audit

The aims of the audit were to provide assurance that the Trust is compliant with the legal requirements of the MHA which could lead to patient safety risks and reputational damage due to inaccurate completion and retention of appropriate section papers, as well as to provide assurance that patients detained under the MHA with the Trust were detained lawfully and being treated within the parameters of section 58 of the MHA. As previously outlined in this report, this audit was undertaken in the early part of last year and proved to be invaluable in regards to addressing inaccuracies with MHA team procedures and therefore it has been agreed that this audit will be embedded into practice.

CQC provider action statement follow ups for assurance purposes

In order to provide assurance following the submission of completed provider action statements to the CQC, a process has been introduced where by ward managers are requested to provide an update for each action by way of a narrative regarding any improvements that have been made, compliance with the Act/Code of Practice or completion of any outstanding works as outlined in the first response. This assurance report will be requested three months after the initial submission of the provider action statement to the CQC.

Challenges

Mobius and Paris Patient Electronic Records

The MHA team continue to experience difficulties and duplication in relation to the current usage of two patient electronic records systems which aid compliance for MHA administration.

Incomplete sets of section papers being received into the MHA office

Whilst in the main complete sets of section papers are sent by email to the MHA office from the wards in a timely manner, however, there still remains a number of incidences where incomplete sets are sent and this has caused a number of issues where by the MHA office have had to spend valuable time in locating the missing documentation. The MHA provides strict deadlines in regards to how section papers are accepted and processed which the Trust must comply with. Non-compliance outside these strict parameters, could have, and on occasions have resulted in patients

being detained unlawfully under the MHA. To mitigate these occurrences and to assist the ward staff in understanding the processes around section paper documentation, a Standard Operational Procedure for Missing Section Papers was devised and consulted on with operational colleagues. Following this consultation the procedure was ratified by the Mental Health Act & Safeguarding Sub Committee and is now embedded into practice.

Late Submission of Tribunal Reports

There continues to be challenges in encouraging clinicians to meet the deadlines set by the Mental Health Tribunal in regards to the submission of reports for patients who have appealed to the Mental Health Tribunal. Any "directions" that are received from the Tribunal for late submissions of reports are now included in the MHA activity report that is presented to the Mental Health Act & Safeguarding Sub Committee on a bi-monthly basis. Following the introduction of an agreed escalation process to operational senior managers for outstanding reports, the situation is seen to be improving with a notable reduction in the number of "directions" being received.

Amendments required to section paper to meet the requirements of section 15 (rectification of application and recommendations) of the MHA

Section 15 allows for rectification of an application and medical recommendations within a period of 14 days from the start of the section. It is accepted that mistakes do happen when completing section paper work which section 15 allows for. The challenge arises in sending the paperwork to the author for any necessary amendments as these amendments require completion within this 14 day window. There have been occasions when the paperwork has not been amended within this window and unfortunately these sections were deemed to be unlawful. To mitigate these occurrences a robust administrative procedure is in place utilizing the MHA team diary with timely notifications to remind MHA team staff of the impending return of the section paper work.

FORWARD PLAN

As in previous years, work will continue to address and streamline the functions of the Mental Health Act Administration, ensuring compliance under the Mental Health Act for all patients detained within EPUT.

The Mental Health Act Senior team members will meet every three months to discuss areas of practice, anomalies in regards to the MHA, along with shared learning around the approach to dealing with complex queries and issues.

In light of the success of the MHA documentation audit this will continue and will form part of the MHA team work plan, scheduling the audit to take place twice in any one year

Delivery of MHA training will continue across the Trust and to colleagues in the acute sector which has proved very successful in the main and have been enhanced by the introduction of the MHA training rolling programme, which provides support to individual staff and teams

Work will continue to improve the content of the completed provider action statement with the introduction of agreed guidelines to help staff with the completion of these detailed statements. In addition and following completed provider action statements to the CQC, staff will be requested to provide an update to the initial responses made to the CQC three months after the CQC visit to provide assurance of actions taken to the response made.

As part of the MHA team objectives for 2024/2025 and to enhance their individual knowledge of the MHA, protected time has been allocated to individual team members as part of their personal objectives to expand their knowledge of the MHA Code of Practice and the Mental Health Act Manual (Jones 20th Edition).

CONCLUSION

This report provides assurance that the Trust has robust systems, comprehensive policies and robust training in place to work within the parameters of the Mental Health Act 1983

The Mental Health Act Administration team will continue to support the Associate Hospital Managers to perform their role/duties by providing robust learning in relation to the Mental Health Act and Mental Health Act Code of Practice 2015.

As always, this report acknowledges the commitment of the Trust and in particular that of the Mental Health Act Senior Manager, Mental Health Act Managers, Mental Health Act Officers, Mental Health Act Administrators and Mental Health Act Assistant who work within the legal framework, which continues to continually improve the way, that Mental Health Services are delivered.

Essex Partnership University NHS Foundation Trust

Trust Head Office
The Lodge
Lodge Approach
Wickford
Essex
S11 7XX

Tel: 0300 123 0808

8.5 TRUST RESPONSE TO THE GREATER MANCHESTER MENTAL HEALTH REPORT

Discussion Item AS 5

REFERENCES

Only PDFs are attached

Greater Manchester Mental Health Report 02.10.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

Report Title:	**Trust Response to the Greater Manchester Mental Health Report**					
Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Ann Sheridan, Executive Nurse					
Report discussed previously at:	Executive Committee & Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with a framework to review the recommendations received through the Greater Manchester Mental Health review, and the gap analysis undertaken against the organisation's strategic plans and enabling strategies, to ensure that these will focus on the relevant learning opportunities. Identified leads will take the detail from the recommendations forward within existing implementation plan, which will go through the Trust Board committees and the Trust Board for assurance.	**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 Points
This report provides the framework for the programme of work to review the Independent Review of Greater Manchester Mental Health NHS Foundation Trust (published January 2024) following the BBC broadcast Panorama (September 2022). Following the report, EPUT using feedback gathered during engagement events including a presentation by Oliver Shanley to the senior leadership team, alongside feedback gathered from frontline staff and patients reflected the Trust position against each recommendation. The Trust has reviewed and appraised its position using its key strategies against each recommendation, identifying areas for improvements and learning that will be addressed as part of its improvement plan. The monitoring will be via relevant groups, committees and the Board with external partnership check and challenge through the ICB Quality Forums.

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			
GMMH	Greater Manchester Mental Health		

Supporting Reports and/or Appendices
Trust Response to the Greater Manchester Mental Health Report

Executive/ Non-Executive Lead / Committee Lead:
Ann Sheridan **Ann Sheridan** **Executive Nurse**

NHS
Essex Partnership University
NHS Foundation Trust

Trust Response to the Greater Manchester Mental Health Report

September 2024

EPUT

Background

This report provides the framework for the programme of work to review the Independent Review of Greater Manchester Mental Health NHS Foundation Trust (published January 2024) following the BBC Broadcast Panorama (September 2022). Whilst the review focused on the abuse and poor care of patients at the Edenfield Centre in Prestwich, Greater Manchester it also offered insights to the governance of the wider organisation.

An Independent Review commissioned by NHS England and led by Oliver Shanley, a senior NHS leader with 30 years' experience in mental health settings, investigated what took place at Edenfield. The team spoke to over 400 people about the "horror" of what was shown in the BBC film and found a "striking" level of distress among patients, families, and staff. The report highlighted a catalogue of failures at the Trust including poor care, poor and "disconnected" leadership, lack of psychological safety and low staff morale, unsafe nursing levels, a lack of openness, and poor physical environment.

Introduction

For EPUT there are some parallels to be drawn with our own experience of the Channel 4 Dispatches Programme (October 2022). Following the report, EPUT using feedback gathered during engagement events including a presentation by Oliver Shanley to the Senior Leadership team, alongside feedback gathered from frontline staff and patients, reflects the Trust position against each recommendation.

The following slides shows the Trust position against each recommendation with the additional opportunities identified to learn and improve our care delivery. The approach taken involves reviewing and appraising each strategy that aligns with each recommendation and adapting the implementation plan to include these areas of improvement that will report into the relevant sub-committee of the Board, with oversight from the Quality Committee and to the Trust Board.

One of the key learning points from the Independent Review was the importance of listening to service users and their carers. We have been working hard to improve our listening skills and creating more opportunities for service users and carers to have a voice and to be directly involved in the work that we do and the decisions we make.

Area for Improvement Patients, Families and Carers:

GMMH had not kept patients, families and carers at the centre of their service delivery.

It missed opportunities to hear the voices of patients, families and carers when services failed to meet expectations and, in the case of Edenfield, care has sometimes been abusive, unkind and unsafe.

The previous strategies in relation to engagement with patients, families and carers have not been fully effective.

EPUT has appraised its enabling strategy working in partnership with people and communities. This new Trust Strategic Plan launched in January 2023 with lived experience, service user involvement, co-production, patient partnership, and peer support highlighted throughout was co produced with patients, families, carers and key stakeholders. It details the 3 year plan where the Trust will continue to strengthen partnerships with patients and families as partners in care.

The EPUT Lived Experience team was formed due to the work underpinned in the previous Involvement Strategy 2021–2023. This is now 190 strong, and growing at rapid rate. It is formed of people with lived or living experience of community and mental health services, be it as a patient, service user, or a supporter, parent or carer. Their input is invaluable to everything we do together.

Since April 2021, EPUT has had a Director of Patient Experience and professional lead for developing the Trust's capability for public participation and lived experience. Further to this, the Patient Experience directorate is now well established, and continuously improving.

The Reward and Recognition Policy is now well established and being utilised to remunerate our Lived Experience team. Along with this there are supporting systems and processes that have made getting involved less complicated.

'I Want Great Care' launched at EPUT in January 2022, and whilst uptake started slowly, we have seen a progressive increase in response rates from those on the receiving end of our services. In addition to this, we are nurturing a network of peer networks to support and enhance our ability to listen to, and collaborate with, people using our services.

Area for Improvement Patients, families and Carers :

Recommendation 1 :

The Trust must ensure that patient, family and carer voices are heard at every level of the organisation.

The Trust must respond quickly when people experience difficulties with the services they receive and make lived experience voices central to the design, delivery and governance of its services.

Gap Analysis Findings:

- Despite the development the Trust has experienced in lived experience practice and the Lived Experience team since 2021, there is a need to develop lived experience practice and the peer workforce at a service and care unit level. As per the Culture of Care programme, we need to move towards having more substantive lived experience and peer roles across the organisation.
- A further development area for the Trust is the presence of formal and intentional lived experience practice / representation at an Executive team level.
- All involvement activity that qualifies for reward and recognition is funded centrally and this will be impacted by financial pressures in the system.
- We need more involvement from people who have recent and contextual experiences of our services from a diverse range of communities, which means it is vital for us to partner in a meaningful way at a service level. Equality, diversity and inclusivity must underpin our development.
- Training generally for our Lived Experience team is challenging. Access, and a clear programme of training development is key. Further, giving our Lived Experience team access to our training environment is difficult, and requires them being set up on ESR and having an NHS mail account.
- Whilst the volume of feedback and opportunities to listen to people who use our services have grown, we still have work to do to close the feedback loop and communicate the changes publicly in response to feedback as evidence that we are listening and improving.
- Having a clear Carers Strategy that listens, supports, and empowers carers and families to influence change is a key next step.

Improvement Plan:

Much of the improvement activity is detailed in the Trust's working in partnership with people and communities 5 year strategy which launched in January 2024, but this area does require organisational commitment and long term investment. These improvements will be monitored via the Strategy Steering Group and will report into the Quality Committee of the Board and to the Board.

Executive Lead – Zephan Trent Timescale – 2024-2027

Area for Improvement Clinical Leadership:

The voice of clinicians was undervalued and weak in GMMH. The investigation heard this from all professional groups, and especially from direct care nursing staff. It has been further muffled by a more dominant operational voice.

The organisation needs to develop and nurture a strong clinical voice that is present at every level and in every forum across the organisation, so that clinical quality is at the centre of every decision made.

The Trust's Operating Model is based around six clinical operational delivery units which are led by multi-disciplinary and multi-professional leadership teams. They are supported and corporately enabled from corporate business units. This model supports a leadership model that includes clinical and quality leadership roles

The EPUT Trust Executive commissioned an external review to consider progress in delivering the new Target Operating Model and the Accountability Framework. A key focus of the review was to seek feedback from the care units on progress, the effectiveness of the enabling corporate functions and business partnering approach.

The review was also asked to consider what organisational development is required to develop the sharing of accountabilities across care unit leadership teams and to achieve a broad ownership of the agenda; the thread from services to Board committees through the Accountability Framework and Executive team (Ward/Service to Board); a review of the KPIs to be used in 2024/25; progress against the internal audit report on the Accountability Framework; and to make recommendations about the future structure of the care units.

The Trust will shortly agree the recommendations with an implementation plan to be developed that will develop and nurture clinical voice and presence across the organisation.

Area for Improvement Clinical Leadership:

Recommendation 2 :

A strong clinical voice must be developed and then heard and championed from Board to floor, and in wider system meetings.

Gap Analysis Findings:

- Develop clear roles and responsibilities for the Care Unit Leadership team with a developmental plan.
- The Patient Safety team need to change their approach, tone and method of communication in line with the Target Operating Model.
- The breadth of the Deputy Director of Quality & Safety and Deputy Medical Director roles in MSE should be reviewed. The remit is wider and more complex than in many other care units, yet the resource is the same.
- The Medical Management Model needs to change in line with the Target Operating Model.
- The new Quality and Safety KPIs should replace the existing KPIs in the Accountability Framework once they are approved by the Trust Executive.
- Ensure that governance functions are adequately resourced to meet the needs of the size of the Trust.
- Developing systems that proactively scan for safety concerns across all services, using and triangulating a range of information and intelligence sources: including, but not limited to, safeguarding referrals, complaints, staff and patient surveys, staffing levels, FTSU cases, and incidents.

Improvement Plan:

Accountability frameworks for each care unit and corporate business will ensure that there is line of sight to Trust Executive Directors each month for more tactical decisions where KPIs/metrics are below plan. This work will report into the relevant sub-committees of the Board and to the Board.

Executive Lead – Alex Green, Chief Operating Officer and Trevor Smith, Chief Finance Officer - Timescale – 2024-2027

Area for Improvement Culture:

The culture of an NHS organisation is determined by the Trust Board. The GMMH Board allowed a dysfunctional Executive team with a culture that valued operational performance above clinical quality. The Board did not balance its responsibilities to its external environment with its responsibilities to its internal quality of services. It had a poor patient safety culture, and the investigation heard consistent reports of management behaviours at every level across a number of services that discouraged and suppressed staff speaking up about quality concerns. This had a major impact on the Trust's ability to deliver safe care.

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

Since the North Essex Partnership and South Essex Partnership NHS trusts merged over six years ago, we have continued to develop our culture across EPUT with a single set of values and behaviours. Where there are differences, and we can learn from each other, we will share best practice to enable us all to be the best that we can be. Similarly, across the different systems and three Integrated Care Boards we work within, we have opportunities for further learning, partnership approaches and sharing across the different geographical areas of our organisation.

Our Staff Survey results show that our colleagues' experiences at work are significantly improving in many areas. Where people do not behave in line with our values and behaviours, we will challenge this through our Behaviour Framework, which is part of our Dignity and Respect Policy.

Our Speak Up, Listen Up, Follow Up Campaign has been very well received and people are feeling more confident about speaking up. Higher Education students at Anglia Ruskin University who have placements at EPUT, have reported far improved confidence with speaking up and feeling their concerns will be addressed (July 2024).

We have signed up to the NHS Sexual Safety Charter which will help us to ensure the sexual safety of our staff and patients across all our sites. This has been further supported by mandatory e-learning training on sexual safety and specific in-reach work by EPUT/HEI staff with learners to ensure their voice is heard and supported.

Well-being is at the centre of our culture and our staff are our number one asset – we need to build on our current offer with staff and build psychological safety as our priority. This will include enhancing our clinical supervision practice and improving the critical restorative aspects of supervision across the whole Trust.

Area for Improvement Culture:

Recommendation 3:

The Board must develop and lead a culture that places quality of care as its utmost priority, which is underpinned by compassionate leadership from Board to floor.

This culture must ensure that no staff experience discrimination.

Gap Analysis Findings:

- Holding regular organisation-wide cultural reviews and ensure actions are met.
- Having regular in-person Executive engagement in the community and on wards, and include in objectives.
- Continue to embed the Freedom to Speak Up approach, including proactive interventions that allow staff to come forward sooner.
- Remodel staff recognition to ensure there is consistent, in-person, and senior acknowledgement of achievements, and recognition that counts towards appraisal and progression.
- Establish regular drumbeat of staff feedback via procurement of staff engagement platform, that also supports the annual and quarterly Pulse Staff surveys.
- Focus on creating a culture of accountability across the organisations, supporting staff to meet standards, and communicating the consequences of not doing so, using the Behaviour Framework as a tool for all staff on expected behaviours.

Improvement Plan:

Workforce improvements and the implementation of the People & Education Strategy is monitored through the Strategy Steering Group that reports into the Executive team and People, Equality & Culture Committee and to the Trust Board for assurance.

Accountability frameworks for each care unit and corporate business units will ensure that there is line of sight to Trust Executive Directors each month for more tactical decisions where KPIs/metrics are below plan.

Executive Lead – Andrew McMenemy, Executive Chief People Officer

Timescale - 2024-2027

Area for Improvement

Workforce:

GMMH Trust failed to provide an environment that supported staff to provide high-quality care and maintain their health and wellbeing.

The national staffing crisis is likely to remain an ongoing issue for some years, and this reality must be factored into the improvements that the Trust can make in its workforce planning.

Adaptations will need to be made to account for this, such as consideration of the training and supervision of temporary staff, as well as permanent staff

The Trust is committed to helping our people be the best they can be, ensuring they have the tools in place to thrive. The 5-Year People and Education Strategy provides the foundations from which we will deliver on that commitment which has been reviewed and appraised. Engagement has taken place at Board level internally and externally, including the views of our main Higher Education partners.

We have already achieved a lot in key areas of the People and Culture directorate – vacancy rates for registered nursing is now at an all-time low at 15% from 26% in July 2022. Our workforce plan for substantive staffing is on track for 2024/25 and we have successfully recruited over 260 international nurses and Allied Health Professionals in the last three years. Agency staffing has reduced across inpatient settings by over 60% in 2023/24, but bank use remains above plan in the first quarter of 2024/25. A Health Care Assistant (HCA) recruitment plan across Autumn 2024 as well as improved rostering practices, which will reduce our reliance on temporary staffing across 2024/25.

Retention across the Trust has improved with turnover currently at 9.3% (July 2024). Our focus is on listening to and responding to staff feedback (you said, we did) from staff surveys and to support enhanced career development and high performing team cultures. EPUT saw improvements overall across the nine domains of the Staff Survey in 2023 associated with violence and aggression and racial discrimination against staff. We are also part of the national People Promise Exemplar Programme which will drive further improvement of staff experience for all.

We actively seek out talent from black and ethnic minority colleagues through our RISE Development programme to help us address that black and ethnic minority staff make up over a quarter of the workforce, but are mainly represented in the lower pay bands. NHS England rated EPUT's Workforce Race Equality Standard Action Plan as outstanding, which shows the Trust is on the right path. We have implemented High Impact Action 1 from the NHS EDI Improvement Plan (EDI objectives for the Executive team), and we now need to ensure that the other actions taken positively shift the experience of black and ethnic minority staff including embedding the Trust's Behaviour Framework

Our Staff Survey results show that people are experiencing their immediate managers as being more supportive and there has been a strong focus on Board and Executive development in the last year.

Area for Improvement Workforce:

Recommendation 4 :

The Trust must work with its current and future workforce levels to recognise, adapt to and manage the safety challenges that a staffing shortfall may pose, ensuring the stability of nursing staff.

The Trust must develop a representative, competent and culturally sensitive workforce which is supported to provide services that meet the needs of its communities.

We need to continue developing our leaders to ensure that they are equipped to take an appropriate and consistent approach to tackling abuse of staff, such as racism and discrimination, leading to staff feeling supported and engaged.

Our Staff Survey results show that we must ensure that the Board, our senior management teams and the frontline workforce are well-connected.

Embedding more lived experience within the mental health workforce (e.g. peer support workers, buddy scheme and lived experience advisors).

While medical vacancies are safely covered with locum doctors, we need to continue to recruit more substantive medical consultants.

Continue efforts to reduce nursing, HCA and other key vacancies, minimise use of temporary staff through improved, targeted domestic recruitment and student conversion. This includes the delivery of the Time to Care programme which will enhance the registered professionals and other key roles across inpatient and specialist services establishments.

We must ensure that we engage more proactively with our Higher Education Institute partners to provide the best learning environments for students.

Ensure the clinical learning environment for students, including routes to raising concerns, is improved in partnership with Higher Education Institutes.

Improvement Plan:

Workforce improvements and the implementation of the People & Education Strategy is monitored through the Strategy Steering Group that reports into the Executive Team and People, Equality & Culture Committee/Trust Board for assurance. Accountability frameworks for each care unit and corporate business units will ensure that there is line of sight to Trust Executive Directors each month for more tactical decisions where workforce KPIs/metrics are below plan. Executive Lead – Andrew McMenemy, Executive Chief People Officer -Timescale - 2024-2027

Area for Improvement Workforce:

We know that the quality of the environment impacts on patients, their families and the workforce; a number of the buildings within the GMMH Trust estate were no longer fit for the purpose of providing modern mental health care. The Trust is undertaking some rebuilding to improve their estate. However, buildings are not always maintained to a standard that allows services to be delivered safely, and issues with the fabric of buildings are not always reported, and if reported, not always maintained in a timely way. Where safety critical maintenance is not being undertaken, mitigation should always be considered to manage risks that this creates. Ward environments are not always clean and uncluttered.

The Trust has a hugely complicated estate which ranges from whole hospitals to sessional room use in shared premises. It covers a mixed portfolio of Freehold, PFI, Leasehold with NHSPS, private Leasehold and Licenced premises. Whilst most of the Freehold premises are utilised for Trust business, there is a sizable investment portfolio which generates a revenue stream to support our clinical activities. The reviewed Estates Strategy is now fully consulted on will be presented to Board in October 2024 and will consider this recommendation in its implementation plan. The Trust has delivered several key programmes over the last number of years which has enhanced patient and staff experiences.

1. Inpatient modernisation - The removal of dormitory accommodation with the replacement of single room accommodation providing high quality care facilities.
2. Backlog maintenance – The Trust has maintained its used estate to a level that provides high quality facilities for patients and staff.
3. Improved the efficiency of its estate – The Trust occupies approx. 150,000 square metres of accommodation and premises costs account for 10% of total expenditure.
4. Working with services - Clinical engagement needs to start with a dialogue about the service and its vision for future development.
5. Work with system partners to co-locate services where appropriate.
6. Compliance and safety - The Trust currently places considerable importance on compliance and risk reduction.

Area for Improvement Workforce:

Recommendation 5 :

The Trust needs to have a good understanding of the quality of its estate and the impact of this on the delivery of high-quality care, including providing a safe environment.

It must ensure that essential maintenance is identified and carried out in a timely manner and that the cleanliness of units is maintained.

Areas for consideration:

- Systems in place that ensure the internal environment is clean, safe and fit for purpose.
- Requires the repurposing of estates to ensure staff have collaboration spaces.
- Bringing new technology to an existing estate to transform its efficiency.
- Buildings and space should be flexible to support different levels of acuity, function and/or technology.
- It's important to focus on what matters to both patients and staff and they see making a difference in the future and adapting estates to suit.

Improvement Plan:

The governance arrangement will include reporting into the Strategy Steering Group with the plan including these areas of improvement that will then report into the relevant sub-committee of the Board and to the Trust Board.

Executive Lead – Trevor Smith, Chief Finance Officer

Timescale – 2024-2027

Area of Concern Governance:

The current (and historical) governance structure had not been effective in escalating information in ways that are sufficiently timely, clear or useful. The reasons for this are twofold. Firstly, the structures and processes in place were unclear, including a poor use of data and intelligence to understand the current quality of services. Secondly, the organisational culture had inhibited the raising of concerns at every level. This has had a significant detrimental impact on the Trust's ability to learn and improve in its services.

EPUT's core business is to provide care services. The Quality of Care Strategy drives care quality principles as a foundation for other enabling Trust strategies. The interdependencies of these strategies will together deliver our Trust strategic vision and support our clinical governance structure.

This strategy has been shaped by listening to a range of important voices. Representatives bringing their experiences of physical and mental health services begun the strategy development and their views and wishes then guided the approach taken thereafter. The strategy was launched in April 2024 and we are in the process of its six month review and appraisal.

Our vision is to continuously improve patient safety, built on two foundations set out in the NHS National Patient Safety Strategy: A patient safety culture and a patient safety system.

We also will ensure that everyone receives the care they need which is beneficial, evidence based and effective, provided by teams who are confident, competent and knowledgeable within a culture of quality care. Our aim is to build consistency, reliability, equity and driving improved outcomes for all. This will also include the Quality Senate providing the Trust with a new process to enable, support and endorse effectiveness through collaborative partnerships.

The key to our success is to fully understand people's experience of care in order to improve. Working in partnership with the people we care for, their loved ones and their supporters. To do this, we are committed to adopting the 10 principles as set out in the national Statutory Guidance from NHS England and the Department for Health and Social Care.

Area of Concern Governance:

Recommendation 6:

The Trust must ensure that its governance structure (and the culture that this is applied within) supports timely escalation and that the right information can be used at the right level, by the right staff. There must be much greater focus on the validation and triangulation of information to ensure that quality issues can be resolved quickly and learning can take place.

Gap Analysis Findings:

- Ensure quality governance structures are robustly in place, rationalising meetings and providing assurance and delivery to Quality Committee and Executive team.
- Ensure that governance functions are adequately resourced to meet the needs of the size of the Trust.
- Develop staff competence training and develop the reset of a quality of care culture though confidence, competence and leadership.
- Ensure that the Governance Framework supports the necessary information flows and insights for staff at all levels to manage and improve quality (from Board to floor).
- Developing systems that proactively scan for safety concerns across all services, using and triangulating a range of information and intelligence sources: including, but not limited to, safeguarding referrals, complaints, staff and patient surveys, staffing levels, FTSU cases, and incidents.
- Design a quality management system to enable the systematic planning for, maintaining and improving quality.
- Ensure financial impact assurance through business planning and budget setting.

Improvement Plan:

The governance arrangement will include reporting into the Clinical Governance Groups and monthly Executive Oversight meetings with the plan including these areas of improvement that will then report into the Quality Committee of the Board and to the Trust Board

Executive Leads – Dr Milind Karale, Executive Medical Director.

Zephan Trent, Executive Director of Strategy, Digital & Transformation

Ann Sheridan, Executive Chief Nurse

Timescale – 2024-2027

Area for improvement Edenfield:

Edenfield had not been able to consistently provide the forensic services that its patients need and deserve. At times, services there have been unsafe, unkind and abusive to those using them.

Management behaviours have actively discouraged and suppressed concerns being raised and there has been long standing dysfunction in the consultant group, which has impacted adversely on relationships and consultants' leadership.

Adaptations in response to the national staffing shortages, such as consideration of the training and supervision of temporary staff alongside permanent staff will need to be made with outside support.

The care unit leadership team at Brockfield House work closely with the collaborative to deliver best clinical forensic model and practice. They are working on systems that deliver and measure key aspects of culture with particular emphasis on compassionate, high-quality care and a positive patient safety culture.

There are systems in place to ensure that the lived experience and expertise of patients and families are central to the work of the service. The use of data and intelligence is supporting the leadership team have meaningful oversight of restrictive practices, complaints, concerns, safeguarding and incidents.

Staff are encouraged to report quality concerns and improvement ideas.

The Safeguarding team is reviewing the use of advocacy services to ensure that they are delivering the intended benefits for patients which includes how leaders value advocacy.

The care unit leadership, together with human resources and corporate nursing, is working with the care unit to support all staff, including those who are temporary, to work effectively in multi-professional teams. This includes consideration of training, supervision, mentoring, coaching, reflective practice and wellbeing.

Area for Improvement Edenfield:

Recommendation 7:

The Trust must ensure that its equivalent services to Edenfield provides compassionate, high-quality care and that all staff, permanent or temporary, have the skills, knowledge, and support to achieve
this.

Gap analysis findings:

- Ensure pace of change on improvements identified with actions being completed in a timely manner.
- Ensure transparency and /or clarity of reporting.
- Governance processes, including consideration of the need for impartiality.
- Ensure scrutiny of key information.
- Issues not treated in isolation.
- Rigour in the monitoring of change / impact of actions.
- Critical that the Trust is able to evidence learning and improvements when things go wrong.

Improvement Plan

The governance arrangement for the plan will include reporting through the monthly Accountability Framework meetings and the Collaborative Steering Group and will then report into the relevant sub-committee of the Board and to the Trust Board.

Executive Lead – Alex Green, Chief Operating Officer – Timescale: ongoing

Area for Improvement Plan:

The GMMH improvement plan was large and ambitious but problems it was trying to solve were not clearly defined, and actions often lack appropriate consideration of how their impact will be evaluated.

The Trust's prioritisation will be focused on what makes the most difference to the quality of care for people using services, or the experience of people working in these services. The safe and sustainable delivery of the plan is fundamental to confidence of stakeholders including patients and staff in the organisation.

The governance arrangement will include reporting into the Improvement Plan Steering Group that has system partner oversight, in addition to a number of sub-committees of the Board and to the Trust Board. This will ensure that there is the right level of oversight and scrutiny that will support sustainable progress.

Area for Improvement Plan:

Recommendation 8:

The improvement plan against the gap analysis findings must be developed with clarity about the problems that need to be taken to achieve better outcomes. It needs to be clear on how all actions will be evaluated so that it can be assured about whether changes being made are having the desired impact. The plan will be prioritised to ensure that actions are sequenced, build on each other, and prioritise the quality of care people receive from EPUT.

This will ensure a balanced approach between the number of improvements required and setting out a realistic timescale for implementing identified actions with the support of our system partners.

Areas to work for the plan:

- Articulate clearly the areas the Trust is trying to resolve. This process needs to involve clinicians and service users.
- Ensure that impact measures are clearly defined and that the Trust knows how it will measure them.
- Ensure the plan is prioritised, sequenced, and the initial months of work are described clearly.
- Make use of data and intelligence to give meaningful oversight of restrictive practices, complaints, concerns, safeguarding and incidents.

Improvement Plan:

The governance arrangement will include mirroring a process similar to the Trust CQC Improvement Plan Group so actions are appropriate and consideration is given on how their impact will be evaluated. Governance will also include reporting into the Executive team to understand and monitor progress and will then report into the Quality Committee of the Board and to the Trust Board.

Executive Leads – Dr Milind Karale, Executive Medical Director.

Zephan Trent, Executive Director of Strategy, Digital & Transformation

Ann Sheridan, Executive Chief Nurse

Timescale – 2024-2027

Area for Improvement Elsewhere in the Organisation:

In each area the investigators were struck again by the commitment of staff and their desire to improve their services.

They found evidence of concerns in all of the services we visited. Some of these reminded them of the culture and working practices at Edenfield, which precipitated the abuse and poor treatment of patients which Panorama uncovered (such as low levels of staffing and psychological safety).

The Trust's Quality Committee receives monthly data on safety metrics with each care unit referenced through the Quality Assurance Report. This will include the controls in place to address any immediate risks.

The Trust has systems in place that identifies safety concerns and initiates sustainable learning when people die unexpectedly while using their inpatient services. This includes a weekly update to Executive Directors.

The Trust works closely with ICB and Local Authority partners who carry out regular visits and monthly deep dives on services which offers further independent assurance.

Quality oversight of specialised commissioned services and 6 weekly (CYP) and 8 weekly (adult services) site visits are undertaken by Case Managers.

Area for Improvement Elsewhere in the Organisation:

Recommendation 9:

The investigation identified some common concerns across services visited at the GMMH Trust, which were also prevalent within Edenfield.

EPUT and the wider system must consider how they understand issues identified in these services (and others) in more detail, including through the actions described below.

Gap Analysis Findings:

- The systems to ensure that the lived experience and expertise of patients and families are central to the work of the service.
- The use of data and intelligence that gives leaders meaningful oversight of restrictive practices, complaints, concerns, safeguarding and incidents.
- The systems that encourage staff to report quality concerns and improvement ideas.
- A review of advocacy services to ensure that they are delivering the intended benefits for patients there which includes how leaders value advocacy.
- The systems that support all staff, including those who are temporary, to work effectively in multi-professional teams. This should include consideration of training, supervision, mentoring, coaching, reflective practice and wellbeing

Improvement Plan:

The governance arrangement will include reporting into the Clinical Governance Groups for the quality of care with the plan including these areas of improvement than reports monthly into the Executive Oversight group into the Quality Committee and to the Trust Board

Trust Leads – Dr Milind Karale, Executive Medical Director,

Zephan Trent, Executive Director of Strategy, Digital & Transformation

Ann Sheridan, Executive Chief Nurse

Timescale – 2024-2027

Area for Improvement System Oversight:

The organisations external to the Trust that have responsibilities for regulating, overseeing quality, and supporting providers did not identify and respond to the failings happening within GMMH prior to BBC Panorama airing. We consistently heard that the Trust had a reputation for strong performance and its ability to deliver, despite there being signals of significant quality concerns across several of the Trust's services. The regulator did not identify some of the key safety issues in relation to closed cultures and poor patient care.

The organisations external to the Trust that have responsibilities for regulating, overseeing quality, and supporting the Trust must be able to identify and respond to the concerns.

This is happening within the Trust with regular scrutiny by ICB Quality Forums and Adult and Children Safeguarding Boards who monitor the Trust performance and its ability to deliver safe services by looking for signals of quality concerns across Trust's services.

Quality Oversight of specialised commissioned services and 6 weekly (CYP) and 8 weekly (adult services) site visits by Case Managers.

The Quality Together forum was established with the ethos of system partnerships so that quality assurance is achieved in collaboration with a shared culture of accountability, working with system partners and patients. Some areas of improvement focus have been made ready for continuous improvement into 2024/25 and has become part of the Quality of Care Strategy.

Area for Improvement System Oversight:

Recommendation 10:

The organisations with responsibility for regulation, oversight and support to GMMH must review their current systems of quality assurance. They must also review how they work together collectively to identify concerns in a provider at an early stage to prevent tragedies like those seen at Edenfield from reoccurring. Where learning is identified that applies nationally, this must be cascaded by the relevant organisation.

There are a number of areas to be considered by system partners:

- For each organisation to review the assurance architecture for the oversight of EPUT and have the ability to identify workforce, culture, and quality concerns at an earlier stage.
- The ICBs have developed a level of mental health expertise it has in its oversight of mental health organisations, ensuring that its staff have the relevant experience and seniority to be able to identify leading quality concerns in providers.
- EPUT will continue working with system partners to support partnership working between external agencies, so that information is shared and understood in a timely way to identify potential services in distress.
- The system partners continue to support the Trust to ensure that their approach is focused on enabling the Trust to identify priorities, make the improvements needed, and model, at a system level, the compassionate leadership that is required to achieve sustainable change.

Improvement Plan

The governance arrangement will be via the Quality Together Forum. There have been seven Quality Together meetings held during 2023/24. Membership includes a range of senior Trust leaders at Executive and Director Level and senior representation from NHS England and the Integrated Care Boards with opportunities for regional and national escalation processes in place. Governance will also include reporting into the Executive team to understand and monitor progress and will then report into the relevant committee of the Board and to the Trust Board.

System Leads: ICBs, LA and NHSE Timescale - ongoing

Trust Executive Leads - Dr Milind Karale, Executive Medical Director.

Zephan Trent, Executive Director of Strategy, Digital & Transformation

Ann Sheridan, Executive Chief Nurse

Area for Improvement System Oversight:

The Greater Manchester Adult Secure (North West) provider collaborative was not effectively fulfilling its quality oversight responsibilities, and lacks the necessary clinical input to support this role.

There appeared to be an overall lack of clarity about the purpose of the collaborative and the subsequent governance structures required to support the delivery of this role. GMMH acted as the lead provider within this collaborative.

NHS England has responsibility to clarify the role of the Adult Secure provider collaborative and the governance structures needed to oversee this role. The responsibilities of the collaborative need to be discharged by staff with the right experience and expertise. In light of the concerns identified in this report in relation to GMMH Adult Forensic services (and wider issues in the Trust's Specialist services), the role of a provider as lead providers needs to be reviewed by NHS England.

The Trust has a good relationship with the East of England Provider Collaborative and their Head of Quality meets regularly with the leadership team, as well as visiting the wards and speaking with patients and frontline staff. All pathways have now been agreed.

Area for Improvement System Oversight:

Recommendation 11:

NHS England must review and clarify the role of the Adult Secure provider collaborative and the governance structures needed to oversee this role. The responsibilities of the collaborative need to be discharged by staff with the right experience and expertise.

NHS England should develop a Standard Operating Procedure within six months to provide clarity around the thresholds for information sharing and escalation of concerns (e.g., relating to IC(E)TRs, and include Contract Performance Notices and other sources) when issued in relation to patient care.

There are a number of areas that must be considered:

- NHS England must review and clarify the role of the Greater Manchester Adult Secure (North West) provider collaborative and the governance structures needed to oversee this role and therefore the implications for other provider collaborative.
- NHS England should develop a Standard Operating Procedure within six months to provide clarity around the thresholds for information sharing and escalation of concerns (e.g., relating to IC(E)TRs, and include Contract Performance Notices and other sources) when issued in relation to patient care.

Improvement Plan

The governance arrangement will be via Quality Oversight of specialised commissioned services and 6 weekly (CYP) and 8 weekly (adult services) site visits by Case Managers. This is in addition to the Quality Together and other system forums. Membership includes a range of senior Trust leaders at Executive and Director Level and senior representation from NHS England and the Integrated Care Boards and Las with opportunities for regional and national escalation processes in place. Governance will also include reporting into the Executive team to understand and monitor progress and will then report into the relevant committee of the Board and to the Trust Board.

System and Trust Leads: Collaborative and Specialist Services Leadership Teams in addition to ICBs, LA and NHSE colleagues

Executive Lead – Alex Green, Chief Operating Officer – Timescale: ongoing

9. STRATEGIC INITIATIVES

9.1 ESTATES STRATEGY

Decision Item | TS | 5

REFERENCES

Only PDFs are attached

Estates Strategy 02.10.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

Report Title:	**Estates Strategy**					
Executive/ Non-Executive Lead / Committee Lead:	Trevor Smith, Executive Chief Finance Officer					
Report Author(s):	Martin Mizen, Director of Estates					
Report discussed previously at:	Executive Team Board Seminar (July) Board Part Two (August)					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	If the Trust does not adapt its infrastructure to support service delivery then it may not have the right estate and facilities to deliver safe, high quality care resulting in not attaining our safety, quality and compliance ambitions.	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Finance and Resources Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Lampard Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital and Data Strategy	✓
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		
Are you requesting approval of financial / other resources within the paper?	No	

If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
The Estates Strategy provides a Strategic oversight of our Estate and a framework to assist in the development of our future Estate plans as part of the annual planning cycle.	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Approve the Estates Strategy.

Summary of Key Points

The Trust has been developing the EPUT Estates Strategy with significant internal and external engagement.

The guidance from NHS England and the exemplar template for an Estates Strategy follows the methodology of

- Where are we now
- Where do we want to be
- How do we get there

Through the engagement and data collection process there is now a far greater understanding of the Trusts property portfolio. This is reflected in the where are we now section of the document.

An assessment of the Estate has been carried out through the Core, Flex and Tail methodology which gives an immediate understanding of the quality and strategic location of each of our buildings.

There are 9 key strategic aims included within the Strategy

- Enhance the quality of care provided via modern, safe, fit for purpose environments that maximise positive experiences (for both patients and staff)
- Improve accessibility of services
- Drive efficiencies: maximise utilisation of and value from the estate
- Enable smart use of our estate via digital enablers and technology
- Work with system partners to collaborate and maximise value from our estate
- Rationalise and consolidate estate where appropriate
- Optimise use of our estate as community assets (support our communities to thrive)
- Create a sustainable estate
- Support the Trust's enabling strategies

The Strategy will support and inform the development of the Trust Plans going forward. It will be shared with the Council of Governors at the Joint Board Seminar in November 2024 and governor views will be sought on the specific Trust estate plans and priorities going forward within the Annual Planning cycle, in line with the Council of Governor role in Foundation Trusts.

Regular Estate and Facility updates will continue to be provided through the Finance & Performance Committee to the Board.

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices

Draft Estates Strategy

Executive/ Non-Executive Lead / Committee Lead:

Trevor Smith
Executive Chief Finance Officer

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

ESTATE STRATEGY

EPUT

FOREWORD

Essex Partnership University NHS Foundation Trust (EPUT) has been on a journey of improvement and we remain committed to driving forward change, to learning, listening and innovating so that we deliver the highest quality and safest care possible.

As we look to the future, the role of our estate is critical in supporting our vision of being the leading health and wellbeing service in the provision of mental health and community care. Our estates strategy therefore serves as a vital blueprint for our commitment to delivering high quality, accessible and sustainable health care services.

Our estate strategy is a comprehensive forward-thinking plan that sets out how we will develop our estate over the next 10 years, ensuring that it is fit for purpose and aligns with our strategic goals. As we navigate the complexities of modern healthcare, our estate must not only respond to current needs but also anticipate future challenges.

In developing our strategy, we have engaged widely with stakeholders including patients, staff and system partners. Their insights and experiences have been fundamental in shaping our strategy and has helped us with our mission in being a leading health and wellbeing service.

Our strategy also embraces our suite of enabling strategies including digital, quality of care, social impact and working in partnership with people and communities. We have also embraced the principles of sustainability, recognising our responsibility to incorporate sustainable development aiming to reduce energy consumption, minimise waste and enhance the overall environmental performance of our estate.

This strategy is a living document, designed to evolve as we grow and adapt to new challenges. Further work will also be required to develop site masterplans and delivery plans.

We are excited about the future and the role our estate will play in it. With this strategy as our guide, we are confident that EPUT will continue to innovate, adapt and excel in meeting the healthcare needs of our communities. Together, we will build an estate that supports our mission to provide outstanding care and improve the health and wellbeing of the people that we serve.

Paul Scott
Chief Executive

Trevor Smith
Executive Chief Finance and Resources Officer

Martin Mizen
Senior Director, Estates and Facilities

CONTENTS.

Version Control

Version	Date	Authors	Reviewed by
Draft v1.0	03.09.24	Lexica	
Draft v2.0	05.09.24	Lexica	
Draft v3.0	07.09.24	Lexica	
Draft v4.0	13.09.24	Lexica	
Draft v5.0	19.09.24	Lexica	
Draft v6.0	23.09.24	Lexica	
Draft v7.0	24.09.24	Lexica	
Draft 8.0	26.09.24	Lexica	

Contents Roadmap

We have summarised the key sections of our Estate Strategy below, including covering the three main strands within the strategy of where are we now, where do we want to be and how do we get there. Key supporting information to build, develop and evidence our strategy is provided within the referenced appendices.

Introduction	Where are we now?	Where do we want to be?	How do we get there?	Funding, Delivery and Action Plan
• Aims • Context • Structure	• Population insights • Our estate • Key risks and challenges • Patient views	• National context • Regional context • Local context • Key strategy objectives • Our strategic plan • Long list summary	• Priority Opportunities • Preferred Options • Planned Disposals • Core, flex and tail	• Funding Options • Delivering the Vision • Measuring Success

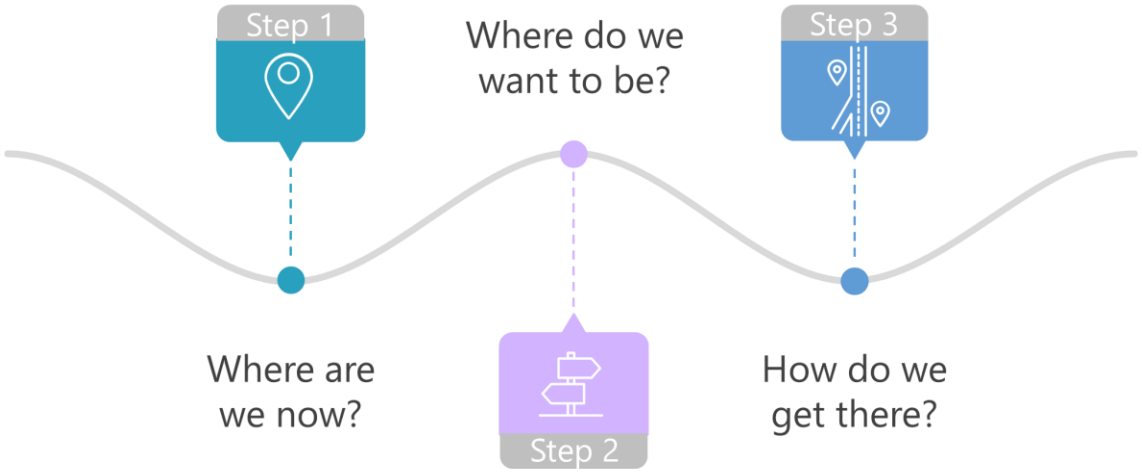
1. INTRODUCTION

Introduction

Our estate strategy aims to set the direction of travel for our estate development over the next 10 years to ensure that our estate enables our vision, values and strategic objectives, is safe and compliant, is fully utilised and agile, and meets our quality aspirations. This strategy is linked to our Trust enabling strategies and estate infrastructure planning within the wider system context in Hertfordshire and West Essex, Mid and South Essex, Suffolk and North East Essex, and Bedfordshire, Luton and Milton Keynes.

Our estate strategy has been developed through a series of workshops and stakeholder engagement to identify current estate risks and issues, and key estate strategy objectives to inform the development of estate options to support our vision to be the leading health and wellbeing service in the provision of mental health and community care.

This estate strategy is considered to be a 'live document' subject to regular review to ensure alignment with the Trust's key objectives. It is structured under the following three key themes:



2. WHERE ARE WE NOW?

Our Service Delivery Locations

EPUT provides community health, mental health, learning disability and social care services to over 3.2 million people across the East of England in Bedfordshire, Luton, Essex, Southend, Thurrock and Suffolk. Our services are delivered by more than 5,500 staff working across more than 150 sites. At any one time, we care for more than 100,000 people.

We are a key partner in four Integrated Care Systems (ICSs) - Hertfordshire and West Essex, Mid and South Essex, Suffolk and North East Essex, and Bedfordshire, Luton and Milton Keynes (providing some specialist services).

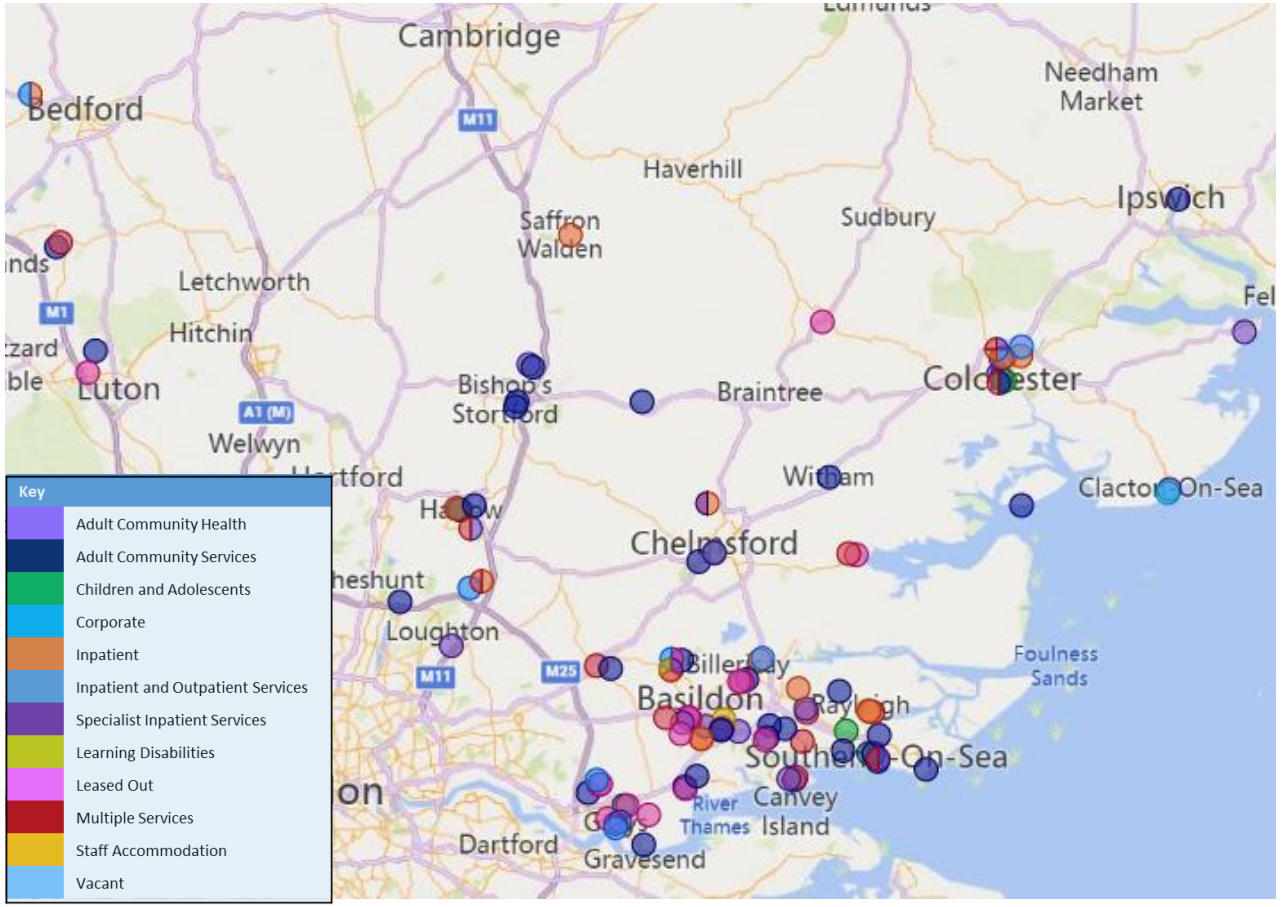
We work in partnership with Essex County Council, Thurrock Borough Council, Southend City Council and local district and borough councils. We also work closely with other providers of NHS services including GP practices, primary care networks, acute trusts, mental health and community trusts, voluntary, community and social enterprise organisation and independent sector providers.

Our place-based and trust wide services are delivered through the following care units:

- Mid and South Essex Community Services
- North East Essex Community Services
- West Essex Community Services
- Specialist Services
- Urgent Care and Inpatient Services
- Psychological Services

The map illustrates the locations for EPUT properties delivering services within the six care units. The majority of properties are clustered around the bulk of the population in South Essex.

The distribution of our services across the East of England



Population and Demographic Impacts

Our population and demographics have a significant bearing on service provision and estate requirements

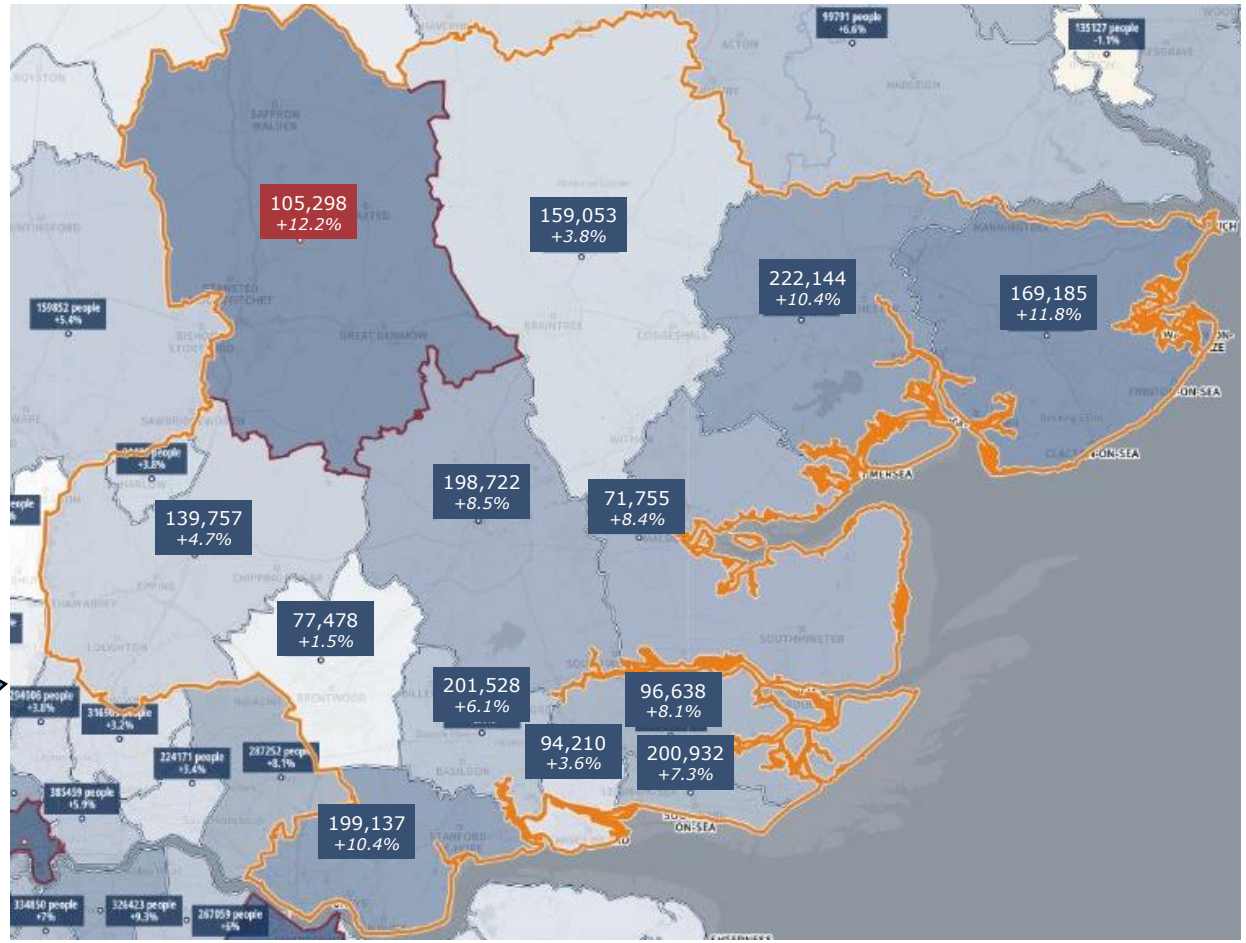
Challenges

Our demand continues to increase. Our population is growing at one of the fastest rates in England, and our ageing population has increasingly complex health and social care needs. The population of Essex, Southend and Thurrock is forecast to grow by 2.9% between 2022 and 2027 with demand for mental health and community services expected to grow at a faster rate. The population over 65 is forecast to increase by 8.3% between 2022 and 2027, which is an extra 32,000 older adults. This is the largest relative rise of any age group, increasing the need for physical healthcare alongside mental health interventions. While forecast population growth among children and young people is unlikely to drive demand in the same way, recent national data show a significant increase in mental health referrals for children and young people.

Key Messages

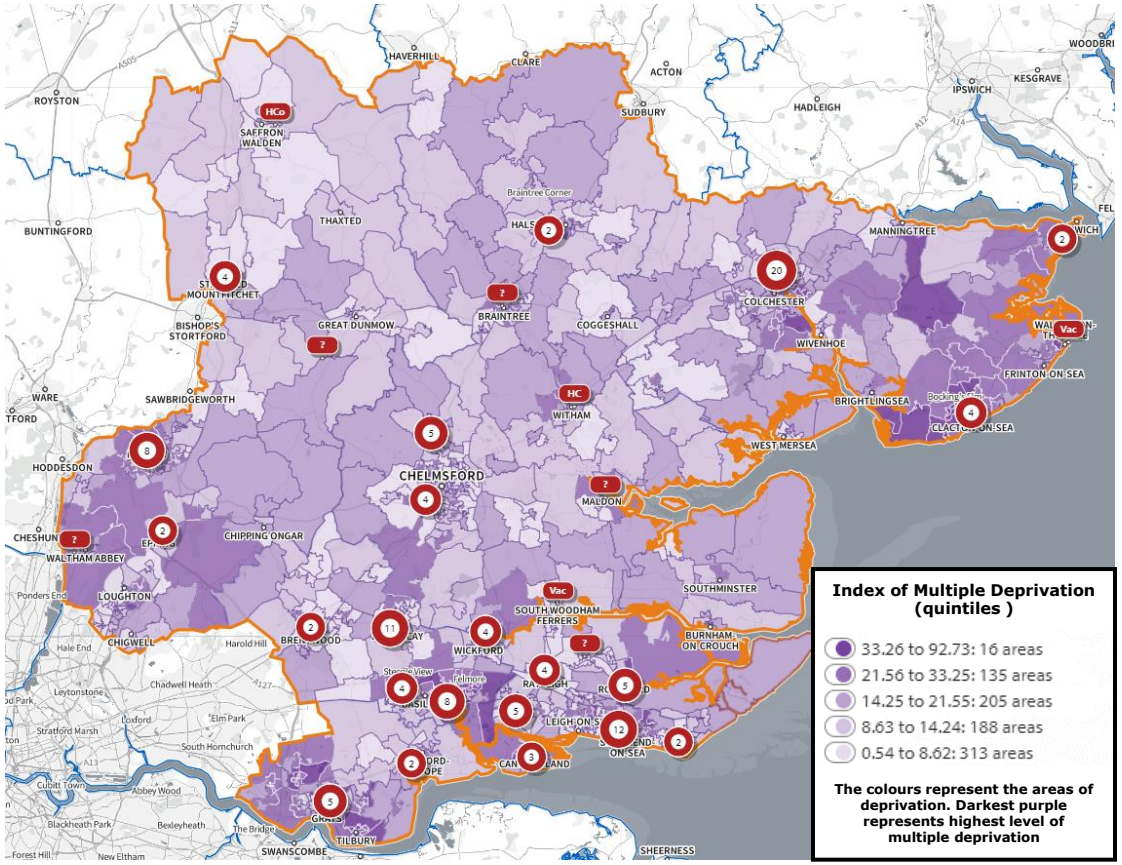
- The highest population growth (%) is expected to be in the northern region of West Essex.
- The lowest population growth is expected to be across part of North Essex and South West Essex.
- South Essex is more densely populated when compared to other areas of Essex.

Essex localities population growth from 2024 to 2037 (Source: SHAPE Atlas)



Impact of Levels of Multiple Deprivation

Multiple deprivation prevalence (Source: SHAPE Atlas)



Some of our most deprived areas have limited access to healthcare facilities

Challenges

Deprivation has increased across our population, leading to significant health inequalities and disparity in health outcomes within vulnerable groups and often in the context of multi-generational need across families. The percentage of Essex residents living in the most deprived 20% of areas is amongst the highest in the East of England. EPUT serves an increasingly diverse population, and we need to continually adapt our services to meet our evolving population needs.

Key Messages

- There are a number of areas of mild to moderate deprivation. These areas are particularly focused in West Essex (towards the Hertfordshire border), South West Essex and South East Essex, lower Mid Essex and pockets of eastern areas of North Essex.
- Some areas of deprivation have limited access to healthcare facilities, especially in the eastern region of North Essex.
- EPUT healthcare facilities are more densely localised to South Essex, when compared to the other areas of Essex.

This illustrates that there are areas that experience both significant economic and health access deprivation. This may be a particular issue as areas of economic deprivation are likely to have significant health needs.

Graphic shows the number of EPUT healthcare facilities, overlaid on a Deprivation Index.

Overview of Our Estate Data

EPUT services are provided from circa 150 properties across Bedfordshire, Luton, Essex, Southend, Thurrock and Suffolk, with a total size of 127,000sqm. A vast majority of the estate is older than 40 years and circa 34% of properties has poor energy performance which does not support the Trust's net zero ambitions.

Age

Buildings older than 40 years is the measure used in ERIC as an indicator of the end of the life cycle, i.e. fitness for purpose relating to both condition (physical condition and statutory compliance) and functional suitability. 51% of EPUT's estate is over 40 years old.

Cost

The cost to occupy a health facility over its useful life will exceed the original capital investment by a multiple of 5-10 depending on its use. The building costs analysed in this strategy are Rent, Service Charge and Business Rates only.

Energy Performance (EPC) Rating

EPCs indicate the energy efficiency of a property and include estimated energy costs as well as a summary of the property's energy performance. Properties that have an EPC of E or below are classed as 'substandard' by regulations. 34% of EPUT's properties have an EPC rating of E or below.

Partnership Working

40% of properties are located with partners. Sharing of properties with partners can help with improving integrated care and patient access, enhancing collaboration and resource sharing.

152 Properties	59% Freehold Based on no. of buildings
127,000 sqm Total size of estate	57% of estate is over 40 years old
74% of estate footprint is clinical	706* Inpatient beds
34% of properties have an EPC rating of E or below	£157 m Value of Freehold Estate (BLDG)
£8.8m total occupational costs (p.a)	800k total income received (p.a)
40% of Properties are located with partners	

Key Messages

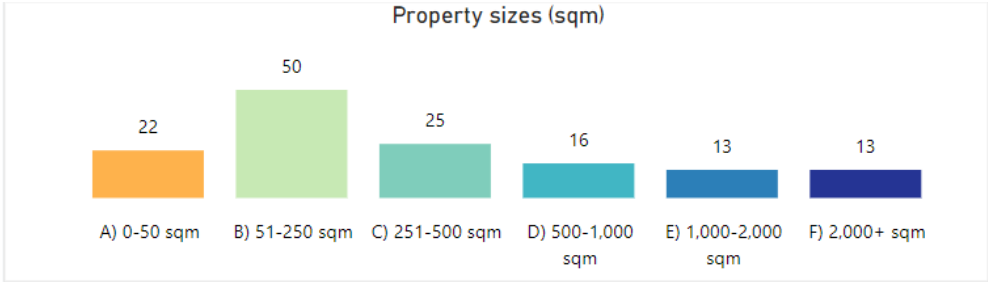
- Majority of properties are freehold
- Just over half of the estate is over 40 years old
- Predominately old estate with poor energy performance
- Adoption of partnership working across the estate

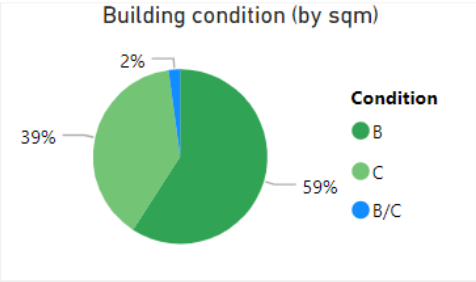
**without Epping beds*

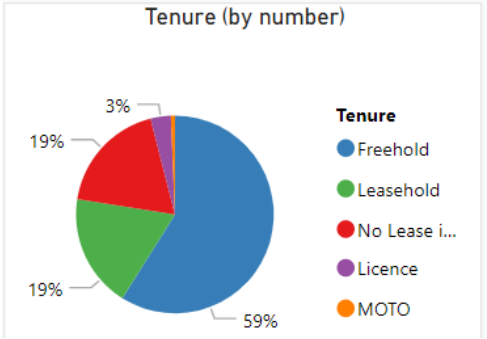
Overview of Our Estate Data

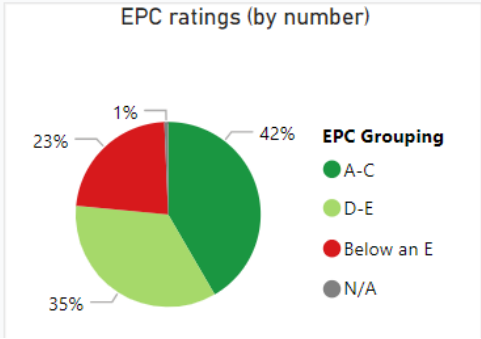
Key Messages

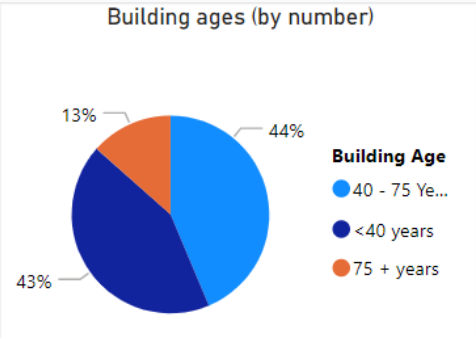
- We deliver many services from a large number of properties. A vast amount of these properties are under 250sqm, indicating small scale delivery across a large geography and number of sites
- However, 85% of our total occupational costs (£8.8m p.a) are derived from 10 key properties
- 59% of properties are freehold with the main properties being Rochford Hospital, Thurrock Hospital and Linden Centre



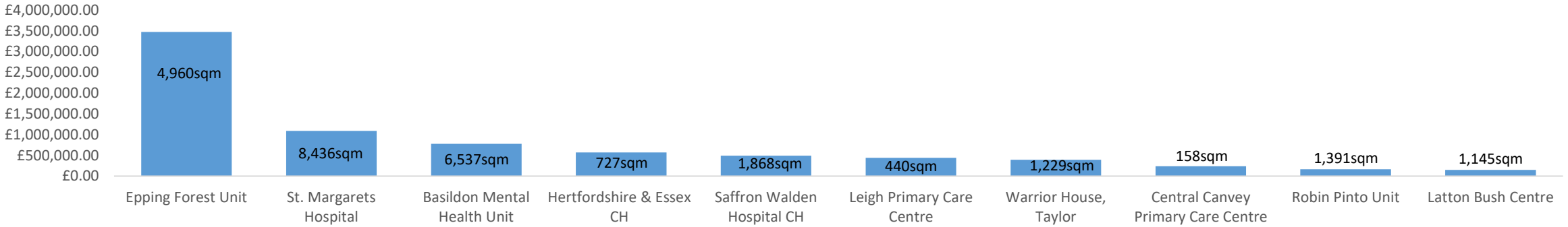








Leasehold properties with the highest net occupational costs



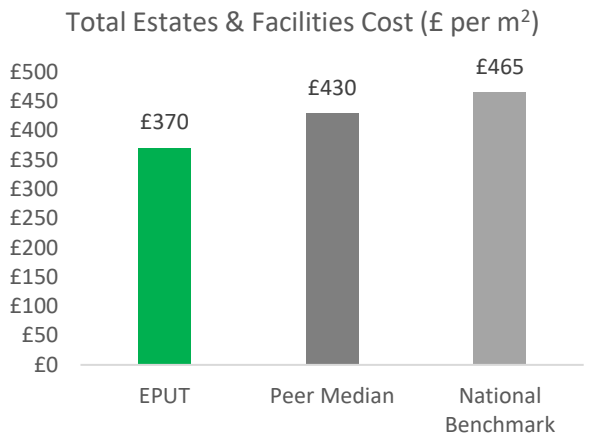
Overview of Our Estate Data

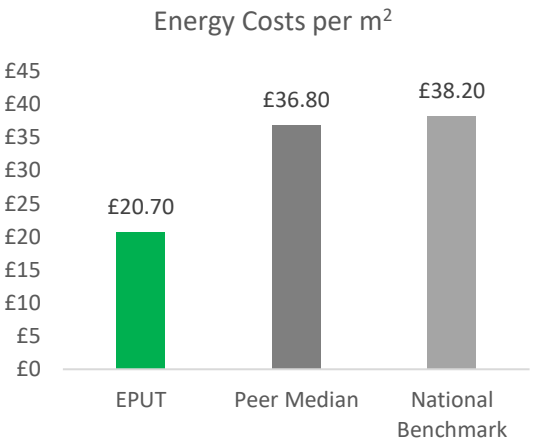
An estate diagnostic was undertaken to provide a baseline reference for key estate condition and performance metrics and to identify key challenges and opportunities offered by the existing estate (source data: 2022/23 Estates Returns Information Collection (ERIC).

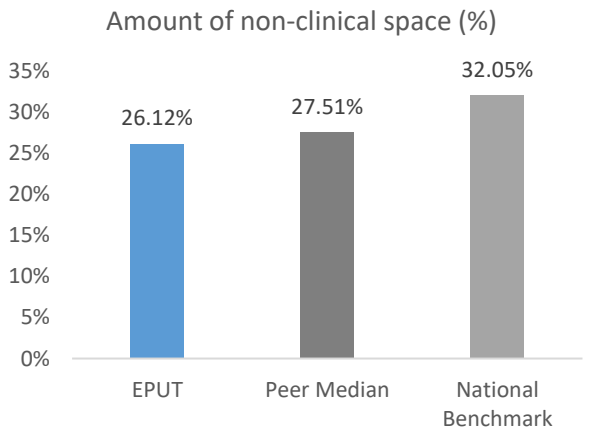
EPUT performance for key metrics compared to national benchmark and peer group medians is shown opposite (list of peer median organisations provided within Appendix 1).

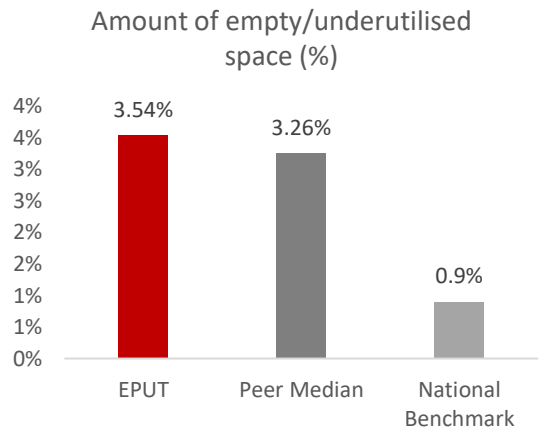
Key highlights:

- Our cost of estate occupancy (£ per m2) is ~14% lower than our peers, and ~20% lower than the national benchmark.
- We are performing well against the Carter Benchmark of no more than 35% of non-clinical space; our performance is similar to peers, and better than national benchmark.
- There is an opportunity to reduce the amount of our empty/under-utilised estate, which at c.3.54% is higher than the Carter benchmark of 2.5%; empty/underutilised space is similar to peers but significantly higher than national benchmark at c.0.9%.
- Our energy costs per m2 ~ 44-46% below our peer median and national benchmark.









Performance better than national benchmark
Below national benchmark (no judgement whether more desirable)
Performance below national benchmark
Above national benchmark (no judgement whether more desirable)

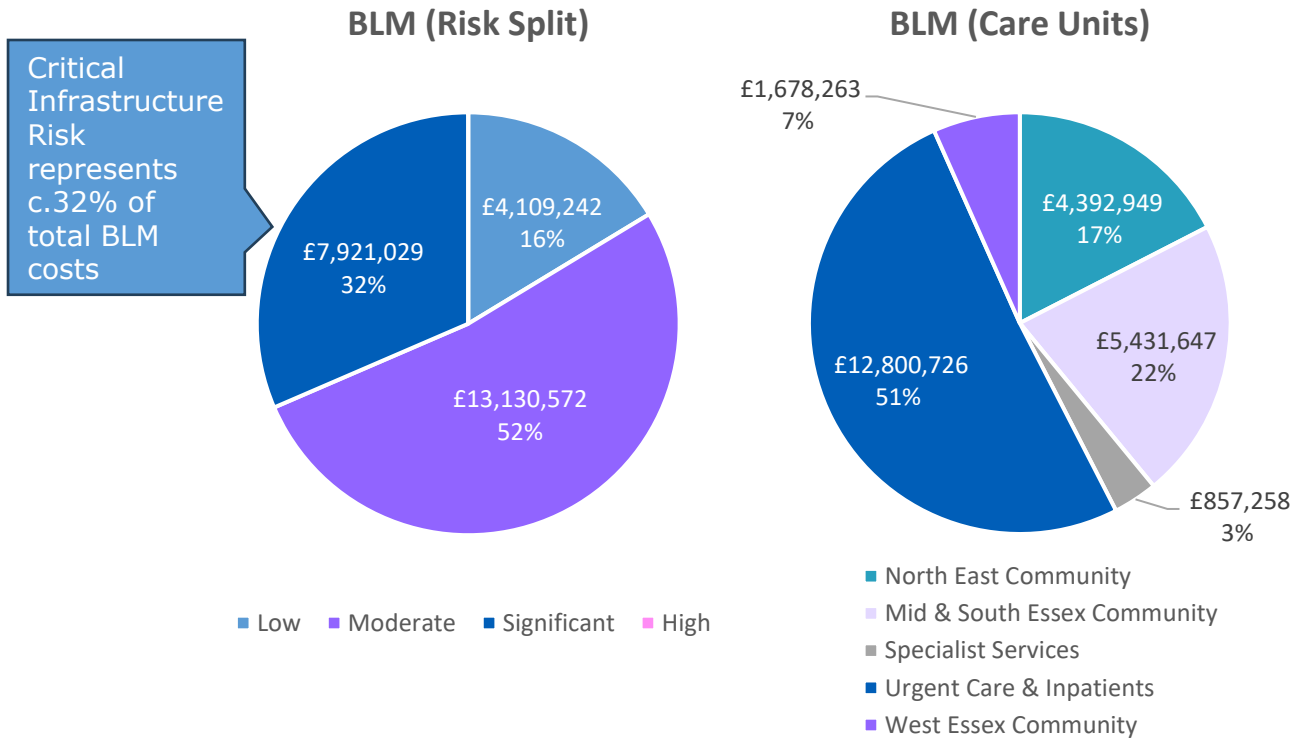
The property data used throughout this report is from the EPUT Master spreadsheet 2024. The data used in the following graphs have been taken from the Model Health System 2022/2023 so the data, therefore, reflects slightly differently from the costs and percentages in the main summary

Backlog Maintenance Across Our Estate

Critical Infrastructure Risk represents ~ 1/3 of our total BLM costs

Healthcare estate deteriorates over time and requires investment to ensure that service delivery remains safe and fit for purpose. A 2023 Six Facet Survey of **49** of EPUT's freehold assets indicated (based on physical condition and statutory compliance) a total backlog maintenance (BLM) cost of **£25,160,843***. While the majority of BLM costs are categorised as 'moderate', critical infrastructure risk represents 32% of total BLM costs.

Phrase	Definition
Low Risk	Should be addressed through agreed maintenance programmes or included in the later years of the estate improvement strategy
Moderate Risk	Should be addressed by close control and monitoring; can be effectively managed in the medium term so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety. These items require expenditure planning for the medium term.
Significant Risk	Require expenditure in the short term but should be effectively managed as a priority so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.
High Risk	Must be addressed as an urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution.



*Data source: 2023 Six Facet Survey of 49 EPUT freehold assets; *Year 0 (no uplift applied)*

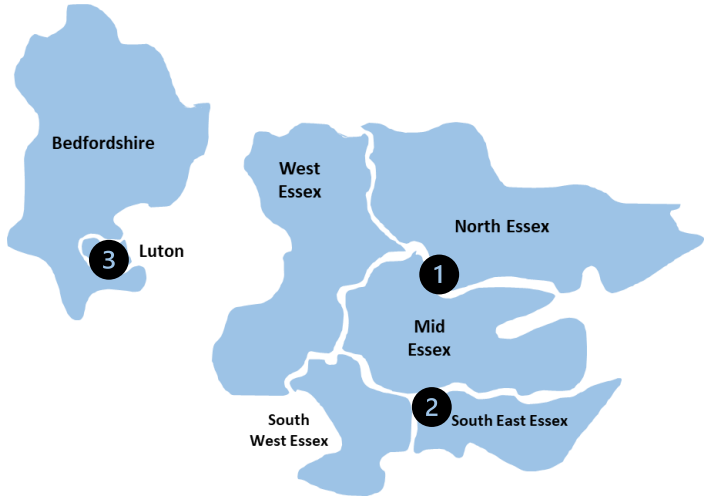
Backlog Maintenance Across Our Estate

We have critical backlog maintenance at key inpatient sites

The highest BLM costs are associated with the Urgent Care & Inpatients Care Unit estate, particularly:

1. The Linden Centre
2. Basildon University Hospital
3. Oakley Court

For each of these facilities, more than 50% of the total backlog can be attributed as significant risk.



Total Backlog (Condition and Statutory) > £500K			
Site	**Total Cost**	**£ per m2**	**Significant Risk**
Derwent Centre	£5,123,684	£640	10.1%
Basildon University Hospital	£2,769,554	£424	87.4%
The Linden Centre	£2,461,874	£595	75.4%
C & E Centre	£2,022,286	£1,085	10.9%
Thurrock Community Hospital	£1,706,062	£188	7.0%
The Lakes	£1,360,557	£437	30.9%
Landermere Centre	£1,054,704	£605	37.6%
Clough Road	£728,237	£379	0.0%
Oakley Court	£673,484	£482	53.1%
The Glade	£638,889	£2,035	20.6%
The Gables	£592,988	£1,002	14.0%
Herrick House	£566,389	£625	3.9%
Heath Close	£555,214	£347	38.6%

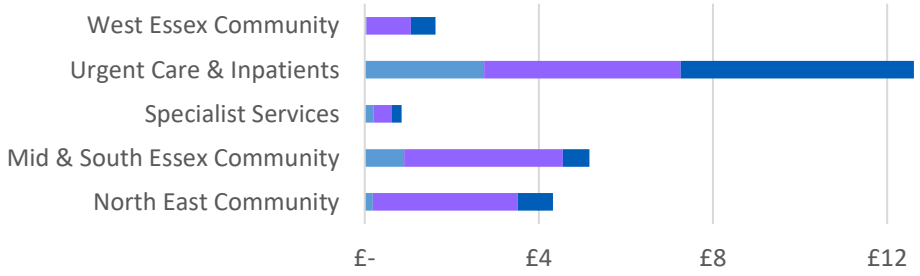
Data source: 2023 Six Facet Survey of 49 EPUT freehold assets

Backlog Maintenance - Breakdown

Some statutory compliance issues also exist

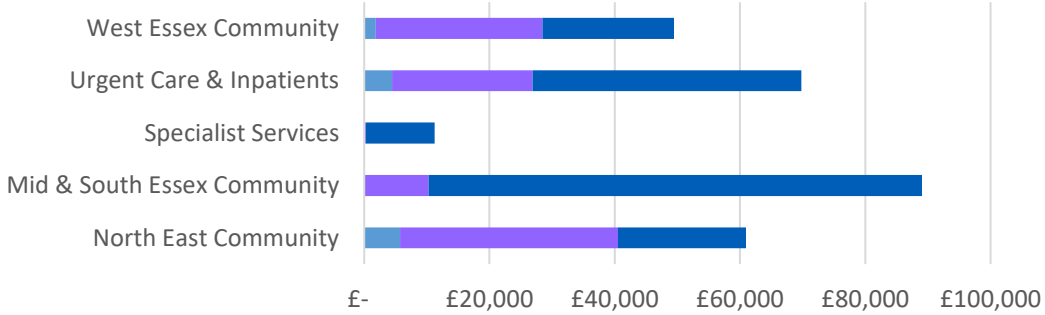
Below is a breakdown of the Physical Condition (PC) and Statutory Compliance (SC) related BLM costs (categorised by risk) across our Care Units estate. While total BLM costs are driven primarily by the physical condition of Urgent Care & Inpatients Care Unit estate, we also have some significant BLM risk associated with the Statutory Compliance of our estate, particularly within the Mid and South Essex Community Care Unit.

Immediate Backlog (Year 0) – Physical Condition (millions)



	North East Community	Mid & South Essex Community	Specialist Services	Urgent Care & Inpatients	West Essex Community
Low	£185,426	£904,999	£205,999	£2,740,494	£37,713
Moderate	£3,330,131	£3,647,920	£417,056	£4,513,536	£1,023,442
Significant	£809,071	£607,881	£222,953	£5,363,319	£567,661
High	£-	£-	£-	£-	£-

Immediate Backlog (Year 0) – Statutory Compliance



	North East Community	Mid & South Essex Community	Specialist Services	Urgent Care & Inpatients	West Essex Community
Low	£5,712	£-	£-	£4,450	£1,862
Moderate	£34,786	£10,250	£250	£22,434	£26,585
Significant	£20,473	£78,830	£11,000	£42,910	£21,000
High	£-	£-	£-	£-	£-

Key Estate Risks and Challenges

Our estate is facing significant risks and challenges and severe limitations on expected future funding. Much of the current estate is not sustainable or viable in the long term. There are a number of associated estates risks (listed below, not in order of priority) which must be considered when prioritising future investment to support high quality service delivery for our patients and staff.

01 Low investment & CDEL availability / affordability

02 Poor Therapeutic Environments

03 Pace and alignment of ICS estate strategies

04 Backlog Maintenance

05 Affordability of creating a Net Zero estate

06 PFI Contract Expiry in 2033 (Clifton Lodge and Rawreth Court) and 2038 (Brockfield House)

Patient Views of Our Current Estate

PLACE Report Summary

The Patient Led Assessments of the Care Environment (PLACE) 2023 Report outlines the following **4 general themes and findings**:

- ✓ Patient assessors were impressed with the attractiveness and availability of recreational activities for patients, with many wards having games rooms, gyms and well kept outdoor spaces.
- ✓ A key area for improvement is accessibility for those with disabilities and for those with visual impairments in particular.
- ✓ By using colour effectively, we can aid patients orientation around our sites. e.g. doors and toilet seats are not the same colour as the walls and surrounding systems.
- ✓ On the majority of sites, signs leading to the centre and car parking availability could be improved to make it easier for people to find our sites.

Overall Top Performers

Brockfield Basildon Thurrock

Overall Lowest Performers

Landermere Linden Centre Byron Court

Domain Performances

Domain 1: Cleanliness
- **Top performers:** Crystal Centre, Thurrock, Rawreth Court
- **Lowest performers:** Landermere, Linden Centre, Christopher Unit

Domain 2: Food & Hydration
- **Top performers:** Thurrock, Rawreth Court, Basildon
- **Lowest performers:** Rochford, Linden Centre, Christopher Unit

Domain 3: Privacy, Dignity and Wellbeing
- **Top performers:** Edward House, Basildon, Brockfield
- **Lowest performers:** Landermere, Saffron Walden, Rawreth Court

Domain 4: Condition, Appearance and Maintenance
- **Top performers:** Brockfield, Derwet Centre, St Aubyn Centre
- **Lowest performers:** Landermere, Linden Centre, Kingswood

Domain 5: Dementia Friendly
- **Top performers:** Brickfield, Thurrock, St Margaret's
- **Lowest performers:** Landermere, Linden Centre, Byron Court

Domain 6: Disabilities and Access
- **Top performers:** Basildon, Brockfield, St Margaret's
- **Lowest performers:** Landermere, Linden Centre, Byron Court

3. WHERE DO WE WANT TO BE?

Strategic Context - Overview

The development of our estate strategy cannot be viewed in isolation. This section considers the most pertinent national, regional, and Trust-wide priorities with which our estate strategy must align to support delivery of our vision and estate strategy objectives.

National Policies and Strategies	• NHS Long Term Plan - Mental Health • NHS Mental Health Implementation Plan • Naylor Review • Fuller Report • Delivering a 'Net Zero National Health Service • NHS Long Term Workforce Plan
Regional Strategies	• Hertfordshire and West Essex Estate Infrastructure Estate Strategy • Suffolk and North East Essex Estate Infrastructure Strategy • Mid and South Essex Estate Infrastructure Strategy • Bedfordshire, Luton and Milton Keynes Infrastructure Strategy
EPUT Strategies and Plans	• Quality of Care Strategy • Green Plan • Digital Strategy • Social Impact Strategy • People and Education Strategy • Research Strategy

Strategic Context - National

The NHS Long Term Plan

The NHS Long Term Plan committed significant investment in mental health services to support an ambitious transformation programme. It also set out how services will be integrated, and community-based services will be expanded, to support more people at home. The new learning disability and autism standards must also be implemented by all trusts by 2023/24.

While the population is increasing, there has also been a record number of people that require NHS mental health services and referrals. However, national capital allocations have largely been prioritised towards acute settings with underinvestment in mental health and community services. This is a particular issue for trusts aiming to redevelop their estates to improve the quality of care offered to patients, reduce the mental health backlog and improve efficiency. Within this context, alignment with national, regional and local strategies needs to be considered within the estate strategy.

The priorities for the NHS Mental Health Long Term Plan include:

Strategic Context - National

The government, NHS and other governing bodies have developed overarching strategies and plans to guide the delivery of health services across England. Those that are particularly relevant to EPUT and the development of this Estate Strategy are briefly summarised below.

NHS People Plan	• Sets out plans to make the NHS the best place work and develop a positive, inclusive, individualised, leadership culture, with a clear focus on improvement and advancing quality and inclusion.
NHS Mental Health Implementation Plan	• Sets out specific commitments to significantly expand access to psychological therapies, perinatal, and children and young people's mental health services and transform community mental health delivery, including greater support for evidence based pharmacological treatments.
Community Mental Health Framework	• Describes a new model for a place-based community mental health model, including personalised condition management, medicines management, individualised recovery, and a more integrated approach to joined-up care.
Draft Mental Health Bill	• The Bill will reform the current Mental Health Act (1983); introducing new requirements to ensure service users' views and choices are respected, that the act's powers are used in the least restrictive way, that admission supports recovery, and that service users are viewed as individuals.
Health and Care Act 2022	• Places stronger emphasis on the integration of health and care services. It has established ICBs and ICPs, and requires ICPs to publish Integrated Care Strategies and ICBs to agree Five Year Forward Plans with their partner NHS providers. It sets the triple aim for the NHS of health and wellbeing, quality of services, and efficiency and sustainability.

Strategic Context - National

The Naylor Review

There is a large disparity and variation across the NHS estate, with nearly 20% of hospital trust estate predating the formation of the NHS (1948) and ~ £5bn in backlog maintenance. The Naylor Review details these issues and presents 17 recommendations and outlines a vision of the future for the NHS.

Recommendations include:

- As a minimum the department of health should provide assurance to STPs (now ICSs) that any sale receipts from locally owned assets will not be recovered centrally provided the disposal agrees with ICS plans;
- ICSs should develop affordable estates and infrastructure plans;
- Land vacated by the NHS should be prioritised for the development of residential homes for NHS staff where there is a need; and
- Substantial investment is needed to deliver service transformation in well evidenced ICS plans.

This Estate Strategy aligns with the ICS to ensure the recommendations from the Naylor Review are achieved where possible.

The Fuller Stocktake Report

Primary care faces numerous challenges which include high demand and inadequate access to urgent care. Built on this, the Fuller Stocktake Report presents a new vision for integrating primary care, and improving the access, experience and outcomes for communities. The key main findings and vision includes:

This vision requires a greater focus on estates data and better infrastructure. This includes investment, time, capacity and a supportive leadership culture.

Strategic Context - National

Carter Report

The Carter Report was developed by Lord Carter, 2016, and details how efficiencies can be achieved across the NHS, specifically focused on "unwarranted variation".

Key findings from the review:

- ✓ Identified £5 billion of unwarranted variation across various functions, including estates and facilities
- ✓ Identified £700 million of potential savings in procurement
- ✓ In terms of estates and facilities, the following recommendations ensure that resources are used in a cost-effective manner:

Trusts should operate at or above the benchmarks agreed by NHS Improvement for the operational management of their estates and facilities functions; with all trusts having a plan to operate with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied or under-used space

Trusts should rationalise their corporate and administrative functions to ensure their costs do not exceed 6% of their income (or have plans in place for shared service consolidation with, or outsourcing to, other providers)

Delivering a 'Net Zero' National Health Service

The NHS aims to deliver the world's first net zero health service, responsive to health emergencies brought about by climate change. Two clear targets have now been developed:

- For emissions we control directly, net zero but 2040, with an ambition to reach an 80% reduction by 2028 to 2032; and
- For the emissions we can influence, net zero by 2045, with an ambition to reach an 80% reduction by 2036 and 2039.

The plan included estates as one of the areas where direct intervention can be taken to reduce emissions.

Refer to page 33 for more information on EPUT's Green Plan to meet these targets.

Upgrading Buildings
LED lighting, HVAC systems, hot water, insulation

Optimising Usage
Real time monitoring

Onsite Energy Generation
Heat pumps, renewable resources

National Electricity Decarbonisation
Converting to 100% renewable energy

Strategic Context - National

NHS Long Term Workforce Plan

The NHS Long Term Workforce Plan was published on 30 June 2023. It sets out how the NHS will address existing and future workforce challenges by recruiting and retaining thousands more staff over a 15-year period, and working in new ways to improve staff experience and patient care.

Commissioned and accepted by the government, it provides a costed plan for how the NHS will develop to meet existing and future demand and challenges, and support population health and wellbeing. Over £2.4 billion has been committed to fund additional education and training places over the next five years, on top of existing funding commitments.

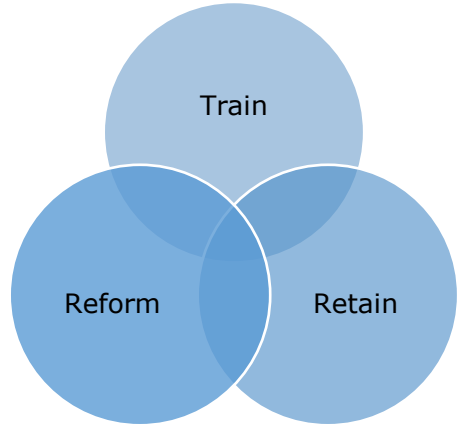
The plan sets out the strategic direction over the long term as well as short- to medium-term actions to be undertaken locally, regionally and nationally. Those actions fall into three priority areas:

- **Train:** Substantially growing the number of doctors, nurses, allied health professionals and support staff. This is underpinned by a £2.4 billion funding commitment.
- **Retain:** A renewed focus and major drive on retention, with better opportunities for career development and improved flexible working options. This comes alongside reforms to the pension scheme, with an aim to retain 130,000 staff working in the NHS for longer.
- **Reform:** Working differently and delivering training in new ways. Advances in technology and treatments will be explored and implemented to help the NHS modernise and meet future requirements.

While it is a national plan, it allows for priority decisions to be taken at system and local level. There is also a commitment for it to be an iterative rather than 'one-off plan', with further versions developed and published on a more regular basis.

The plan aims to increase the total number of NHS staff through an unprecedented expansion in recruitment and significant improvement in retention, so the NHS keeps more existing staff in post. Routes into the NHS will change through the development of apprenticeships and reform of medical education and training.

The plan also aims to deliver productivity improvements through making the most effective use of emerging technologies such as artificial intelligence. It also signals a shift from reliance on international recruitment to a largely domestic recruitment model.



Strategic Context – Regional (Mid and South Essex ICS)

The Mid and South Essex ICS Estate Strategy highlights the ICB's ambition to develop its infrastructure to support the transformation of their services. As part of this ambition extends to mental health and community services, a primary component of EPUT. The EPUT Estate Strategy has been aligned to the ICS future direction for infrastructure (below) and the adjacent core principles.

Mental Health

Accessibility and maximising utilisation of it are key Priorities

- Cultural and physical shift to better use of existing estate
- Improve accessibility to outpatient facilities
- Achieving consistency in estate quality of our outpatient estate.
- Clear mapping of our estate to understand the optimum location of mental health services driven by colocation, workforce and accessibility

Community

Ensuring we maximise opportunities to integrate services at a local level

- High proportion of NHS Property Services estate needs to be better utilised
- Plan for utilisation of void at Brentwood Hospital PFI which represents nearly 40% of the NHSPS void space
- Initiate asset strategies for our multi-occupied health centres
- Use our community estate to bring services closer to home and integrate our system services
- Create flexibility around use of estate
- Strategic planning around tail estate

The ICS Infrastructure Core Principles

- ✓ Utilise our estate as an enabler to reduce our costs and create efficiencies
- ✓ Build an integrated and collaborative approach to infrastructure decision-making
- ✓ Create a strategy that is owned and supported by all system stakeholders
- ✓ Use data and insight to drive our priorities and decision-making
- ✓ Optimise use of our core estate
- ✓ Have a prioritised approach to infrastructure provision
- ✓ Create efficiencies
- ✓ Integrate sustainability into decision-making and processes
- ✓ Focus on infrastructure which supports prevention and areas of deprivation
- ✓ Focus on infrastructure which supports prevention and areas of deprivation
- ✓ Drive infrastructure transformation from our Places
- ✓ Reduce inequalities in health outcomes
- ✓ Be creative and innovative

Strategic Context – Regional (Hertfordshire and West Essex ICS)

The below outlines the key Hertfordshire and West Essex ICB objectives for infrastructure. These are categorised into 3 key components: population health, quality and efficiency, and are consistent with the key objectives of our Estate Strategy.

POPULATION HEALTH	QUALITY	EFFICIENCY
• Address health inequalities by providing good quality facilities in areas of greater deprivation, noting that HWE is generally below the national average • Planning for population growth and demographic trends and forecasts to ensure appropriate care • Providing services having regard to accessibility, notable public transport • Facilitate Integrated Service Delivery in Places and Neighbourhoods • Support and encourage co-location of multi-disciplinary teams	• Facilitate high quality service delivery. • The infrastructure to support digital service delivery • Create the environment to recruit and retain staff • Create the environment for training and development	• Optimise the use of the existing good quality estate and premises, offering extended hours and additional services • Rationalise spaces such as multiple reception areas, waiting areas, staff areas and administration spaces • Disinvest from assets classified as 'tail' to reduce the footprint where running costs are non-efficient • Work towards an environmentally net carbon zero and financially sustainable estate

Strategic Context – Regional (Suffolk and North East Essex ICS)

The below outlines the key estates objectives and priorities for Suffolk and North East Essex ICB. The ICB's ambition for the population is to have '**an integrated estate that allows the delivery of care at the right time, in the right way, in the right place, by the right person**'. The objectives below are consistent with the objectives of our Estate Strategy.

Estate Planning	Primary Care Estates Strategies	Future Systems	Developing Centres of Excellence	Meeting Future Demand	Ownership and Management
• To develop effective and efficient estate management arrangements through increased coordination and collaboration between individual Estates and Facilities Management (EFM) teams and consolidated estate ownership within the ICB area. • To have a consistent but appropriate and proportionate methodology for collecting, reporting and presenting data relevant to the system estate.	• To identify opportunities to address short, medium and long-term capacity issues through estate development, optimisation and utilisation. • To prioritise primary care estate development to support the delivery of services within the community.	• To work as a system to ensure the system infrastructure underpins new ways of working. • To work alongside and ensure strategies are aligned with other key enablers including workforce planning and digital. • To align estate intelligence and planning to activity, performance, and finance planning, to create a sustainable estate to meet health population needs.	• To support the development of the best possible estate in the correct locations for the delivery of clinical services.	• Work with the local authorities to understand, plan for and mitigate the proposed housing growth planned to ensure health care provision is adequate for increased population. • To work to secure adequate and appropriate mitigations from housing developments to support the development and expansion of health and wellbeing services to meet the growth in population.	• To work as a system to ensure assets are owned by the most appropriate system partner for the benefit of the delivery of patient care.

Strategic Context - Local

High interdependency of key enabling Trust strategies and estates

There are strong interdependencies between several of our key enabling strategies and our estates and facilities. Further detail on these strategies and how they link to estates and facilities is provided below.

Vision	Strategy	Aim	Link to estates and facilities
To be the leading health and wellbeing service in the provision of mental health and community care	Quality of Care Strategy	• Ensure patients and families are including in driving quality of care • Integrating services with a person centred approach • Shift from providing reassurance to assurance • Ensure alignments with national strategy and ICS priorities	• Ensure that the physical environments are conducive to high quality care • Co-designing in partnership with patients, their families, loved ones and supporters
	Green Plan	• Net zero by 2040 and Net Zero Plus by 2045 • Prioritise the best value and consider lifetime cost • Reduce the Trust travel and transport impacts • Formalise an approach to climate adaptation to reduce climate risk • Improve the collection of was stream data	• Identify energy saving opportunities on high consuming sites • Ensure refurbs/new development implement appropriate consideration of its environmental credentials • Maximise opportunity for green space and biodiversity across estate • Minimise waste sent to landfill
	Digital Strategy	• Modern, reliable digital clinical & operational tools to provide safe care • Accessible and accurate digital information and intelligence Service users and staff empowered through digital capabilitiess that they feel confident in using • Reliable, resilient and sustainable digital infrastructure	• Enable agile working by working together across sites & buildings • Increase access to non face to face services e.g. virtual consultations, remote monitoring and virtual wards • Operational excellence/smart infrastructure through use of technologies to drive productivity, reduce energy production and increase staff satisfaction
	Social Impact Strategy	• Invest locally • Collaborate with local partners • Provide more work opportunities • Support communities through use of available estate • Reduce carbon footprint	• Local estates and facilities apprenticeships • Extension of rough sleeps projects – allow sleeping in buildings • Use of EPUT estates to house community hubs e.g. foodbanks • Community garden projects on EPUT sites
	Working in partnership with people and communities	• Deliver safe, high quality integrated care services • Work with our partners to make our services better • Enable each other to be the best we can be • Help our communities to thrive	• Ensure patients and the communities are involved in the decision-making processes • Sharing estate with system partners

Strategic Context - Local

Our Quality of Care Strategy

The Quality of Care Strategy supports the significance of safety, effectiveness and experience, building on the previous strategies developed by the Trust.

The intention of this strategy is to outline the importance of:

- ✓ Collaboration to ensure that patients and families are included in driving the quality of care.
- ✓ Improving the approach to care.
- ✓ Integrating services with a person-centred and collegiate approach.
- ✓ Shifting from providing reassurance to assurance.
- ✓ Ensuring there is constant alignment with national strategies and ICS priorities.

As mentioned in the strategy, EPUT will use the 7 NHS guiding principles of delivering quality care when developing the delivery plan:

Strategic delivery success measures:

- **Year 1:** Establish baseline data
- **Year 2:** Benchmark against ourselves and incrementally improve on year 1 baseline setting
- **Year 3:** Benchmark against ourselves and incrementally improve on year 2 baseline setting
- Qualitative **evaluation**

Trust Strategic Vision

Care Unit Delivery Strategies	Professional Strategies	Estate Strategies	Clinical Model Strategies	Data Strategies	People, Culture and Education Strategies

Quality of Care Strategy

Safety	Effectiveness	Experience
• We will consistently improve patient safety through involvement and insight. • Culture and systems will be our key foundations to improve patient safety.	• The care we provide will be beneficial, evidence-based, and effective. • Care will be provided by staff that are confident, competent, and knowledgeable.	• We will enhance care by understanding people's experiences and collaborating with them and their loved ones. • We'll start with people, ensuring valuable processes for care, celebrating achievements, and facilitating improvement.

Key Messages – Link to Estates and Facilities

- Ensure that the physical environment is conducive to high quality care
- Co-designing in partnership with patients, their families loved ones and supporters

Strategic Context - Local

Trauma-Informed Care

Our Strategic Plan 2023 – 2028 emphasises the Trust's mission to introduce trauma-informed care and to be a psychologically-informed organisation. This specifically aligns with the Plan's key strategic objective to deliver safe, high-quality, integrated care services and empowering the service users, families and carers. Plans for the Care Unit include:

- ✓ Increase continuity of care
- ✓ Empower service users have a choice in decisions about their care and recovery goals
- ✓ Work with families and support networks to involve them in trauma-informed approaches
- ✓ Upskill staff in trauma-informed care approaches

As part of this initiative, EPUT is introducing a Clinical Associate in Psychology (CAP) role to strengthen their psychological workforce. EPUT are the only NHS Trust to hold a main provider role for delivering CAPs training*.

This Infrastructure Estates Strategy is aligned with the principles of trauma-informed care and provisions need to be made where possible.

Key Message – Link to Estates and Facilities

Enhance the quality of care provided via co-designed modern, safe, fit for purpose environments that maximise positive experiences for patients

*In partnership with the University of Essex

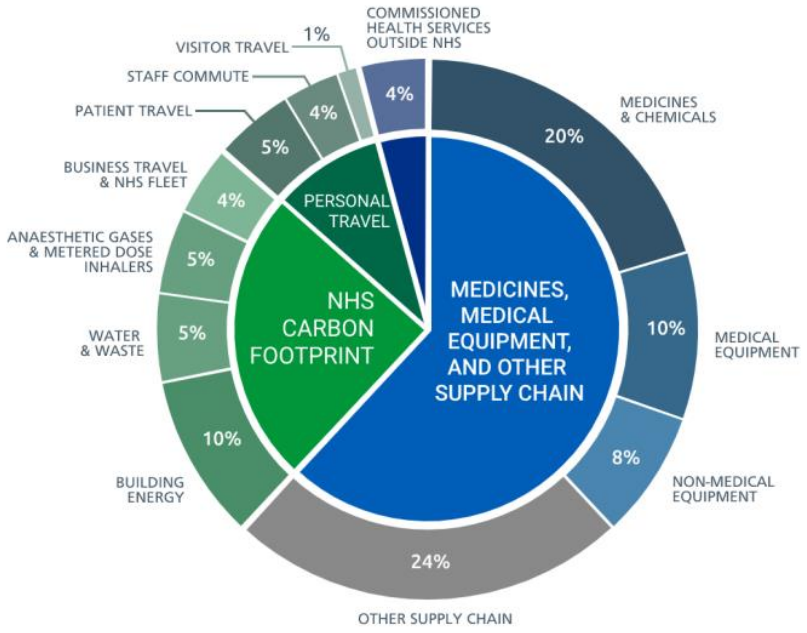
Strategic Context – Local

Our Green Plan

According to the World Health Organisation, 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.

As seen below, in 2020, the NHS was responsible for 4% of England's overall carbon footprint, with 24.9m tonnes of carbon dioxide equivalents (tCO2e).

2020 NHS Carbon Footprint Plus – 24.9 mtCO2e



The current Green Plan (2021), establishes our carbon footprint and sets out actions to improve sustainability within the Trust, to ensure we meet all national and local legislative guidelines. The Green Plan was developed to have measurable targets and the areas of focus align with the 10 assessment areas in the Sustainable Development Assessment Tool (SDAT), a tool for organisations to monitor their impact and measure progress. The next update to EPUT's Green Plan will move away from the SDAT use and align more with the 'Delivering a net zero national health service' guidance. 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.

Key Messages – Link to Estates and Facilities

Asset management and utilities:

- Perform energy audits of high-consuming sites to identify energy and waste saving opportunities
- Develop site-specific energy strategies

Capital projects:

- Put the correct processes in place such that any major refurbishment or new development can be implemented with the appropriate consideration of its environmental credentials

Green space and biodiversity:

- Maximise the opportunity potential of green space and biodiversity across our estate.

Sustainable use of resources:

- Minimise waste sent to landfill

Strategic Context – Local

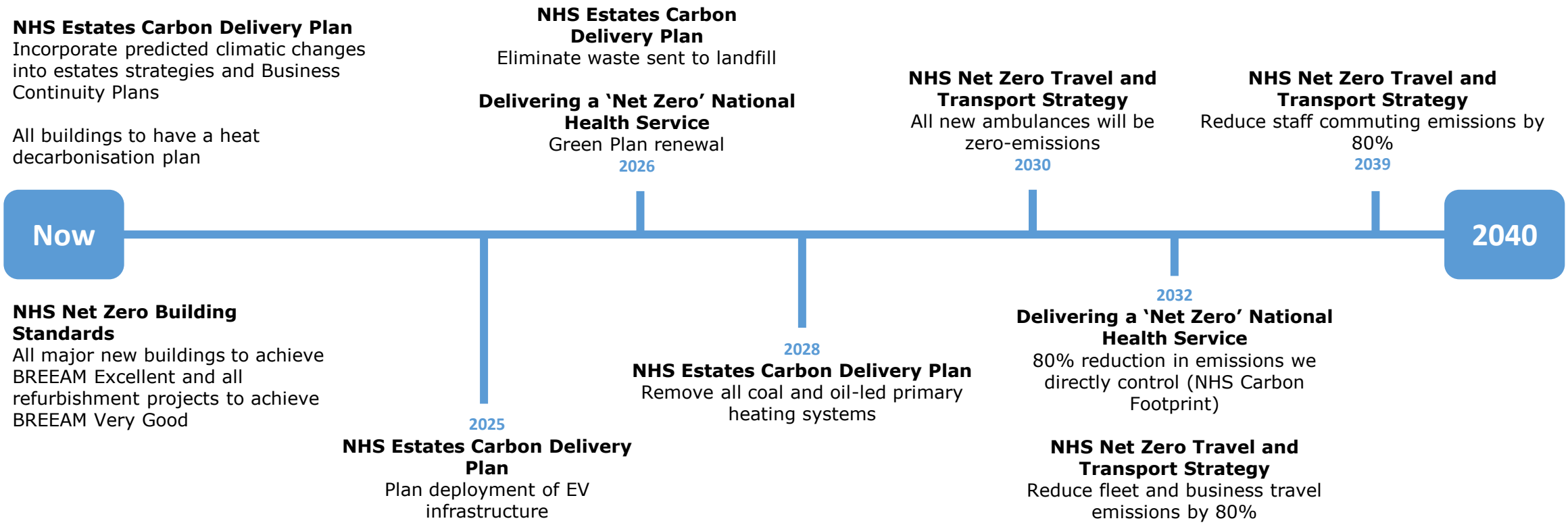
Our Green Plan – Estates Integrated Sustainability

Shown below are the key sustainability themes, and associated objectives, that we prioritising within their estate. The KPIs were developed working together with the EPUT sustainability manager to align with the Trust's future goals and NHS net zero targets. Integrating sustainability into estate decisions can reduce costs and move the Trust closer to a net zero estate.

Key Theme	**Net Zero Estates**	**Procurement**	**Travel**	**Adaptation**	**Waste**
Objective	Net Zero by 2040 and Net Zero plus by 2045	Prioritise the best value and consider lifetime cost	Reduce the Trust travel and transport impacts	Formalise an approach to climate adaptation to reduce climate risk	Improve the collection of waste stream data
KPI	Carbon emissions equivalent (CO_2e) Green Plan delivery	Procurements providing 10% net zero and social value weighting	Travel survey data Zero emissions fleet vehicles	Measures taken to improve climate adaptation	Tonnes of waste disposed of per waste category

Strategic Context – Local

This timeline below collates all the net zero benchmarks outlined in all the current NHS guidance. Creating a roadmap of targets for EPUT to work towards. EPUT must ensure they are considering these goals to avoid barriers in the future. Ensuring buildings have sufficient infrastructure to accommodate an electric fleet and considering climate risks and transport connections when considering new sites.



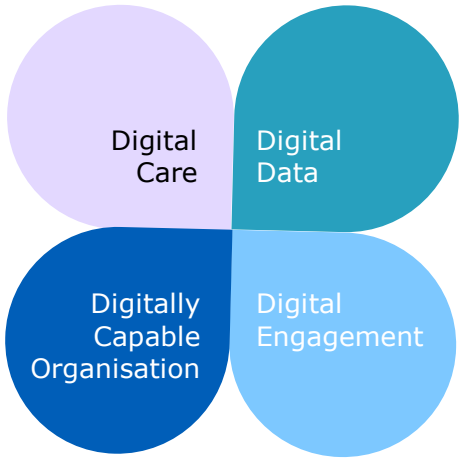
Strategic Context – Local

Our Digital Strategy

The EPUT Digital Strategic Plan (2023 – 2029) is an ambitious plan that sets out how the Trust will transform the quality and safety of care through creating a digitally capable organisation. Successful implementation of the plan is dependent on a shift in culture, continuous transformation and prioritised investment. The Digital Strategy outlines the capabilities required to achieve the Trust's aims and priorities:

- **Digital Care:** replace existing clinical systems with modern technology
- **Digital Data:** ensure that data is recorded on a centralised database to ensure consistency
- **Digital Engagement:** build digital services, capabilities and communication between services users, staff and partners
- **Digitally Capable Organisation:** ensure infrastructure, estate and literacy is able to support digital capabilities

Capabilities:
- Electronic Patient Record
- Shared Care Records
- Virtual Wards



Capabilities:
- Service delivery evidence and analytics
- Population health management analytics

Capabilities:
- Organisation, clinical and leadership capabilities, culture, processes, operating models and modern (Cloud) infrastructure

Capabilities:
- Collaborative technologies
- Service user portal
- Online advice and guidance
- E-Learning and digital literacy

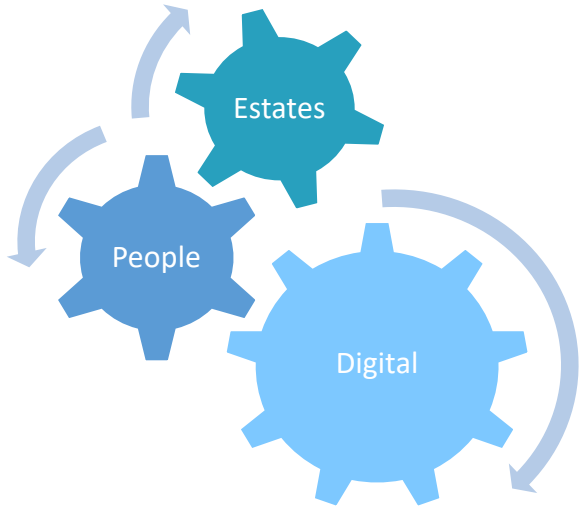
Vision	"EPUT aspires to be a digitally and data enabled organisation"
Purpose	"We will deliver the Digital Technology capabilities that are fundamental to the achievement of the Trust's Strategic Plans"
Aims	• Modern, reliable digital clinical and operational tools to provide safe care consistently • Accessible and accurate digital information and intelligence to support day to day service delivery and strategic population health responses • Our service users and staff empowered through digital capabilities that they feel confident in using • Reliable, resilient and sustainable digital infrastructure
Themes	• Digital Care • Digital Data • Digital Engagement • Digitally Capable Organisation

Strategic Context – Local

Our Digital Strategy – link to estates and facilities

There are strong links and dependencies between Estates, Digital and the People Team. For example, there are often large IT contracts that may impact the cost of infrastructure plans, and this needs to be considered.

In order to avoid the inefficient use of resources, the teams should work in constant collaboration – this may include establishing a Change Management Board that consists of representatives from each team. The intention of this Board is to review Business Cases and 'big picture' strategies to ensure that they are aligned and correctly resourced before presentation to the Capital Projects Group.



Key Messages – Link to Estates and Facilities

- **Digital infrastructure**: ensure the digital infrastructure is robust to support the safety and quality of care. This may require investment.
- **One single system**: Unified Electronic Patient Record (UEPR) across mental health and community settings and acute partners in Mid and South Essex, replacing our current clinical systems by 2026.
- **Agile working**: work closely together in a flexible way across sites and buildings.
- **Data-Driven**: require data guided by the Data Strategy and with a move to "Cloud" based solutions and storage.
- **Data Driven decisions**: effective data to drive estates and facilities.
- **Digitally empowered patients**: aligned with the anchor strategy, there is an increasing focus for patients to be more involved in their treatment. In terms of digital, this includes provision of a Service User Portal; online advice and guidance; and e-Learning and digital literacy programs.
- **Operational excellence/smart infrastructure**: use technology to drive productivity, reduce energy consumption, increase patient and staff satisfaction.
- **Hospital without walls**: increase use of different for service users to access non-face-to-face services (e.g. virtual consultations, remote monitoring, virtual wards).

Agile Working

Our continued development of agile working principles should consider an evidence-based approach

NHS organisations are consistently reviewing how to enhance the efficiency and effectiveness of their clinical and non-clinical space to increase flexibility and resilience. Working patterns and standards post-pandemic are continuously evolving and this has accelerated the need for modern, flexible space to support activities – it may be less than before, and it may be in different locations.

The pandemic amplified several trends in the workplace including the growth of a dispersed workforce and the proliferation of digital engagement. This is therefore creating an emerging work environment that promotes agility and growth through a mix of on-site and remote employees.

We need to therefore consider workforce and working practises within the context of our estate redevelopment plans. This needs to be driven by an evidence based approach, reflecting changing working practises and linked to technological advances, and on a site by site basis. As an example, any potential redevelopment or refiguration of the Lodge will be pivotal in the adaptation and integration of agile working practises across the Trust.

Key Messages – Link to Estates and Facilities

To support a fit for purpose estate, guided by the strategic analysis of our estate through the Core, Flex and Tail Model we have adopted, we must ensure alignment and integration of our supporting strategies within digital, estate strategy and people and workforce strategies.

The Strategy recognises the importance of a future ready infrastructure and an estate that not only adapts to agile working but one that helps to drive innovation and collaborative working including virtual organisation, shared facilities and flexible workspaces whether in Trust or partner properties.

Strategic Context – Local

Our Social Impact Strategy

Our Social Impact Strategy acts as the anchor strategy for the Trust and directly supports the delivery of the strategic objectives in the Strategic Plan. This Strategy particularly sets out how EPUT will help communities to thrive and how best to support the local population. In addition, the Strategy aligns with the operating principles of the three Essex ICB Anchor Programmes and the pan-Essex Programme.

Focusing on delivering maximum social impact is in direct alignment with caring for our communities, empowering our colleagues to innovate, and learning what works and what does not

Invest locally

Collaborate with local partners

Unlock more work opportunities

Support communities through use of available estate

Reduce carbon footprint

Key Messages – Link to Estates and Facilities

- Delivery of local estates and facilities apprenticeships
- Extension of rough sleeps projects – allow sleeping in buildings
- Use of EPUT estates to house community hubs e.g. foodbanks
- Community garden projects on EPUT sites

Position EPUT has a community enabler

Short-term Priorities

- Linking with local schools and colleges to encourage NHS careers, especially in most deprived areas
- Local apprenticeship schemes
- Staff time allocation for volunteering in local charities
- Collaboration for increased buying power
- Community garden projects on EPUT sites
- Use of EPUT estates to house community hubs e.g. foodbanks
- Extension of rough sleepers projects - allow sleeping in buildings
- Offer our wellbeing services to other local employers

Longer Term Priorities

- Offer our wellbeing services to other local employers
- Staff time allocation for volunteering in local charities or internally
- Develop partnership with large corporates and/or other community anchors e.g. sports clubs, to work with local communities

Strategic Context – Local

Working in partnership with people and communities

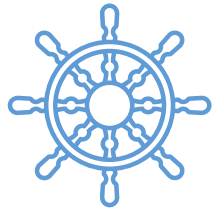
Our People and Education Strategy was developed in line with the NHS Long Term Plan and its particular focus to train, retain and reform the workforce. The Operating Model extends across the EPUT Care Units and comprises 6 Operational Care Units: HR Business Partnering, Employee Relations, Workforce, Education and Leaning, Medical Staffing, Organisational Development and Recruitment. Each of these Care Units require adequate, agile and robust infrastructure to support their objectives. The pillars of the People and Education Strategy include:

Key Messages – Link to Estates and Facilities

- Involving patients and communities in the decision-making process
- Sharing estate with system partners
- Need to implement agile working policy

Equality, Diversity & Inclusion

Having a diverse and inclusive workforce helps tackle health inequalities and also helps create a culture where everyone is valued and respected.



Leadership & Management

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

Education & Learning

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

Culture

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

Workforce

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

Strategic Context – Local

Our Research Strategy

The Research Strategy (2023 – 2026) was developed to highlight the importance of research, the challenges faced by the field and outlines a 3-year implementation programme to address these challenges.

Key challenges:

- **Workforce:** the workforce is often unable to partake in research due to capacity, tools, space and access availability.
- **Funding sources:** access to NIHR funding can be challenging
- **Communication:** communication needs to be improved to improve research awareness and knowledge sharing

Key milestones:

- **Year 1:** increase research awareness
- **Year 2:** improve research activity and involvement of EPUT workforce
- **Year 3:** increase NIHR research and grant fund portfolio, including an increase in commercial clinical trials

Key Messages – Link to Estates and Facilities

- Ensuring access to sufficient and appropriate estate capacity to support the research vision
- Align research activities with care units and with other provider partners

Vision

Visibility & Awareness	• Make research visible in all aspects of the Trust's core business • Increase awareness of the value and impact of clinical research
Workforce Development	• Support the development of and nurture a sustainable workforce • Empower staff to promote evidence-based practice
Working Together	• Empower people and staff together in high quality research • Collaborate to align our research activities with care units and with other provider partners
Investment	• Embed integration of learning through evidence-based practice. • Grow aspirations to become a recognised centre of excellence

On-going Collaborative Working Across Our ICS

Our collaborative, partnership working between health and care providers and local government is key to promoting effective investment decision making.

We have established specific collaborative arrangements with other providers of the NHS services in:

- Mid and South Essex Community Collaborative
- North East Essex Community Collaborative
- East of England Regional Specialist Mental Health

By continuing to build on this successful collaborative working and delivering more integrated and coordinated health and wellbeing services we will speed up care and reduce inequalities across Essex.

Key Messages – Link to Estates

- The 2024/2025 focus is to rationalise MSE community estates and deliver cost improvements related to estate utilisation
- More focus should be put on partnership working to provide safe, high quality spaces and a flexible estate that responds to net zero targets
- Ensure we are working with Local Authorities to keep up to date and become more involved in any discussions about new health care developments or available S106 funding.

Mid and South Essex Community Collaborative

A partnership between three organisations: EPUT, NELFT and Provide, who's role is to work with health and care providers to review how community services can best address the needs of the local communities. The intention of the MSE Community Collaborative is to:

- ✓ **Improve access and health outcomes** across the population, irrespective of where the service user resides, or which organisation delivers their care
- ✓ **Better collaboration and partnership** between the organisations to deliver best clinical practices and high-quality care
- ✓ Futureproof community services by **delivering services closer to the patients**

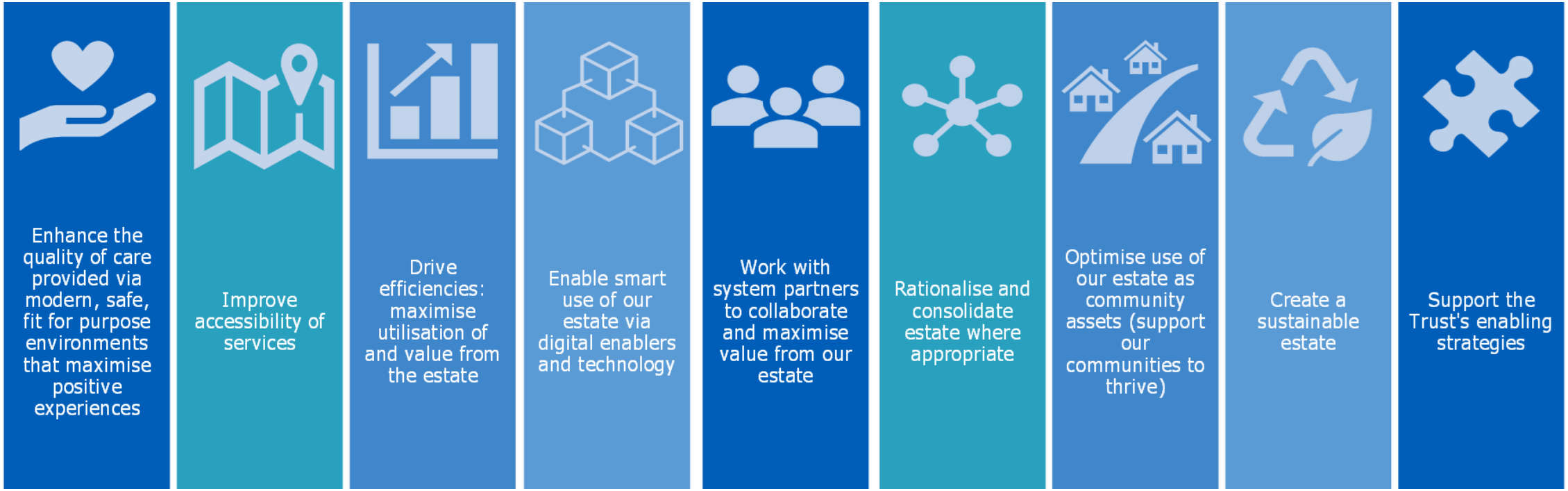
East of England, NHS Specialist Mental Health, Learning Disability and Autism provider collaborative

The collaborative have established new ways of working together to create services and support our patients in a better way that brings together all organisation with the patient voice at the heart of all we do. The aim is to start to tackle inequalities in care and create more specialised care, closer to home by developing what we call 'hospital at home' type care.

Here are EPUT, we are one of the three lead providers that host the commissioning contract with NHS England for our Provider Collaborative covering adult medium and low secure services including learning disabilities and autism across the region.

Our Key Estate Strategy Objectives

The key objectives to inform the estate strategy (summarised below) were identified through relevant strategic policy review and targeted engagement with ICS stakeholders (listed in Appendix 2). Further detail on the principles underpinning these estate strategy objectives is provided in the pages overleaf.



Our Key Estate Strategy Objectives and Principles

Estate Strategy Objectives	Principles
Enhance the quality of care provided via modern, safe, fit for purpose environments that maximise positive experiences (for both patients and staff)	• Improving the physical environment of all our inpatient and community services sites to support therapeutic recovery • The estate should support our objective to provide Trauma Informed Care and a Trauma Informed Environment • Our estate supports our models of care and services that we offer to service users • Address the poor condition of some of our estate (particularly community estate) and ensure sites are fit for purpose • Put patients and families at the heart of what we do and our approach to quality (strengthen the voice of the service user and their supporters in estate transformation) • Provide an inpatient services long term development path that identifies future requirement for investment or replacement
Improve accessibility of services	Ensure our estate is in the right locations to support patient access, our models of care (e.g. out of hospital care: community services based in the community, not on acute hospital sites), and respond to health inequalities.
Drive efficiencies: maximise utilisation of and value from the estate	• Agility: optimise utilisation of clinical and administrative spaces, supported by digital enablers and technology* • Transition to culture of 'space usership' not 'space ownership' • Maximise the amount of clinical space within clinical areas (provision of space for clinical work should take precedence over non-clinical space) • Reduce the utilisation of premium estate (value for money) • Reduce Estates and Facilities costs
Enable smart use of our estate via digital enablers and technology	• Smart working, smart buildings and departments (e.g. wards) • Alignment with Trust Digital Strategy • Enabling remote care and remote working

**May include use of basic technology to support agile working, such as noise cancelling headphones in agile working environments.*

Our Key Estate Strategy Objectives and Principles *cont.*

Estate Strategy Objectives	Principles
Work with system partners to collaborate and maximise value from our estate	• Co-locate with system partners where possible* • Use the estate collaboratively to optimise utilisation and efficiency
Rationalise and consolidate estate where appropriate	• Rationalise corporate buildings and office accommodation via implementation of mature agile working policies (supported by digital enablers and technology) and consolidation of sites • Share accommodation with other system partners • Consolidation of inpatient sites: long term (10-20 years) reduction in the number of inpatient sites (fewer, larger sites) • Rationalisation of community properties where appropriate
Optimise use of our estate as community assets (support our communities to thrive)	• Opening up our spaces for the local communities to use • Maximising the use of the estate for the benefit of the local population (e.g. through mixed site use, out of hours offer to community organisations, offering EV charging to local communities etc) • Co-location of services and partners from VCSE
Create a sustainable estate	• Reduce our carbon footprint and environmental impact of our services in line with our Green Plan • Ensure the estate supports care models, is fit-for-purpose, lean and minimises our carbon footprint
Supporting the Trust's enabling strategies	• Our estate supports the Trust's Clinical Strategy, Social Impact Strategy, Digital strategy, Green Plan, People and Education Strategy, Quality of Care Strategy, Commercial Strategy, Innovation Strategy etc

**Provide some guidance on operational issues that may result from colocation of system partners e.g. contractual issues of space payment etc*

Summary Vision: Estates Supporting Delivery of Our Strategic Plan

Purpose	We care for people every day. What we do **together** matters.			
Values	We Care	We Learn	We Empower	
Objective	We will deliver safe, high quality, integrated care services	We will enable each other to be the best we can be	We will work together with our partners to make our services better	We will support our communities to thrive
Priorities	• Provide integrated care closer to home • Achieve world-class outcomes, with a focus on recovery • Empowering service users, families, and carers • Embedding a digital mindset & culture	• Ensure EPUT is a preferred employer • Build capabilities enabling us to deploy a flexible, multi-skilled workforce model • Develop future leaders and grow own workforce • Improve organisational digital literacy	• Build partnerships with services users, carers, and their families • Drive collaboration and integration through our partnerships • Continuously improve quality, experience, access, and outcomes through collaboration • Better enable local joint working	• Reduce health inequalities • Engage proactively with our communities • Reduce our environmental impact • Prevent illness and intervene earlier

Our estate strategy key objectives will support delivery of our strategic plan

Enhance the quality of care provided via modern and safe environments that maximise positive experiences	Improve accessibility of services	Drive efficiencies: maximise utilisation of and value from our estate	Enable smart use of our estate via digital enablers	Work with system partners to collaborate and maximise value from system estate	Rationalise and consolidate estate where appropriate	Optimise use of our estate as community assets (support our communities to thrive)	Create a sustainable estate
The key estate strategy objectives support the Trust's enabling strategies							

4. HOW DO WE GET THERE?

Introduction

To ensure we have an estate that is good quality, fit-for-purpose and aligns with our strategic vision, it is necessary evaluate the EPUT estate and identify opportunities to generate capital for future investment and relocate services to better locations. The below summarises the process of identifying the key areas of opportunity.

Long List

- Stakeholder engagement workshops with key EPUT Care Unit, Operational, and Corporate stakeholders identified a long list of potential estate options to meet the key estate strategy objectives.

Key Areas and Short List

- Further evaluation of the long list of estate options with key EPUT stakeholders identified a set of priority options/ areas.

Evaluation and Preferred Options

- Workshop sessions with key EPUT stakeholders identified the following criteria to evaluate clinical and non-clinical (administration space) estate options to provide an early indication of preferred options and the required direction of travel.

Potential Disposals

- The Trust has identified properties for potential disposals based on those that are not fit-for-purpose or vacant.

Core, flex and tail

- An assessment was done on all EPUT properties (leasehold and freehold) to categorise the estate into core, flex and tail, based on 6 criteria. This exercise will inform future decisions on the estate.

Estate Options Development: Long List Summary

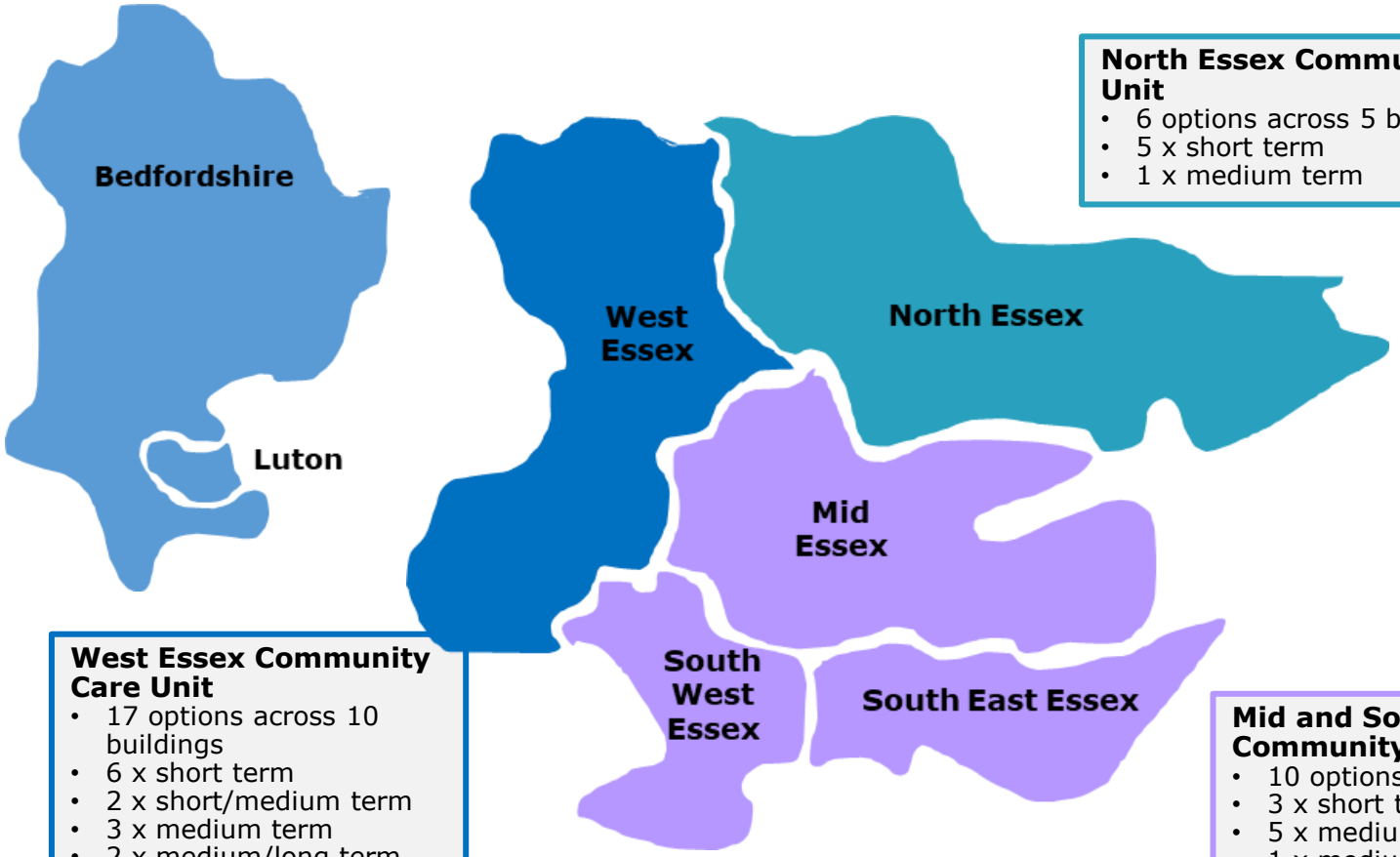
Stakeholder engagement workshops with key EPUT Care Unit, Operational, and Corporate stakeholders identified a long list of potential estate options to meet the key estate strategy objectives. A summary of the 54 options identified is provided below. Further detail on long list options is provided in Appendix 3.

Care Units Across EPUT Estate

Urgent Care and Inpatients Care Unit
- 9 options across 3 buildings
- 4 x short term
- 4 x medium/long term
- 1 x long term

Specialist Services Care Unit
- 7 options across 6 buildings
- 4 x short term
- 1 x short/medium term
- 2 x medium term

Psychological Services
- 5 options across 5 buildings
- 1 x short term
- 1 x short/medium term
- 3 x medium term



North Essex Community Care Unit
- 6 options across 5 buildings
- 5 x short term
- 1 x medium term

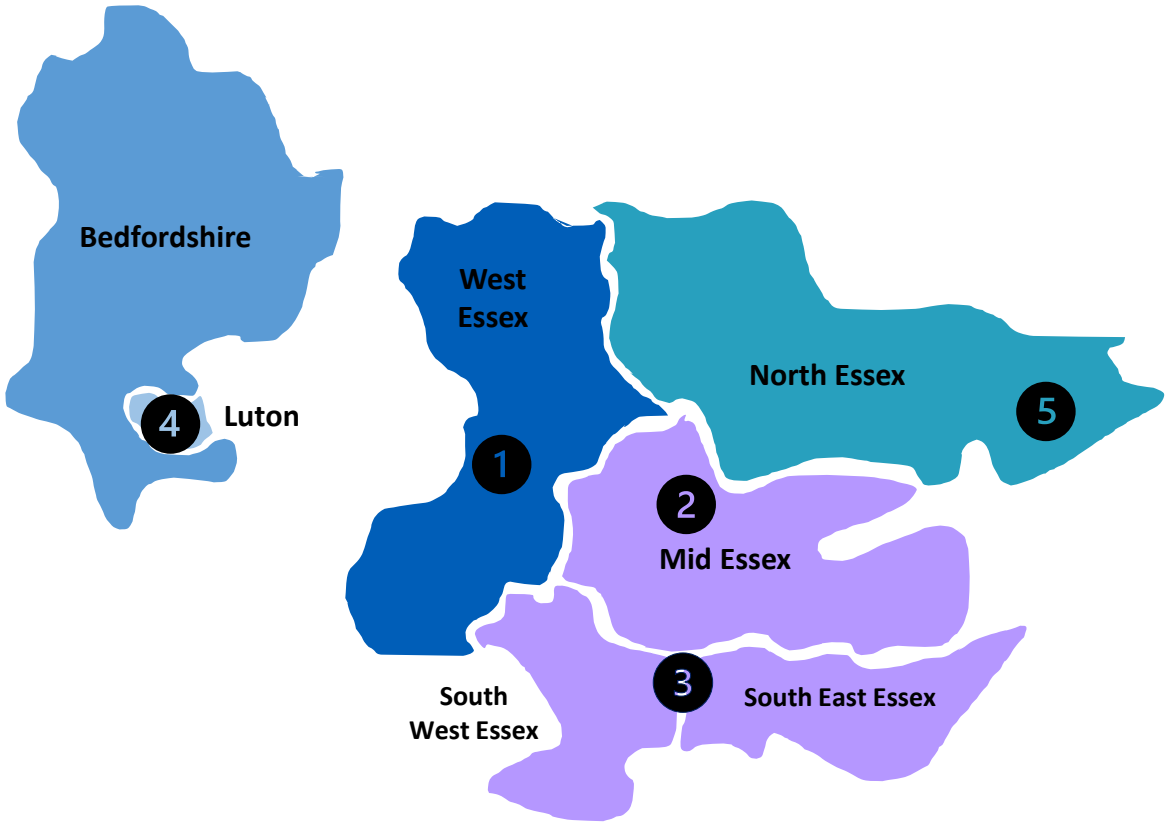
West Essex Community Care Unit
- 17 options across 10 buildings
- 6 x short term
- 2 x short/medium term
- 3 x medium term
- 2 x medium/long term
- 4 x long term

Mid and South Essex Community Care Unit
- 10 options across 8 buildings
- 3 x short term
- 5 x medium term
- 1 x medium/long term
- 1 x long term

Priority Areas for Option Appraisal and Evaluation

Further evaluation of the long list of estate options with key EPUT stakeholders identified a set of priority options/areas (shown below) to further develop and evaluate against an agreed set of criteria to identify early preferred estate options.

Priority Area	Considerations
1. Derwent Centre	Examining whether to improve existing facilities or to align to PAH redevelopment
2. Linden Centre/Crystal Centre	Looking at future options to improve facilities in the Linden Centre, and potential redevelopment of the Crystal Centre
3. Thurrock Hospital Site	Looking at co-location of services in Thurrock, and potential redevelopment of the site
4. Robin Pinto	Examining options around Robin Pinto – leased property, refurbishment or movement to Oakley Court
5. Landermere Site	Future provision of services on the Landermere site, and the future use of Bernard Ward
Corporate Services Hub	What is the estates solution to support the future corporate services model, and its link to agile working?
MSE Community Estate	Review of leased properties in poor condition, and potential options for relocation
Planned Disposals	Options review of owned estate for disposal including Great Warley, The Glades, Regents Road, Bradd Close, Mountnessing Road and other investment properties



Estate Option Evaluation Criteria and Weightings

Workshop sessions with key EPUT stakeholders identified the following criteria to evaluate clinical and non-clinical (administration space) estate options to provide an early indication of preferred options and the required direction of travel.

Clinical options - Agreed evaluation criteria and weighting

Assessment Criteria	Weighting (%)	Sub-weighting (%)	Weighted (%)
Financial criteria			
Capital costs	30%	50%	15%
Decant/Enabling/Site costs		50%	15%
Non-financial criteria			
Patient safety and compliance	70%	30%	21%
Patient and staff experience		20%	14%
Strategic fit		20%	14%
Net Zero		0%	0%
Social value and public wellbeing		10%	7%
Deliverability and timescale		20%	14%
Total / Overall Rating	100%		100%

Administration options - Agreed evaluation criteria and weighting

Assessment Criteria	Weighting (%)	Sub-weighting (%)	Weighted (%)
Financial criteria			
Capital costs	30%	50%	15%
Decant/Enabling/Site costs		50%	15%
Non-financial criteria			
Facilitate delivery of target agile working vision	70%	10%	7%
Drive efficiencies: maximise utilisation of and value from our estate		15%	11%
Staff experience		15%	11%
Consolidation with other Trust teams/ICS partners		10%	7%
Strategic fit (including right location for Trust HQ; support of operational delivery)		20%	14%
Net Zero		0%	0%
Social value and wellbeing		10%	7%
Deliverability and timescale		20%	14%
Total / Overall Rating	100%		100%

Summary – Initial Preferred Options

Using the criteria above, a range of options were evaluated for the key areas identified during stakeholder engagement. Green below summarises the preferred options for each of the 6 opportunity properties. A full evaluation can be found in Appendix 4.

Property	Options				
Derwent Centre	Option 1 – Do nothing	Option 2 – Do Minimum	**Option 3 – New MHU collocated with new PAHT hospital**	Option 4 – Buy additional parking from PAH. Relocate service/produce DCP	Option 5 – New MHU (stand alone)
Linden Centre/Crystal Centre	Option 1 – Do nothing	Option 2 – Do minimum	Option 3 – Dispose of Linden Centre	**Option 4 – Utilise the Crystal Centre as an Adult inpatient, Heath base of safety, and 10/12 bedded assessment**	Option 4a – As per 4 but relocate Ruby Ward to Thorpe Ward in Basildon MHU
Thurrock Hospital	Option 1 – Do nothing	**Option 2 – Do minimum. Close admin building and transfer services to Thameside House**	Option 3 – Close admin building. Relocate Grays Hall services to an appropriate new build on site	Option 4 – Relocate Thurrock Hospital wards to new mental health / physical health village	
Robin Pinto Unit	Option 1 – Do nothing	Option 2 – Refurbish existing Robin Pinto Unit	**Option 3 – Relocation of service to refurbished Oakley Court (medium term)**		
Landermere Site	Option 1 – Do nothing	Option 2 – Refurbish Bernard ward to allow transfer of services from Reunion House & Kingswood Centre (medium term option)	**Option 3 – Refurbish Bernard ware into a decant ward in order to carry out other trust ward refurbishments**		
The Lodge	Option 1 – Do nothing	Option 2 – Do minimum	**Option 3 – Develop building as the Trust's 'Worksmart Hub'**	Option 4- Property disposal	

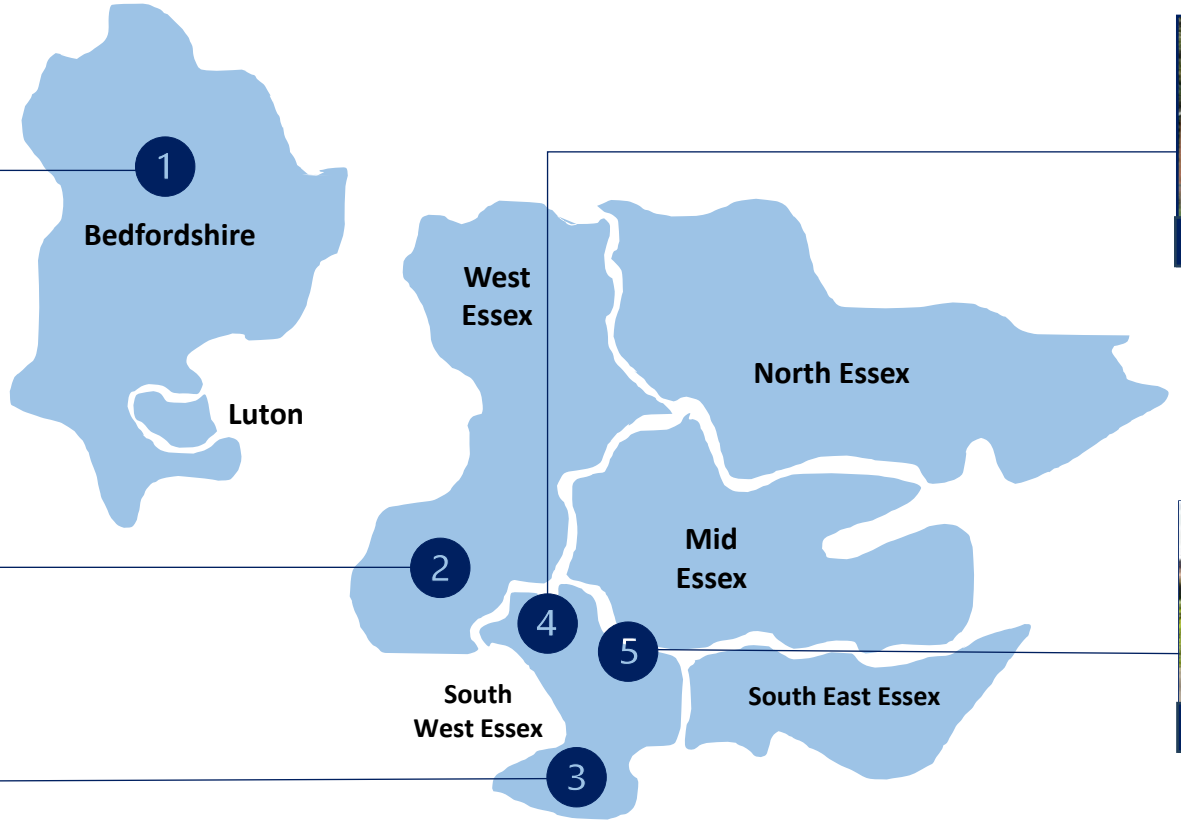
Planned Disposals

We have identified 5 priority buildings for disposal as seen below. These buildings have been identified as they are current vacant properties. The disposal of these assets will generate a £4,500,000 capital receipt for the Trust.

The Glades, Bromham

Regent Road, Epping

Bradd Close, South Ockendon



Great Warley, Brentwood

Mountnessing Road, Billericay

Core, Flex and Tail

Categorisation of our estate and development requirements

A safe, modern, well-planned and patient-centred estate enables delivery of high quality services and adds value for money.

To ensure we have an estate that is good quality, fit-for-purpose and aligns with our strategic vision, it is necessary to categorise our sites into core, flex and tail.

Core – Good quality, fit-for-purpose and future-proof estate that aligns with national, regional and local strategies.

Flex – Estate that is of an acceptable quality, or provides unique access to services, but does not fully enable the strategic ambitions.

Tail – Poor quality estate that is not fit-for purpose for patient-facing services and should be phased out when alternative estate is available.

We have evaluated our estate using the following criteria:

- Age
- Size
- Condition
- Functional suitability
- EPC
- Strategic Location

Core, Flex and Tail Evaluation Criteria

Criteria	Green	Amber	Red
Age	< 40 years	40-75 years	75+ years
Size (m^2)	> 500	200 - 500	< 200
Condition	**A -** As new and can be expected to perform adequately to its full normal life **B -** Sound, operationally safe and exhibits only minor deterioration	**B(C) -** Currently as B, but will fall below B within five years **C -** Operational, but major repair or replacements is currently needed to bring up to condition B	**D -** Operationally unsound and in imminent danger of breakdown **X -** Supplementary rating added to C or D to indicate that it is impossible to improve without replacements
Functional Suitability	**A -** Very satisfactory, no change needed **B -** Satisfactory, minor change needed	**C -** Not satisfactory, major change needed	**D -** Unacceptable in its present condition **X -** Supplementary rating added to C or D to indicate that besides a total rebuild or relocation will suffice
EPC	**A-B** Most/very good efficiency	**C-D** Average to below average efficiency	**E or below** Less/least efficient
Strategic Location	**A -** Critical importance – the services cannot be provided elsewhere **B -** Significant importance – the services would be difficult to provide elsewhere	**C -** Moderate importance – the services could be re-located with moderate difficulty	**D -** Limited importance – the services could be re-located to a more suitable location

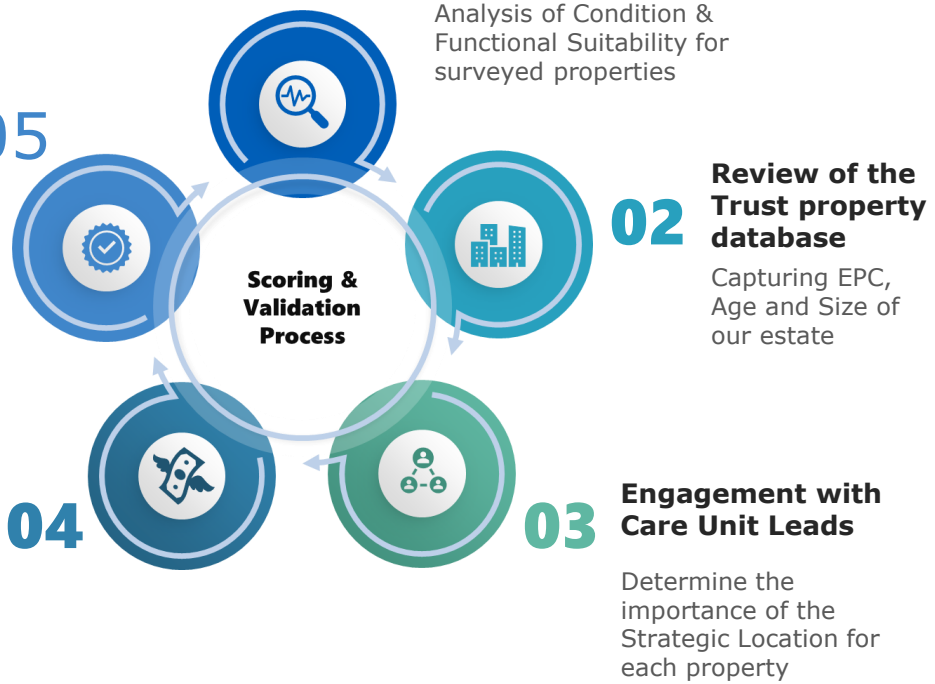
Core, Flex and Tail

Categorisation of our estate and development requirements

To categorise our estate into core, flex and tail, we have used the used the assessment criteria and weightings as per below and the scoring process as summarised opposite.

Assessment Criteria	Weighted (%)
Strategic Location	30%
Condition	30%
EPC	15%
Functional Suitability	15%
Size	5%
Age	5%
Total / Overall Rating	100%

Scoring and Validation Process



Core, Flex and Tail

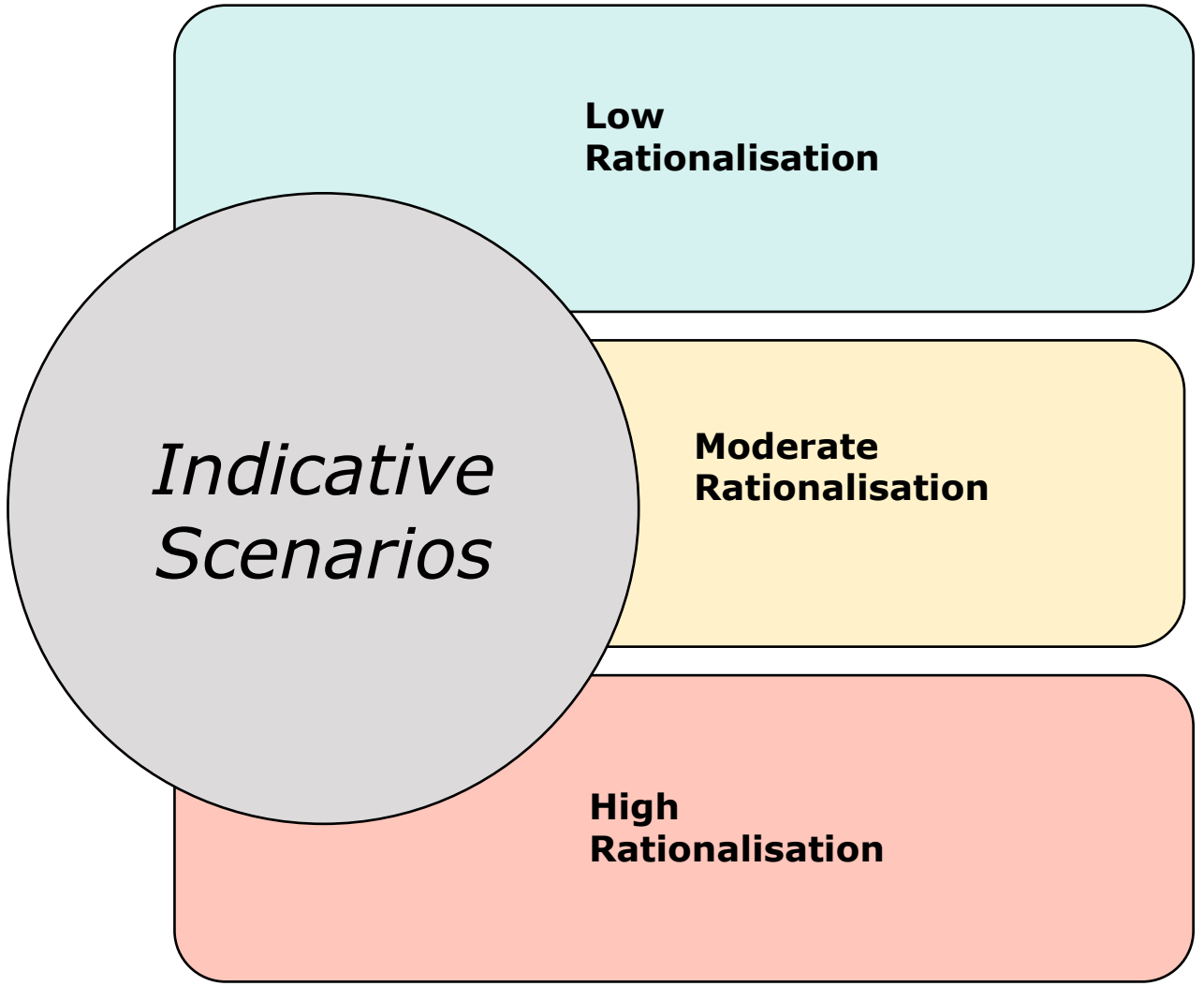
Development of core, flex and tail

To further analyse what our future EPUT estate could comprise, we have developed three indicative scenarios.

All three scenarios look at rationalising our estate in order of the weakest scoring assets as a result of the Rag rated property analysis.

Each scenario will generate a capital receipt which could be reinvested into upgrading our retained estate.

The next slide summarises each indicative scenario, outlining details of what the future standard estate could comprise, but also details of the potential revenue savings by exiting both non core freehold and leasehold estate, in addition to the future capital savings made by disinvestment through removal of backlog maintenance in the freehold estate.



Core, Flex and Tail – Scenario Summary

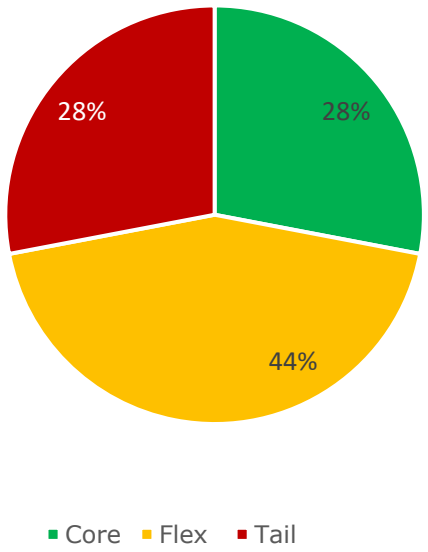
Intervention	Core, Flex and Tail Sites	Est. Capital Receipts Generated & Associated Opportunity Cost – **Tail**[4]
Option 1: Low Rationalisation[1] Core: sites that score > 55 points Flex: sites that score between 30 and 55 points Tail: sites that score < 30 points	Core: 38 sites Flex: 76 sites Tail: 22 sites	Capital Generated (freehold)[2]: £7,200,000 Backlog Maintenance Savings[3]: £3,100,000
Option 2: Moderate Rationalisation[1] Core: sites that score > 55 points Flex: sites that score between 35 and 55 points Tail: sites that score < 35 points	Core: 38 sites Flex: 59 sites Tail: 39 sites	Capital Generated (freehold)[2]: £10,000,000 Backlog Maintenance Savings[3]: £4,000,000
Option 3: High Rationalisation[1] Core: sites that score > 55 points Flex: sites that score between 40 and 55 points Tail: sites that score < 40 points	Core: 38 sites Flex: 37 sites Tail: 61 sites	Capital Generated (freehold)[2]: £15,100,000 Backlog Maintenance Savings[3]: £9,300,000

[1]Based on a maximum score total of 100 points; [2]Based on Net Book Values; [3]Based on the information available from a Nifes 6 Facet Survey;[4]A full list of sites included can be found in Appendix 5.

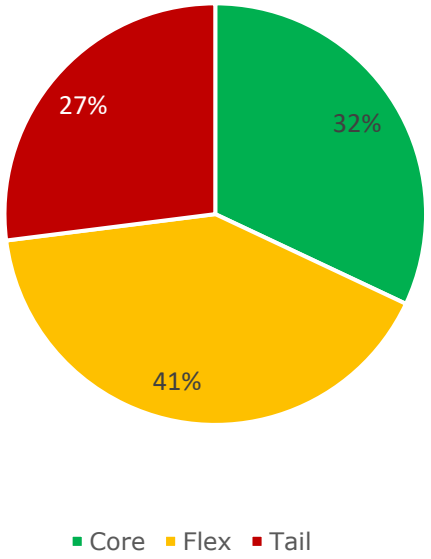
Core, Flex and Tail Sites

As mentioned above, and in accordance with NHSE guidance, categorisation of our existing acute and community estate into core, flex and tail indicates that 28% of the estate is core, 44% is flex and 28% is tail[1]. This categorisation enables strategic decisions to be developed, investments to be focused and rationalisation to occur. The categorisation for each Care Unit is summarised in Appendix 6. Please note that the below is based on the moderate scenario mentioned above.

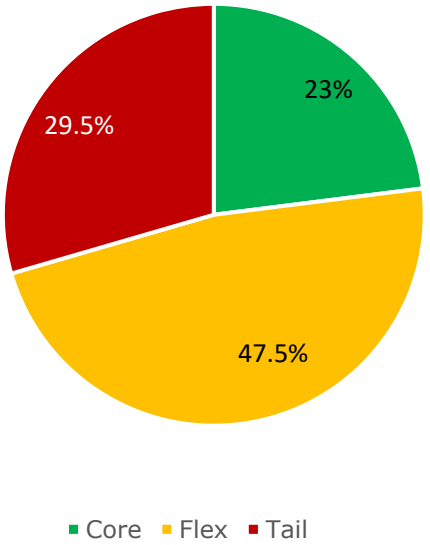
All Trusts Total Area – By No of Sites



All Trust Freehold – By No of Sites



All Trust Leasehold – By No of Sites



[1]Based on 136 properties and on the moderate scenario

Target Deep Dive Analysis

Our estate strategy forms a key component of a suite of EPUT enabling strategies which are interdependent and complementary to successful delivery. The EPUT enabling strategies are interdependent and must be complementary to ensure successful delivery. EPUT strategies will require regular updating.

Further detailed information and analysis may be required to inform projects and enable better evaluation and prioritisation of estate options. Further detailed information and analysis may be required to inform projects and enable better evaluation and prioritisation of estate options.

Targeted deep dive analyses will be dependent on projects but may include:

- ✓ Demand and capacity modelling to determine future capacity requirements, - this analysis is particularly important for the inpatient services
- ✓ Space utilisation studies to identify baseline capacity surplus/shortfall – this may be particularly relevant to the corporate estate options
- ✓ Analysis to support access and travel times to specific properties and locations
- ✓ Security requirements of different properties
- ✓ Impact of new models of care and site locations for staffing models and requirements
- ✓ Equality Impact Assessment for the estate options
- ✓ Socio-Economic Impact Assessment for the estate options

Working Groups Example

Following the evaluation and prioritisation of projects, an agreed prioritisation investment plan will be defined during our 10 year strategy. All projects will be subject to the development of appropriate business cases for formal approval. Business cases will establish the benefits to be realised and define the quality, costs and time parameters. Projects will be required to comply with EPUT's policy and procedures for managing capital projects. Discrete project boards should be established to deliver the agreed projects. Each project board will be led by a Project Director, under the overall leadership of a Senior Responsible Owner, with a clear responsibility to ensure that the project is delivered within the agreed parameters and realises the expected benefits.

The Trust is proposing to establish a series of working groups to drive projects forward and align project objectives with core Trust objectives. One such working group would explore opportunities around vacating tail estate to optimise service delivery, generate capital receipts and annual revenue savings, and reduce backlog maintenance costs. This will develop on from the work undertaken within the strategy to identify the core flex and tail estate.

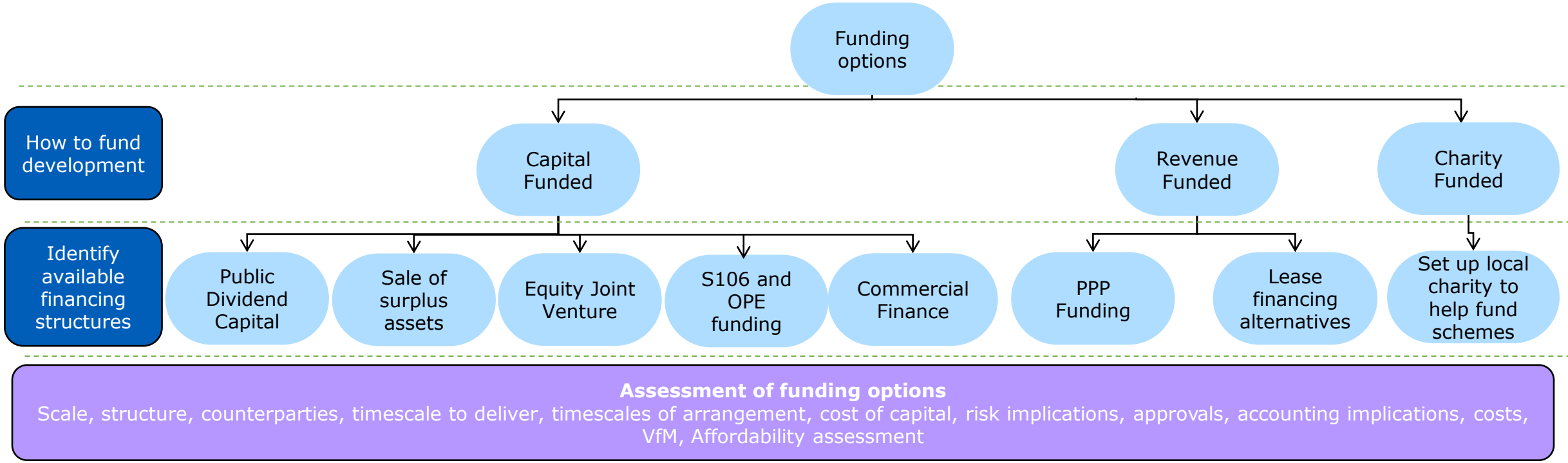
The initial priority is to dispose/sell the 5 identified properties, as seen on page 54, followed by an evaluation of currently empty properties owned by the Trust. The disposal of our estate is subject to our internal approval process, requires careful consideration and consultation with staff, patients, and the public, where necessary, prior to making any final decisions. We will also actively collaborate with our system partners to ensure we deliver the best health outcomes to our local population through estate reconfiguration and rationalisation. This process will be supported by robust business cases on a property-by-property basis.

An assessment needs to be done on the properties that are currently leased out to determine the benefits of selling that estate. Following the evaluation and prioritisation of projects, an agreed investment plan will be defined. Projects will be required to comply with EPUT's policy and procedures for managing capital projects. Discrete project boards should be established to deliver the agreed projects. Please refer to Appendix 7 for further details on the proposed working group objectives and governance structure.

5. FUNDING, DELIVERY AND MEASURING SUCCESS

Funding Options

The decision tree below sets out a shortlist of potential funding options and relevant structures, focusing on new developments. The development and viability will need to be worked through collaboratively with EPUT and the chosen route will be dependent on the ability to obtain appropriate CDEL cover. This doesn't account for the revenue savings of colocation and exiting buildings. Additional sources of capital would include Section 106, CIL and OPE funding.



Delivering the Vision – Key Steps

We are developing a clear prioritised plan to deliver the estate strategy vision. Next steps will involve the development of implementation plans that further establish key actions and additional new working groups to be undertaken to deliver the estate strategy. A high level timeline for implementation and delivery of key projects within the strategy is included within Appendix 8.

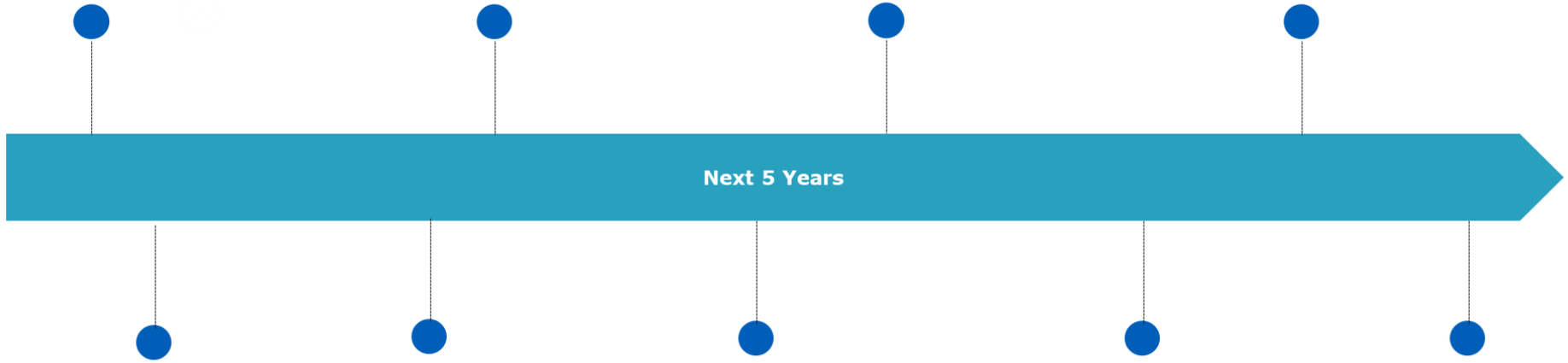
Prioritisation
- Financial criteria
- Non-financial criteria
- Agree methodology
- Funding

Targeted deep dive analysis

For example:
- Utilisation, access, compliance
- Equality Impact Assessment
- Socio-Economic Impact Assessment

Collaborative delivery
- Develop an integrated partnership approach with the Local Authorities
- LCPs / Local Authorities
- VCSE Sector

Managing delivery
- Prioritised project pipeline
- Annualised Service Estate Plans
- Business case process and funding
- Project Boards / Working groups
- Iterative implementation of strategy



Strategy Alignment
- National
- ICS
- EPUT: Quality Care, Green Plan, Digital, Social Impact, Working in Partnership with people and communities

Financial Recovery
- Identify opportunities to improve estate utilisation– reducing void/vacant space and dispose/vacate buildings surplus to requirements /not fit for purpose

Continued engagement and consultation
- Patients/Service Users, stakeholders, staff, communities
- Further develop estate requirements and implementation plans
- Formal consultation may be required

Repurpose, Reconfigure Rationalise
- In response to EPUT strategies
- Improve patient pathways
- Ratioanlise not fit for purpose estate to support net zero agenda

Measuring success
- Monitoring of KPIs
- Dashboard reporting
- Review targets/strategy and update

Measuring Success

Through individual stakeholder meetings and workshops, we have identified several key estate objectives and associated KPI's to measure success and performance against. The key estate objectives and associated KPI's can be found below. Implementation of the estate strategy will be an iterative process that must be flexible and able to respond to changing needs, priorities and financial challenges of EPUT.

Estate Objectives								
Enhance Quality of Care	Improve Accessibility of Services	Drive Efficiencies	Enable smart use of estate	Work with system partners	Rationalise and consolidate	Use of estate as community assets	Create a sustainable estate	Support Trust's enabling strategies

Indicator	EPUT KPI and Target	
Property portfolio that is core estate (right sized and fit for purpose)	• **A minimum of 50% of the estate should be defined as core.**	• **Reviewed annually**
Total estates and facilities cost/m2	• **Reduction in estate revenue cost**	• **3% annually**
Statutory Compliance	• **A minimum of 90% of the estate should comply with relevant statutory requirements**	• **Meet national target within 10 years**
Backlog maintenance (BLM)	• **90% reduction in high risk BLM** • **75% reduction in significant risk BLM** • **70% reduction in risk adjusted BLM**	• **Meet target within 10 years**
Physical condition	• **Minimum of 90% of the estate should be sound, operationally safe & exhibit only minor deterioration**	• **Meet target within 10 years**
Functional suitability (occupied floor area)	• **A minimum of 90% of the estate should meet operational requirements; only minor changes needed**	• **Meet target within 10 years**
Space Utilisation	• **A minimum of 95% of the estate should be fully used**	• **Meet target within 10 years**
Room utilisation	• **Key clinical rooms should have a minimum utilisation rate of 85%**	• **Meet target within 5 years**
Carbon emissions	• **Reduce carbon emissions from building energy, water & waste, anaesthetic gases, metered dose inhalers, business and patient travel by 80% to 28ktCO2e**	• **Meet target by 2028-32**
Energy Performance	• **The estate should consume no more than 410 kWh/m²**	• **Meet target within 10 years**

Delivery Assurance:

Twice yearly delivery reviews with finance and planning committee

APPENDIX 1 – Peer Group

EPUT

Model Hospital: Peer Group

- Black Country Healthcare NHS Foundation Trust
- Central and North West London NHS Foundation Trust
- Cornwall Partnership NHS Foundation Trust
- Cornwall Partnership NHS Foundation Trust
- East London NHS Foundation Trust
- Herefordshire and Worcestershire Health and Care NHS Trust
- Leicestershire Partnership NHS Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Somerset NHS Foundation Trust
- Southern Health NHS Foundation Trust

APPENDIX 2 –

Stakeholder Engagement

EPUT

Stakeholder Engagement

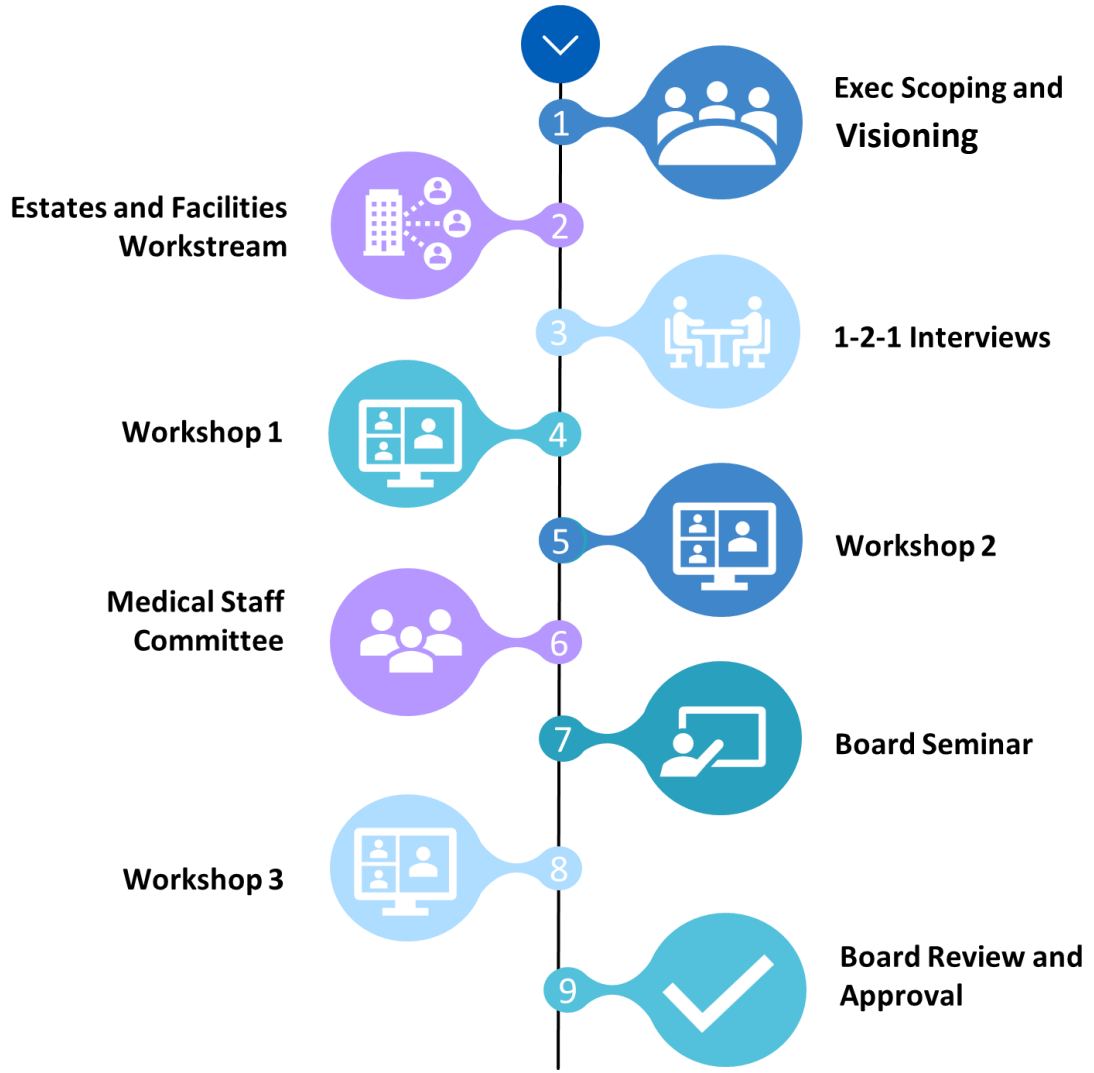
Engagement with key EPUT and system stakeholders was undertaken via structured interviews or workshops to understand the existing estate risks and issues, and the key objectives, priorities, and opportunities to inform the development of the future estate vision.

Workshop 1 – Long List of Options
- Urgent and Inpatient Care Unit
- North Essex Care Unit
- HR
- Director of Psychological Services
- Specialist Services Care Unit
- Finance
- Delivery and Partnerships SE Essex
- Estates and Facilities
- Property and Capital Planning
- West Essex Care Unit
- Delivery and Partnerships
- Partnerships, Adults, Health & Social Care
- Contracts
- Operations

Workshop 3 – Summary
- Urgent and Inpatient Care Unit
- North Essex Care Unit
- HR
- Director of Psychological Services
- Specialist Services Care Unit
- Finance
- Delivery and Partnerships SE Essex
- Estates and Facilities
- Property and Capital Planning
- West Essex Care Unit
- Delivery and Partnerships
- Partnerships, Adults, Health & Social Care
- Contracts
- Operations

Workshop 2 - Corporate Office
- Operational Services
- Finance
- Estates & Facilities
- Property and Capital Planning
- HR
- Procurement

Workshop 1 – Review and comment on initial long list of estate options and opportunities
Workshop 2 – Review and comment on options for the corporate estate.
Workshop 3 – Review shortlisted estate options and agree on a preferred way forward.



APPENDIX 3 –

Long List Estate Options

EPUT

Long List of Options

Care Unit	Building	Option	Timescale
Mid and South Essex Community Care Unit	Phoenix House, Basildon	Opportunity to relocate admin from the Lodge, admin hub at Rochford Hospital, medical secretaries based at Rochford and admin at Thurrock Hospital	Short term
Mid and South Essex Community Care Unit	Grays Hall, Grays	Dispose?	Long term
Mid and South Essex Community Care Unit	Cherry Trees Unit, St Peter's Hospital	Relocate services to Wantz Chase (will need some capital spent on the building and is currently leased to NELFT)	Dependent on sale of St Peters (medium term)
Mid and South Essex Community Care Unit	Dengie Locality	Collaborate with Provide to deliver MH services from provider estate (Burnham?). Need to speak to Maldon Local Authority to see if they have any space	Medium term
Mid and South Essex Community Care Unit	Taylor Centre, Warrior House, Southend	Vacate premise	Medium term
Mid and South Essex Community Care Unit	Sankey House, Pitsea	Vacate premise; Closely located to where MSE NHSFT are building a community diagnostics centre – possible to co-locate if there is space?	Medium term
Mid and South Essex Community Care Unit	The Lodge	Option 1: Do nothing	Short term
Mid and South Essex Community Care Unit	The Lodge	Option 2: Develop into agile office accommodation as "Worksmart Hub" with bookable desks and meeting rooms. Should link to mature agile working polices	Short term
Mid and South Essex Community Care Unit	The Lodge	Option 3: Market for sale and transfer out all offices and services. If dispose of The Lodge, need to relocate vaccination service to community location.	Medium/Long term
Mid and South Essex Community Care Unit	The Gables, Braintree	Vacate and consolidate services with Provider teams and Council at Causeway House (Braintree District Council building)	Medium term
North Essex Community Care Unit	Severalls House	Option 1: relocate Enable East Team to Rivendell	Short term
North Essex Community Care Unit	Severalls House	Option 2: Establishment of a reception area could unlock another 3 consult/exam rooms	Short term
North Essex Community Care Unit	Reunion House	Relocate community services into vacant Bernard ward in Landermere Centre	Short term

Long List of Options

Care Unit	Building	Option	Timescale
North Essex Community Care Unit	Rivendell Flats	Relocate all offices above the ground floor to release clinical space	Short term
North Essex Community Care Unit	Holmer Court	Relocate Single Point of Access Team from Severalls House to Holmer Court (office upstairs that is underutilised)	Short term
North Essex Community Care Unit	The Northgate Centre	Relocate 18-25 Psychology Services from Severalls House to The Northgate Centre (requires review of clinical utilisation)	Medium term
Psychological Services	Rectory Lane Health Centre	Relocate to alternative accommodation. Existing Trust sites?; Discussions with NHSPS regarding upgrades to building condition	Short/Medium term
Psychological Services	Reunion House	Relocate community services into vacant Bernard ward in Landermere Centre	Short term
Psychological Services	The Gables, Braintree	Vacate and consolidate services with Provider teams and Council at Causeway House (Braintree District Council building)	Medium term
Psychological Services	Cherry Trees Unit, St Peter's Hospital	Relocate services to Wantz Chase (will need some capital spent on the building and is currently leased to NELFT)	Dependent on sale of St Peters (medium term)
Psychological Services	Taylor Centre, Warrior House, Southend	Vacate premise	Medium term
Specialist Services Care Unit	Health Outreach, St Helens Street, Ipswich	Requirement to relocate to more suitable premises within Ipswich area	Short term
Specialist Services Care Unit	Operation Courage (Veterans), The Lakes	Require new office base due to service expansion	Short term
Specialist Services Care Unit	Brockfield House, Runwell	Currently under refurbishment	Short term
Specialist Services Care Unit	Poplar Adolescent Unit – Rochford Hospital	Option 1: Requirement to relocate to larger premises (preferably same site) due to service growth; possibility to swap from the 1st floor to the ground floor – there would need to be a discussion around bed numbers	Short/Medium term
Specialist Services Care Unit	Poplar Adolescent Unit – Rochford Hospital	Option 2: Possibility to swap from the 1st floor to the ground floor – there would need to be a discussion around bed numbers	Short term

Long List of Options

Care Unit	Building	Option	Timescale
Specialist Services Care Unit	Robin Pinto Unit (Low Secure)	Relocation of service to refurbished Oakley Court	Medium term
Specialist Services Care Unit	Byron Court, Heath Close, Billericay	Potential expansion to provide 4x additional beds (at commissioner's request) and additional car parking; Community Learning Disability teams - potential requirement for additional or larger premises with anticipated service expansion	Medium term
Urgent Care and Inpatients Care Unit	Crystal Centre / Linden Centre	Option 1: Utilise the Crystal Centre as an Adult Inpatient, Health Base of Safety, and 10/12 Bedded Assessment Unit	Medium/Long term
Urgent Care and Inpatients Care Unit	Crystal Centre / Linden Centre	Option 2: Close Linden Centre; develop Assessment Unit at Crystal Centre to support FLOW	Medium/Long term
Urgent Care and Inpatients Care Unit	Crystal Centre / Linden Centre	Option 3: Reduce beds: instead of having 3 adult treatment wards with Linden and Topaz, have 2 treatment wards and an assessment unit which would have the same amount of beds but would re-purpose	Medium/Long term
Urgent Care and Inpatients Care Unit	Crystal Centre / Linden Centre	Option 4: Retain Linden as community clinical space/training space	Medium/Long term
Urgent Care and Inpatients Care Unit	Basildon Mental Health Unit	Option 1: MSE NHSFT donate the building to EPUT (pursue discussions with MSE Trust)	Short term
Urgent Care and Inpatients Care Unit	Basildon Mental Health Unit	Option 2: Vacate site to MSE NHSFT (potential exchange of land with MSE NHSFT?)	Long term
Urgent Care and Inpatients Care Unit	Basildon Mental Health Unit	Option 3: Utilise vacant Urgent Care space for Assessment Unit (4-5 beds) plus support	Short term
Urgent Care and Inpatients Care Unit	Basildon Mental Health Unit	Option 4: If there is money to refurb previous assessment unit (sits behind urgent care department) would be good to move Grangewaters back and then move Ruby Ward into Basildon if the option is to come out of the Linden	Short term
Urgent Care and Inpatients Care Unit	Landermere Centre, Clacton & District Hospital	Refurbish closed Bernard ward and relocate services from Reunion House to Landermere to create a Clacton Community services / 24 hour hub	Short term

Long List of Options

Care Unit	Building	Option	Timescale
West Essex Community Care Unit	Dolittle Mill, Bedford	Immunisation Team has insufficient space. Have a year extension but this service will then be going out to tender. If team don't get contract, will need to exit property	Short term
West Essex Community Care Unit	Western House	Opportunity to relocate services to new build in Takeley (completion date tbc); commissioners awaiting EPUT response	Medium term
West Essex Community Care Unit	Saffron Walden Community Hospital	Option 1: Trust to acquire freehold from NHS PS	Medium/Long term
West Essex Community Care Unit	Saffron Walden Community Hospital	Option 2: Site well placed to become integrated health and wellbeing hub for the North Uttlesford PCN	Medium/Long term
West Essex Community Care Unit	Dunmow Clinic	Relocate services to alternative space in Dunmow (existing underutilised or new)?	Medium term
West Essex Community Care Unit	Derwent Centre	Option 1: Do nothing	Short term
West Essex Community Care Unit	Derwent Centre	Option 2: Do minimum: Remain on the existing Derwent Centre site and produce a Development Control Plan to relocate Trust Community Services within existing NHSPS properties in the Harlow area, and any other clinical services.	Medium term
West Essex Community Care Unit	Derwent Centre	Option 3: New MHU colocated with new PAHT hospital; work in partnership with PAH to develop a new Mental Health Unit on the redevelopment site; relocating the Derwent Centre adult in-patient wards (Chelmer & Stort) and St Margaret's Hospital (Kitwood & Roding) one older people inpatient ward with accommodation for supporting services (e.g. UC/assessment unit, therapy space, admin accommodation)	Long term
West Essex Community Care Unit	Derwent Centre	Option 4: New MHU (standalone?)	Long term
West Essex Community Care Unit	Waltham Abbey Health Centre	Relocate to alternative accommodation. Existing Trust sites? Discussions with NHSPS regarding upgrades to building condition	Short/Medium term

Long List of Options

Care Unit	Building	Option	Timescale
West Essex Community Care Unit	Rectory Lane Health Centre	Relocate to alternative accommodation. Existing Trust sites?; Discussions with NHSPS regarding upgrades to building condition	Short/Medium term
West Essex Community Care Unit	St Margaret's Hospital, Mental Health Unit	Option 1: relocation of one/two wards to new MHU colocated with new PAHT hospital?	Long term
West Essex Community Care Unit	St Margaret's Hospital, Mental Health Unit	Option 2: incorporate Kitwood dementia ward within current EFU community hospital ward	Short term
West Essex Community Care Unit	CDC	PAHT CDC to be developed on site of existing Spencer Close Building 4 (operational from 2025/6)	Short term
West Essex Community Care Unit	Hawthorn Lodge and Annex	Utilise space to increase clinical research activity (as per Trust Research Strategy)	Short term
West Essex Community Care Unit	St Margaret's Hospital, Storage Building	Exit lease	Short term
West Essex Community Care Unit	St Margaret's Hospital	Possible future new build; Future strategy for site being developed by NHSPS, EPUT, and HWE ICB	Long term

APPENDIX 4 –

Short List Options Analysis

EPUT

Derwent Centre - Initial Preferred Option

Initial evaluation of the following Derwent Centre options indicates that the preferred option is Option 3 – New Mental Health Unit collocate with the new PAHT hospital.

DERWENT CENTRE OPTIONS												
				Option 1 - Do Nothing		**Option 2 - Do Minimum**		**Option 3 – New MHU colocated with new PAHT hospital**		**Option 4**		**Option 5 – New MHU (stand alone)**	
				Invest in the vacant space when a need is identified and capital funding can be provided		> Remain on the existing site > Produce a DCP to relocate Trust Community Services within existing NHSPS properties in the Harlow area (and any other clinical services).		Relocate Derwent Centre adult IP wards (Chelmer & Stort) and St Margaret's Hospital (Kitwood & Roding) two older people IP ward with accommodation for supporting services (e.g. UC/assessment unit, therapy space, admin accommodation)		> Buy additional parking from PAH > Relocate services / produce DCP as per option 2		> Aligns with development of Mental Health / Physical Health Village concept > Requires identification of new development site	
Assessment Criteria	**Weighting (%)**	**Sub-weighting (%)**	**Weighted (%)**	Score	Weighted score	Score	Weighted score	Score	Weighted score	Score	Weighted score	Score	Weighted score
Financial criteria													
Capital costs	30%	50%	15%	4	0.6	3	0.5	1	0.2	2	0.3		0.0
Decant/Enabling/Site costs		50%	15%	4	0.6	3	0.5	2	0.3	2	0.3		0.0
Non-financial criteria													
Patient safety and compliance	70%	30%	21%	2	0.4	3	0.6	5	1.1	3	0.6		0.0
Patient and staff experience		20%	14%	2	0.3	3	0.4	5	0.7	3	0.4		0.0
Strategic fit		20%	14%	2	0.3	3	0.4	5	0.7	3	0.4		0.0
Net Zero		0%	0%		0.0		0.0		0.0		0.0		0.0
Social value and public wellbeing		10%	7%	2	0.1	2	0.1	5	0.4	2	0.1		0.0
Deliverability and timescale		20%	14%	3	0.4	3	0.4	3	0.4	2	0.3		0.0
Total / Overall Rating	100%		100%	19	2.7	20	2.9	26	3.7	17	2.5	0	0.0

Preferred option
Option 3 – New MHU colocated with new PAHT hospital

Option 5 – New MHU (stand alone as per Mental/ Physical Health Village concept) not scored

Linden/Crystal Centre - Initial Preferred Option

Initial evaluation of the following Linden/Crystal Centre options indicates that the preferred option is Option 4 – Utilise the Crystal Centre as an Adult Inpatient, Health Base of Safety, and 10/12 Bedded Assessment Unit.

LINDEN CENTRE/CRYSTAL CENTRE OPTIONS													
				Option 1		Option 2		Option 3		Option 4		Option 4a	
				Do nothing		Do minimum (refurbishment to provide some ensuites at compromise of reduced bed capacity)		Disposal of Linden Centre; aligned with creation of mental health / physical health village concept		Utilise the Crystal Centre as an Adult Inpatient, Health Base of Safety, and 10/12 Bedded Assessment Unit		As per 4 but relocate Ruby ward to Thorpe Ward in Basildon MHU	
Assessment Criteria	**Weighting (%)**	**Sub-weighting (%)**	**Weighted (%)**	Score	Weighted score	Score	Weighted score	Score	Weighted score	Score	Weighted score	Score	Weighted score
Financial criteria													
Capital costs	30%	50%	15%	5	0.8	3	0.5	1	0.2	2.0	0.3	2	0.3
Decant/Enabling/Site costs		50%	15%	5	0.8	3	0.5	1	0.2	2.0	0.3	2	0.3
Non-financial criteria													
Patient safety and compliance	70%	30%	21%	2	0.4	2	0.4	5	1.1	4.0	0.8	4	0.8
Patient and staff experience		20%	14%	1	0.1	3	0.4	3	0.4	4.0	0.6	3	0.4
Strategic fit		20%	14%	2	0.3	2	0.3	3	0.4	4.0	0.6	4	0.6
Net Zero		0%	0%		0.0		0.0		0.0		0.0		0.0
Social value and public wellbeing		10%	7%	1	0.1	1	0.1	3	0.2	2.0	0.1	2	0.1
Deliverability and timescale		20%	14%		0.0	3	0.4	1	0.1	4.0	0.6	3	0.4
Total / Overall Rating	100%		100%	16	2.4	17	2.5	17	2.5	22	3.3	20	3.0

Preferred option
Option 4 – Utilise the Crystal Centre as an Adult Inpatient, Health Base of Safety, and 10/12 Bedded Assessment Unit

Thurrock Hospital Site - Initial Preferred Option

Initial evaluation of the following Thurrock Hospital site options indicates that the preferred option is Option 2 – Close the Admin Building and transfer services to Thameside House.

THURROCK HOSPITAL OPTIONS											
				Option 1		Option 2		Option 3		Option 4	
				Do nothing		Do minimum > Close Admin building and transfer services to Thameside House		> Close Admin building and transfer services to Thameside House > Relocate Grays Hall services to an appropriate new build on Thurrock Hospital site (DCP for site) > New build includes provision of commercial opportunities eg. Café		Relocate Thurrock Hospital wards to new Mental health / physical health village?	
Assessment Criteria	**Weighting (%)**	**Sub-weighting (%)**	**Weighted (%)**	Score	Weighted score	Score	Weighted score	Score	Weighted score		
Financial criteria											
Capital costs	30%	50%	15%	5	0.8	4	0.6	2	0.3	1.0	0.2
Decant/Enabling/Site costs		50%	15%	5	0.8	4	0.6	2	0.3	1.0	0.2
Non-financial criteria											
Patient safety and compliance	70%	30%	21%	3	0.6	3	0.6	4	0.8	5	1.1
Patient and staff experience		20%	14%	2	0.3	2	0.3	3	0.4	3	0.4
Strategic fit		20%	14%	2	0.3	3	0.4	4	0.6	3	0.4
Net Zero		0%	0%		0.0		0.0		0.0		0.0
Social value and public wellbeing		10%	7%	2	0.1	2	0.1	3	0.2	3	0.2
Deliverability and timescale		20%	14%		0.0	4	0.6	3	0.4	1	0.1
Total / Overall Rating	100%		100%	19	2.8	22	3.2	21	3.1	17	2.5

Preferred option
Option 2 – Close the Admin Building and transfer services to Thameside House

Robin Pinto Unit - Initial Preferred Option

Initial evaluation of the following Robin Pinto Unit options indicates that the preferred option is Option 3 – Relocation of the service to the refurbished Oakley Court (medium term).

				ROBIN PINTO OPTIONS					
				Option 1		Option 2		Option 3	
				Do nothing		Refurbish existing Robin Pinto Unit. Key assumptions for level of refurbishment > environmental refurbishment (medium term option) > M&E refurbishment to meet compliance standards > No layout changes		Relocation of service to refurbished Oakley Court (medium term)	
Assessment Criteria	**Weighting (%)**	**Sub-weighting (%)**	**Weighted (%)**	Score	Weighted score	Score	Weighted score	Score	Weighted score
Financial criteria									
Capital costs	30%	50%	15%	5	0.8	3	0.5	3	0.5
Decant/Enabling/Site costs		50%	15%	5	0.8	3	0.5	3	0.5
Non-financial criteria									
Patient safety and compliance	70%	30%	21%	2	0.4	3	0.6	3	0.6
Patient and staff experience		20%	14%	2	0.3	3	0.4	3	0.4
Strategic fit		20%	14%	2	0.3	3	0.4	4	0.6
Net Zero		0%	0%		0.0		0.0		0.0
Social value and public wellbeing		10%	7%	2	0.1	2	0.1	3	0.2
Deliverability and timescale		20%	14%		0.0	3	0.4	3	0.4
Total / Overall Rating	100%		100%	18	2.6	20	2.9	22	3.1

Preferred option
Option 3 – Relocation of service to refurbished Oakley Court (medium term)

Landermere Site - Initial Preferred Option

Initial evaluation of the following Landermere site options indicates that the preferred option is Option 3 – Refurbish Bernard ward into a decant ward to enable wider Trust ward refurbishments.

LANDERMERE SITE OPTIONS									
				Option 1		Option 2		Option 3	
				Do nothing		Refurbish closed Bernard ward to allow transfer of services from Reunion House and dementia friendly service from Kingswood Centre (medium term option)		Refurbish closed Bernard ward into a decant ward in order to carry out other trust ward refurbishments (assume no intitial decant)	
Assessment Criteria	**Weighting (%)**	**Sub-weighting (%)**	**Weighted (%)**	Score	Weighted score	Score	Weighted score	Score	Weighted score
Financial criteria									
Capital costs	30%	50%	15%	5	0.8	3	0.5	3	0.5
Decant/Enabling/Site costs		50%	15%	5	0.8	4	0.6	5	0.8
Non-financial criteria									
Patient safety and compliance	70%	30%	21%	2	0.4	4	0.8	4	0.8
Patient and staff experience		20%	14%	2	0.3	4	0.6	4	0.6
Strategic fit		20%	14%	3	0.4	4	0.6	4	0.6
Net Zero		0%	0%		0.0		0.0		0.0
Social value and public wellbeing		10%	7%	2	0.1	3	0.2	3	0.2
Deliverability and timescale		20%	14%		0.0	3	0.4	3	0.4
Total / Overall Rating	100%		100%	19	2.8	25	3.6	26	3.8

Preferred option
Option 3 – Refurbish Bernard ward into a decant ward to enable wider Trust ward refurbishments

The Lodge - Initial Preferred Option

Initial evaluation of the following Lodge options indicates that the preferred option is Option 3 – Develop The Lodge as the Trust's 'Worksmart Hub'

				THE LODGE OPTIONS							
				Option 1 - Do Nothing		Option 2 - Do Minimum		Option 3 - Worksmart Hub		Option 4 – Property Disposal	
				Continue to accommodate Head Office and Corporate Services		> Continue to accommodate Head Office and Corporate Services > Relocate some teams (TBC) to occupy underutilised space.		> Develop the building as the Trust's 'Worksmart Hub' > Remains as Trust Head Office > Bookable spaces (clear desk policy) > Phased approach? > Assumes partial refurb/recofiguration of spaces		> Market the building for sale > Transfer Head Office functions and other services to alternative locations(s). > Assume that alternative locations provide target agile working environment	
Assessment Criteria	**Weighting (%)**	**Sub-weighting (%)**	**Weighted (%)**	Score	Weighted score	Score	Weighted score	Score	Weighted score	Score	Weighted score
Financial criteria											
Capital costs	30%	50%	15%	5	0.8	4	0.6	3	0.5	3	0.5
Decant/Enabling/Site costs		50%	15%	5	0.8	4	0.6	3	0.5	1	0.2
Non-financial criteria											
Facilitate delivery of target agile working vision	70%	10%	7%	2	0.1	2	0.1	3	0.2	4	0.3
Drive efficiencies: maximise utilisation of and value from our estate		15%	11%	1	0.1	2	0.2	4	0.4	4	0.4
Staff experience		15%	11%	3	0.3	3	0.3	4	0.4	4	0.4
Consolidation with other Trust teams/ICS partners		10%	7%	2	0.1	2	0.1	4	0.3	4	0.3
Strategic fit (including right location for Trust HQ; support of operational delivery)		20%	14%	2	0.3	2	0.3	3	0.4	4	0.6
Net Zero		0%	0%		0.0		0.0		0.0		0.0
Social value and wellbeing		10%	7%	2	0.1	2	0.1	2	0.1	2	0.1
Deliverability and timescale		20%	14%		0.0	3	0.4	2	0.3	2	0.3
Total / Overall Rating	100%		100%	22	2.6	24	2.8	28	3.1	28	3.0

Preferred option
Option 3 – Develop The Lodge as the Trust's 'Worksmart Hub'

APPENDIX 5 – Core Flex and Tail

EPUT

Core, Flex and Tail – Tail Properties

A list of the tail properties across the 3 scenarios. Those marked with an asterisk have been included in the Capital Generated on page 58.

Property	Low	Moderate	High
Benfleet Clinic	✓	✓	✓
Bradd Close, 1/1a - (Vacant)*	✓	✓	✓
C & E Centre	✓	✓	✓
Central Avenue, 2 (Leased Out)*	✓	✓	✓
Coach House (Leased Out)*	✓	✓	✓
Corporate House	✓	✓	✓
Hockley Clinic	✓	✓	✓
Laindon Health Centre	✓	✓	✓
Long Lane, 295 (Leased Out)*	✓	✓	✓
Mansard House	✓	✓	✓
Mountnessing Road, 230/230a - VACANT*	✓	✓	✓
Periphery Homes - VACANT	✓	✓	✓
Pride House*	✓	✓	✓
Regent Road, 15 - VACANT*	✓	✓	✓
South Ockendon Health Centre	✓	✓	✓
St Margaret's Hospital	✓	✓	✓
Stanford Clinic	✓	✓	✓
The Glades, 4 - VACANT*	✓	✓	✓
The Northgate Centre	✓	✓	✓
Tilbury Health Centre	✓	✓	✓

Property	Low	Moderate	High
West Gate	✓	✓	✓
Wickford Health Centre	✓	✓	✓
Hadleigh Clinic		✓	✓
Health Close, 5		✓	✓
Heath Close, 1		✓	✓
Heath Close, 2		✓	✓
Heath Close, 3		✓	✓
Heath Close, 4/4a		✓	✓
Pickwick Close, 30/31*		✓	✓
Raphael House		✓	✓
Shoebury Health Centre		✓	✓
Southgate House		✓	✓
Southview Road		✓	✓
Tye Common Road, 10 (Leased Out)*		✓	✓
Tye Common Road, 12 (Leased Out)*		✓	✓
Tye Common Road, 14 (Leased Out)*		✓	✓
Tye Common Road, 8 (Leased Out)*		✓	✓
Warrior House, Taylor		✓	✓
Western House		✓	✓
Addison House Health Centre			✓
Ashingdon Road, 10a (Leased Out) *			✓

Property	Low	Moderate	High
Ashingdon Road, 10b (Leased Out)*			✓
Ashingdon Road, 10c (Leased Out)*			✓
Ashingdon Road, 10d (Leased Out)*			✓
Civic Offices, Grays			✓
Derwent Centre			✓
Ely House			✓
Fairview, 19 (Leased Out)*			✓
Grays Hall*			✓
Grays Health Centre			✓
London Road, 72/74 (Leased Out)*			✓
London Road, 86 (Leased Out)*			✓
Marsh Farm Health Centre			✓
Steppingley Hospital			✓
Thundersley Clinic			✓
Vange Health Centre			✓
Weymarks, 11 (Leased Out)*			✓
Weymarks, 5 (Leased Out)*			✓
Weymarks, 7 (Leased Out)*			✓
Weymarks, 9 (Leased Out)*			✓
Witham Health Centre			✓

APPENDIX 6 – Core Flex and Tail

EPUT

Core, Flex and Tail

Categorisation of our estate and development requirements

A safe, modern, well planned and patient centred estate means we can deliver high quality services for all improved value for money.

Part of this process is categorising all of the sites in our estate into core, flex and tail:

Core – Good quality, fit-for-purpose and future-proof estate that aligns with national, regional and local strategies.

Flex – Estate that is of an acceptable quality, or provides unique access to services, but does not fully enable the strategic ambitions.

Tail – Poor quality estate that is not fit-for purpose for patient-facing services and should be phased out when alternative estate is available.

We have used the RAG Rating Criteria to determine whether the property is Core, Flex or Tail. This has been based on the sites:

- Age
- Size
- Condition
- Functional suitability
- EPC
- Strategic Location

RAG Rating Criteria

Criteria	Green	Amber	Red
Age	< 40 years	40-75 years	75+ years
Size (m^2)	> 500	200 -500	< 200
Condition	**A -** As new and can be expected to perform adequately to its full normal life **B -** Sound, operationally safe and exhibits only minor deterioration	**B(C) -** Currently as B, but will fall below B within five years **C -** Operational, but major repair or replacements is currently needed to bring up to condition B	**D -** Operationally unsound and in imminent danger of breakdown **X -** Supplementary rating added to C or D to indicate that it is impossible to improve without replacements
Functional Suitability	**A -** Very satisfactory, no change needed **B -** Satisfactory, minor change needed	**C -** Not satisfactory, major change needed	**D -** Unacceptable in its present condition **X -** Supplementary rating added to C or D to indicate that besides a total rebuild or relocation will suffice
EPC	**A-B** Most/very good efficiency	**C-D** Average to below average efficiency	**E or below** Less/least efficient
Strategic Location	**A -** Critical importance – the services cannot be provided elsewhere **B -** Significant importance – the services would be difficult to provided elsewhere	**C -** Moderate importance – the services could be re-located with moderate difficulty	**D -** Limited importance – the services could be re-located to a more suitable location

Core, Flex and Tail – West Essex Example

Site Name	Age	Size (m2)	Condition	EPC	Suitability	Strategic Location	Classification
Addison House Health Centre	< 40 years	380	C	C	C	C	Flex
Doolittle Mill, 14	< 40 years	202	B	B	C	D	Flex
Dunmow Community Clinic	< 40 years	79	C	E	C	B	Flex
Hertfordshire & Essex Community Hospital	< 40 years	727	B/C*	C	C	C	Flex
Independent Living Centre	< 40 years	943	B	C	C	D	Flex
Latton Bush Centre	40 - 75 years	1,145	C	D	C	B	Flex
Marsh Farm Health Centre	40 - 75 years	60	B/C*	C	C	C/D	Flex
Nuffield House Health Centre	< 40 years	17	B/C*	F	C	B	Flex
Oakley Court (Leased Out)	< 40 years	1,397	C	F	C	B	Flex
Rectory Lane Health Centre	< 40 years	711	B/C*	C	C	A	Core
Regent Road, 15 - VACANT	40 - 75 years	216	C*	C	C	D	Tail
Saffron Walden Hospital Community Hospital	< 40 years	1,868	C*	C	C	A	Core
Stansted Surgery	< 40 years	174	B*	C	C	B	Core
Steppingley Hospital	75 + years	88	B/C*	D	C	C	Flex
The Glades, 4 - VACANT	< 40 years	314	C	G	C	D	Tail
Waltham Abbey Health Centre	< 40 years	150	B/C*	E	C	C	Flex
Western House	75 + years	426	B	D	C	D	Tail

Note: the classifications below are based on the moderate scenario.

**Assumed by Estates Working Group*

Core, Flex and Tail – North East Essex

Site Name	Age	Size (m^2)	Condition	EPC	Suitability	Strategic Location	Classification
All Saints House	75 + years	387	B	C	B	B	Core
Beach Hut 546	< 40 years	12	C	E	D	A	Flex
Clough Road	< 40 years	1922	C	D	D	A	Flex
Coach House (Leased Out)	75 + years	210	C	C	C	C/D	Tail
Corporate House (leased out)	40 - 75 years	20	C	E	C	C/D	Tail
Herrick House	75 + years	906	C	F	B	B	Flex
Holmer Court	< 40 years	491	C	C	B	C	Flex
Hospital Road, 1/2	< 40 years	125	B	C	C	B	Core
Reunion House	75 + years	505	B	F	C	C	Flex
Rivendell Flats	40 - 75 years	491	B	E	B	B/C	Core
Severalls House	75 + years	425	B	C	D	B/C	Flex
Severalls Training Centre	40 - 75 years	150	B	C	C	B/C	Core
St.Helens Street	75 + years	302	C	B	C	B/C	Flex
The Lakes Bungalow	40 - 75 years	142	B	E	D	B	Flex
The Northgate Centre	75 + years	468	C	E	D	B/C	Tail
Witham Health Centre	40 - 75 years	12	B/C*	D	C	C	Flex

Note: the classifications below are based on the moderate scenario.

*Assumed by Estates Working Group

Core, Flex and Tail – Mid and South

Site Name	Age	Size (m2)	Condition	EPC	Suitability*	Strategic Location	Classification
Ashingdon Road, 10a (Leased Out)	40 - 75 years	86	B	C	C	D	Flex
Ashingdon Road, 10b (Leased Out)	40 - 75 years	86	B	C	C	D	Flex
Ashingdon Road, 10c (Leased Out)	40 - 75 years	86	B	C	C	D	Flex
Ashingdon Road, 10d (Leased Out)	40 - 75 years	86	B	C	C	D	Flex
Avalon Bungalow (Leased Out)	< 40 years	341	B	C	C	D	Flex
Benfleet Clinic	75 + years	29	C	F	D	C/D	Tail
Billericay Health Centre	40 - 75 years	36	C	C	D	B	Flex
Bradd Close, 1/1a - (Vacant)	< 40 years	341	C	D	C	C/D	Tail
Brentwood Community Hospital	< 40 years	20	B	C	B	D	Flex
Brentwood Resource Centre	< 40 years	850	B	D	B	B	Core
C & E Centre	75 + years	1,864	C	F	D	C	Tail
Central Avenue, 2 (Leased Out)	75 + years	171	C	F	C	C/D	Tail
Central Canvey Primary Care Centre	< 40 years	158	B	D	B	B	Core
Chelford Court	< 40 years	376	B	D	B	B/C	Core
Cherry Trees Unit	75 + years	348	B	D	B	B/C	Core
Churchview (Leased Out)	< 40 years	384	B	C	B	C/D	Core
Civic Offices, Grays	40 - 75 years	50	C	E	D	B	Flex
Coombewood	40 - 75 years	535	C	D	B	B	Flex
Corringham Integrated Medical & Wellbeing Centre	< 40 years	20	B	C	B	A	Core

Note: the classifications below are based on the moderate scenario.

Assumed by Estates Working Group

Core, Flex and Tail – Mid and South cont.

Site Name	Age	Size (m2)	Condition	EPC	Suitability*	Strategic Location	Classification
Fairview, 19 (Leased Out)	40 - 75 years	170	B	D	C	C/D	Flex
Gallimore Lodge (Leased Out)	< 40 years	344	B	B	B	C/D	Core
Gordon Road, 17 (Leased Out)	40 - 75 years	152	B	C	C	C/D	Flex
Grays Hall	75 + years	920	C	G	D	B	Flex
Grays Health Centre	< 40 years	20	C	F	C	B	Flex
Hadleigh Clinic	75 + years	178	C	F	D	B	Tail
Harland Centre	< 40 years	588	B	G	B	A	Core
Heath Close, 2	< 40 years	177	C	C	C	C/D	Tail
Hockley Clinic	40 - 75 years	109	C	G	D	C	Tail
Knightswick Clinic	40 - 75 years	493	C	F	B	A	Flex
Laindon Health Centre	40 - 75 years	18	C	D	D	D	Tail
Leigh Primary Care Centre	< 40 years	440	C	C	C	B	Flex
London Road, 72/74 (Leased Out)	75 + years	152	B	D	B	C/D	Flex
London Road, 86 (Leased Out)	40 - 75 years	188	B	D	C	C/D	Flex
Long Lane, 295 (Leased Out)	40 - 75 years	163	C	D	C	D	Tail
Maldon Clinic (Leased Out)	40 - 75 years	281	B	B	C	C	Core
Meadowside Home (Leased Out)	40 - 75 years	189	B	D	B	C/D	Flex
Mollands Lane, 117/119 (Leased Out)	75 + years	230	B	B	C	C/D	Flex

Note: the classifications below are based on the moderate scenario.

Assumed by Estates Working Group

Core, Flex and Tail – Mid and South cont.

Site Name	Age	Size (m2)	Condition	EPC	Suitability*	Strategic Location	Classification
Mollands Lane, 51/53 (Leased Out)	< 40 years	344	B	C	C	C/D	Flex
Mountnessing Court (Leased Out)	< 40 years	1,314	B	C	B	B	Core
Mountnessing Road, 230/230a - VACANT	< 40 years	344	C*	C	D	D	Tail
North Road	< 40 years	20	B	C	B	C	Core
Periphery Homes - VACANT	40 - 75 years	1,151	C	E	C	D	Tail
Pickwick Close, 30/31	< 40 years	270	C	C	C	C/D	Tail
Pride House	< 40 years	865	C	D	D	D	Tail
Rochford Hospital	40 - 75 years	10,850	B	F	D	A	Core
Sankey House	40 - 75 years	564	B	B	B	B	Core
Shoebury Health Centre	40 - 75 years	26	C	C	C	C	Tail
South Ockendon Health Centre	40 - 75 years	20	C	D	C	D	Tail
Southend Civic Centre	40 - 75 years	50	B	C	B	C	Core
Southgate House	40 - 75 years	3421	C	D	C	C	Tail
Southview Road	40 - 75 years	50	C	C	C	C	Tail
St.Davids Road, 19 (Leased Out)	40 - 75 years	197	B	C	B	D	Flex
Stanford Clinic	40 - 75 years	1211	C	D	C	D	Tail
Sydervelt	40 - 75 years	170	B	C	D	C	Flex
Temple Farm, Unit 8	< 40 years	250	C	C	C	A	Flex
The Gables	40 - 75 years	592	C	C	C	B/C	Flex
The Lodge	40 - 75 years	2,592	B/C	C	C	C	Flex

Note: the classifications below are based on the moderate scenario.

Assumed by Estates Working Group

Core, Flex and Tail – Mid and South cont.

Site Name	Age	Size (m2)	Condition	EPC	Suitability*	Strategic Location	Classification
The Tyrells	< 40 years	160	B	B	C	C	Core
Thundersley Clinic	40 - 75 years	69	C	D	C	B	Flex
Tilbury Health Centre	40 - 75 years	20	C	B	C	D	Tail
Tye Common Road, 10 (Leased Out)	40 - 75 years	87	B	D	C	D	Tail
Tye Common Road, 12 (Leased Out)	40 - 75 years	87	B	D	C	D	Tail
Tye Common Road, 14 (Leased Out)	40 - 75 years	87	B	D	C	D	Tail
Tye Common Road, 8 (Leased Out)	40 - 75 years	87	B	D	C	D	Tail
Tyler's House	< 40 years	20	B	D	C	C	Flex
Vange Health Centre	40 - 75 years	39	C	E	C	B	Flex
Warrior House, Kingsley	40 - 75 years	281	B	D	B	B	Core
Warrior House, Taylor	40 - 75 years	1229	C	D	C	C	Tail
Weymarks, 11 (Leased Out)	< 40 years	94	B	D	C	D	Flex
Weymarks, 5 (Leased Out)	< 40 years	94	B	D	C	D	Flex
Weymarks, 7 (Leased Out)	< 40 years	117	B	C	C	D	Flex
Weymarks, 9 (Leased Out)	< 40 years	130	B	C	C	D	Flex
Wharf Close (Leased Out)	40 - 75 years	176	B	D	B	D	Flex
Wickford Health Centre	40 - 75 years	20	C	E	C	D	Tail

Note: the classifications below are based on the moderate scenario.

Assumed by Estates Working Group

Core, Flex and Tail – Specialist Services

Site Name	Age	Size (m^2)	Condition	EPC	Suitability*	Strategic Location	Classification
Brockfield House	< 40 years	9297	B	F	D	A	Core
Edward House	< 40 years	1255	B	E	D	B	Core
Ely House	40 - 75 years	100	C	B	C	C	Flex
Heath Close, 1	< 40 years	209	C	D	C	C	Tail
Heath Close, 3	< 40 years	153	C	D	C	C	Tail
Heath Close, 4/4a	< 40 years	406	C	C	C	C	Tail
Heath Close, 5	< 40 years	655	C	F	D	B	Tail
Lighthouse Children's Development Centre	< 40 years	100	B/C	B	B/C	C	Core
Mansard House	40 - 75 years	20	C	D	C	C/D	Tail
Mary St.Aubyn Centre	< 40 years	4190	B	B	B	A	Core
Raphael House	< 40 years	87	C	C	C	C	Tail
Rayleigh Clinic	40 - 75 years	151	C	C	C	B	Flex
Robin Pinto Unit	< 40 years	1391	B	F	D	C	Flex
West Gate	40 - 75 years	20	C	F	D	C/D	Tail
Woodlea Clinic	< 40 years	710	B	G	B	B	Core

Note: the classifications below are based on the moderate scenario.

Assumed by Estates Working Group

Core, Flex and Tail – Urgent and Inpatient Services

Site Name	Age	Size (m^2)	Condition	EPC	Suitability*	Strategic Location	Classification
Basildon Mental Health Unit	40 - 75 years	6,537	B	E	B	B	Core
Clifton Lodge	< 40 years	1,724	B	G	B	B	Core
Crystal Centre	< 40 years	3,776	B	E	B	A	Core
Derwent Centre	40 - 75 years	8,006	C	F	B	C	Flex
Epping Forest Unit	< 40 years	4,960	B	C	B	C	Core
Hadleigh PICU	40 - 75 years	750	B	E	B	B	Core
Ipswich Road, 439	75 + years	456	C	E	B	A	Flex
Kingswood Centre	< 40 years	2,560	B	C	B	A	Core
Landermere Centre	40 - 75 years	1,743	C	C	B	B	Core
Linden Centre	< 40 years	4,141	C	E	C	B	Flex
Rawreth Court	< 40 years	1,724	B	D	B	B	Core
St Margaret's Hospital	75 + years	8,436	C	E	C	C	Tail
The Lakes, (136 Suite)	40 - 75 years	3,115	C	B	B	A	Core
Thurrock Hospital	75 + years	9,089	B	C	B	B	Core

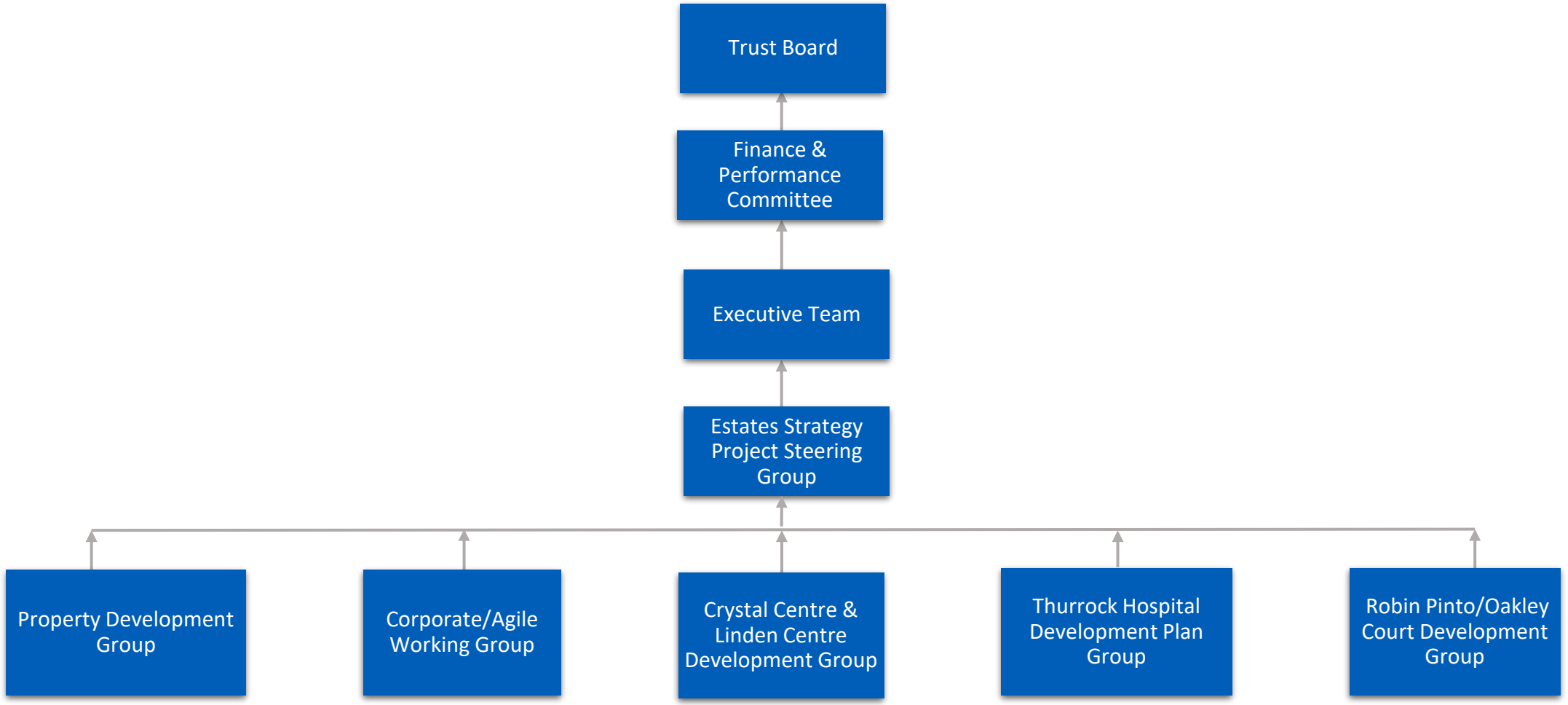
Note: the classifications below are based on the moderate scenario.

Assumed by Estates Working Group

APPENDIX 7 – Working Groups

EPUT

Estates Strategy Working Groups Structure



Objectives of Estates Strategy Working Groups

Crystal Centre & Linden Centre Development Group

- To review Strategic Brief document completed in September 2023 and agree/change options to transfer in-patient services from The Linden to the Crystal Centre based on the Broomfield Hospital site.
- To develop a Feasibility Study which details the design options, scope of works, estimated budget costs and outline delivery timescales.
- To submit highlight reports on progress and timescales of feasibility study on a monthly basis.
- To issue completed Feasibility Study to Estates Strategy Project Steering Group for approval to submit to Trust's Executive Team.
- To complete a Mental Health Programme of Works Template Bid to Mid and South Essex ICS

Robin Pinto/Oakley Court Development Group

- To meet with East London NHS Foundation Trust to review the possibility of ending the Trust's occupation of Robin Pinto Unit and transferring the service to Oakley Court with ELFT services from Oakley Court to Robin Pinto Unit.
- To conduct a site visit to Oakley Court to develop a condition survey.
- To develop a Strategic Brief to determine if Oakley Court can facilitate the schedule of accommodation of services provided at Robin Pinto including design options and estimated costs.
- To submit a Strategic Brief to Estates Strategy Project Steering Group for further actions.

Objectives of Estates Strategy Working Groups

Thurrock Hospital Development Plan Group - Closure of the Administration Building

- To develop a plan to transfer staff/services from the Administration Building to Thameside House and close the Administration Building (not including staff rest area).
- To review Thameside House office accommodation and identify un-utilised/vacant offices which will become 'worksmart/agile working accommodation for all Trust staff and services transferring from the Administration Building.
- To issue Proposal Report on the closure of the Administration Building to Estates Strategy Project Steering Group for approval to submit to Trust's Executive Team.

Thurrock Hospital Development Plan Group - Future of Thurrock Hospital

- To review all services currently being delivered from Thurrock Hospital and determine future need including buildings leased to NELFT.
- To explore the commercial opportunities for providing better patient and staff facilities at Thurrock Hospital.
- To review the future of Grays Hall to determine if services could be transferred to Thurrock Hospital in the future.

Objectives of Estates Strategy Working Groups

Corporate/Agile Working Group

- To determine the future of The Lodge with the option of the development of all floors into a hub for corporate services or dispose of the building and transfer services to alternative Trust/partner organisations buildings.
- To review all buildings where corporate services currently are accommodated to determine any under-utilised areas to develop future plans for these buildings e.g. transfer other services to these buildings, possible closure or disposal.
- To make recommendations to the Estates Strategy Project Steering Group.

Property Development Group

- To identify buildings that could be listed for disposal and develop a 5/10 Year Plan for capital receipts for those buildings the Trust has agreed are not required in the future.
- To review all buildings that are currently leased by the Trust and develop plans for the future of these buildings e.g. remain in building, consolidation of services or exit to Trust building.
- To report progress and submit recommendations to the Estates Strategy Project Steering Group.

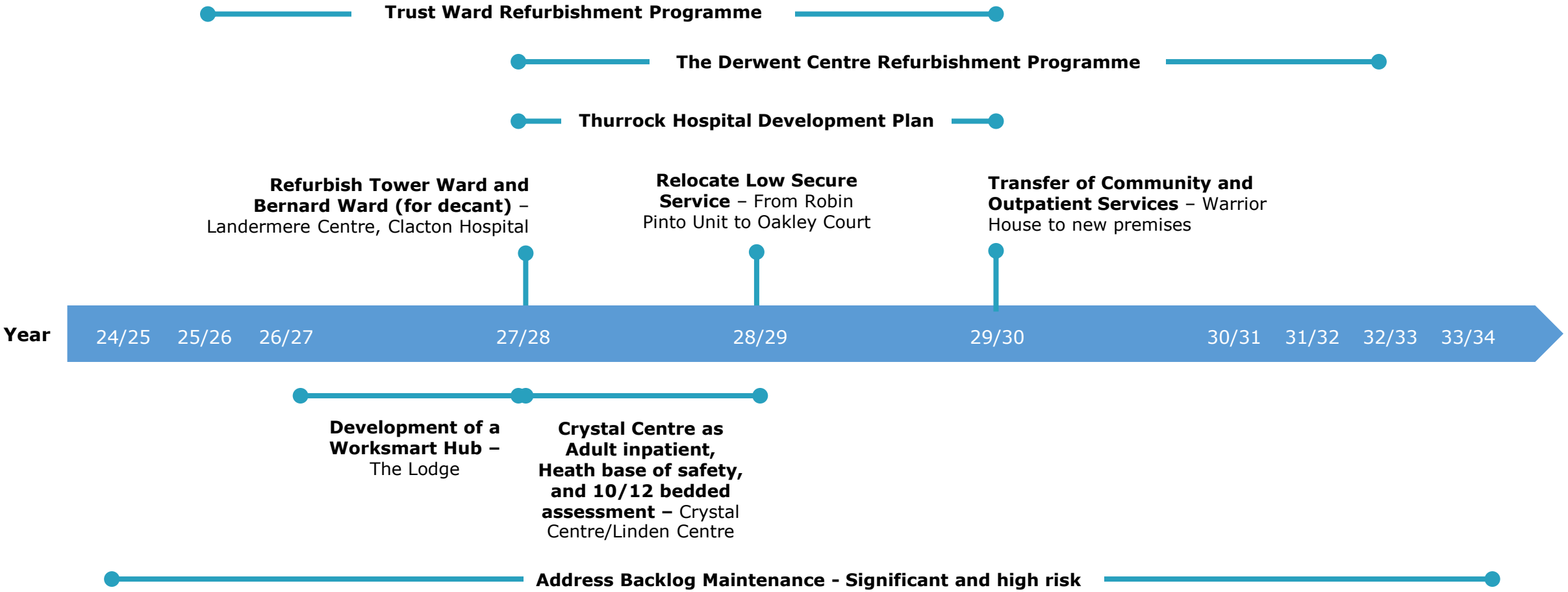
APPENDIX 8 –

Implementation Timeline

EPUT

High Level Timeline For Implementation and Delivery

We have a high-level 10 year plan for implementation and delivery of the key schemes, projects, and programmes identified within this estate strategy. This reflects our recently reported ICB capital funding requirements which will support the NHSE Capital Strategy and Governmental Capital Spending Review.



10. REGULATION & COMPLIANCE

10.1 RESPONSIBLE OFFICERS AND REVALIDATION ANNUAL REPORT AND STATEMENT OF COMPLIANCE

Decision Item MK 5

REFERENCES

Only PDFs are attached

Responsible Officers and Revalidation Annual Report and Statement of Compliance 02.10.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

Report Title:	**Responsible Officers and Revalidation Annual Report and Statement of Compliance**					
Executive/ Non-Executive Lead / Committee Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr Gladvine Mundempilly – Director for Medical Appraisal and revalidation					
Report discussed previously at:	People Equality and Culture Committee 02.09.2024					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	None identified		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		
	SR2 People (workforce)		
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	N/A		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors information on the implementation of revalidation within the Trust for 2023/24 appraisal year in order to provide an 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 Receive 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.

Summary of Key Points

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 to follow the format specified by NHS England and includes comprehensive details on quality assurance, clinical governance, the Trust's performance on revalidation, action plans to enhance the revalidation process, audits on concerns regarding doctors' practice, and audits on appraisal inputs and outputs.

As of 31st March 2024, 198 doctors had prescribed connection to EPUT. Of these, 170 (86%) completed their annual appraisal, within the timeframe during the period from 1st April 2023 to 31st March 2024. The remaining 28 appraisals were delayed with approval: 18 doctors were new starters not due for appraisal within the 2023-24 year, 4 delays were due to long-term sickness or maternity leave, and 6 doctors had other valid reasons for the delay. These 6 doctors have since completed their appraisals, meaning that all connected doctors, except for the four on long-term sickness or maternity leave, have now been appraised. Excluding the new starters not due for appraisal, the annual appraisal rate for EPUT stands at 95%.

An independent external quality assurance review of the medical appraisal process has been completed, confirming that we have appropriate policies and procedures in place and strong governance arrangements for medical appraisal and revalidation. Based on the feedback, we have developed an action plan to further improve our processes.

Steps are also being taken to increase the recruitment and retention of medical appraisers to ensure that appraisals are conducted to the expected standards.

The Board will need to continue supporting the annual appraisal and revalidation processes to maintain and enhance current practices, ensuring compliance with the Responsible Officer Regulations Act.

The report was discussed at the People Equality and Culture Committee on the 02 September 2024 and is recommended to the Board for approval.

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			
Equality Impact Assessment (EIA) Completed	**NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
GMC	General Medical Council	RO	Responsible Officer

Supporting Reports and/or Appendices

EPUT (Designated Body) Annual Board Report and Statement of Compliance

Executive/ Non-Executive Lead / Committee Lead:

Dr Milind Karale
Responsible Officer (Revalidation)

EPUT (Designated Body) Annual Board Report and Statement of Compliance

This sets out the information and metrics that a designated body is expected to report upwards, to assure EPUT compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

1A – General

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

1A(i) 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:	None

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	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.

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer 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 Manager. Triangulation of this information is carried out with Human Resources – Medical Staffing Department and the clinician concerned. This is cross-checked with our Prescribed Connection list with the GMC and is amended as appropriate.
Action for next year:	Continue to carry out process and amend the prescribed connection list as Appropriate.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Continue to monitor and review the policies in place to support medical revalidation
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 2021 and due for renewal in November 2024.
Action for next year:	Continue to monitor and review the policies in place to ensure that these support medical revalidation.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Organise a peer review of our appraisal and revalidation processes.
Comments:	An independent quality assurance process of our appraisal policies and procedures has been completed by an external provider. This was concluded in February 2023. The external provider completed a comprehensive report on our appraisal and revalidation policies and processes and the findings have been presented to Board. An action plan has been drawn up utilising the feedback we have received to further improve on our existing policies and procedures. We have also continued to carry out internal quality assurance processes and annual audits. 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:	To carry out the action plan resulting from the feedback that we have received from the independent quality assurance process and to continue the internal quality assurance processes and annual audits.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Continue to ensure that all doctors are supported in their induction, continuing professional development, appraisal, revalidation and governance.
Comments:	All doctors are supported in their induction, continuing professional development, appraisal, revalidation and governance. The Medical Education department has regular internal CPD activities and all the doctors are encouraged to attend. The doctors are also assisted with their external CPD requirements both in terms of study leave and financial support. 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, such as agency locums, 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 induction, continuing professional development, appraisal, revalidation and governance.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, 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.

Action from last year:	Continue to ensure all doctors on our prescribed connection list have a whole practice annual appraisal.
Comments:	All doctors with a 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. The Trust has a process in place to assist the doctor to collate this information held internally. The doctor is required to declare all their medical work, both with EPUT and any external, within the appraisal document. Where the appraiser is not the line manager of the doctor, the latter provides a medical managers report covering specific issues if any, to be discussed during the appraisal. Where EPUT is not the doctor's 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. The Trust has adopted the new Appraisal 2022 model whilst still allowing our doctors to choose the standard appraisal template if they wish to. The majority of the doctors are now using the 2022 model.
Action for next year:	Continue to ensure all doctors on our prescribed connection list have a whole practice annual appraisal.

1B(ii) Where in Question 1B(i) 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 explored and a plan put in place for its completion. These are further analysed to improve the process and ensure that the doctor is supported to complete these in a timely manner. 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 an audit on missed or incomplete appraisals.

1B(iii) 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:	Continue to review national policy and update the Medical Appraisal policy and procedure accordingly.
Comments:	EPUT has a Medical Appraisal policy in place, which is in line with national policy. This was updated and ratified in 2021. It is due for renewal in November 2024 and will be included within the action plan for 2024-25 year.
Action for next year:	Continue to review national policy and update the Medical Appraisal policy and procedure when it is up for renewal.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Organise new and appraiser refresher training
Comments:	The recruitment and retention of the appraisers has been challenging under the current work pressures of the doctors. As of 31st March 2024 we have 198 doctors on our prescribed connection list and 34 medical appraisers for the Trust who are not currently remunerated for the role. This equates to our medical appraisers completing a minimum of 5-6 appraisals per year which is above the minimum of 4 we would usually expect. To meet the demand of the organisation we need at least 40 trained medical appraisers at a time with the expectation of completing 5 appraisals per appraiser each year. Until now we have relied on volunteering and goodwill to carry out the appraiser role by incorporating them into their job plans. With increasing demands on the clinical work situation, it has become unsustainable and most appraisers are either relinquishing or reluctant to take on the role. This has put pressure on the remaining appraisers causing them to do more than what was previously agreed leading to a vicious cycle. We have invited expressions of interest to this role and uptake has been very minimal and does not meet current or future requirements. We therefore need to look at ways to recruit and retain our appraisers. Further new and refresher training for appraisers has taken place in June 2024.
Action for next year:	At the time of this report, new and appraiser refresher training has taken place in June 2024. We will look at further training opportunities for 2024-25 year. Look at options to encourage recruitment and retention of medical appraisers.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) 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 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.
Comments:	There is on-going support for the medical appraisers by way of regular updates. The Appraisal and Revalidation Team is available to address their queries as and when they arise. Training is also made available to the appraisers periodically. 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.
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.

1B(vi) The appraisal system in place for the doctors in our 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 the Board.
Comments:	Annual audits of our appraisal system are completed and shared with the Executive Team and discussed at the Quality Committee. This is submitted with the Board Report. Please see attached Appendix A and Appendix B for 2023/24 findings. As per section 1A(v), we have also had an independent quality assurance process of our appraisal policies and procedures completed by an external provider. This was concluded in February 2023 and the findings have been submitted to Board.
Action for next year:	Continue to complete annual audits and submit to Board.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last 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.
Comments:	The GMC Connect is reviewed regularly and recommendations are made in a timely manner.
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.

1C(ii) 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, or where this does not happen, the reasons are recorded and understood.

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 in advance and a plan is put in place to ensure a subsequent positive recommendation.
Action for next year:	Continue to ensure that revalidation recommendations are communicated promptly.

1D – Medical governance

1D(i) Our 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 includes regular Trust wide learning sessions and audit presentations. In addition, reports are published regularly on the Trust intranet by the Lessons Learned Team. The doctors are also encouraged to contribute to the clinical governance process by undertaking investigations and reviewing the incidents.
Action for next year:	Continue to provide an environment which delivers effective clinical governance for doctors.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Continue to monitor the conduct and performance of all doctors working in our organisation.
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. In addition the Clinical Directors have a monthly meeting with the doctors under their line management to discuss any concerns relating to working practices or performance.
Action for next year:	Continue to monitor the conduct and performance of all doctors working in our organisation.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	Continue to provide all relevant information to include at their appraisal.
Comments:	Corporate data such as information on complaints, significant events, audits and attendance at internal weekly teaching sessions are provided to the doctor to include in their annual appraisal. In the appraisal, the doctors include their updated job plan, mandatory training record, probity declaration and issues relating to any suspensions/investigations that they are subjected to. This is triangulated with Trust and GMC Connect data.
Action for next year:	Continue to provide all relevant information to include at their appraisal.

1D(iv) There is a process established for responding to concerns about a medical practitioner's 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 2022. The Trust has an adequate number of trained Case Managers and Case Investigators. Refresher training is provided periodically.
Action for next year:	Continue with established process and update the policy and procedure as and when required.

1D(v) 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 and country of primary medical qualification.

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. Please see Appendix C
Action for next year:	Continue to complete annual audit and submit to Board.

1D(vi) 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 our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

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.

1D(vii) 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 to ensure that those involved in investigations are adequately 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 appropriately trained for the role. 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 adequately trained.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	Continue to ensure that systems are in place to capture development requirements and opportunities in relation to governance from the wider system.
Comments:	The organisation has systems in place to capture development requirements in relation to governance from the wider system. The Trust's Clinical Director for Clinical Governance takes the lead on learning lessons within the organisation. This is in the form of regular Trust wide learning sessions and audit presentations. In addition, reports are published regularly on the Trust intranet by the Lessons Learned Team and relevant reminders are sent to the doctors by the Medical Director. Our policies and procedures are updated as and when necessary in light of information from the wider system.

Action for next year:	Continue to ensure that systems are in place to capture development requirements and opportunities in relation to governance from the wider system.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	No actions from last year regarding this matter.
Comments:	Systems are in place to review professional standard arrangements for medical staff. This is done through appraisals and there are systems in place to provide doctors with copies of their complaints, patient safety incidents and report from the line manager. The Trust has a system for appraising nursing staff.
Action for next year:	To review the systems in place for assessing professional standards for clinical staff other than medical and nursing.

1E – Employment Checks

1E(i) 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.
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 doctor joining the Trust. Once the doctor is in the post the Appraisal and Revalidation Team carries out further assurance checks, which include the name of the last Responsible Officer, revalidation due date, copies of previous appraisals, appraisal due date and the MPIT Form. The Medical staffing department follows an agreed process for recruiting agency locums ensuring that they meet the expected standards for their role.

Action for next year:	Continue with new starter processes.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Continue with the systems in place to ensure that professional standards activities support an appropriate organisational culture.
Comments:	As mentioned previously, we have regular Trust wide learning sessions and audit presentations. In addition, reports are published regularly on the Trust intranet by the Lessons Learned Team and relevant reminders are sent to the doctors by the Medical Director. This has created a learning culture within EPUT whereby excellence in clinical care can flourish and be continually enhanced.
Action for next year:	Continue with the systems in place to ensure that professional standards activities support an appropriate organisational culture.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	Develop and continue to enhance our People and Culture Strategy
Comments:	Our people strategy will support EPUT to be recognised as an attractive place to work, and that our leaders are best placed to make EPUT the best mental health and community provider. At the core of our strategy is our ambition to ensure that staff not only have a great experience but feel happy and valued at work. We will also tackle equality, diversity, and inclusion issues within our Trust to collectively improve civility and respect and ensure that staff from underrepresented backgrounds have equal opportunities. The strategy will have 3 key pillars: 1) workforce planning at strategic and operational levels, 2) leadership development at all levels of the organisation and, 3) culture with a specific focus on wellbeing, lived experiences, equality, diversity, and inclusion.

	We want EPUT to be an employer of choice, and we recognise that to achieve this we need to continuously identify opportunities to transform our workforce, support our people to grow, and take steps to ensure that our staff feel happy and valued at work, and connected and supported in a positive work environment. We will tackle equality, diversity, and inclusion issues within our Trust to collectively improve civility and respect and ensure that staff from underrepresented backgrounds have equal opportunities. We will plan for the future by ensuring that our staff have the tools required to be successful in their current and future roles and strive to offer attractive, flexible and accessible health and care role opportunities to local people within our communities. We will utilise and upskill our corporate support services, and volunteers, to add value to our patient facing services in an intelligent and meaningful way.
Action for next year:	Develop and continue to enhance our People and Culture Strategy

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	Continue to enhance these processes within the Organisation at all levels.
Comments:	Behaviour framework in place -Where people do not behave in line with our values and behaviours we will challenge this and will ensure that where performance and behaviour are not consistent with our vision for a high performing organisation, this is addressed. Leaders are role models for personal and professional development. They equally encourage all of those in their teams to develop the values, skills and knowledge to be their best for patients and their families. Reflective learning is part of the appraisal and 1-1 process so that shared learning and action becomes ‘how we do things around here’. Feedback is regularly provided and time for critical reflection promotes individual and organisational learning. Leaders consistently demonstrate compassion with their staff and take a genuine interest in their lives and well-being. They actively role model what high standards of care look and feel like, both in clinical or non-clinical roles. Leaders care for themselves and others so they are psychologically able to manage the challenges of leadership - they create a just culture of fairness, openness and learning.
Action for next year:	Continue to enhance these processes within the Organisation at all levels.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	Continue to ensure that mechanisms exist that support the feedback process and that our doctors know how and when to utilise them.
Comments:	We have mechanisms that support feedback about the organisation' professional standards processes. Feedback can be provided in a number of ways in both a formal and informal manner. Such processes include freedom to speak up, complaints and grievance procedures.
Action for next year:	Continue to ensure that mechanisms exist that support the feedback process and that our doctors know how and when to utilise them.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	No actions from last year.
Comments:	The organisation has not collected the data in terms of their country of primary care qualification or protected characteristics while addressing concerns about doctors' practice. The line managers are often aware of protected characteristics and take these into account. This is however not formally recorded.
Action for next year:	Formally record and review any parity issues due to protected characteristics or country of primary qualification

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	Continue to calibrate and network with others and engage with peer review programmes when requested.
Comments:	The Appraisal and Revalidation Team regularly attend the NHS England networking events and read any updates. The Responsible Officer also meets with the GMC ELA on a routine basis. As mentioned previously, we have had an independent review of our appraisal and revalidation processes this year.
Action for next year:	Continue to calibrate and network with others and engage with peer review programmes when requested.

Section 2 – metrics

Year covered by this report and statement: 1April 2023 - 31March 2024 .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	198

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	170
Total number of appraisals approved missed	28
Total number of unapproved missed	0

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	34
Total number of late recommendations	0
Total number of positive recommendations	26
Total number of deferrals made	8
Total number of non-engagement referrals	0

2D – Governance

Total number of trained case investigators	Approx. 40
Total number of trained case managers	Approx. 40
Total number of new concerns registered	8
Total number of concerns processes completed	8
Longest duration of concerns process of those open on 31 March	12 months

Median duration of concerns processes closed	Exact data not available
Total number of doctors excluded/suspended	1 excluded
Total number of doctors referred to GMC	None by the organisation

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	63
Number of new employment checks completed before commencement of employment	63

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	N/A
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	N/A

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Our action plan for the 2023-24 appraisal year consisted of: • Continuing our existing well established appraisal and revalidation policies and processes • Complete the independent quality assurance process of our appraisal and revalidation policies and procedures • Carry out further new and refresher appraiser training • Continue to maintain and improve on our completed appraisal rates We have achieved all of these within the year with the exception of the new and refresher appraiser training. At the time of this report this has now taken place.

Actions still outstanding
The new and refresher appraiser training did not take place within the 2023-24 appraisal year but at the time of this report has now taken place.
Current issues
The main current issue is to recruit and retain our medical appraisers. As of 31 March 2024 we have 198 doctors on our prescribed connection list and 34 medical appraisers for the Trust who are not currently remunerated for the role. This equates to our medical appraisers completing a minimum of 5-6 appraisals per year which is above the minimum of 4 we would usually expect. To meet the demand of the organisation we need at least 40 trained medical appraisers at a time with the expectation of completing 5 appraisals per appraiser each year. Until now we have relied on volunteering and goodwill to carry out the appraiser role by incorporating them into their job plans. With increasing demands on the clinical work situation, it has become unsustainable and most appraisers are either relinquishing or reluctant to take on the role. This has put pressure on the remaining appraisers causing them to do more than what was previously agreed leading to a vicious cycle. We have invited expressions of interest to this role and uptake has been very minimal and does not meet current or future requirements. We therefore need to look at ways to recruit and retain our appraisers.
Actions for next year:
• Look at ways to recruit and retain our medical appraisers • New and refresher appraiser training • Update our Medical Appraisal Policy and Procedure • Re-introduce an appraiser network • Undertake a peer review • Procurement process of an appraisal system
Overall concluding comments:
As of 31st March 2024, there were 198 doctors with a prescribed connection to EPUT. Of these, 170 (86%) completed their annual appraisal, within the timeframe during the period from 1st April 2023 to 31st March 2024. The remaining 28 appraisals were delayed with approval: 18 doctors were new starters not due for appraisal within the 2023-24 year, 4 delays were due to long-term sickness or maternity leave, and 6 doctors had other valid reasons for the delay. These 6 doctors have since completed their appraisals, meaning that all connected doctors, except for the four on long-term sickness or maternity leave, have now been appraised. Excluding the new starters not due for appraisal, the annual appraisal rate for EPUT stands at 95%. An independent external quality assurance of the medical appraisal process has been completed and the findings reflected that we have appropriate policies and procedures in place and have established good governance arrangements for medical appraisal and revalidation. We have drawn up an action plan based upon the feedback to improve further. Steps are being taken to increase the recruitment and retention of the medical appraisers to ensure that appraisal processes are carried out at the expected standards. 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.

Section 4 – Statement of Compliance

The Board have 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 the designated body:	Essex Partnership University NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

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

	Totals
Number of doctors on GMC Connect as of 31 March 2024	198
Number of Completed appraisals for 2023-24	170
Number of doctors who were not due for an appraisal by 31 March 2024 (new starters after April 2023)	18
Number of doctors who were LTS/Maternity Leave for the majority of the appraisal year	4
Number of Approved Incomplete/Missed Appraisals for 2023-24	6 (all have now been completed)
Number of Unapproved Incomplete/Missed Appraisals for 2023-24	0

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

Total number of appraisals completed		170
	Number of appraisal portfolios sampled	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs - Is there sufficient supporting information from all the doctor's roles and places of work? (To include CPD, QIA & evidence from external roles)	34	34
Review of complaints: Have all complaints been included?	34	34[1]
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	34	34[1]
Has a patient and colleague feedback exercise been sufficiently completed by year 3 of the revalidation cycle?	34	20
Appraisal Outputs		
Appraisal Summary	34	33
Appraiser Statements	34	34
Personal Development Plan (PDP)	34	32

[1] Based on evidence submitted within appraisal portfolio.

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

Concerns about a doctor's practice	High level[2]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months (Apr 2023 – Mar 2024) 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	1	6	1	8
Capability concerns (as the primary category) in the last 12 months	0	1	1	2
Conduct concerns (as the primary category) in the last 12 months	1	4	0	5
Health concerns (as the primary category) in the last 12 months	1	0	0	1
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2024 who have undergone formal remediation between 1 April 2023 and 31 March 2024. 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 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)				1
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)				0
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
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,				0

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

research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.) All Designated Bodies	
TOTALS	1
Other Actions/Interventions	0
Local Actions:	0
Number of doctors who were suspended/excluded from practice between 1 April 2023 and 31 March 2024: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	1
Were referred by the designated body to the GMC between 1 April and 31 March	
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	4
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	1
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:	0
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	2
Number of NCAS assessments performed	0

11. OTHER

11.1 USE OF CORPORATE SEAL

Information Item | PS | 2

REFERENCES

Only PDFs are attached

Use of Corporate Seal 02.10.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	2 October 2024

Report Title:	**Use of Corporate Seal**					
Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Laverick, PA to the Chair, Chief Executive & Non-Executive Directors					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	N/A – Information item confirming use of corporate seal		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		
	SR2 People (workforce)		
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	Yes/ No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	Yes/ No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	Yes/No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides a summary of when the corporate seal has been used.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report

Summary of Key Points
The EPUT Corporate Seal has been used on the following occasions: • 117 – 119 Mollands Lane, South Ockendon Lease Surrender and Re-grant

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices

Non-Executive Lead:
 **Paul Scott,** **Chief Executive Officer**

11.2 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

Information Item SS 1

Verbal

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

Decision Item | ALL | 1

Verbal

11.4 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

Information Item ALL 5

Verbal

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

Information Item ALL 1

12. ANY OTHER BUSINESS

Information Item | ALL | 5

Verbal

13. QUESTION THE DIRECTORS SESSION

10

14. DATE AND TIME OF NEXT MEETING

1

Wednesday 4 December 2024 at 10am, The Lodge, Training Room 1