NHS
Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors

Wednesday 30 November 2022

EPUT

Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public via Microsoft Teams
Wednesday 30 November 2022 at 10:00

Vision: Working to Improve Lives

PART ONE: MEETING HELD IN PUBLIC via Microsoft Teams

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
	PRESENTATION **Urgent Care Response Teams** ***Rita Thakaria, Partnership Director, Adults Health and Social Care (Thurrock Council/EPUT/NELFT) and Yvonne Mubu Head of UCRT Service***			
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 28 September 2022	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chair's Report (including Governance Update)	SS	Attached	Noting
6	Chief Executive Officer Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	PS	Attached	Noting
(b)	Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services	PS	Attached	Discussion
(c)	End of Life Annual Report	NH	Attached	Approval
(d)	Learning from Deaths – Morality Review Quarterly Update	NH	Attached	Noting
(e)	Final Charity Accounts 2021/2022	TS	Attached	Approval
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework (November 2022)	DG	Attached	Approval
(b)	Standing Committees:			
	(i) Audit Committee	JW	Attached	Noting
	(ii) Finance & Performance Committee	LL	Attached	Noting

	(iii) Quality Committee	RH	Attached	Noting
	(iv) People, Equality and Culture Committee	ML	Attached	Noting
(c)	Board Safety Oversight Group	SS	Attached	Noting
(d)	Risk Management and Assurance Framework 2020-2023 (Interim Update September 2022)	DG	Attached	Approval
9	**RISK ASSURANCE REPORTS**			
	(i) Ligature Risk Management Q2 Report	AG	Attached	Noting
10	**REGULATION AND COMPLIANCE**			
(a)	CQC Compliance Update	DG	Attached	Noting
(b)	Safe Working of Junior Doctors Quarterly Report (July – September 2022)	MK	Attached	Noting
(c)	Standing Orders for the Council of Governors	DG	Attached	Approval
(d)	Emergency Preparedness, Resilience and Response (EPRR) Energy Resilience Questionnaire	NL	Attached	Noting
11	**OTHER**			
(a)	Use of Corporate Seal	PS	Attached	Approval
(b)	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
(c)	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
(d)	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
(e)	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
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 25 January 2023			
15	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** Wednesday 29 March 2023 Wednesday 31 May 2023 Wednesday 26 July 2023 Wednesday 27 September 2023 Wednesday 29 November 2023			

Professor Sheila Salmon, Chair

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 28 September 2022
Held Virtually via MS Teams Video Conferencing

Attendees:

Prof Sheila Salmon (SS)	Chair
Paul Scott (PS)	Chief Executive
Alex Green (AG)	Executive Chief Operating Officer
Milind Karale (MK)	Executive Medical Director
Nigel Leonard (NL)	Executive Director of Major Projects and Programmes
Natalie Hammond (NH)	Executive Nurse
Zephan Trent (ZT)	Executive Director of Digital, Strategy and Transformation
Trevor Smith (TS)	Executive Director of Finance and Resources
Sean Leahy (SL)	Executive Director of People and Culture
Denver Greenhalgh (DG)	Senior Director of Corporate Governance
Janet Wood (JW)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director
Amanda Sherlock (AS)	Non-Executive Director
Alison Rose-Quirie (ARQ)	Non-Executive Director
Mateen Jiwani (MJ)	Non-Executive Director

In Attendance:

Angela Horley	PA to Chief Executive, Chair and NEDs (minutes)
Adrian Kirkby	Service Manager
Angela Wade	Director of Nursing (for Natalie Hammond)
Lorraine Hammond	Director of Employee Experience (for Sean Leahy)
Stuart Scrivener	Governor
David Short	Governor
Pam Madison	Governor
Paula Grayson	Governor
Dianne Collins	Governor
Pippa Ecclestone	Governor
Megan Leach	Governor

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

The meeting commenced at 09:59

099/22 APOLOGIES FOR ABSENCE

Apologies were received from Rufus Helm.

100/22 DECLARATIONS OF INTEREST

There were no Declarations of Interest.

101/22 PRESENTATION: HEALTH OUTREACH – SUPPORTING MARGINALISED ADULTS ACROSS SUFFOLK

AG introduced Adrian Kirkby, Service Manager of the Health Outreach which supports marginalised adults across Suffolk. AG was very proud to introduce a presentation from this team that is a fantastic example of a service proactively responding to whole person health and wellbeing needs for vulnerable members of society.

AK advised that the Health Outreach Team is based in Ipswich to support marginalised adults across Suffolk and has provided services in Suffolk for circa 25 years. This is a county wide service covering a large geographic area. Partnership working is essential to delivering services in Suffolk and the team work closely with many agencies. The team has a number of specific target groups including homeless, offenders, migrant workers, asylum seekers and refuges, gypsies and travellers, as well as providing a special allocation scheme (GP provider for those excluded from primary care) and outreach services for the Covid-19 vaccination programme.

Health / social care community outcomes for these populations is poor. The average age of death for a homeless person is 47 (male) and 43 (female). Suicide rates are also significantly higher in these populations as well as other issues that make it difficult to live a normal and healthy lifestyle. The team work with migrant workers, in sectors where there are existing health and safety concerns, and have found that within this group the knowledge of UK health and safety systems is low. The team take services to these groups and bring health and safety aspects to them.

Cultural and language barriers as well as limited knowledge of the UK health and welfare system is a barrier for asylum seekers and refugees who suffer significantly with the effects of poverty and racial discrimination. This cohort is often particularly isolated and face many obstacles, often having come to the UK facing tragedies and violence – the challenges faced within this group from a mental health / PTSD perspective is enormous. Suffolk / Ipswich is a dispersal site for asylum seekers, with generally 100 people going through the process at any one time. At the moment there are 1700 asylum seekers in Suffolk – more than a tenfold increase in demand over a challenging two years.

The remit of the team is to provide interim direct services to patients, working to enable patients to access mainstream services, advocate for clients in mainstream services and highlight gaps in service provision or barriers to accessing services. All services are under pressure so the ability to assist a move into mainstream services is restricted and the team can often hold these cases for some time.

The multi-disciplinary team includes sessional GPs, general nurses, RMNs, outreach practitioners, social workers, physician assistant, counsellor, support workers vaccinators and administrators. This is a small team where many roles overlap, there are also several bi-lingual staff. The team focusses on outreach for vulnerable groups, seeing patients in their own environments, other agencies or at the St Helens Street base.

The skills and knowledge of the team have been built over 25 years and there is a real specialist knowledge to deliver to harder to reach groups. Issues faced by service users include substance misuse, domestic violence, honour based violence, FGM, mental health, learning disabilities and Autism Spectrum Disorder (ASD), social isolation, offending, financial difficulties, poor nutrition, poor physical health, physical assault and intimidation. The team sees people from vulnerable groups with specific and traumatic histories.

SS thanked AK for the very interesting presentation stating that AK and team exemplify the values of the Trust. Some suprising figures were contained within the presentation in terms of demand, but we must be hugely proud of the achievements for outcomes and quality of life improvements.

NH thanked AK for the impactful presentation, and shared her admiration to AK and team. Understanding the complexity and trauma faced within this multi-faceted role is challenging, NH queried how the team remained resilient in the face of trauma and rise in demand? AK agreed that

this was an important point, and was something the team had benefited from being a part of EPUT with the psychology team being an integral part of service. Mortality review groups have taken place to manage and implement changes to benefit life expectancy of service users as well as learning and work to coproduce with service users, there is also a strong link with the voluntary sector. AK commented that every day is different and inspires staff to come in and deliver, the team support each other and have a support system across the Trust, learning from incidents and building resilience.

ARQ agreed that this was a fantastic example of the values of the Trust, and an example of how integration and partnership can improve health inequalities. In relation to hard to reach groups, ARQ was interested in how the team managed to reach and gain the trust of people who have a mistrust of authorities because of experiences they may have been through. AK responded that within the team there are 3 staff who are former service users as well as volunteers, all of whom are experts by experience in addition to mentors through the volunteering matters programme who also provide support. AK provided an example of building trust within hard to reach groups, noting that with the Covid-19 vaccination programme, the team were not accepted on initial outreach efforts. The team spent the day and talked to people on a traveller site. The team did not push, but were visible, provided information and let people know they would come back. The team continued to visit the site and gained trust and built up professional relationships. The team tailor an approach that works with various groups without pressure, being open and honest to show the desire to coproduce and with time this approach has worked.

PS noted that the team demonstrated inclusion, advocacy, partnership, addressing health inequality and targets population health management and suggested there is a conversation to be held regarding what can be learned from the team and how we can scale this approach to the general population.

AG commented that the inequalities are stark and shock us, which even though there is continued improvement demonstrates need for this service. AG had been privileged to see first-hand service users assessment and was staggered by the resilience of staff who witness tragic personal circumstances and still exude hope. AG agreed that there was learning from the team around resilience and resourcefulness of staff. AK responded that resilience comes from the service users who, when faced with such extreme circumstances, provide inspiration.

NL thanked AK for the impressive presentation, advising that he had worked with AK and the team through the vaccination programme and had been very impressed by the resilience and resourcefulness of staff dealing with transient populations and the way they worked within the confines of guidance given. NL emphasised that this was an award winning service that had received international recognition with work undertaken with sea farers and was one of the reasons the Trust has a good and growing reputation in SNEE.

SL stated that the presentation had been both sobering and exceptional at the same time, and queried what further steps can be made to support this outstanding workforce. AK responded that over last year or so the team are learning that the Trust can provide resources and tools that add value to the service and are benefiting from that.

TS advised that AK reports clearly on services each month within the Accountability Framework meetings, which is deeply moving and inspirational, not only with the work the team carry out daily, but how the team show determination, resilience and positivity to keep going. TS thanked all within the team.

SS echoed heartfelt thanks from the Board, reiterating that the work of the team inspired and exemplified the values of trust and what we aspire to be for the people we serve.

102/22 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 27 July 2022 were agreed as an accurate reflection of discussions held.

103/22 ACTION LOG AND MATTERS ARISING

The action log was reviewed and noted that there were no other matters arising that were not on the action log or agenda. Responses to questions raised by governors were noted.

The Board discussed and approved the Action Log.

104/22 CHAIRS REPORT INCLUDING GOVERNANCE UPDATE

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

Following the sad passing of the beloved Queen Elizabeth II, SS had been privileged to lead staff in a short tribute and period of silence. The sad passing and national period of mourning had resulted in delays in the appointment of two new Non-Executive Directors, interviews for these positions had been rescheduled for October.

SS advised that with sadness we say farewell to a longstanding colleague AS, SS paid tribute to all AS had achieved whilst with the Trust over a period of nearly 8 years, both with the current organisation and its predecessor. On behalf of the Board, SS wished AS well going forward as she moved forward in a new chapter of her life.

SS also advised that ARQ would also be leaving the Trust in October and thanked ARQ who had served faithfully and powerfully over four years. ARQ's time with EPUT had been valuable and SS thanked ARQ for her leadership around strategy and board safety oversight as well as her support around the freedom to speak-up programme. On behalf of the Board, SS wished ARQ every success in her future endeavours.

The AMM had also taken place this week, this had been an interactive virtual session that had enabled the event to reach a number of governors and members. The session was recorded and the Communications Team are working to upload the recording to the EPUT website for viewing. The event enabled a look back and forwards at key areas of focus.

The Board received and noted the Chair's Report.

105/22 CEO REPORT

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

PS advised that there is a national issue across the NHS to find qualified staff and the Trust were trying to address this in a proactive way. The Time to Care project is a vehicle for that, working with colleagues on wards and leadership teams, as well as in partnership with Deloitte to expand our thinking, thinking about new roles and how technology can support. This project is currently in the planning phase with anticipated implementation by the end of October to ease pressure for colleagues.

The Trust was also beginning to receive some recognition of the hard work of our staff, services and colleagues and a list of nominations received was included within the report – PS extended thanks to all in preparing applications / nominations.

Executive Directors provided the following updates:

Operations – AG
The pressure on services was incredibly challenging across a number of services, in particular inpatient. The Trust declared OPEL 4 in response to unprecedented pressures and measures were put in place to manage demand in a safe way. The number of performance measures rose to 5 and saw the inclusion of the safer staffing domain. There are a number of projects underway to ensure services are safely staffed and use time appropriately. In terms of inadequate performance indicators, CPA reviews have improved, inpatient capacity, Out of Area placements, length of stay and psychology waiting times continue. There is continued sustained improvement in Psychology waiting times and delayed transfers of care (DTOC). AG advised that the Trust were delighted to work with Getting It Right First Time (GIRFT) Team, and are one of first MH trusts to work with GIRFT, this will allow us to look at productivity to reduce unwarranted variation in service and improve quality of care.

August had been an incredibly challenging month, during which the Trust had sustained services, with none paused or ceased despite the OPEL 4 declaration. Patient safety remains at forefront of care delivered.

ARQ noted there were two of six contracts with inadequate KPI increase, AG advised that mid and south Essex saw the inclusion of 111 calls, this had now been rectified, West Essex saw the inclusion of Beech and the early supported discharge contract, this was due to the fact that the 6 week length of stay which is agreed target for those services was exceeded. This was pre agreed with commissioners, so although is reported, is a known and planned intervention taken through contract discussions and removed from KPIs, this is down to ensuring patients reach their goals and some patients require an extended stay to achieve that.

PS noted that where KPIs were under performing against a standard set, the Trust are working to look at the root cause with the Executive Team, Finance and Performance Committee and the Accountability Framework meetings providing oversight. AG described the governance around this advising that the five key domains focussed on at monthly Accountability Framework meetings. The meeting members reviewed and scrutinised performance data, taking mitigating actions where performance was under par and report back monthly. With support from the Executive Team in any areas causing particular challenge, any exceptions are brought to the appropriate Board sub-committee to retain oversight; for example, community care units have a focus on CPA, and a focus on how teams manage caseloads and that most vulnerable patients are reviewed and seen. In psychology, waiting time had been real focus of the Accountability Framework meetings and we were now seeing sustained improvement. For inpatients there is a slightly different process, with daily, weekly and monthly scrutiny of performance reviewed during the Accountability Framework meetings. In addition the leadership team had stood up “Gold” executive review of mitigating actions, these are reviewed daily and an after action review on was held on 08 September. A number of actions have now been put in place as business as usual and some have been brought forward from OPEL 4 actions to OPEL 3 actions to be put in place when OPEL 3 is declared. A monthly update is provided to the Finance and Performance Committee. PS added that when a new approach is put in, it is helpful for the Board to see in context and it how is applied.

Nursing – NH
The Quality Committee have commissioned a deep dive into flow and capacity which helps look at how to maintain quality and safety while responding to increased pressure. Following which over 60 activities associated with the safety strategy were identified. Deep dives are being undertaken into

elements themed with the Safety Strategy and NH was pleased to report that completion of Safety Strategy activities was on track with many underway, in progress or complete. Coproduction is also demonstrated, this is an area where coproduction and work with service users can ultimately see safer outcomes and improvements of services. NH confirmed that the Board would receive an update on the position of the Safety Strategy in 2023.

Medical – MK
MK extended thanks to all clinical and operational staff for their continued dedication during the OPEL 4 period and the innovative ways of team working, decision making and staff going the extra mile during this challenging period of increased demand. MK noted that part of the challenge is the future approach to manage urgent care and advised that the Trust had secured funding to establish a Mental Health Urgent Care Department and was on track to implement this new service from February 2023. The diversion service had also helped acute partners with occupancy of diversion rooms being over 90%. MK was also pleased to share news of the appointment of two deputy medical directors, Dr Pila for NE and Dr Sebastian for Mid and South. These appointments complete the full cohort of Deputy Medical Directors for all care units. SS was pleased to see strong clinical leadership come through care units.

AG added that we were now seeing how collaboration is resulting in a real fusion in the care unit model of quality and safety leadership, with clinically led leadership and operational leads coming together and this gives hope of what can be delivered in the future in that way.

PS agreed that this was an important time and was delighted with recent appointments. PS reflected on the pressures experienced and recognised colleagues stepping in to help support people in crisis.

Transformation, Strategy, Digital – ZT
In terms of the Strategic Plan this is being built around care units and taking a service led approach with service users and staff at the heart, with strengthening of clinical leadership also feeding in to development of plans. Many engagement events have been held, including representation from service users, staff and managers; these events have focussed on how to deliver our vision to be the leading mental health and community care provider. Individual plans are being developed for care units, working with the Executive Team and Non-Executive Directors as well as Governors and others across trust. Steps have been taken to develop and improve project management across the Trust; a steering group has been established and there is now a single front door for transformation projects to make sure all are clear on what is to be achieved, timeline and outcomes. To date, there have been over 90 transformation projects come through the single front door; this gives a sense of the amount of change driven by committed staff and service users. There is an increasing focus on how to manage projects through their lifecycle, closing and embedding change; the Transformation Team are also engaged with and supporting the Time to Care project. Significant work has been taken with regards to developing the data strategy, discussions have been held previously regarding the need to mature the use of digital and data information to support the Trust, and work has been taken place supported by KPMG to support staff and consider the way we use data in future to support clinical and corporate decisions.

Power BI is a fantastic tool to pull information together in a simple and accessible way and we have developed a patient safety dashboard through Power BI to get board level overview. The ability to traverse from board level view to detailed review is a powerful tool to understand incidents happening across the organisation. We will increasingly be using the useful Power BI tool throughout the Trust.

In regards to digital partnerships, the Trust are working with Microsoft and other partnerships in the digital space, EPUT are also part of the BT vanguard programme to develop technological solutions to support health care.

ZT advised of a recent cyber incident related to advanced hosting provider. EPUT responded to this incident through the cyber and finance team to ensure isolated access to the e-financial system which was a key point of risk, and then reconnect when appropriate to do so. ZT extended thanks to cyber tem and finance team for their excellent enactment of business continuity plans over that period and the work done to ensure safe reconnection.

LL commented that in view of the various transformation programmes underway, consideration may be given to what might be good time to consider coaching on agile methodology. LL was concerned that there is potential for projects that do not progress well and consideration must be given to what we can do better to become quicker and smarter at that transformation. ZT acknowledged that agile methodology is an approach where there was a focus on shorter term sprints to make progress, with continuous re-evaluation to allow responsiveness. ZT had alluded to a shift in focus to a single front door and the lifecycle of projects and was keen to move towards agile principles. The Team are also focussing on transparency of reporting. There is work to do which is supported by Power BI work to communicate at an Executive Team and Board level. LL commented that if this was the direction of travel, there was a need to plan and budget for agile coaching and champions / buddies, as this is substantial behavioural change.

People and Culture – SL
SL thanked and congratulate staff, stating that throughout the meeting pressures on the organisation and staff had been highlighted, compounded by the increase in cost of living which was a concern to many. SL confirmed that staff on the Agenda for Change contract had been offered a pay rise nationally, and EPUT were working hard as an organisation to help and support individuals and would continue to do so.

A recent Ofsted visit resulted in a 'Good' rating for the Trust in providing apprenticeships. Compliance with mandatory training for August is currently reported at 93%, which is an increase of 2% against the previous month. Overall compliance is still reported at 89% and continues to be worked on. In terms of recruitment, the national shortage of healthcare workers continues, EPUT have successfully hired 170 local nurses, over 150 health care assistants and 157 student nurses. EPUT are on track to exceed the target of 195 international nurses joining the Trust by the end of the calendar year. The Trust is currently reporting 500 vacancies but have and identified pipeline of 320 nurses offered positions. Overall turnover is just below 12%, with a vacancy rate of 6% and an identified pipeline of resources to reduce this.

From an employee relations point of view, the Trust had seen a decrease in employee relations activity in relation to both disciplinary and bullying and harassment cases. Sickness levels continue to be low at 3.69%. The NHS Staff Survey has now been launched with a big campaign in progress to encourage staff to complete the survey; this is a very important tool for staff to provide feedback.

The Trust are in the process of relaunching the Freedom to Speak-Up (F2SU) programme, with a piece of work assessing the service over the past 12 months being undertaken, which will be presented to the Board.

Major Projects – NL
The Trust continue to work closely with the Essex Mental Health Independent Inquiry secretariat who continue to collect evidence from relatives, family and people with lived experience. The secretariat have also confirmed they wish to hear from clinical and clinical support staff.

NL acknowledged the excellent work from AK and team in relation providing the Covid-19 vaccination for hard to reach communities. The Vaccination Team are increasing the availability of appointments and are starting to see significant increase in demand following the launch of the

Autumn booster programme. All vaccination centres are now open and the team also work with PCN colleagues to deliver vaccinations to housebound people and care homes.

Finance – TS
TS advised that the operating / revenue position remains within plan as we approach the mid financial year. TS was mindful of the significant scale of financial matters being tackled both internally and externally from the organisation and as we approach the planning phase for the next financial year.

Longer term capital investments in estates, facilities, equipment etc continue to be the focus and priority as we go through the remainder of the financial year.

ML noted that the government had recently released mini budget statements which indicated that NHS energy costs would be covered to some degree by additional funding and queried whether this had materialised. TS confirmed that the Trust had received additional allocations during the course of this year towards non pay pressures being experienced including utility costs. The Trust were mindful of how those costs could continue to increase and have undertaken a financial management check list as part of that to ensure funds and overall resources are being used as best they can and are securing value for money.

PS commented that through leadership, finance is seen as a facilitation of services, and regular updates are received through the Executive Team around the financial performance of the organisation which is fundamental to safe care going forward. The Executive Team were conscious of the cost of improvement gap and get a sense of confidence that we can close that. TS presented at the Annual Members Meeting, advising that within the previous year, £10m of saving had been identified, with a target this year of £17m (£14m identified to date) and were confident of delivery of a further £2.5m of efficiency. Discussion at the Finance and Performance Committee has included recurrence of efficiencies and how we drive efficiencies locally through quality improvement.

JW queried whether these efficiencies would be part of narrative there within the Accountability Framework meetings. TS confirmed this was the case, stating that a significant amount of work is channelled into the reporting packs into those meetings with real focus on that. For the Executive Team and Finance and Performance Committee, a detailed position of care units and corporate departments is provided so there is absolute transparency across all corporate, operational and clinical areas. TS agreed that this was a part of the vision to be operationally led and corporately enabled.

Following a query from ARQ, SL confirmed that the F2SU service is currently being reviewed to ensure it provides the best possible service to the organisation. The service is currently managing 30 cases. A report is due imminently and will presented at a board seminar session. SL confirmed that Elliot Judge had been appointed to the position of Interim F2SU Guardian and had been well received thus far across the organisation.

The Board received and noted the CEO's Report.

106/22	**QUALITY AND PERFORMANCE SCORECARD**

Discussed as above.

The Board of Directors received and noted the report.

107/22	**BOARD STANDING COMMITTEES ANNUAL EVALUATION**

DG advised that a self-assessment had been undertaken by members of the Board Standing Committees to assess its effectiveness in 2021/22 and inform our governance business flow going forwards. Overall feedback was positive, although there are always of areas for improvement – the Trust continues to operate within the scope of continuous improvement and feedback will be collated and taken forward in the planning for next year.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Noted the positive assurance provided for higher scoring statement**
3. **Noted that the identified lower scoring statements will be addressed with the review of wider governance business flow.**

108/22 SAFEGUARDING ANNUAL REPORT

NH was pleased to present the report and acknowledged the link to how AK presented real life challenges staff work with. There had been an increase in trend in safeguarding activities, and it was noted that we are seeing more complexity in patient profile. The safeguarding team's advice and counsel to clinicians has never been more needed. Increased activity for operational services had resulted in an increase in safeguarding referrals and the duty line had been of great benefit. The duty system is open to both children and adult cases so is a single point of access. An increase in the number of commissioned services has also risen resulting in a patient population increase. With the team's creativity and innovation they had been able to meet demand, streamline processes, increased the use of virtual technology and use of multiple caseloads taken in to one supervision. If the increase continues to be seen, there would be a need to review resource capability to continue to provide this service. Mandatory training had also increased significantly and it was noted this was partly due to the exemplary work to recruit to deliver the vaccination service. EPUT have taken a key role within the community collaborative around safeguarding and have received positive recognition by other organisations. The family approach has started to embed, and an increase in activity for referrals has been seen with clinicians being very proactive within this agenda and seeking support through the safeguarding team.

NH confirmed that sexual safety guidance is included in the training provision and learning lessons integrated into the culture of learning. The forward plan is driven by challenges seen over the past year.

LL thanked NH for this excellent report and was struck by some of the high profile safeguarding cases that had occurred through communication between organisations and queried whether there was potential to consider what the digital strategy is in context of the wider system. NH agreed that there is a connection about how to bring safety within the digital strategy. This is a key learning point as an organisation, many cases are seen through organisations where we have no ingress into their digital strategy or commissioned digital tools. Partnership working is focussed on trying to resolve this and encourage shared learning. ZT agreed adding that the Trust are working on how to improve accessibility of information within the Trust but also work within the ICS regarding shared care records and are working closely and fully engaged with system partners.

JW highlighted that a 27% increase in referrals is stark, noting this is a national issue, which is challenging and difficult for the team. JW continued that as a national issue, there may potentially be a recruitment issue for people with these skills. NH acknowledged that it is anticipated that there will be a resource issue through new regulations. The Psychology team provide support to the Safeguarding team and we see the whole organisation coming round this agenda. Nationally this is an issue as well as the pandemic and cost of living crisis. We need to look at activity as positive as this demonstrates that staff are recognising the need and referring.

ARQ noted that a comment in the report referred to the absence of identified resources within safeguarding which is a concern. NH confirmed that the team are forward planning against what we know around the increase in safeguarding activity to streamline services to deliver as it stands, NH continued that the liberty protection standards will generate an increased resource pressure for organisations in the space of best interest assessments and as such there is a need to look at resources, and whether it can it meet demand in light of the new legislation. NH continued that this was a case of forward planning and taking the opportunity to work differently.

AG noted that the team were seeing a rise in activity that was squashed during the Covid period and had seen in national media the horrifying rise in domestic violence, that increase has a direct impact on safeguarding and operational teams, AG put on record our thanks collectively to the team for their expert advice and support to operations during this period adding that the team are a very valued resource.

The Board of Directors:

1. **Noted the contents of the report, the improvements made during 2021/22 and the priority areas for implementation during 2022/23.**
2. **Approved the report for its publication.**

109/22 WORKFORCE DISABILITY EQUALITY STANDARD (WDES) DATA ANALYSIS

SL introduced LH and advised that the WDES and WRES reports would be presented together, stating that equity for the entire workforce is essential on the journey to provide outstanding care.

WRES

LH advised that the WRES had been devised to challenge organisations to improve performance in equality and ensure BAME staff have access to equal opportunities. There are 8 metrics measured within WRES.

It is important to note that NHSE had developed separate WRES for bank staff (BWRES) which has had an impact on indicators 1, 4 and 9 which will no longer include bank staff as previously.

The overall percentage of BAME staff within EPUT was 22.7%, which had declined slightly from last year.

The Trust had seen modest improvement in comparison to 2021. 6 of 9 indicators had seen improvement. Whilst there has been progress, there are significant improvements to be made in the following areas:

- Relative likelihood of BME staff entering the formal disciplinary process compared to white staff, as measured by entry into a formal disciplinary investigation (indicator 3).
- Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives of the public in the last 12 months (indicator 5).
- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (indicator 6).

With regards to bullying and harassment, stakeholder engagement sessions will be held with all staff invited to share findings of the WRES. Due to the national mourning period following the death of Queen Elizabeth II, some stakeholder sessions were delayed but looking at general themes as a result of these sessions is that people want to see action:

- The need to create an environment which is open and people are able to speak up.
- Behaviours – there is work to be done on a behaviour toolkit, there are some historical behaviours to overcome to ensure staff are at the heard.
- Leadership development – support given to staff that may be abused or harassed.

WDES
There are 10 metrics overall, with subsections making 13 in total. In EPUT there are 4.31% of staff recorded as having disability which is a growth of 1% in the last year. Overall there has been and improvement in metrics, with 11 out of 13 comparing favourably. In comparison to the national average, the Trust are faring well.

The in-year trend in WDES metrics in 2022 relative to 2021 shows positive improvements reported in a range of staff experience metrics. Whilst continuing to support staff across the Trust with a disability and long term conditions, the focus for 2022/23 will be bullying and harassment faced by staff with disabilities and long term conditions. It was also observed through the team's wider work and staff feedback that there should be a focus on how we as an organisation support those with invisible conditions.

PS thanked LH for the insightful analysis, noting the good discussions that had also been held at the People, Equality and Culture Committee. PS noted that clear measures and direction for improvement adding that it is important from a moral and ethical point of view, but also a service point of view. We can make a difference when we focus and the RISE programme demonstrates that. PS advised that LH was invited to attend the Executive Team regularly to update on WRES and WDES action plans and would report back to board throughout the year.

ARQ noted that the marked improvements in some areas was pleasing, however it was concerning that the bullying and harassment measure is causing an issue, and queried whether we have a real understanding of why staff are experiencing this as any action plan needs to address the cause. SL responded that as an organisation we cannot turn away our patients, and as we know there has been an increase in patients with acute illness and less capacity. Levels of abuse staff receive is challenging and it is our role to ensure we have the facility to support colleagues; SL had requested a programme to be created on resilience to actively work on building psychological safety and resilience for our workforce. ARQ accepted that and understood the issue, however challenged that this was not only from patients and service users and this was something we should be able to understand and control. SL agreed however advised that the biggest issue was ongoing abuse from patients and as such the team were building a programme for managers and an infrastructure was going in place around education on how to deal with this situation.

ZT noted that the two reports made it clear that the NHS as a whole nationally is not where it needs to be on these important issues. ZT welcomed the focus this will give to action plans and the need to be clear as a Board that there is a huge distance to go on these important agendas.

ML noted that there was a good appraisal of the reports at PECC, highlighting there is an ongoing pattern of the same indicators and this does require a level of radical thinking and action. ML was particularly encouraged by executive engagement at PECC and ownership and leadership. ML added that there is also a need to undertake deep dives in wards and services where issues manifest.

The Board of Directors:
1. **Received and noted the contents of the report.**
2. **Noted that the People, Equality and Culture Committee have reviewed the detail and recommended the report to the Board of Directors.**
3. **Approved the data for publication in line with national requirements.**

110/22 WORKFORCE RACE EQUALITY STANDARD (WRES) DATA ANALYSIS

Discussed above.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **Noted that the People, Equality and Culture Committee have reviewed the detail and recommend the report to the Board of Directors.**
3. **Approved the data for publication in line with national requirements.**

111/22 A FRAMEWORK OF QUALITY ASSURANCE FOR RESPONSIBLE OFFICERS AND REVALIDATION – ANNUAL REPORT

MK presented the report which reminds the Board of their responsibilities under the Medical Regulations Act. MK felt well supported by the Board in terms of resource and process to ensure the Trust are compliant. MK added that this also allows the Chair and CEO to submit the report to the second tier responsible officer at NHSE.

During the pandemic, medical appraisals were suspended by NHSE and therefore the compliance rate decreased. The Trust are fully compliant in terms of maintaining accurate records and ensuring access to a full practice appraisal. Nine concerns raised were addressed appropriately. MK summarised that overall, this had been a satisfactory year with actions for the coming year to commission an external peer review and improve appraisal rate.

SS commented that the revaluation and appraisal process was both important and essential and as such a progressive move back to 90% compliance was welcome.

The Board of Directors:

1. **Received and noted the contents of the report.**
2. **The Designated Body (EPUT) through its Chair of Chief Executive Officer to submit the compliance statement to the Higher Responsible Officer at NHS England.**
3. **Did not request any further information or action.**

112/22 BOARD ASSURANCE FRAMEWORK 2021/22

PS extended thanks to DG for her leadership and assurance reporting. Strategic risks have been covered in discussions held during the meeting and at standing committees. There is a huge amount of work ongoing and the Trust are redefining a new approach which has been well received by colleagues.

LL placed on record the welcome for the new format which allows focus on a page.

The Board of Directors:

1. **Approved the full BAF summary report for September 2022.**
2. **Noted one new Corporate Risk (Loggists with a risk score 16).**
3. **Noted the change in risk score (CRR94 Engagement and Supportive Observation).**
4. **Considered effectiveness of controls and assurances.**

113/22 STANDING COMMITTEES

(i) **Audit Committee**

JW advised the verbal update due to the timing of papers. The recent meeting had been a good assurance meeting with NH in attendance to present assurance on the clinical audit

process which was making good progress. Updates were received on cyber assurance covering the recent cyber-attack, learning and planning for the future and also business contingency plans going forward. Internal audit gave a report on SFIs and waivers and suggested strengthening internal controls. A review of financial internal controls had been requested nationally to secure value for money and funding. There were no new risks to highlight from the Audit Committee.
The Board received and noted the report and confirmed acceptance of assurance provided.

(ii) Charitable Funds Committee
AS presented the assurance report advising that there were no further issues to highlight.
The Board received and noted the report and confirmed acceptance of assurance provided.

(iii) Finance and Performance Committee
LL presented the report, highlighting the Lighthouse Centre contract, the Finance and Performance Committee continue to explore how performance can improve over the duration of the contract and look at how we can go beyond the national target. The MHUCD business case continue was discussed and the committee continue to monitor progress. LL advised that this is a promising project and the committee were keen to see the project achieve what had been set out in the business case.
The Board received and noted the report and confirmed acceptance of assurance provided.

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

(v) People, Equality and Culture Committee including Terms of Reference Approval
ML advised that the recent meeting had been strong with good commitment from the team and incisive reports. The committee were better assured around international recruitment, with the focus of the meeting around the scale of ambition; the committee were looking forward to seeing innovative and nationally leading schemes come forward. ML echoed congratulations following the assessment on apprenticeships by Ofsted.
The Board received and noted the report and confirmed acceptance of assurance provided.

(vi) Board Safety Oversight Group
ARQ advised that the Culture of Learning Team had produced an excellent safety dashboard on a page, which was excellent and a good tool for the Board to see how the Trust are performing against safety priorities. ZT noted that this was the same dashboard referred to earlier within Power BI and welcomed that feedback.
The Board received and noted the report and confirmed acceptance of assurance provided.

114/22 POLICY OVERSIGHT AND RATIFICATION GROUP

DG advised that there had been lots of discussion and feedback around the policy ratification process being duplicative and taking significant time at board assurance committees. As such an interim process around new policy panels chaired by DG had been designed, alongside a system of internal controls to the audit committee which allows to link in to coproduction with service users where appropriate and also link in with the governance processes. JW welcomed this approach.

DG confirmed that there is commitment from members to prioritise attendance but this will continue to be monitored. ZT also requested a digital representative on the panel.

The Board of Directors:

1. **Approved the stand up of a Policy Oversight and Ratification Group and its terms of reference.**
2. **Approved changes to the Trust policy for the Development Review and Control of Trust Approved Documents to reflect the new Policy Oversight and Ratification Group.**
3. **Noted the phased programme of work associated with the quality assurance, approval and maintenance of trust wide policies and procedures.**

115/22 LIGATURE RISK MANAGEMENT Q1

AG presented the report which gave an overview of governance, continued learning and enhancing environments. AG noted that there is a risk on the Corporate Risk Register around ligature, and confirmed this is monitored through the LRRG, with the terms of reference of that group reviewed to reflect a focus on both environment and practice mitigations.

The Board of Directors:

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

116/22 CQC REPORT AND ACTION PLAN

DG advised the report provided an update on the key CQC related activities being undertaken within the Trust, provided details of CQC guidance / updates received and provided an update on progress with actions agreed in response to the CQC inspection report for CAMHS.

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

117/22 ANNUAL REVIEW OF:

(i) Standing Orders for the Board of Directors

(ii) Scheme of Reservation and Delegation (SoRD)

(iii) Detailed Scheme of Delegation

(iv) Standing Financial Instructions

TS presented the report which provided the revised documents for approval following review and recommendation to the Board of Directors by the Audit Committee.

The Board of Directors:

1. **Received and noted the four documents following review by the Audit Committee.**
2. **Approved the four documents.**

118/22	EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) NATIONAL CORE STANDARDS RETURN

NL advised that as Board colleagues were aware, there is a requirement to complete a self-assessment in terms of EPRR. For assurance, NL advised that this had gone through the challenge of HSSC and the Executive Team prior to sign off from the Quality Committee. Of the 55 standards to self-assess against, it was concluded that the Trust were compliant with 51, with 4 non-compliant and action plans in place.

JW noted that an area outstanding is corporate training and this was picked up through the BAF around loggist training, querying whether there was a time scale and plan. NL responded that the Trust are in touch with the regional team and there is also an audit taking place as national training is affected by Covid. The Trust are currently in discussion with region to work on a programme of our own internal training.

The Board of Directors:

1. **Ratified approval of the Emergency Preparedness, Resilience and Response national core standards self assessment 2022/23 for EPUT.**

119/22	CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

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

120/22	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.

121/22	REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

TS noted that there had been a significant agenda today with much discussion. Explicitly discussions had picked up the breadth and scale of our services. Less explicitly; discussions had touched on the breadth of geographic service delivery. Overall there had been an inclusive set of discussions across the Executive Team and Non-Executive Directors that had been very thorough and considered, with the key focal points to discussions being our patients, our people and equality. There is a long way for the NHS to go but the fact that these elements were core to our agenda today was right and fitting.

122/22	CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

It was noted that all Board members had remained present during the meeting and heard all discussions with the following exceptions:

10:27 – 11:38 MJ left
11:46 – 11:49 NH left

123/22	ANY OTHER BUSINESS

Signed: …… Date: ……

In the Chair

There was no other business.

124/22 DATE AND TIME OF NEXT MEETING

SS thanked all for joining the meeting.

The next meeting of the Board of Directors is to be held on Wednesday 30 November 2022, which will be held virtually via the MS Teams video conferencing facility.

125/22 QUESTION THE DIRECTORS SESSION

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

The meeting closed at 12:37.

Signed: …… Date: ……

Appendix 1: Governors / Public / Members Query Tracker (Item 125/22)

Governor / Member / Public	Query	Response provided by the Trust
Pippa Ecclestone	In spite of the fact that the COVID19 message has been withdrawn from the "111" service, it still takes over 2 minutes to access "Option2" for service users in a Mental Health Crisis. Physical Health Emergencies have the "999" line. We strive for equality between physical and mental health services but this is an unequal Crisis service. It may be better than it was but it is not good enough. Please could EPUT increase its efforts to persuade 'the powers that be' to make "OPTION 2" the initial question on this "National Mental Health Crisis Line"?	LL suggested that there may be opportunities to work with BT. AG thanked PE for raising in such an impassioned way, acknowledging that there are challenges to equity with our service users and was happy to join with other colleagues to see what profile can be given to this. ZT added that there were two elements, one around anything we can do technically with our role in providing the service and will speak to colleagues. The second around influencing and the need to raise through the regional MH Board to register and take forward with colleagues.
Paula Grayson (via the Chat function)	At the appropriate time, please can Zephan explain this information about the Power BI: "the patient safety dashboard as the visualisation of serious incidents (Datix) has been developed to promote the culture of learning opportunities. This Is the first Power BI dashboard to be published on the back of the aggsoft Power BI mobilisation and paves the way for how data can be visualised."	
Paul a Grayson (vis the Chat function)	When appropriate, please can Trevor comment on the effect on EPUT of the ICS deficit ("The ICS is reporting an actual deficit of £38.4m, £27.1m adverse to plan with recovery actions underway and further actions being developed".	

Signed: …… Date: ……

Paula Grayson (via Chat Function)	When appropriate (WDES and WRES) Reports, please can Sean set out the additional plans for reducing bullying and harassment of our staff who have disabilities and / or are ethnically diverse? Thank you Alison and Manny for making your points and understanding, managing and improving outcomes for staff who have been bullied or harassed, especially those with disabilities and / or ethnically diverse.	

Agenda Item 4
Board of Directors Part 1 Meeting
30 November 2022

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 28 September 2022)

Lead	Initials	Lead	Initials	Lead	Initials

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

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

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The report attached provides information in respect of:

- Farewell to Alison Rose-Quirie and NED Recruitment
- Cavell Nursing Award and Queens Nurse Award
- Service Visits
- Recognition in National Awards
- Dr Abdul Raoof appointed as an Associate Dean of the Royal College of Psychiatrists
- Equality and Diversity Week
- Remembrance Day

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

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

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

Acronyms/Terms Used in the Report			
CAMHS	Children and Adolescent Mental Health Services	NED	Non-Executive Director
CQC	Care Quality Commision		

Supporting Reports/ Appendices /or further reading
Main Report

Lead
Professor Sheila Salmon **Chair**

Agenda Item: 5
Board of Directors Part 1
30 November 2022

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 Farewell to Alison Rose-Quirie, NED and NED Recruitment

October saw the departure of Alison Rose-Quirie from her Non-Executive Director Role. Alison has contributed significantly to EPUT during her tenure, bringing a wealth of experience and knowledge that will be sorely missed. On behalf of the Board, I wish Alison every success in her future endeavours.

Following the stepping down of Amanda Sherlock and Alison Rose-Quirie, Mateen Jiwani has taken on the role of Chair of the Charitable Funds Committee and has joined the Audit Committee as a Non-Executive Director member. Further to this as a holding position until our new Non-Executive Directors are in place I will be chairing the Board Safety Oversight Group.

The process to recruit two new Non-Executive Directors is completed. The Council of Governors was pleased to approve the appointments of Jill Ainscough and Professor Stephen Heppell as Non-Executive Directors and they will be joining the board as of 30 November. In addition the Council of Governors was pleased to prospectively appoint Elena Lokteva, who has a strong audit background to work closely with Janet Wood our existing Audit Chair in the run up to filling that vacancy later in 2023. Elena will associate with the Trust from a date to be determined in 2023. I am delighted by the outcome of a very strong recruitment round.

2.2 Cavell Nursing Award and Queens Nurse Award

I was delighted to be asked to present two of our nurses from the Epping Forest District Nursing Team, Amanda New and Tracy Burn, the Cavell Nursing Award. An inspiring national awards programme, Cavell Star Awards are given to nurses, midwives, nursing associates and healthcare assistants who shine bright and show exceptional care to one of three groups of people – their colleagues, their patients and their patients' families. Hearing from Amanda and Tracy the challenges faced, particularly during the height of the Covid 19 pandemic; I can say that their nominations and awards were truly deserved. Tracy has also been awarded the Queen's Nurse Title, this title is available to individual nurses who have demonstrated a high level of commitment to patient care and nursing practice.

2.3 Service Visits

As we begin to return to life without social distancing restrictions, the NEDs and I are pleased that we have been able to recommence face-to-face visits to services to gain a real insight into the challenges experienced by our staff, but also to see the exceptional care provided and dedication of our workforce. Recent visits by NED colleagues and myself have included Wren House, Herrick House, Derwent Centre, Edward House, Dementia Intensive Support Team (DIST), West Essex District Nursing Team and the Lakes, with further visits scheduled to take place over the coming weeks.

2.4 Recognition in National Awards

The Positive Practice Mental Health Collaborative is a user led multi agency collaborative of more than 50 organisations including NHS Trusts, Integrated Care Boards, police forces, charities, service user groups and third sector providers. The Positive Practice in Mental Health Awards is a national awards scheme that celebrates the work of mental health services across England, Wales and

Scotland and is open to organisations in the NHS, Social Care, third sector and independent sector. The Trust won three awards and was highly commended in two further categories:

- Child and Adolescent Mental Health Services (CAMHS) inpatient services - winner of Addressing Inequalities in Mental Health
- Brockfield House, Runwell - Winner of Integration of Physical and Mental Healthcare
- Festus Meshe - one of five winners of Outstanding Leadership
- Service User Network for Personality Disorder and Complex Needs - Highly commended for Innovation in Digital Mental Health
- Adult Mental Health Family Group Conference Service - Highly Commended for Complex Mental Health Needs

2.5 Dr Abdul Raoof appointed as an Associate Dean of the Royal College of Psychiatrists

Dr Raoof, Consultant psychiatrist and Director of Medical Education at EPUT has been appointed as the next Associate Dean for Advanced Learning and Conferences at the Royal College of Psychiatrists. The College is the professional medical body for supporting and training psychiatrists in the UK; Dr Raoof will oversee the College's International Congress and will also continue his clinical work at EPUT. Many congratulations to Dr Raoof on this achievement.

2.6 Equality and Diversity Week

Monday 07 November saw the beginning of the Equality, Diversity and Inclusion (EDI) Week at EPUT. Throughout the week the team revealed plans for EDI for the coming year by publishing a framework which demonstrated our actions to tackle EDI issues. A drop in event that focussed on tackling bullying and harassment took place with guest speakers and examples of lived experience. Results from our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) were shared, there were opportunities for managers to sign up to workshops on micro-incivilities as well as other events. The EPUT Board and leadership team are committed to ensure all of our staff have the space to be themselves at work and to ensure that there is full equality of opportunity and fair treatment across the Trust – the EDI week highlights our plans in this area and provides a focus for this very important agenda.

2.7 Remembrance Day

Friday 11 November was remembrance day and I was honoured to host a virtual event alongside Paul Scott, Paul Walker and Helen Semoh from our Chaplaincy Team, Lorraine Hammond Director of Employee Experience and David Powell our Armed Forces Champion. This event was an opportunity to come together to pay our respects, pay tribute and remember those in the armed forces and their families who have sacrificed so much. Lest we forget.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

3.1 Medical Device Reform – Two Important Updates from The MHRA

Please see the first link below for a copy of report published on 1 November 2022 focusing on the requirements for software and AI as a medical device to provide assurance that these devices are acceptably safe and function as intended, thereby protecting patients and public. The second link is a copy of the Software and AI as a Medical Device Change Programme Roadmap that was updated on 17 October 2022.

This report is extremely useful for ITT Department as it relates to artificial intelligence.

For Information: Link; Link

3.2 Changes to Provider Licence Requirements Reflect Integration and NHS England Newfound Enforcement Power

Please see the link below for a copy of a report published on 8 November 2022 that focuses on bringing requirements in line with the Health and Care Act 2022 and accompanying policy changes that outlines that NHS Trusts previously exempt will now need to be licensed along with all all NHS foundation trusts and independent providers of NHS services.

For Information: Link

3.3 CQC New Quality Statements

Please see the link below for a copy of a second alert on CQCs new ways of working under its forthcoming Single Assessment Framework published on 7 November 2022 that focuses on the new statements under "Safe".

For Information: Link

3.4 Combatting Racial Discrimination Against Minority Ethnic Nurses and Midwives

Please see the link below for a copy of the report published by NHS England on 3 November 2022 aimed at all nursing and midwifery professionals registered with the Nursing and Midwifery Council working in the NHS.

This report is extremely useful for staff as it supports the professionals of the Trust to feel confident about challenging discrimination.

For Information: Link

4.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by

Angela Horley
PA to Chair, Chief Executive and NEDs

On behalf of

Professor Sheila Salmon, Chair

		Agenda Item No: 6
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

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

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

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

Recommendations/Action Required

The Board of Directors is asked to:

1 Receive and note the content of the report

Summary of Key Issues

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

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

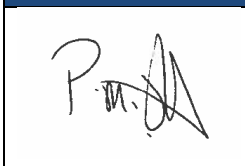
Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report

Lead



Paul Scott
Chief Executive Officer

Agenda Item: 6
Board of Directors Part 1
30 November 2022

CHIEF EXECUTIVE OFFICER REPORT

1.0 INTRODUCTION

Communications with our staff is critical and I personally write to all staff on a fortnightly basis via my blog, as well as hosting an all staff live event (virtually) on a fortnightly basis so I can make sure that staff hear directly from me on a weekly basis. It is also important that staff have a voice and can raise questions – they can either raise questions at all staff briefs and via the communications team. These communications are part of the regular flow of communications across the Trust and in addition we of course make sure that staff are updated on any urgent or ad hoc information.

Alongside this I regularly informally visit our sites and saying thank you to our staff for the work, putting our staff first.

2.0 UPDATES

2.1 Dispatches Documentary

EPUT featured in a Channel 4 Dispatches documentary about our mental health wards which was first broadcast on Monday 10 October 2022. The programme included covert surveillance from an undercover reporter working as a member of staff on Willow ward at Rochford Hospital and Galleywood ward at the Linden Centre in Chelmsford. Both wards are (female) adult acute mental health wards.

The scenes in the Channel 4 Dispatches documentary were distressing for all, especially patients and their families. I can assure the Board that these allegations were taken seriously and I immediately commissioned an urgent inquiry. Our prime concern is always the care of our patients.

In addition to the investigation we took immediate action when first alerted to the allegations made by Channel 4 including conducting clinical reviews, ward visits and staffing reviews on the two wards featured. We temporarily closed the two wards to admissions while further investigations were carried out, and our Deputy Directors of Quality and Safety undertook observations on the wards. We also put in place enhanced management oversight and presence on the two wards, this included myself and the Executive Team at EPUT.

EPUT raised an individual safeguarding concern with Essex County Council in relation to de-escalation and restraint in advance of broadcast. The EPUT Safeguarding Team have visited both wards to review Safeguarding procedures and compliance. Further visits are planned. The Safeguarding team has held a welfare conversation with all patients on Willow ward. I attended the Essex Safeguarding Adults Board on 19 October 2022 at the invitation of the Safeguarding Board Independent Chair.

We took extensive steps ahead of broadcast to obtain assurances from the broadcaster regarding patient and staff anonymity.

Our existing community meetings for patients on wards continued, with additional support from the Patient Experience team. We sent out a communication to Volunteers and our Lived Experience team after the broadcast and we are planning further communications and engagement to involve service users, their families and carers in the actions we will take as a result of our investigation.

We established a standalone process for the triage and handling of service user, family and carer contacts in relation to the programme via our PALS and Complaints teams, and a confidential helpline via our contact centre.

The CQC visited Willow Ward on 5 October and Galleywood Ward on 6 October following advanced notification by the Trust of the allegations it had been informed of by the production company. As a consequence of these concerns the CQC considered that there was a need for significant improvement and under a section 29A notice asked the Trust to make improvements by the 18 November 2022. The Trust fully complied and reported back to the CQC. On Tuesday 22 November 2022, the CQC commenced an unannounced inspection six of our core services.

We continue to work with our partners and regulators to ensure that lessons are learned and that we can further improve care for our patients.

Since I joined the organisation in October 2020, we have remained focused on improving all aspects of patient care, with the development of a safety strategy at the core of this. Alongside our £20m investment into our community services to enable better care at home for those who use our services, we have also invested £20m in our inpatient wards to create safe and therapeutic spaces for our patients. This investment has included improvements in order to reduce the risk of fixed point ligature and abscond rates. Alongside practical steps to enhance the environment and increase security, we have installed state-of-the-art technology, provided enhanced training programmes for our staff and have changed the way in which we provide supportive observations and engagement for our patients, with care tailored to their needs. It is a testament to all this hard work that we have seen a significant decrease in total absconds since 2020, decreasing by over 60% between 2019 and 2021, a 32% reduction in fixed ligature incidents this year compared to the previous year, and a dramatic decrease in the use of prone restraint. We are making good progress, nevertheless we know there is always more we can do and will continue to focus on providing the best possible environment for care and recovery with the safety and wellbeing of patients at the heart of everything we do.

2.2 Cost of Living support

The Trust uplifted all business mileage rates by 5 pence a mile from 1 September 2022. This uplift remains in place and will be reviewed once the outcome of the national NHS mileage rates evaluation has been announced. The Trust also introduced a mechanism for staff to reclaim costs for purchasing a blue light card (£4.99 for a two year membership) the first window of opportunity to claim closed on the 9 November 2022. To date 1,145 EPUT workers have submitted a reimbursement request. On the 9 November 2022, staff started receiving a £50 gift vouchers as a small gesture to ease the pressure and help with the impact of the rising cost of living. We have also set up dedicated intranet pages with access to a variety of sources of financial advice and support including information on discounts available. The intranet also hosts a site where staff can offer items free of charge or for sale and we utilised this for school uniform and plan to do the same for Christmas gifts.

2.3 Time to Care Programme

We are doing some work called Time to Care that is principally focussed on our inpatient wards – however many of the steps we take will also apply to other areas of the Trust. The focus is about releasing more time for our clinical staff to spend with patients and service users and we are piloting some initial projects in eight areas.

Staff have suggested and shaped the projects, which are the first to be implemented as part of the Time to Care programme. You will be seeing this pilot projects starting from this month.

We are looking to identify new roles and make changes to existing roles to give staff more time to focus on patient care. This will help reduce the amount of time they need to spend on administration and tasks outside of their role. Staff and service user data is helping us to develop new staffing models, which we aim to start piloting from next month in ten wards.

We are looking to give more staff across the Trust access to Shared Care Record, which will give medical staff and prescriber's access to full patient medical history and help pharmacists easily prescribe medications.

And we are looking at making online forms instead of paper ones, to save you time manually copying information from paper forms and printing and scanning paper documents.

The other ideas we're also piloting are:

- A Ward Manager Development Programme
- A Safe Staffing Dashboard to give clinical teams easy access to vital information about staffing levels on the wards.
- A standard approach to handovers and list of core behaviours, which have been developed by staff. We will also trial using a cut-off time for ordering non-urgent medication on the pilot wards.
- Improving the Sitrep Process in Specialist Services, including rolling out SafeCare

We are supporting trialling an updated version of the SMART bed capacity reporting tool, SMART V2. This will include patient flow activity and SitReps

2.5 Stakeholder Perceptions

EPUT commissioned an independent review of stakeholder perceptions in the summer of 2021. A refresh of stakeholder perceptions was undertaken between June and September 2022. Opinions were gathered via a series of one-to-one interviews with key partners carried out by Graeme Jones

The tone of the stakeholder feedback was more positive than in 2021 with stakeholders acknowledging the scale of change underway at EPUT, giving strong credit for an improved approach to working with partners, describing and observing better relationships in the health and care system. There is support for the new vision and strategic objectives, and positive feedback on the new Operating model and Care Unit structures.

Partners raised some issues and concerns, some of which were repeated from 2021. The challenge of working across three Integrated Care Systems is recognised by partners with EPUT seen as less visible than other providers by some ICS leads. Partners identified further opportunities for joint work and for EPUT to take a lead with cross system work.

Stakeholders gave strong credit to the EPUT leadership team, the focus on quality and safety, and raised a range of examples of positive collaboration to improve and integrate services.

The feedback will inform a new stakeholder engagement framework for the Trust and inform our strategic plan and 2023/24 operating plan.

3.0 OTHER NEWS

3.1 Quality and Excellence Awards

I recently launched our 2022 Quality and Excellence Awards.

The awards are a chance for us to recognise and reward the excellent work that happens at EPUT every day. They are our opportunity to recognise our rising stars, our outstanding volunteers, our exceptional leaders and teams, our heroes, our partners and those who have left a legacy.

This year, there are 18 award categories to choose from, and these align with our EPUT vision, values and strategic objectives. Anyone who has worked at EPUT, from 1 March 2020 to 31 October 2022 can be nominated, whether as a permanent or temporary staff member, including bank staff and volunteers. There is also a category to specifically recognise our partners and collaborative working across organisational boundaries.

We have so many committed and dedicated colleagues and volunteers across EPUT. We are looking for people who demonstrate excellence and who embody our values in everything they do. The response so far has been fantastic with 37 nominations on the first day of launching.

3.2 Award Nominations

Alongside East London Foundation Trust and Sheffield Health and Social Care Foundation Trust, EPUT was a winner at the Health Service Journal awards for the collaborative work around "Clinical Associate in Psychology: An apprenticeship model for a future sustainable and diverse psychology workforce"

The NHS needs to increase the psychology workforce by 60% by 2024. Yet in England in 2020 only 18% of psychology graduates were accepted onto Clinical Psychology courses via traditional training routes. To address this, a Trailblazer Group was established in 2018 bringing together clinical psychology leads from three NHS trusts, and the CAP apprenticeship programme was created. Greg Wood (EPUT), Ravi Rana (ELFT) and Linda Wilkinson (SHFT) came together to lead on the development and implementation of the CAP role.

Our vision is to build a sizeable, sustainable, diverse psychology workforce representative of communities themselves. Partnerships with universities to develop locally sensitive training courses alongside strategic workforce plans have been developed and EPUT's Dr Barbara Mason and her team have established the first NHS Main Provider master's apprenticeship course for training CAPs. NHSE/HEE formally welcomed CAP into the family of psychological professions in 2022. The first training cohort at EPUT successfully completed their apprenticeship recently and we have a second cohort established. We have CAPs on our in-patient wards, in community teams, perinatal services, EIP and planned in many other services. We have trained CAPs for HPFT, SNFT and ELFT.

I would like to extend my congratulations to all our staff involved. It is testament to all their hard work and commitment to providing the best possible care to our communities, and demonstrates the improvements we continue to make as a Trust.

3.3 National Safeguarding Week - Paul

National Safeguarding Adults Week takes place from 21 November, a time for organisations to come together to raise awareness of important safeguarding issues.

To mark the event our safeguarding team will be holding roadshows at inpatient sites across the Trust.

Tendayi Musundire, our Associate Director of Safeguarding, and the team will be visiting Rochford Hospital, St Margaret's Hospital, The Linden Centre, Basildon Mental Health Unit and The Lakes to give colleagues a chance to meet with them face to face, ask questions and find out more about safeguarding processes.

The safeguarding team is also hosting three webinars throughout the week focusing on Carers Assessment, Breaking the Cycle of Domestic Abuse and Neurodiversity. Invitations have been sent to everyone so check Outlook for yours.

3.4 Self-care week

We also marked Self Care Week is a national awareness event, which started on Monday 14 November, aimed at providing an opportunity to focus on self-care, and providing resources to help our staff take care of their health and wellbeing.

Our health and wellbeing toolkit includes information on:

- Professional wellbeing support available at EPUT such as Here for You, occupational health, fast-track physio, staff health checks, domestic abuse support, ACT for You and more

- Resources to help you improve personal health and wellbeing, which cover topics such as physical, emotional and financial wellbeing, menopause, long COVID, addiction and men's health
- Improving your working environment
- Guidance for managers and leaders including how to hold wellness conversations with colleagues
- Fulfilment at work including flexible working, awards, buying and selling annual leave and development opportunities
- Improving relationships and forums to voice concerns

Sign up to ACT for You - NHS

Our 'ACT for You – NHS' workshops are based on acceptance and commitment training techniques, which are developed from an evidence-based psychological therapy called Acceptance and Commitment Therapy (ACT). These online workshops aim to develop greater psychological flexibility in the way we respond to life's challenges. Whilst the focus of this training is on our work roles, these techniques can also be applied to our lives generally.

The skills we practice have been shown to be most useful when we are experiencing things like stress, worry, anxiety, low mood or loss of life purpose.

This training is not therapy and you don't have to feel that you are experiencing high levels of stress at work to benefit from the training**.** These skills are designed to both manage every-day stress and to help you improve effectiveness and performance in many different areas of life – at work, in your personal and family relationships, in relation to your health and well-being, and in your leisure time. All EPUT staff are welcome to attend.

The training consists of four half day online workshops that are sequential, so starting with workshop 1 and working through to workshop 4. In order to register, please seek line manager approval and email epunft.act4nhsworkshops@nhs.net with the dates you wish to attend. You will then be sent the course agenda, and pre course information. Find more information on the ACT for You page including dates for our forthcoming workshops.

EDI week

EPUT also marked Equality Diversity and Inclusion week. We celebrated the diversity of our workforce and demonstrated how we are determined to create a culture where everyone can be themselves in the workplace.

We've made great strides in this area, but of course there's more to do, and throughout the week we focussed on the things we are going to do to improve equality, diversity and inclusion in all areas of the Trust.

We have produced a one pager of our EDI framework demonstrating our aims for four strategic pillars; which include culture & leadership, talent management & acquisition, recruitment & retention and data. .

- **Bullying and harassment drop in webinar**

  In collaboration with colleagues from Mid and South Essex (MSE) Integrated Care System (ICS), we held a day-long drop in event on Thursday 10 November, from 9am to 4.30pm, aimed at tackling bullying and harassment. Our WRES data tells us that bullying and harassment is an issue that still concerns colleagues both in EPUT and the wider system. We know that being bullied or harassed at work is distressing and we need to work towards making transformative change in this area. With the help of external speakers, including author Roger Kline and organisational psychologist John Amaechi, and colleagues across the system, we covered a number of topics:

- **Manager opportunity: sign up to micro-incivilities training pilot**

  Managers at EPUT were also invited to sign up to micro-incivilities workshops as part of a pilot taking place in EPUT and Mid and South Essex Foundation Trust (MSEFT) with the ultimate aim of rolling out to the wider system. Micro-incivilities, also known as micro-aggressions, are commonplace behaviours or aspects of an environment which signal, wittingly or unwittingly, that someone does not belong, or they

are not welcome. The intent to harm can be ambiguous in these instances. The workshops are designed to equip our managers with tools and skills to understand and respond.

4.0 PERFORMANCE AND OPERATIONAL ISSUES

4.1 Operations – Alex Green, Executive Chief Operating Officer

Our numbers of inadequate and requiring improvement quality and performance measures remained stable in October. However, we have experienced challenges with inpatient mental health capacity, with out of area placements, inpatient occupancy and length of stay reflecting those pressures. Our regional colleagues are experiencing a similar position.

Work on purposeful admission and the Getting it Right First Time Programme continues and together with the Time to Care Programme is anticipated to support sustainable improvement in inpatient units. The collaboration of partners across Southend, Essex and Thurrock is key to delivering improvement and there is a commitment, as we take forward the development of a Southend Essex and Thurrock Mental Health Collaborative, to a focus on unified approach to adult urgent and emergency care and inpatient services.

More widely, our care units are working very closely with our system colleagues to support local pressures, with a number of services such as virtual wards and urgent care response teams enabling people to be cared for in their home t.

I'm pleased to report that our Psychiatric Intensive Care Unit (PICU) performance has improved. Psychology waiting lists are also showing an improved positon from last year and the service has turned its attention to digital solutions and outsourcing capacity. This is a great step in innovation and future focused thinking.

Temporary staffing usage remains under scrutiny by our operational teams with consistent challenges however I can report that agency usage has reduced again in October for the third consecutive month and we continue to progress the work to fast track temporary staff to permanent roles.

4.2 Safety and Quality – Natalie Hammond, Executive Nurse

Work has continued to identify activities that are contributing to the delivery of our Safety, First, Safety Always Strategy. Since the last Board meeting, two further areas have been presented to Executive Safety Oversight Group / Board Safety Oversight Group, these being wellbeing and innovation.

As part of this process, we continue to identify new initiatives that were not originally stated in the Safety Strategy although are contributing to the objectives. Examples include:

- The introduction of an improved ePMA system will bring reductions in prescribing errors and omitted dosages along with a reduction in clinical incidents, while also helping to ease the pressure on our pharmacy team

- The new Safety Dashboard will support the analysis and interrogation of aggregated data from various source like Datix, Paris, Mobius and HealthRoster in an organised and efficient way. We intend to use this triage tool to provide timely visual trends and data analysis to develop collaborative improvements across all services.

- The digital engagement platform which will promote a positive organisational culture where every employee has a voice, a platform to provide feedback and feels their input is respected.

- Business Information (BI) transformation is an encapsulation of the depth and breadth of effort required to transform Data Analytics and BI functions to support business decisions and transform the Trust into a data-driven intelligent enterprise

Using the information and data we have captured over the last six months we are now building the final storyboard and content for the safety strategy update for the Board next year. This report will focus on what we have delivered to date, the associated benefits and supporting data/KPIs and provide details on our areas of continued focus.

4.3 Medical Directorate – Dr Milind Karale, Executive Medical Director

In order to make North East Area more attractive to work, NE care unit is now imbibing work force planning principles into medical recruitment and has appointed 2 Consultants and 4 career grade doctors. NE Directorate has developed and cemented a Good Relationship with the Local ICB (SNEE). EPUT is now part of its Quality Dashboard Development. The Directorship meet now meets regularly with the ICB mental health lead.

EPUT continues to have regular presence through various EPUT Clinicians in leadership positions and successfully organised the Royal College of Psychiatry division conference.

4.4 Digital, Strategy and Transformation – Zephan Trent, Executive Director of Digital, Strategy and Transformation

Strategy - We continue to develop our strategic plan to support delivery of the vision, purpose, strategic objectives and values agreed by the Board in 2021. Each care unit has developed a draft strategic plan, identifying priorities for their services, and we are using these to develop our overall trust strategic plan over the next two months. We shared key themes for our strategy work with the Public Forum and at a joint Board and Council of Governors seminar in November.

Work on a draft framework for stakeholder engagement, building on the feedback from the stakeholder perceptions work, has been shared with the Executive Director of Strategy, Transformation and Digital. A second draft will be presented to the Executive Team for comment ahead of Christmas. The framework is based around the Care Unit structure.

Transformation - The new end to end change methodology including “Single Front Door” process and Transformation Steering Group has now been running for 6 months. This continues to be supported by the Trust executive and senior leadership, and there have now been over 125 submissions through the new process, which are now under management by the Transformation Team as they move through their lifecycle from initiate to closure and benefits realisation.

We are carrying out a 6-month review of the change methodology and will be implementing a number of changes to embed the learning to date and further strengthen the process. This will include changes to the initiate phase of projects to ensure we have fully understood the resources required to deliver the change and have clearly articulated the outcomes and benefits. We will also be looking at how we can design lived experience into our change process throughout.

The Transformation and Digital teams have been working together to capture the overall portfolio of change and prioritise these using our prioritisation methodology. All submissions will now be scored based on ‘opportunity’ and ‘feasibility’ and we aim to have an overall prioritised portfolio by the end of the financial year. The Time to Care programme has used this process to score its ‘quick wins’ and will be using this for the longer list of initiatives which will be presented to the Transformation Steering Group in due course.

Digital - We are pleased that the implementation of the interim Digital strategy for year one is well underway and is on track to deliver on its commitments for 2022/23. The digital strategy will be reviewed in line with the emerging trust strategic plan to ensure alignment.
We have been progressing with the development of a business case to modernise our Electronic Patient Record (EPR) systems at the trust. The Strategic Outline Case was approved at a private session of the Board in September and we are now working on an Outline Business Case. We are working closely with system partners on this important work which will benefit our patients and staff.

We continue to develop our Business Intelligence capability in EPUT using the Microsoft Power BI platform including interactive dashboards to support clinical and operational decision making. We are working to develop the trust performance report as an interactive power BI dashboard that will promote the use of data as an enabler for change and transformation. The first draft of a new data strategy has been developed in

partnership with clinical and corporate leaders across the trust which calls out the vision and opportunities for data as a tool to support effective clinical, operational and corporate decision making.

Patient Experience - The patient experience team have started running inpatient patient experience drop-in days at the Linden Centre and Rochford, which have already led to some quick wins for service users. In addition to this, the team has been working closely with the Time to Care programme to ensure that lived experience is a key part of this work.

We have made progress on redesigning our complaints process working with service users who have made complaints to EPUT in the past. Our new approach will focus on early resolution and a more collaborative approach to resolving complaints. We are currently recruiting into the complaints team to support this model.

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

Mental Health Inpatient and Specialist Staffing - Workforce support has taken place with Rochford and Linden sites. This has included a review of both substantive and temporary workforce and ensuring we have a greater regularity and skill mix of the workforce at these sites. A high-level action plan, congruent with the Time to Care programme will be progressed so clear workforce programmes of work for delivery are agreed across inpatient and specialist services.

Equality, Diversity and Inclusion -The Board received at its previous meeting the EPUT Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) against national benchmark data and noted the improvement in comparison to 2021. Action Plans have now been produced to monitor the activity and progress against indicators and close the gaps between white and Black and Ethnic Minority (BME) and Disabled staff of their comparative experience in the workplace. The action plans include objectives and assigned nominated leads with responsibilities and tasks to make the delivery of the plan impactful for employees. There is a strong focus on bullying and harassment this year.

Annual Staff Survey - As at 11 November 2022, the Trust core staff response rate sits at 37% and the bank staff response rate is 20%. At the same period last year, our Trust core staff response rate was 36%, which means we are performing 1% higher in comparison to the same point last year. Please note there are no comparisons for Bank staff as this is the first year that Bank staff have been included in the National Staff Survey.

Industrial Action - The Trust has established an Emergency Planning Group for response to any potential industrial action and we are currently undertaking our self-assessment for preparedness for industrial action as part of the integrated care system resilience response and plan.

The Royal College of Nursing (RCN) ballot for strike closed on 2 November 2022, the RCN did not reach the turnout threshold (50%) required for a mandate to take strike action within EPUT. The RCN did meet the mandate in 136 Trusts / associated organisations. It is expected that the British Medical Association (BMA) will open a ballot on industrial action with Junior Doctors in early January 2023, with dates to be confirmed.

Unison's ballot for industrial action closes on 25 November 2022 – there are 792 EPUT employees eligible to vote in the ballot. GMB's ballot for industrial action closes on 29 November 2022 – there are 78 EPUT employees eligible to vote in the ballot. Unite are not balloting for industrial action in EPUT but they do have open ballots in all 10 Ambulance Trusts in England, and in other selected Trusts, which closes on 2 December 2022.

Communications, Brand and Marketing -

Planning is in hand for an internal and external campaign for the launch of the strategic plan and refreshed safety strategy in Jan 2023 – to include use of film and video to give perspective of staff, service users etc. and to bring the vision, values and strategic objectives to life for all key audiences.

The marketing team continue to support on a number of targeted recruitment campaigns and a Christmas Communications plan will target internal and external audiences – supporting and thanking staff and presenting a review of positive stories through the year

4.6 Major Projects – Nigel Leonard, Executive Director of Major Projects and Programmes

Essex Mental Health Independent Inquiry - EPUT continues to support the Essex Mental Health Independent Inquiry, who are still in phase 2, collecting evidence from a range of people. A significant aspect of this, to date, has been requesting documentary evidence from the Trust, and inviting people to attend evidence sessions, or to provide their evidence in writing. Initially, the Inquiry has been focusing on hearing evidence from families, friends, and carers of inpatients who died during the relevant period and others with lived experience of Essex Mental Health services. EPUT understands those evidence sessions are now drawing to a close and the Inquiry is moving to the next stage and giving an opportunity for staff with experience in working in mental health services to speak with them. The Inquiry Team have written to all current EPUT staff, and some former staff, asking them to come forward and speak to them. The Inquiry will also be inviting specific members of staff to attend evidence sessions. EPUT's CEO has asked staff members who are invited or volunteer to give evidence to fully engage with the Inquiry Team. EPUT welcomes the Inquiry and will continue to work with the Inquiry team. Patient safety remains our top priority and is at the forefront of everything we do at EPUT.

Vaccination Programme - Since the last update in September EPUT has continued to contribute a vital role to the Covid-19 vaccination programme. This has been achieved through its vaccination centres and other delivery models such as vaccination buses and targeted pop up sessions. As the Board will recall, EPUT is part of the expanded hybrid model of delivery that also includes local PCNs and Pharmacies in both MSE and SNEE.

The autumn programme is due to come to a close in December 2022. NHSE/I, MSE and SNEE ICBs have all acknowledged the significant contribution EPUT have made to delivering almost 1.6m vaccinations. However, moving forward it is looking increasingly likely that an annual Covid-19 vaccination offer will come in line with the autumn flu vaccination programme and be delivered largely by PCNs and pharmacies.

EPUT services have continued to support the delivery of Covid-19 vaccinations to care home residents and staff, and a number of housebound patients on behalf of each system. In addition to this, EPUT's vaccination buses have continued to provide a number of busy sessions at various locations throughout Essex including Chelmsford, Burnham and Thurrock. Outreach services have also continued with a comprehensive service to the homeless, refugees, asylum seekers, the travelling community and seafarers.

The autumn booster programme, which began on 5 September 2022 with the over 65s cohort, initially brought about a very busy time in the vaccination centres and take-up was good averaging 25k vaccinations per week during September. This dropped to around 13k per week in October with the release of the over 50s and other remaining cohorts. We have seen a continued decline in vaccination volumes to under 6k per week during November.

Whilst we have confidence that we will meet our commissioned autumn booster target of 155k, at this level EPUT is not meeting its minimum breakeven targets so we have made preparations to decommission most vaccination centres in both systems by the middle of December, with the exception of The Lodge which can continue until 31 December 2022 and beyond if deemed necessary. The final vaccination dates for our centres which are scheduled to close are 25 November 2022 in SNEE and 17 December 2022 in MSE. Notice to all non-EPUT owned premises have been served and a decommissioning programme is fully in progress.

Discussions are taking place with each system lead and NHSE/I to identify the options for Quarter 4 as each system needs to maintain an Evergreen offer and booster vaccinations for those individuals that were not able to participate in the autumn programme due to Covid-19 infection. A verbal update will be provided to the Board on the latest position in both SNEE and MSE.

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

M7 Revenue results: Year to date (YTD) deficit of £2.1m, £0.2m behind plan.

Year-end revenue forecast remains to deliver a breakeven position consistent with plan.

YTD Capital spend is £4.3m, £4.9m behind plan. Tenders for key schemes are now approved and will enable acceleration of expenditure in future months. Capital leads continue to forecast capital plan will be delivered in full.

The Trust continues to participate and support the Integrated Care System Financial Recovery Programme.

Trust and Integrated Care System has begun 2023/24 planning process.

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

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

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

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

Recommendations/Action Required
The Board of Directors is asked to: 1. Note the contents of the reports. 2. Request further information and / or action by Standing Committees of the Board as necessary.

Summary of Key Issues

Performance Reporting

This report presents the Board of Directors with a summary of performance for month 7 (October 2022).

The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) have reviewed performance for October 2022.

Six inadequate indicators (variance against target/ambition) have been identified at the end of October 2022 and are summarised in the Summary of Inadequate Quality and Performance Indicators Scorecard.

- Safer Staffing
- CPA Reviews
- Inpatient MH Capacity Adult & PICU
- Out of Area Placements
- Psychology
- Temporary Staffing

There is one inadequate indicator which is an Oversight Framework indicator for October 2022.

- Out of Area Placements

There are two inadequate indicators in the EPUT Safer Staffing Dashboard for October 2022.

- Day Registered Fill Rates
- Number of wards with fill rates of <90%

There are no inadequate indicators within the CQC scorecard. All Must Do actions are within timescale.

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

- Temporary Staffing

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

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

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

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

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

Supporting Documents and/or Further Reading
Quality & Performance Scorecards

Lead
Paul Scott **Chief Executive Officer**

Trust Board of Directors
EPUT Integrated Quality and Performance Score Cards
October 2022

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

Report Guide

Use of Hyperlinks

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

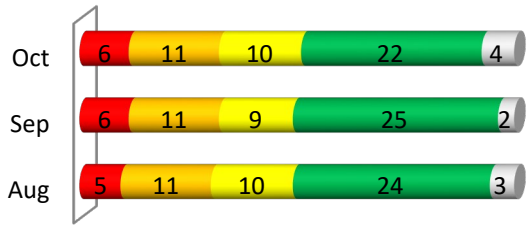
How is data presented?

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

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

SECTION 1 - Performance Summary

Summary of Quality and Performance Indicators

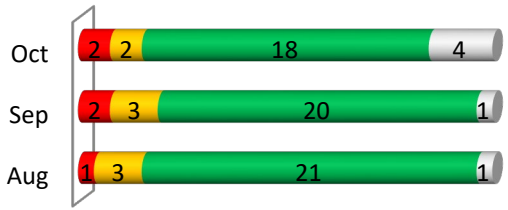


October Inadequate Performance

- Safer Staffing
- CPA Reviews
- Inpatient MH Capacity Adult & PICU
- Out of Area Placements
- Psychology
- Temporary Staffing

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

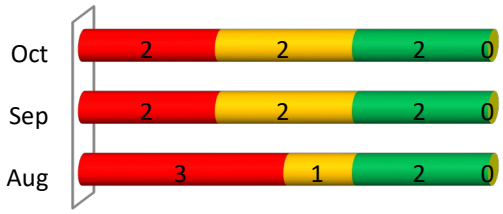
Summary of Oversight Framework Indicators



October Inadequate Performance

- Out of Area Placements
- Temporary Staffing (Agency)

Summary of Safer Staffing Indicators



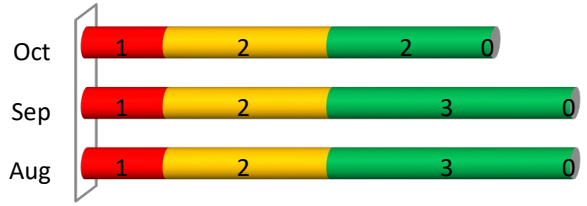
Two inadequate items identified within the Safer Staffing section for Day Qualified Staff & Fill Rates.

This data is collected from SafeCare.

Summary of CQC Indicators

CAMHS Wards CQC Inspection March and April 2022: The CAMHS improvement planning group is currently meeting monthly to provide oversight and support to the delivery of the plan.
20 (80%) individual 'must do' actions are reported as being complete; and 0 (0%) individual 'must do' actions are reported as being past timescale.
Galleywood Ward and Willow Ward CQC Inspection October 2022: the CQC wrote to the Trust on 7th October 2022 setting out 4 areas for immediate actions and subsequently issued a Section 29 Warning Notice on 1st November 2022, outlining 6 areas for improvement. Actions required to address the Warning Notice are being taken forward by an Intensive Support Group.

Finance Summary

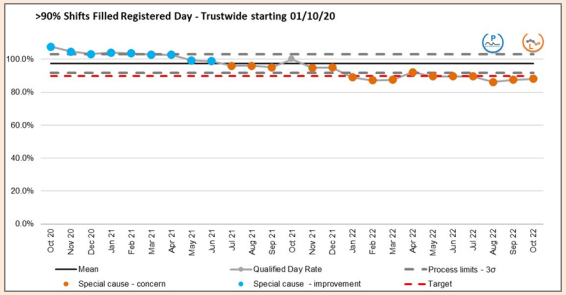


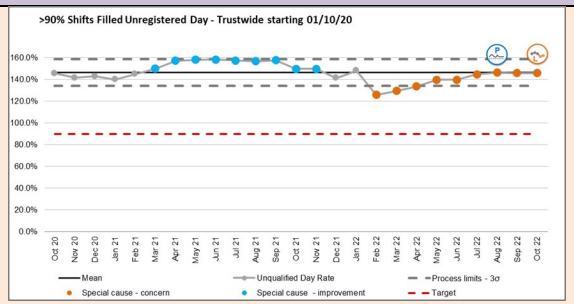
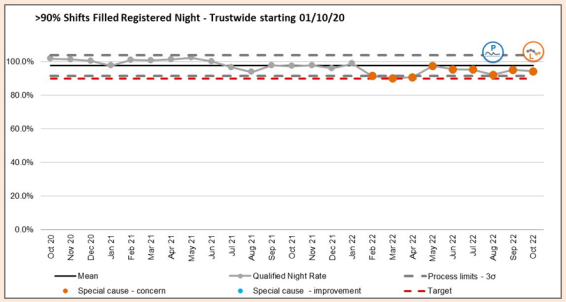
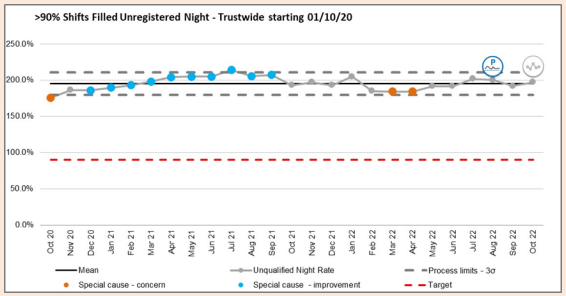
October Inadequate Performance

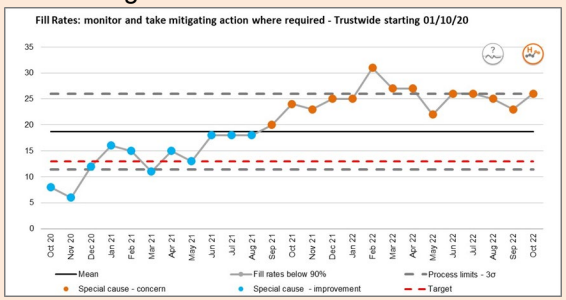
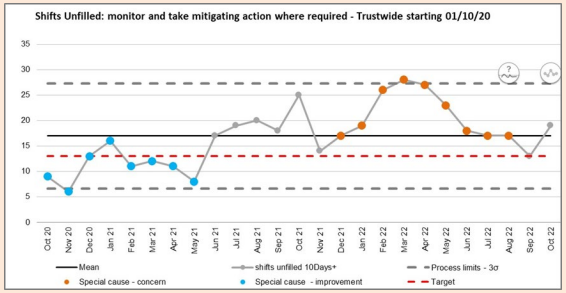
- Temporary Staffing Costs

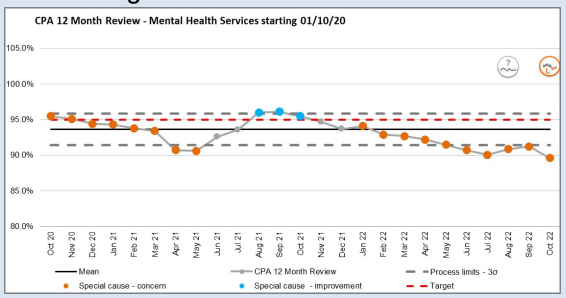
Please be advised that the Capital Expenditure and Capital Resources has been merged as one indicator under Maximising Capital Resources.

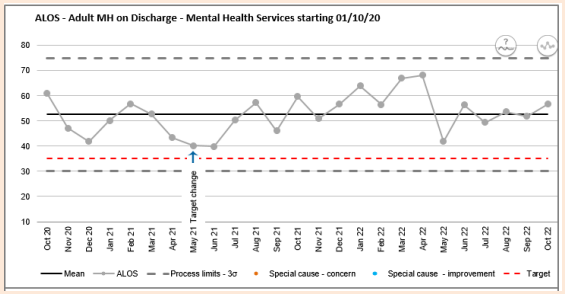
SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

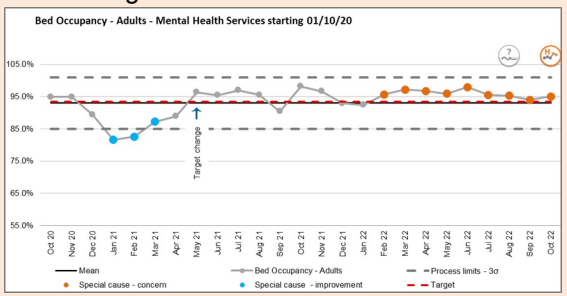
Safe Indicators							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
1.7 Safer Staffing Committee: Quality Indicator : National Data Quality RAG: Blue	**Inadequate** The Trust continues to fail targets for Day Registered Staff Fill Rates and one further measure regarding wards with fill rates of less than 90%. Work progresses with Deloitte on the Time to Care programme and this includes work to improve the systems and structures used within the 2x daily sitrep calls. This work looks to utilise SafeCare to save clinical time spent on collating data and will be piloted on Stort, Chelmer, Longview, and Alpine. In addition, work streams continue to be underway to ensure our wards are safely staffed and clinical time is used appropriately, these include Getting it Right First Time (GIRFT), International Recruitment, and KPMG initiatives. Dashboards are also being developed across multiple teams to provide real time information to support clinical colleagues and allow ward staff to access information as and when they need it. Wards continue to use bank and agency staff to fill vacancies and unfilled shifts where possible. Ward staffing is continuously monitored through x2 daily sitrep calls and any issues are escalated through this route. Please be assured that any staffing issues raised on these calls are able to be mitigated immediately to ensure safe practice						
	1.7.1 Day Qualified Staff Fill Rate 90% of above	88.1%		Trend below target 	N/A	Special cause of concern, trend of decrease.	
	1.7.2 Day Unqualified Staff Fill Rate 90% of above	144.3%		Trend above target = good	N/A	Assurance of consistently Passing target	

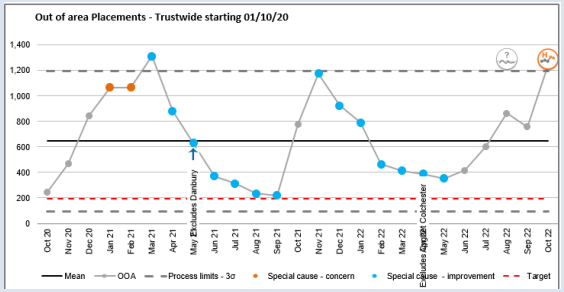
Safe Indicators							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
							
	1.7.3 Night Qualified Staff Fill Rate 90% of above	94.3%	●	Trend above target = good 	N/A		
	1.7.4 Night Unqualified Staff Fill Rate 90% of above	196.8%	●	Trend above target = good 	N/A		

Safe Indicators							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	1.7.5 Fill Rates: We will monitor fill rates and take mitigating action where required	26	●	Below Target = Good 	N/A	Special cause of concern for number of wards with less than 90% fill rates.	
	1.7.6 Shifts Unfilled: We will monitor fill rates and take mitigating action where required	19	●	Below Target = Good 	N/A	19 wards where there were more than 10 days with shifts unfilled.	

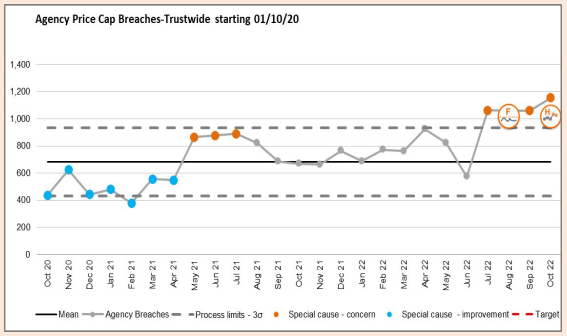
Effective Indicators							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.3 CPA Review Committee: Quality Indicator: National Data Quality RAG: **Amber**	**Inadequate** CPA Reviews has remained as inadequate in October, overall performance remains below target at 89.6%, this is a decrease from the position reported in September (91.2%) The Trust awaits guidance on new measures that will come in to place from the new financial year once CPA has been abolished in March 2023. Review reminders are sent to the Care Coordinators 6 weeks prior and again at 3 weeks prior to the review due date by the Operational Productivity Team. A deep dive has been carried out into the compliance and historic breaches remain a large factor affecting this performance. Compliance is being addressed, with Team Leads and Team Managers regularly updated on breaching patients. The Information & Performance team circulate a weekly list of patients that have not been seen for 6 months and 12 months, this list is then reviewed and addressed. A Red, Amber, Green ratings system also enables staff to monitor, prioritise and undertake regular client calls. Staff can also use the MaST tool (management and supervision tool) to assist with identifying emerging risks and for caseload management. Vacancies and staffing pressures continue to present a challenge and are mitigated where possible however some vacancies are not always able to be covered.						
	People on CPA will have a formal CPA review within 12 months **Target 95%**	89.6%		Above Target = Good 				

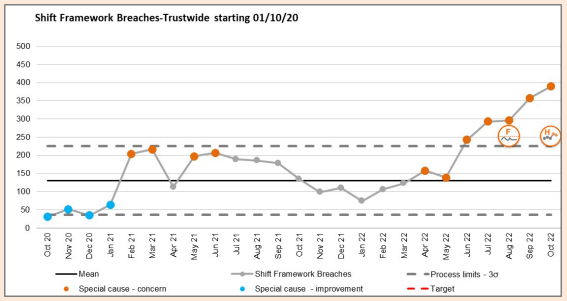
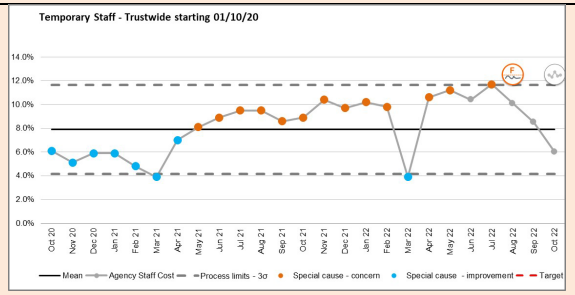
Effective Indicators							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.9 Inpatient Capacity Adult & PICU MH Committee: Quality Indicator: Local Data Quality RAG: TBC	**Inadequate** Adult average length of stay increased in October and remains outside the benchmark of <35 with performance at 56.7 (52.2 in September). There were 72 discharges, 18 of whom were long stays (60+ days). There have been less discharges and less long stays in October. Length of Stay data continues to be run to include the Assessment Units, this resulted in an October position of 37.6, which continues to be just outside the <35 target. Adult occupancy rates have increased slightly to 95.1% in October, compared with 94.9% in September. This does remain outside the benchmark of <93.4%. Positive performance continues to be seen in adult delayed transfers of care with October at 2.9% which continues to be within the benchmark of <5%. There were 9 clients delayed in October, up from 8 in September. Cedar ward currently has the highest number of delays (4). All PICU inpatient indicators are within benchmark in October. Monthly inpatient Quality & Safety meetings continue to take place with pressures regularly discussed, the Purposeful Admissions steering group work is ongoing, and the therapeutic offer on wards is being increased with activity coordinator roles. The therapeutic programme (MDT) is to be reflected in all care plans as well as be more visible and consistent across all units. Reviews of extended 28+ day length of stay clients continue to take place. The System Escalation of Delayed Transfers of Care meetings and the Joint Inpatient and Community review meetings are all well established and meet regularly. These provide oversight of clinical progression, discharge planning, and LOS reviews, all informed by the Red to Green Principles.						
	2.9.2a Adult Mental Health ALOS on discharge less than NHS benchmark **Target: <35** (Adult Acute Benchmark 2020 35)	56.7 days	●	Below Target = Good 	●	Consistently failing target 72 discharges in October (18 of whom were long stays (60+ days)). Adult Acute 2020 benchmark EPUT result was 31, against a National mean of 35.	TBC

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.9.4 % Adult Mental Health Bed Occupancy below national benchmark **Target: 93.4%** (Adult Acute Benchmark 2020 93.4%)	95.1%	●	Below Target = Good 	●	Adult Acute 2020 benchmark EPUT result was 99.7%, against a National mean of 93.4%.	N/A

Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M7**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.5 Out of Area Placements Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Amber**	October has seen a significant increase in out of area bed days, from 757 to 1241 (excluding Danbury & Cygnet). An OOA system recovery plan is in place being led by the Associate Director of Flow and Operational Transformation. The high numbers in OOA placements have added significant pressure to the discharge coordination team in maintaining oversight of clinical progression towards discharge. Further development of the Flow and Capacity team is underway to support this. This surge is not EPUT specific and is also being experienced by Regional colleagues. There is still a high demand for inpatient admissions and a Whole Essex System Flow and Capacity group has been established to review current and future bed modelling. An NHS England Data Scope development is in progress to inform purposeful admission and future bed modelling discussions. Getting it Right First Time (GIRFT) work has also begun with the Inpatient and Emergency Care group. 35 new clients were placed OOA (33 Adult & two PICU) in October, and following the repatriation of 18 (16 Adult & 2 PICU), there were 47 remaining (40 Adult & 7 PICU) OOA at the end of the month.						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by end of March 2023**	1241 Days		Below Target = Good 		Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Data excludes patients placed on Danbury Ward & Cygnet Colchester.	Mar 2023

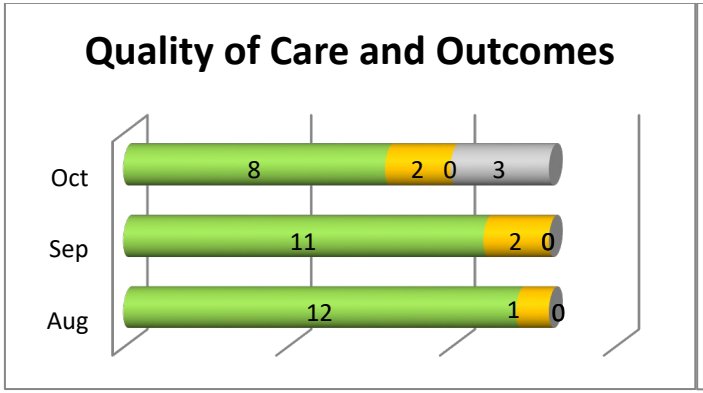
Responsive Indicators		
RAG	**Ambition / Indicator**	**Position M7**
4.10 Psychology Committee: Quality Indicator: Local Data Quality RAG: **Blue**	4.10 Clients waiting on a Psychology waiting list	Within South East; wait times and numbers waiting to access the front end of the clinical pathway continue to be lower than last year. This ensures responsive reviews of risks across both ACP and the PD&CN streams of service delivery. Psychology Awareness Programmes (PAPs) continue to be offered at regular intervals to reduce bottlenecks and clinicians have DBT/STEPPS screening slots as part of their job plans. DBT and STEPPS access reports small increases in people waiting and wait times. This is due a STEPPS group running across 20 weeks being half way through, resulting in an accruing of people waiting for the next programme scheduled to start in Jan/Feb. 3 DBT groups across South East have been completing one module and are preparing new participants to commence the next module. All are due to recommence during October which will again reduce numbers waiting and wait times. The number of people waiting for individual therapy has reduced by, on average, 40%. This is largely as a result of transfers to the Therapy for You+ Provision. Wait times remain static due to the number of historical waiters and the average length of therapy being 16-22 sessions. Risk calls continue to be made to those waiting (not on CPA) and to ensure any additional needs have a care plan and are documented. Recruitment and retention continues to present a challenge when working to reduce and mitigate waits however a number of plans are in place to address this; • Recruitment has been completed for 3 year high intensity psychotherapeutic counselling training – to increase staffing model (longer term recruitment plan). • Recently re-evaluated Care Therapist role to a High Intensity Psychotherapeutic Counsellor, which should widen recruitment opportunities. • Long term utilisation of agency staffing, however recent switch as part of direct engagement model has impacted on retention. • Paper submitted to the Executive Team in support of outsourcing clinical capacity to Xyla digital therapies. This would generate additional clinical capacity to assess and treat 3,558 patients. • Service has undertaken quantitative audit of step 3 and step 2 clinical capacity. Now in the process of producing a qualitative analysis. Waiting List: South East – There are 232 clients awaiting intervention. Face to Face DBT/STEPPS currently has the longest average wait time with 11 months, there are just 5 clients waiting for this. South West – There are 230 awaiting intervention. EMDR therapy currently has the longest wait at 23 months. There are 5 clients waiting for EMDR therapy.

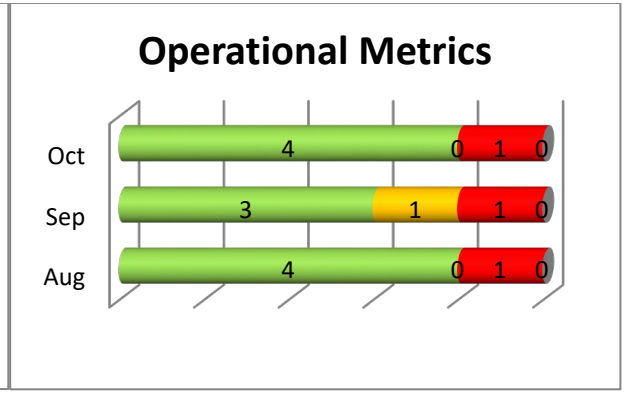
Well-Led Indicators							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.7 Temporary Staffing (Agency) Committee: FPC Indicator: Oversight Framework Indicator Data Quality RAG: Green	**Inadequate** Agency cap and shift framework indicators continue to breach targets in October. There were 1155 agency cap breaches and 390 shift framework breaches in October. There were also 313 cases that breaches both framework and price cap. The Trust will go to off framework once all framework agencies have been exhausted & the service still requires temporary staffing to cover placements urgently, this is agreed by Service Director. Price breaches are occurring due to CPN's not willing to work within agreed cap rates & the Service Director agreeing to breach to ensure roles are covered. Recruitment and HR Business partners have been asked to work with management on ensuring all vacancies are actively being recruited to, a list of the agency CPN and cost centres has been provided to recruitment and the HR Business Partners. The temporary staffing lead is currently holding discussions through bank supervision on fast tracking bank to permanent, and agency to bank or permanent, as a way to encourage movement into substantive posts. Medical breaches are occurring due to a high number of vacancies at consultant level and although the Trust is using framework agencies, they are finding is very difficult to supply locums, and the ones that are supplied will not work at a capped rate. The Trust has recently recruited a number of new consultants and spend is expected to reduce, however nationally there remains a problem with recruitment especially to inpatient roles. A medical working group is being set up to try and address the workforce and retention issues. The proportion of temporary staff (Agency) has improved again in October for the third consecutive month and is currently at 6%, down from 8.4% in September. The Major Projects & Programmes and Central Budgets directorates possess the highest proportions of temporary staff.						
	5.7.1 Agency Cap Breaches Shift Price Cap **Target = 0**	1155		Below Target = Good 	N/A	534 of these breaches were pertaining to the Medical staffing group and 543 were due to Nursing & Midwifery.	

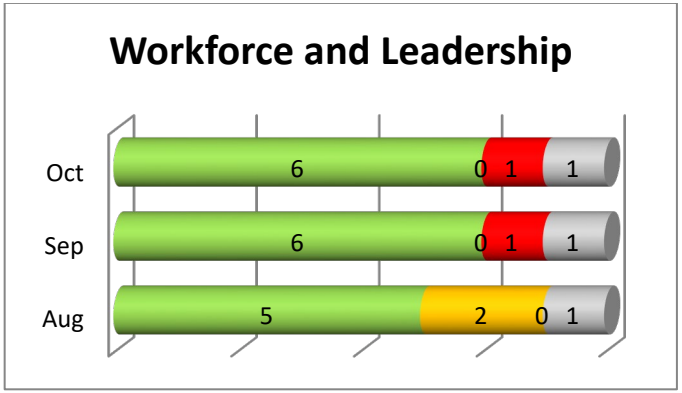
Well-Led Indicators							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	5.7.2 Shift Frame-work **Target = 0**	390	●	Below Target = Good 	N/A		
	5.7.3 Proportion of temporary Staff (Provider Return) No Oversight Framework Target	6%	●		N/A	The Major Projects & Programmes and Central Budgets directorates possess the highest proportions of temporary staff.	

SECTION 4 - OVERSIGHT FRAMEWORK

Click here to return to summary page





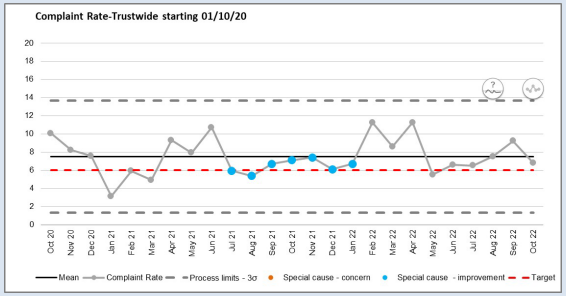


Inadequate

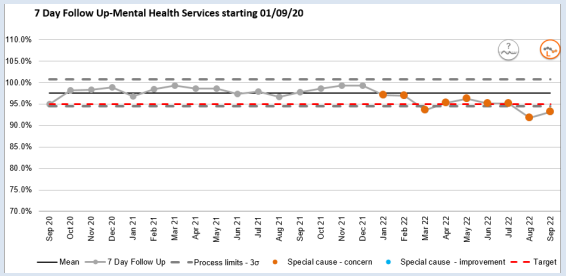
- Out of Area Placements
- Temporary Staffing (Agency)

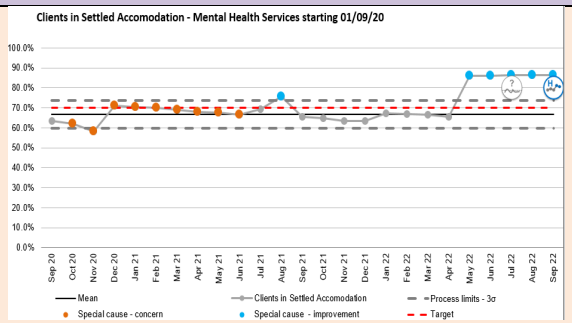
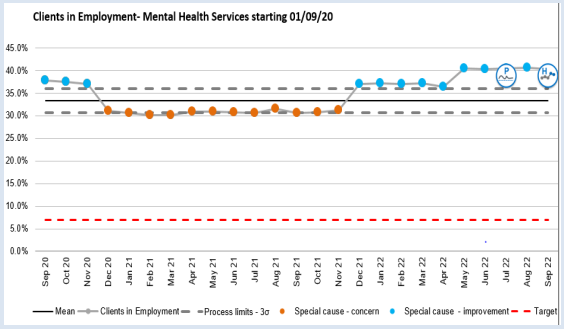
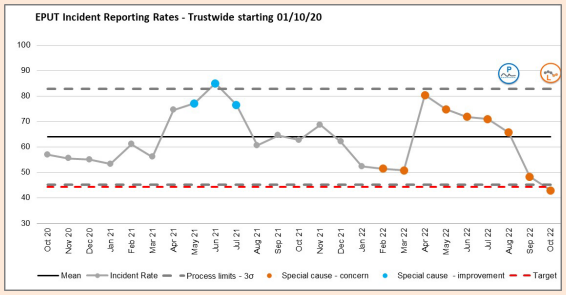
Requires Improvement

- Complaint Rate
- Incident Reporting Rates

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1.1 CQC Rating Committee: FPC Data Quality RAG: **Green**	Achieve a rating of Good or better	Good		The restrictions on our children and adolescent mental health services (CAMHS) have been removed by the CQC.			
	No action plans past timescale			CAMHS Wards CQC Inspection March and April 2022: The CAMHS improvement planning group is currently meeting monthly to provide oversight and support to the delivery of the plan. As of 1th1 November 2022, 20 (80%) individual 'must do' actions are reported as being complete; 5 (20%) individual actions are in progress and are not yet due for completion and 0 (0%) individual 'must do' actions are reported as being past timescale. Galleywood Ward and Willow Ward CQC Inspection October 2022: the CQC wrote to the Trust on 7th October 2022 setting out 4 areas for immediate actions and subsequently issued a Section 29 Warning Notice on 1st November 2022, outlining 6 areas for improvement. Actions required to address the Warning Notice are being taken forward by an Intensive Support Group.			
4.1.1 Complaint Rate Committee: FPC Indicator: Oversight Committee Data Quality RAG: **Green**	4.1.1 Complaint Rate **OF Target TBC** Locally defined target rate of 6 each month	6.8		Below Target = Good 			N/A
5.6 Staff FFT Committee: FPC	National Quarterly Pulse Survey Results	The Staff FFT has been replaced with the National Quarterly Pulse Survey. In the most recent publication released in July, 449 responses were received in total. Response rates have seen a positive increase with 109 more respondents than Q1. A robust communications campaign has supported this and we also encouraged staff to fill in the survey at meetings, inductions and training. This support our drive to embed feedback and the NQPS as BAU and work will continue to develop the campaign after the National NHS Staff Survey has taken place. Quarter 4 will launch in January 2023.					

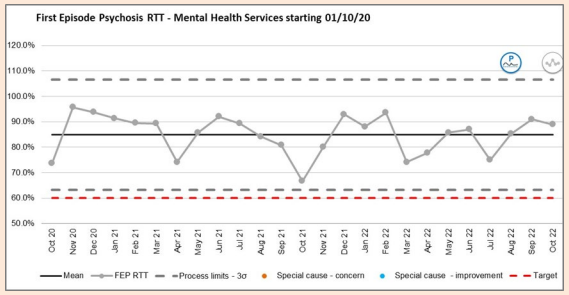
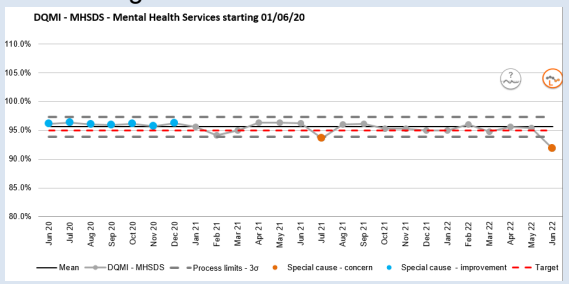
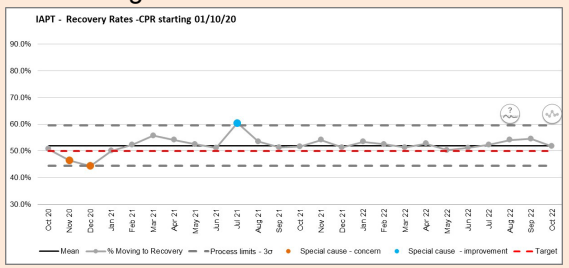
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Green**		We received 301 unique comments. Key themes of comments: 70 in relation to rest/break areas, 66 in relation to support for staff, 27 relating to working from home, 24 relating to management, 14 relating to staffing, and 22 in relation to training. Staff requesting adequate areas to rest and take breaks is still a notable theme through the comments.					
1.1 Never Event Committee: Quality Indicator: OF Data Quality RAG: **Blue**	0 Never Events **2021/22 Outturn 0**	0	●	Year to Date 0	●		N/A
1.6 Safety Alerts Committee: Quality Indicator: OF Data Quality RAG: **Green**	There will be 0 Safety Alert breaches **2020/21 Outturn 0**	0	●	Year to date there have been no CAS safety alerts incomplete by deadline.	●		N/A
3.1 MH Patient Survey Committee: Quality	Positive Results from CQC MH Patient Survey	The 2021 survey results have now been published. 1,250 EPUT clients were invited to take part, and 324 responded. This is a response rate of 27%. EPUT achieved “about the same” for 26 questions in the 2021 survey when compared with other Trusts. 2 questions scored “somewhat worse than expected”. These 2 questions fell under the NHS Talking Therapies domain.					

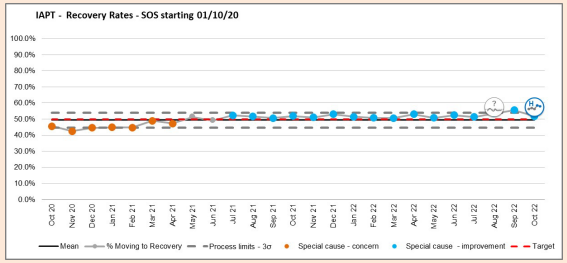
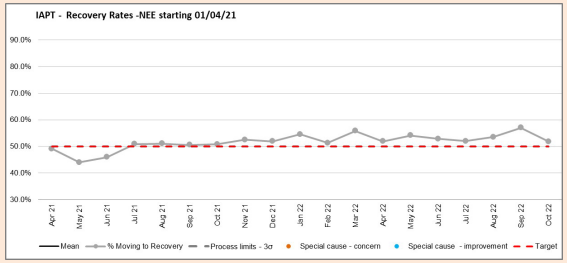
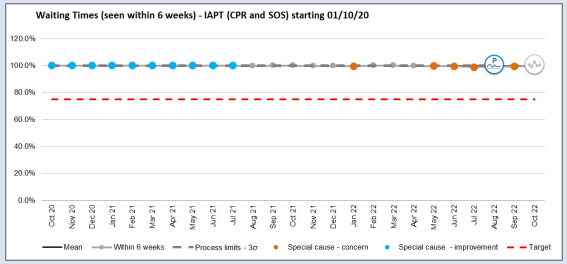
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: Oversight Framework Data Quality RAG: **Green**							
3.3 Patient FFT Committee: Quality Data Quality RAG: **Green**	3.3.1 Patient FFT MH response in line with benchmark Target = 88% (Adult Acute 2020 Benchmark 88%)	90.5%	●	I Want Great Care was implemented across the Trust from 23rd January 2022. We are awaiting further FFT configuration. We are hoping to hear from the I Want Great Care team shortly.	●	90.9% for the positive score in October. This is currently not split between MH and CHS.	
	3.3.2 Patient FFT CHS response in line with benchmark Target = 96%				●		
2.8.1 Mental Health Discharge Follow up Committee: Quality Data Quality RAG: **Blue**	2.8.1 Mental Health Inpatients will be followed up within 7 days of discharge **Target 95% Benchmark 98%** (Adult Acute 2020 Benchmark 98%)		●	Above Target = Good 	●	Awaiting October figures. Discharge follow ups form part of EPUT's "10 ways to improve safety" initiative.	
2.4 MH Patients in Settled	We will support patients to live in settled accommodation		●	Above Target = Good	●	Awaiting October figures	N/A

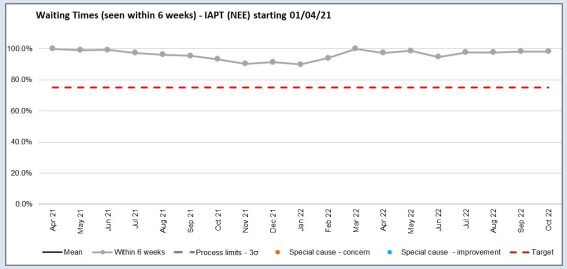
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Accommodation Committee: Quality Indicator: Oversight Framework Data Quality RAG **Green**	**Target 70% (locally set)**						
2.5 MH Patients in Employment Committee: Quality Indicator: OF Data Quality RAG: **Green**	We will support patients into employment **Target 7% (locally set)**			Above Target = Good 		Awaiting October figures	N/A
1.8 Incident Rates Committee: Quality Data Quality RAG: **Amber**	Incident Rates will be in line with national benchmark **>44.33** Benchmark	42.9		Above Target = Good 		This is below target for October and a trend of decrease can be witnessed through SPC analysis. Staffing pressures are impacting on the time available for staff to sign off all incidents. This data is also extracted very early in the month due to reporting timescales and can sometimes improve on refresh.	

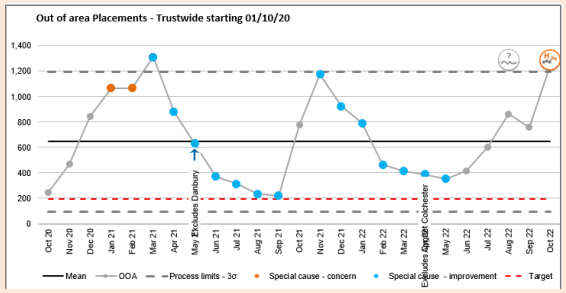
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
1.15 Admissions to Adult Facilities of under 16's Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	0 admissions to adult facilities of patients under 16	0	●	Zero admissions in October	N/A		N/A

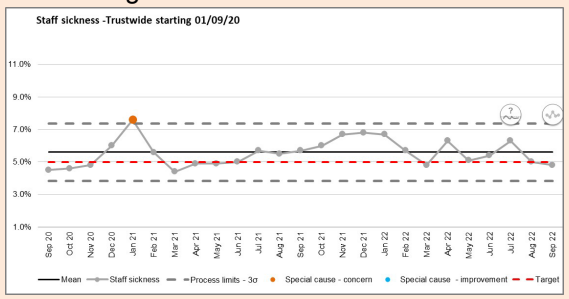
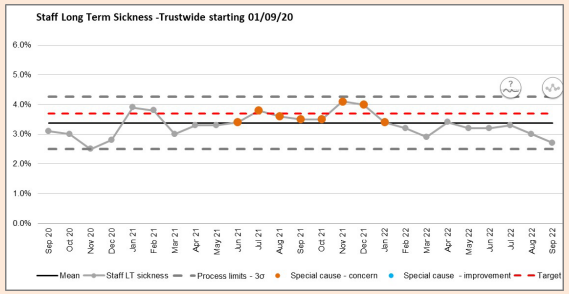
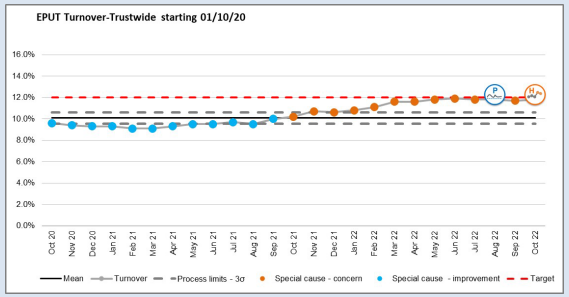
Click here to return to Summary

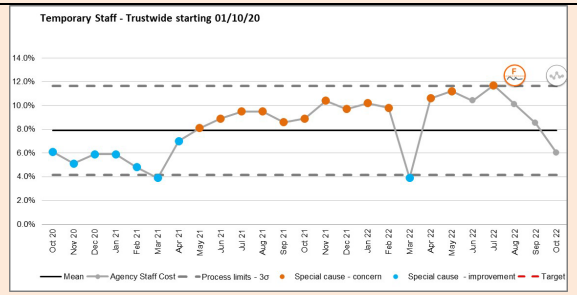
Operational Metrics							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.6 First Episode Psychosis Committee: Quality Data Quality RAG: **Green**	All Patients with F.E.P begin treatment with a NICE recommended package of care within 2 weeks of referral **Target 60%**	88.9%	●	Above Target = Good 	●	October performance represents: 24 / 27 patients.	N/A
2.2.1 Data Quality Maturity Index Committee: FPC Data Quality RAG: **Green**	2.2.1 Data Quality Maturity Index (MHSDS Score – Oversight Framework) **Target 95%**	95.8%	●	Above Target = Good 	●	Latest published figures are for July 2022. A Data Quality Improvement Plan for Mental Health has been produced to identify the areas of the MHSDS that we can improve upon.	
2.16.4/5/6 IAPT Recovery Rates Committee: FPC	2.16.4 IAPT % Moving to Recovery CPR **Target 50%**	51.7%	●	Above Target = Good 	●		

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: National Data Quality RAG: **Green**	2.16.5 IAPT % Moving to Recovery SOS **Target 50%**	51.7.%	●	Above Target = Good 	●		
	2.16.6 IAPT % Moving to Recovery NEE **Target 50%**	51.8%	●	Above Target = Good 	●		
2.16.7/8 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.7 % Waiting Time to Begin Treatment – 6 weeks CPR & SOS **Target 75%**	100%	●	Above Target = Good 	●		

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.16.8 % Waiting Time to Begin Treatment – 6 weeks NEE **Target 75%**	98.2%	●	Above Target = Good 	●		
2.16.9/10 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	2.16.9 % Waiting Time to Begin Treatment – 18 weeks CPR & SOS **Target 95%**	100%	●	Above Target = Good	●		
	2.16.10 % Waiting Time to Begin Treatment – 18 weeks NEE **Target 95%**	100%	●	Above Target = Good	●		
4.5 Out of Area Placements ●	October has seen a significant increase in out of area bed days, 1241 (excluding Danbury & Cygnet). There is still a high demand for inpatient admissions and a Whole Essex System Flow and Capacity group has been established to review current and future bed modelling. An NHS England Data Scope development is in progress to inform purposeful admission and future bed modelling discussions. Getting it Right First Time (GIRFT) work has also begun with the Inpatient and Emergency Care group. The revised NHSE/I target has been set to 0 placements by the end of March 2023. There continues to be comprehensive action plans in place across the Trust to meet this. Neighbouring Trusts also face similar challenges in reducing their placements.						

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Amber**	The Trust continues to hold contracts with the Priory (Danbury ward) and with Cygent Colchester. NHSE/I confirmed these placements are to be classed as appropriate and are therefore not included in these numbers. Wider conversations are in progress with System, Operations, Finance and Contract teams to explore opportunities for financial efficiencies and improved quality. 35 new clients were placed OOA (33 Adult & two PICU) in October, and following the repatriation of 18 (Sixteen Adult & Two PICU), there were 47 remaining (40 Adult & seven PICU) OOA at the end of the month.						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by end of June 2022**	1241 Days	●	Below Target = Good 	●	Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Data excludes patients placed on Danbury Ward & Cygnet Colchester.	Mar 2023

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3.1 Staff Sickness Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Blue**	5.3.1 Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**	4.8%	●	Below Target = Good 	●	The sickness figures are reported in arrears to allow for all entries on Health Roster. National data June 2022: The overall sickness absence rate for England was 5.2%. This is higher than May 2022 (4.9%) and higher than June 2021 (4.6%). Anxiety/stress/depression/other psychiatric illnesses is consistently the most reported reason for sickness absence (23.2%). EPUT reported in line with the England average for this period at 5.4%.	
	5.3.2 Long Term Sickness Absence below 3.7% **Target 3.7%**	2.7%	●	Below Target = Good 	N/A		
5.2.2 Turnover Committee: FPC Data Quality RAG: **Green**	5.2.2 Staff Turnover (Benchmark 2020 MH 12% / 2017/18 CHS 12.1%) **OF Target TBC** **Target <12%**	11.8%	●	Below Target = Good 	●	Special Cause of concerning nature of higher pressure due to higher values. Performance remains outside of the limits of expected variation. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.	N/A
5.7.3 Temporary Staffing (Agency)	**Inadequate** The temporary staffing lead is currently holding discussions through bank supervision on fast tracking bank to permanent, and agency to bank or permanent, as a way to encourage movement into substantive posts.						

<table>
<tr><th colspan="8">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M07
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td rowspan="2">Committee: FPC
Indicator: Oversight Framework Indicator
Data Quality RAG: Green</td><td colspan="6">Recruitment and HR Business partners have been asked to work with management on ensuring all vacancies are actively being recruited to, a list of the agency CPN and cost centres has been provided to recruitment and the HR Business Partners.
The Trust has recently recruited a number of new consultants and agency spend is expected to reduce, however nationally there remains a problem with recruitment especially to inpatient roles. A medical working group is being set up to try and address the workforce and retention issues.</td></tr>
<tr><td>5.7.3 Proportion of temporary Staff (Provider Return) No Oversight Framework Target</td><td>6%</td><td></td><td> 
</td><td>N/A</td><td>The Major Projects & Programmes and Central Budgets directorates possess the highest proportions of temporary staff.</td><td></td></tr>
<tr><td>5.5 Staff Survey

Committee: FPC
Indicator: Oversight Framework
Data Quality RAG: Green</td><td>5.5 Outcome of CQC NHS staff survey</td><td colspan="5">The 2022 Staff Survey launched on the 22nd September 2022 and this year the biggest change is that bank only workers are now able to participate. As at the 11th November 37% of colleagues have had their say.
The results of the survey will be produced in spring 2023.

<u>Information from the 2021 Staff Survey</u>
The Staff Survey ran from September to November 2021. This year saw the biggest change in how results were formalised. The themes have been aligned to the People Promise which means in some areas we are unable to compare results against previous years. The Trust was measured against nine themes in the 2021 Survey. EPUT scored above average in three themes, in line with average on three themes, and below average against three themes.

Actions:
• Internal Communications Campaign to share results after embargo is lifted. This is to be a regular item moving forward to ensure engagement and staff feedback is a continuous topic and agenda item at EPUT. A clear focus on ‘you asked, we delivered’.
• Focus groups with staff to understand the survey results co-create solutions/ actions to tackle from areas of focus below, share good practise and work on improvements in their local areas.
• Focus groups to support with the development of a trust wide action plan.
• Update to Engagement Champions with a focus on their role in sharing results and supporting with ‘you asked, we delivered’.</td><td></td></tr>
</table>

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				

Areas of Focus:

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

Highlights of each theme:

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

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

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

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

Theme: We are always Learning	**Score**

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				

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

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

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

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

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

SECTION 5 - SAFER STAFFING SUMMARY

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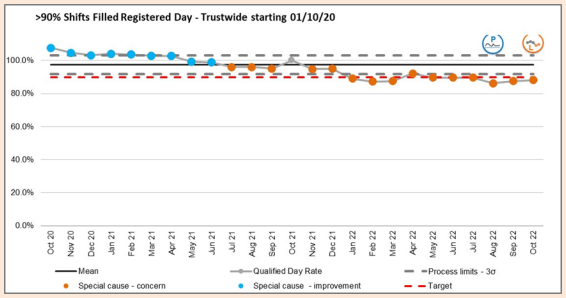
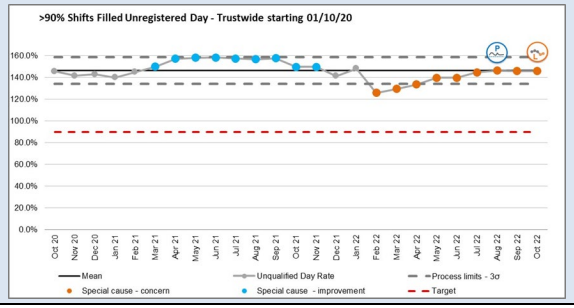
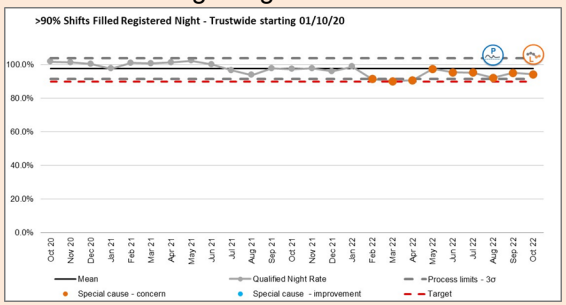
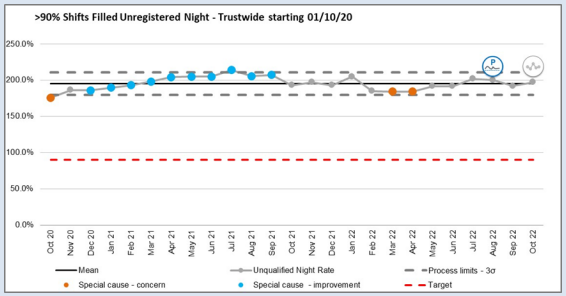
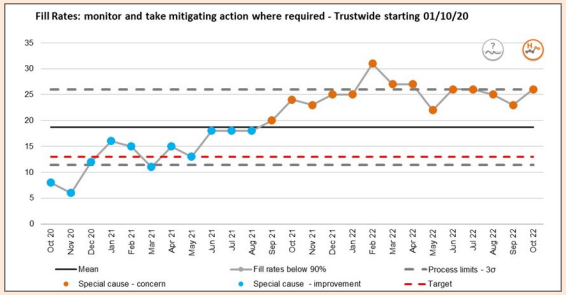
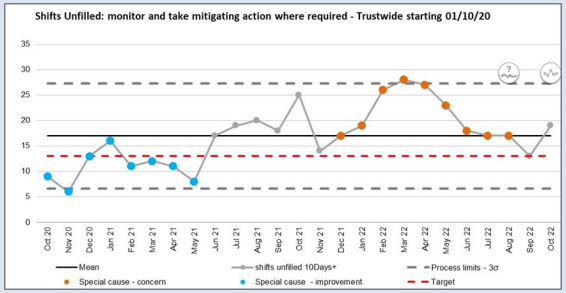
Safer Staffing							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards. Safe staffing performance continues to be monitored by the Quality SMT and Quality Committee.							
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	88.1%		Trend below target 		The following wards were below target in October: Adult: Ardleigh, Cedar, Willow, Finchingfield, Galleywood, Gosfield Adult Assessment: MHAU, Peter Bruff CAMHS: Larkwood, Longview, CHS: Cumberlege Centre, Beech Nursing Home: Rawreth Court, Older: Beech(Rochford) , Meadowview, Ruby, Tower, Henneage Specialist: Edward House, Fuji, Lagoon, LD: Heath Close	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	144.3%		Trend above target = good 		The following wards were below target in October: Adult: Finchingfield, Specialist: Rainbow, CHS: Cumberlege, Poplar Nursing Home: Rawreth Court	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	94.3%		Trend above target = good 		Concerning trend of lower values. The following wards were below target in October: Adult: Ardleigh, CHS: Cumberlege CAMHS:, Larkwood, Longview, Nursing Home: Rawreth, Specialist: Rainbow, Alpine, Forest Older: Tower,	N/A
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts filled	196.8%		Trend above target = good 		The following wards were below target in October: CHS: Cumberledge Specialist: Rainbow	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required	26		Below Target = Good 	N/A	The following wards had fill rates of <90% in October: Adult: Finchingfield, Ardleigh, Cedar, Willow, Galleywood, Gosfield Adult Ass: Basildon MHAU, Peter Bruff CAMHS: Larkwood, Longview Nursing Homes: Rawreth Court, Specialist: Edward House, Rainbow, Alpine, Forest, Fuji, Lagoon, CHS: Cumberledge, Beech, Poplar	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M07**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
						LD: Heath Close Older: Beech, Henneage, Meadowview, Ruby, Tower	
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	19		Below Target = Good 	N/A	The following wards had more than 10 days without shifts filled in October: Adult: Ardleigh, Cedar, Willow, Gosfield Adult Assessment: Basildon MHAU, Peter Bruff CAMHS: Longview, Larkwood Older: Beech, Tower, Henneage PICU: Hadleigh Nursing Home: Rawreth Specialist: Edward House, Fuji, Lagoon	N/A

Fill Rates

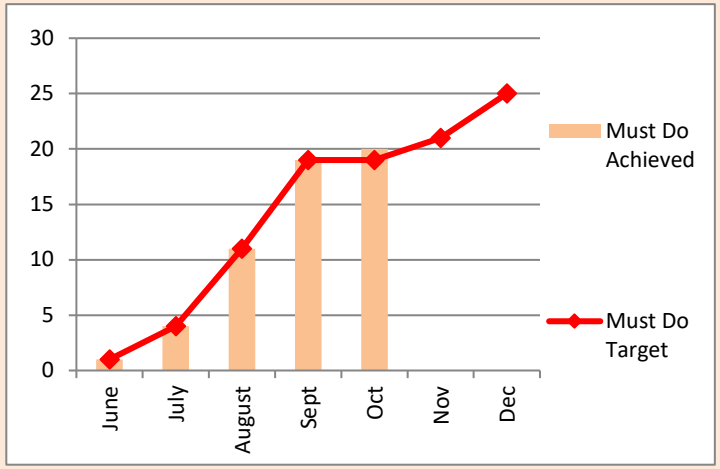
	Day Rates		Night Rates		Day Rates		Night Rates		Day Rates		Night Rates	
	Aug-22				Sep-22				Oct-22			
	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED
TARGET >90%												
MH ADULT ACUTE												
ARDLEIGH WARD	71.4%	125.4%	73.5%	145.4%	56.7%	140.8%	69.4%	136.2%	55.8%	129.9%	61.6%	132.9%
CEDAR	103.0%	234.2%	99.2%	270.2%	109.3%	255.0%	115.6%	274.9%	87.3%	217.1%	108.1%	232.7%
WILLOW	75.2%	251.9%	88.5%	366.9%	91.8%	226.0%	110.0%	322.9%	83.7%	213.2%	119.4%	328.5%
CHELMER WARD	92.0%	382.8%	99.2%	700.1%	94.4%	362.2%	88.9%	713.8%	91.7%	347.2%	95.9%	661.3%
FINCHINGFIELD WARD	38.8%	67.6%	190.0%	168.9%	44.6%	68.0%	193.3%	159.6%	40.3%	68.9%	199.6%	155.1%
GALLEYWOOD WARD	59.0%	90.1%	98.4%	101.0%	46.9%	108.2%	96.7%	143.2%	60.9%	103.3%	98.4%	152.6%
GOSFIELD WARD	80.4%	244.0%	85.3%	402.9%	80.4%	259.6%	95.0%	396.7%	77.6%	239.3%	97.4%	403.2%
KELVEDON	127.1%	324.8%	111.4%	426.6%	94.8%	338.0%	111.4%	453.6%	107.9%	287.4%	116.0%	359.7%
STORT WARD	99.1%	166.3%	91.9%	280.1%	108.0%	196.8%	101.8%	362.1%	114.5%	192.3%	102.2%	387.0%
CHERRYDOWN	70.7%	321.0%	100.2%	493.3%	92.9%	275.5%	110.0%	342.2%	99.4%	262.9%	100.4%	382.1%
MH ASSESSMENT UNIT												
BASILDON MHAU	74.5%	359.9%	105.0%	401.0%	81.9%	368.6%	100.5%	394.9%	89.2%	362.1%	111.5%	435.2%
PETER BRUFF UNIT	85.6%	198.5%	78.9%	261.5%	84.1%	221.6%	93.5%	246.4%	78.8%	212.3%	92.3%	269.0%
MH OLDER ADULT												
BEECH (ROCHFORD)	76.3%	173.4%	79.8%	401.7%	81.3%	179.5%	70.2%	359.1%	69.3%	164.2%	90.4%	344.0%
GLOUCESTER	90.3%	202.5%	98.4%	249.2%	98.3%	184.1%	98.5%	265.3%	103.2%	136.8%	100.0%	181.5%
HENNEAGE WARD	95.3%	209.8%	91.4%	379.9%	96.7%	258.9%	93.3%	443.2%	84.2%	280.2%	91.8%	493.0%
KITWOOD WARD	99.7%	153.5%	143.2%	151.9%	115.6%	165.5%	146.7%	151.7%	111.4%	161.7%	139.3%	162.2%
MEADOWVIEW	82.9%	227.1%	98.2%	304.2%	87.1%	183.5%	100.1%	242.2%	74.4%	185.2%	92.0%	251.2%
RODING WARD	100.8%	151.3%	142.2%	151.5%	103.8%	177.5%	143.9%	166.4%	101.1%	162.9%	145.2%	156.1%
RUBY WARD	52.4%	309.1%	183.9%	246.3%	78.1%	334.5%	190.0%	274.0%	82.7%	300.1%	189.9%	230.6%
TOPAZ WARD	91.4%	103.4%	96.8%	306.5%	99.8%	90.9%	96.2%	265.9%	102.1%	116.1%	97.1%	346.8%
TOWER	93.9%	147.4%	77.4%	164.5%	72.5%	172.0%	71.2%	180.1%	60.8%	159.9%	61.2%	176.0%
MH ADULT PICU												
CHRISTOPHER UNIT	90.9%	183.8%	93.5%	211.8%	115.9%	175.0%	93.0%	212.5%	145.3%	194.2%	98.4%	253.7%
HADLEIGH PICU	104.5%	262.4%	109.6%	496.2%	100.4%	251.2%	117.9%	458.4%	118.7%	254.5%	112.1%	471.2%
MH ADULT REHAB												
IPSWICH ROAD	90.1%	100.3%	97.6%	196.8%	107.7%	106.7%	100.6%	200.0%	108.8%	102.8%	101.1%	196.8%
CAMHS SERVICES												
LARKWOOD	70.0%	194.9%	60.1%	148.2%	86.1%	99.4%	73.0%	76.6%	73.2%	163.7%	70.5%	232.1%
LONGVIEW	74.1%	238.0%	59.8%	307.1%	76.0%	177.7%	69.2%	234.8%	72.5%	148.9%	68.5%	102.2%
POPLAR	71.8%	281.2%	88.7%	328.9%	90.5%	243.5%	81.5%	271.9%	100.0%	77.2%	95.2%	107.4%

	Day Rates		Night Rates		Day Rates		Night Rates		Day Rates		Night Rates	
	Aug-22				Sep-22				Oct-22			
	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED
TARGET >90%												
SPECIALIST SERVICES												
EDWARD HOUSE	73.5%	104.1%	103.0%	83.5%	77.3%	129.0%	103.3%	88.2%	86.0%	137.8%	98.4%	116.0%
ALPINE	86.3%	114.3%	74.6%	113.8%	94.1%	120.4%	93.4%	118.3%	98.5%	125.0%	79.8%	113.1%
AURORA	98.7%	93.8%	100.0%	100.0%	96.7%	97.1%	100.0%	125.1%	100.7%	96.1%	100.0%	100.0%
CAUSEWAY	143.2%	145.6%	98.5%	100.0%	98.8%	136.6%	98.0%	108.3%	109.2%	134.4%	94.9%	111.9%
DUNE	96.7%	111.2%	97.1%	99.6%	95.1%	138.0%	95.3%	100.0%	95.1%	141.6%	93.8%	101.9%
FOREST	161.1%	145.8%	91.9%	127.1%	170.5%	117.7%	98.5%	100.0%	150.9%	130.1%	85.6%	96.8%
FUJI	79.6%	131.3%	90.2%	111.8%	86.9%	171.9%	94.9%	138.7%	87.1%	216.1%	94.5%	200.4%
LAGOON	84.1%	110.7%	98.4%	106.4%	80.2%	118.1%	100.1%	114.2%	85.5%	111.6%	91.2%	98.6%
ROBIN PINTO UNIT	113.9%	125.3%	97.0%	222.6%	107.7%	126.5%	97.9%	210.0%	111.3%	127.6%	95.9%	212.9%
WOODLEA CLINIC	121.8%	115.4%	117.3%	107.8%	121.3%	121.1%	138.5%	147.3%	126.4%	120.7%	147.3%	142.9%
RAINBOW UNIT	87.1%	62.7%	53.2%	68.4%	81.2%	66.8%	58.5%	65.6%	97.3%	67.7%	50.6%	80.5%
LEARNING DISABILITY SERVICES												
HEATH CLOSE	100.8%	111.5%	100.0%	121.5%	99.0%	120.1%	103.3%	103.3%	87.4%	132.7%	93.6%	135.5%
NURSING HOMES												
CLIFTON LODGE	97.8%	112.0%	85.5%	211.8%	100.6%	115.0%	80.0%	218.1%	99.6%	119.4%	90.2%	211.8%
RAWRETH	78.3%	79.2%	50.0%	170.0%	80.6%	81.8%	52.0%	169.8%	92.5%	88.1%	50.0%	172.7%
COMMUNITY HEALTH SERVICES												
CUMBERLEGE ICC	60.7%	57.7%	66.7%	80.7%	60.9%	67.0%	66.7%	80.0%	59.5%	58.4%	67.4%	81.9%
AVOCET	104.2%	90.5%	91.2%	104.6%	120.8%	100.4%	100.4%	108.7%	120.3%	97.5%	101.6%	145.4%
BEECH WARD	100.1%	96.0%	101.7%	83.2%	87.0%	90.7%	92.5%	85.5%	88.5%	94.4%	93.5%	91.2%
PLANE	129.0%	101.7%	100.4%	96.7%	107.6%	98.3%	107.0%	99.8%	105.2%	101.4%	103.5%	99.1%
POPLAR UNIT	123.1%	78.8%	100.1%	112.1%	101.7%	83.9%	98.3%	113.4%	100.0%	77.2%	95.2%	107.4%

Click here to return to summary page

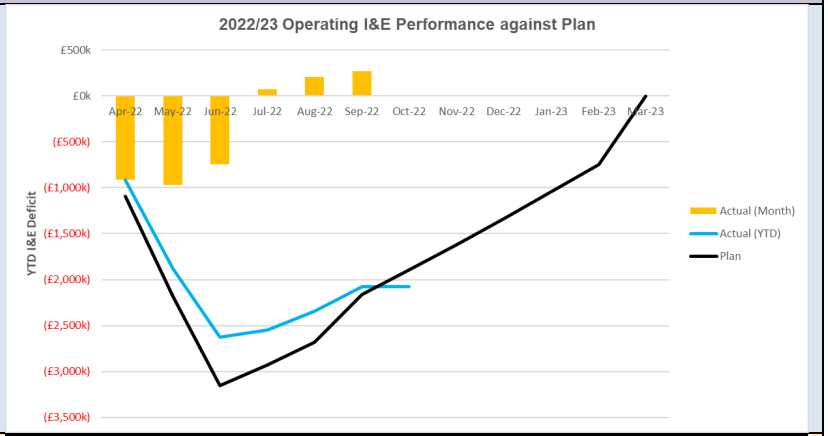
SECTION 5 – CQC

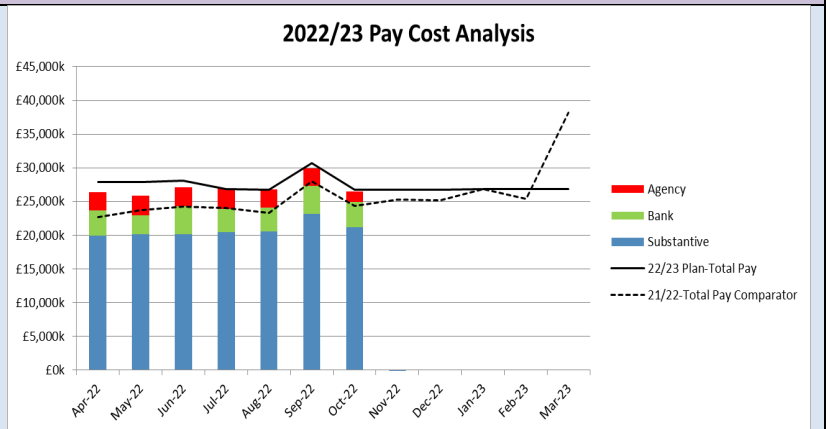
Click here to return to summary page

RAG	Ambition / Indicator	Position M7	Trend (above target = good)	Narrative
CQC Must do Actions	There will be 0 CQC Must Do actions past timescale	At the end of October 0 actions were past timescale	Achieve target = good performance 	0 CQC Must Do action is past timescale at the end of October 2022

SECTION 6 - Finance

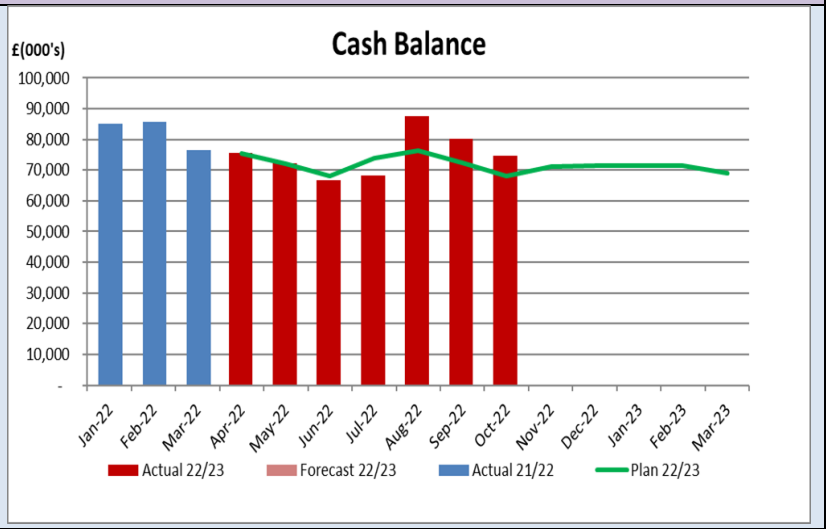
Click here to return to summary page

<table>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position</th><th>Trend</th></tr>
<tr><td>Income and Expenditure</td><td>Income and Expenditure</td><td>The YTD month 7 position was a deficit of £2.1m, £0.2m adverse to plan. The in month financial performance has been supported by non-recurrent benefits. The Trust continues to FOT a breakeven position.</td><td> 
</td></tr>
<tr><td>Efficiency Programmes</td><td>Efficiency programme</td><td>The YTD reported delivery is £4m against the plan of £7.4m, £3.4m behind plan. The adverse variance is caused by two key schemes with full recovery of one scheme expected to be delivered in a future period. The Trust has identified additional schemes totalling £14.8m and is against the £17.3m target.</td><td>
<table>
<tr><th></th><th>Efficiencies £000</th><th>YTD Plan £000</th><th>YTD Delivery £000</th><th>YTD Variance £000</th></tr>
<tr><td></td><td>£000s</td><td>£000s</td><td>£000s</td><td>£000s</td></tr>
<tr><td>Identified</td><td>7,087</td><td>2,315</td><td>1,305</td><td>(1,010)</td></tr>
<tr><td>Unidentified</td><td>10,203</td><td>5,081</td><td>2,670</td><td>(2,411)</td></tr>
<tr><td>Total</td><td>17,289</td><td>7,396</td><td>3,975</td><td>(3,421)</td></tr>
</table>
</td></tr>
</table>

RAG	Ambition / Indicator	Position	Trend
Temporary Staffing	Temporary Staffing Costs	In month temporary staffing was £5.3m (£6.7m in M6); bank spend £3.8m (M6 £4.1m) and agency spend £1.6m (M6 £2.6m). The M6 bank spend included £0.4m which related to the 22-23 national pay award and back dated pay. The decrease in agency spend in M7 was due to the release of an accrual no longer required for prior period/year invoices, following a review of invoices paid and accrued.	
Maximising Capital Resources	Maximising Capital Resources	The Trust plan for 22/23 is £12.3m (of which £11.3m relates to system allocation). YTD spend is £4.3m, £4.9m behind original plan and £0.6m ahead of reforecast plan. Project leads continue to forecast delivery of the programme with a number of the key projects now underway following recent tender awards.	

Capital

	Annual Plan	YTD Original Plan			YTD Reforecast Plan		
	£000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
2021/22 Carry Forward	2,319	2,127	1,278	849	1,262	1,278	-16
Business As Usual	3,873	3,277	1,051	2,226	976	1,051	-74
Strategic Schemes	5,064	2,645	1,536	1,109	1,334	1,536	-202
Charge against Allocation	**11,256**	**8,049**	**3,865**	**4,184**	**3,573**	**3,865**	**-292**
Critical Cybersecurity	39	0	0	0	7	0	7
High Dependency Units	0	0	68	-68	68	68	-1
Mental Health ED	0	0	271	-271	35	271	-236
The Lakes - HBPOS	0	0	40	-40	0	40	-40
New Leases (fleet)	877	877	0	877	0	0	0
PFI Residual Interest	113	66	66	0	66	66	0
Net CDEL	**12,285**	**8,992**	**4,310**	**4,682**	**3,748**	**4,310**	**-562**
Variance (%)				52%			-15%

RAG	Ambition / Indicator	Position	Trend
Cash Balance	Positive Cash Balance	Cash balance as at the end of M7 was £74.6m against a plan of £68m, £6.6m ahead of plan.	

Please be aware that the Capital Expenditure and Capital Resources has been merged as one indicator under Maximising Capital Resources.

END

NHS
Essex Partnership University
NHS Foundation Trust

Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services

November 2022

EPUT

Introduction

Essex Partnership University NHS Foundation Trust

In response to the BBC Panorama programme which showed patients being abused while in the care of an NHS Trust, Claire Murdoch, National Mental Health Director wrote to all Mental Health, Learning Disability and Autism provider CEO's asking them to take the three actions:

1. Review the safeguarding of care
2. Consider independent peer-led support
3. Review plans for people in seclusion and long term segregation

Further to this the letter referred to the potential to fast track the launch of the inpatient quality programme, which tackles the root causes of unsafe poor-quality care, looks at best evidence for preventing and uncovering abuse. Our Executive Director of Nursing has made contact with Liz Durrant, Head of Programme to register our expression of interest in being involved in the development of this programme.

From review EPUT has systems and process in place and can demonstrate action taken as part of good governance to respond where improvements were identified. It is acknowledge that some of the improvements are newly implemented or reinstated (following COVID-19) and therefore we will need to maintain oversight.

1. Review the safeguarding of care and identify any immediate issues requiring action now.

- Freedom to speak up arrangements
- Advocacy provision
- Complaints
- CETRs and ICETRs
- Any other feedback on services

2. Consider independent peer-led support to people being cared for in your most restrictive settings and peer-led feedback mechanisms.

3. Review why people in your services are in Seclusion and Long Term Segregation, how long for, what is the plan to support them out of these restrictive settings.

Freedom to Speak Up Arrangements

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Policy and Procedure:
The Trust has in place a Freedom to Speak Up / Whistleblowing Policy and Procedure 2022- 2025. A significant aspect of our Culture of Learning Programme, which is our commitment to excellence and willingness to learn from the experiences of others.

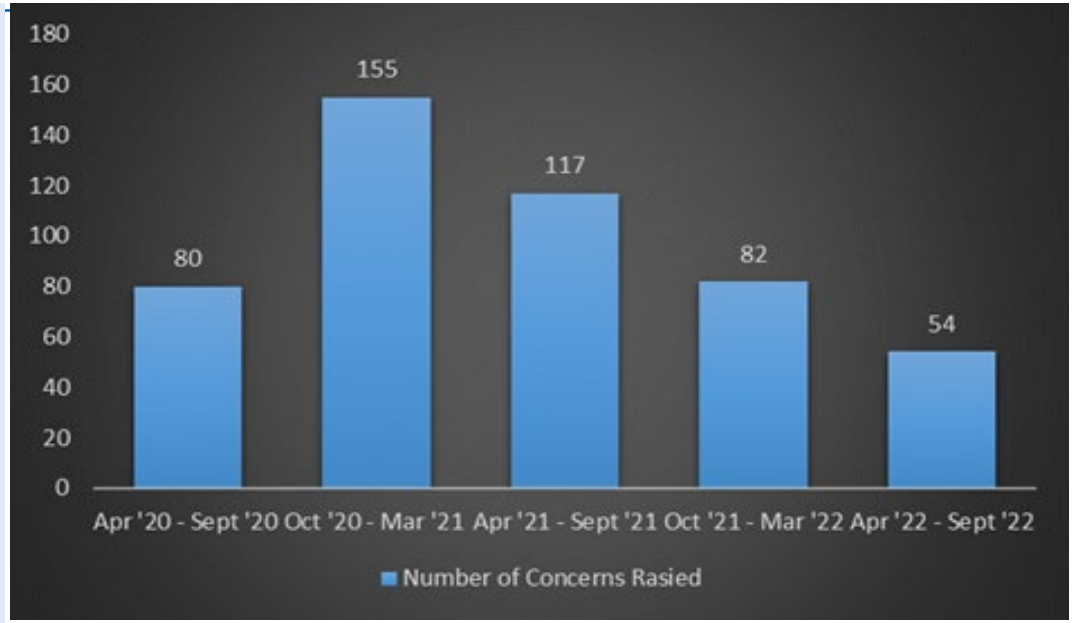
All new starters receive, as part of corporate induction, a session on Freedom to Speak Up led by the principal Freedom to Speak Up Guardian (F2SUG), Elliot Judge. The principal F2SUG has direct reporting lines into the Chief Executive and is supported by a network of guardians.

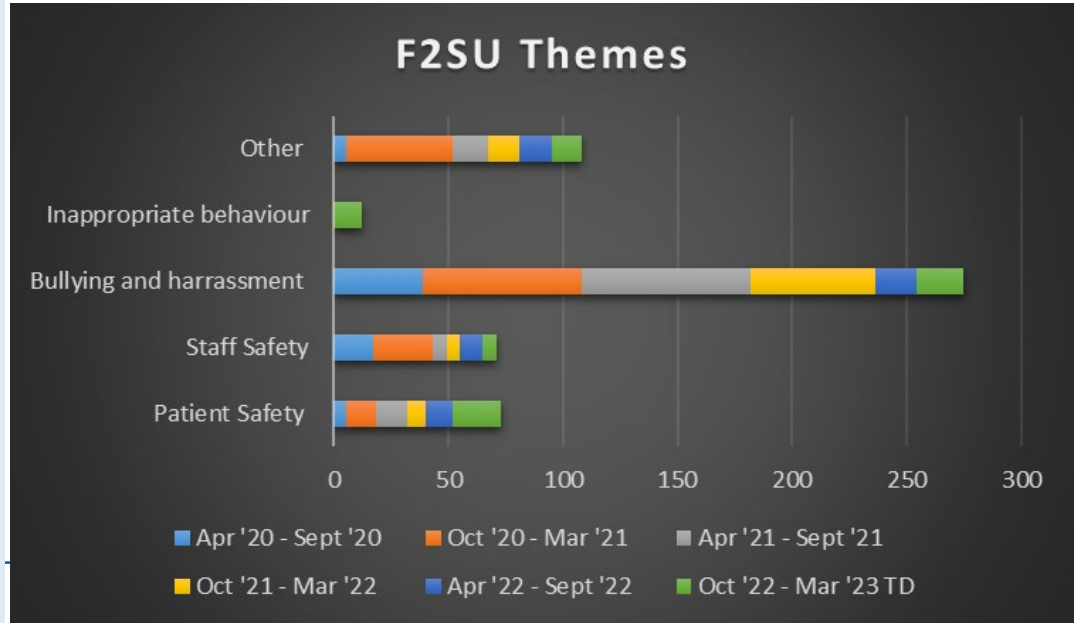
Monitoring:
- Direct access to Executive Team to raise any concerns requiring action.
- Bi-yearly reporting to the People Equality and Culture Committee (note this previously was quarterly – changed due to change in structure of the Committee).
- Bi-yearly reporting to the Board of Directors (including an annual report, with F2SUG Annual Report 2021/22 being reported to the Board in May '22).

Analysis:
- Data in figures is sourced from the F2SUG Annual Report 2021/22 which provided trend data from April 2020.
- A significant theme raised over time to the F2SUG was associated with alleged 'bullying and harassment'. The Trust put in place in May '22 a new appraisal process, which includes a regular 1-2-1 meeting between staff member and their line manager (every 8 weeks for clinical staff and 12 weeks for non-clinical staff). These meetings have a focus on wellbeing and aim to support staff to be mentally and physically well and feel safe. The data demonstrates that from that time the number of 'bullying and harassment' concerns have reduced.
- Concerns raised relating to staff safety appear to have mirrored the COVID-19 Pandemic.
- From Oct '22 the Trust has seen patient safety concerns raised may correlates with the promotion work undertaken by the new F2SUG.

It is **good governance** to routinely review processes and a review of the Trust F2SU arrangements undertaken by the new Principal F2SU Guardian (Interim), with work undertaken to date and actions being taken defined in the action chart:

- Design of a new notification document
- Collaboration to set up an Essex F2SU online forum for local health providers
- Draft communications plan for the next 12 months
- Established a F2SU local guardian forum
- Revised induction material for new starters.
- Commenced F2SU evaluation against the national reflection and planning tool.





Complaints Management

Essex Partnership University NHS Foundation Trust

Policy and Procedure:

- Complaints Policy and Procedure (requiring review following improvement programme 2022).
- Director of Patient Experience – Matt Sisto
- Head of Complaints and PALS – Clare Lawrence.

Monitoring:

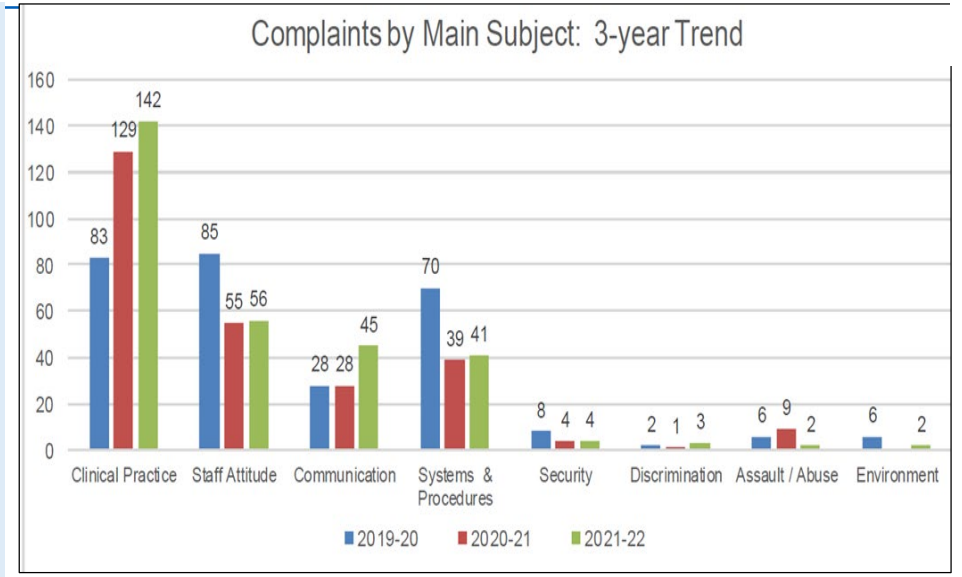
- Complainant feedback is sought and factored into reviews of our process. For 2021/22 34 complainants provided feedback to the complaints handling survey.
- Non-Executive Director Complaint Quality Reviews
- Annual Complaints and Compliments Report (2021/22 report to the Board of Directors May '22).
- Executive Directors meet with complainants to hear of their experience.

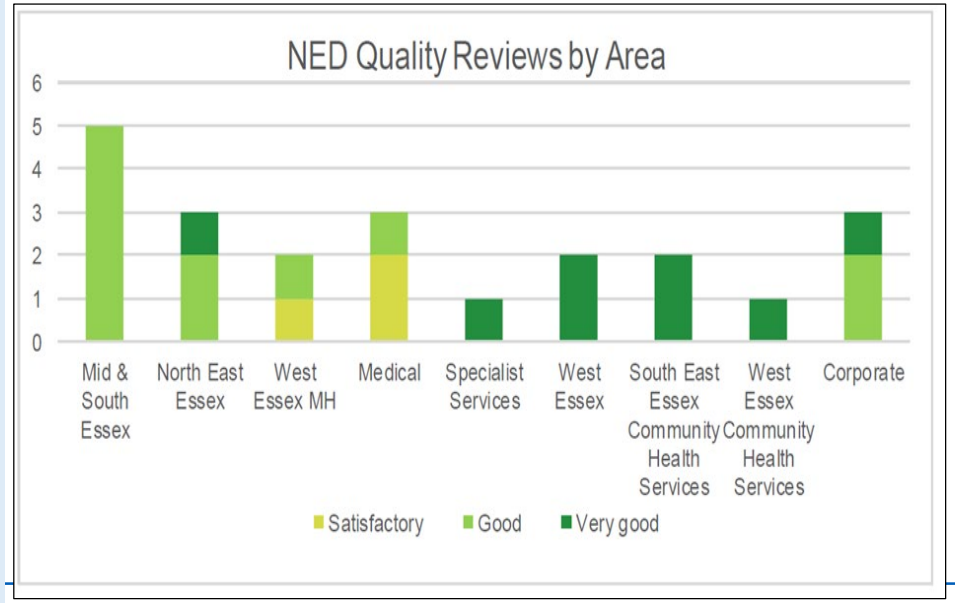
Analysis:

- The Trust experienced a 37% increased number of complaints in 2021/22 when compared to previous years (Nb. COVID Vaccination programme). Source Annual Complaints and Compliments Report 2021/22.
- 4 referrals made to the PHSO
- PHSO Investigations closed during 2021/22 were all partly upheld by the PHSO: Links to this piece of work include: May 2021 case failure to communicate wife's progress before discharge and when she was in seclusion. Aug 2021 case record keeping.
- Of our internal process: 15% of complaints upheld; 52% partially upheld and 30% not upheld. 8% of complaints were reopened due to dissatisfaction with the outcome of the complaint handling process.

It is **good governance** to routinely review processes:

- Quality Account 2022/23 set out our patient experience priority 'To increase use of patient / service user feedback and experience data, to include the complaints process'. The programme of work will look to improve satisfaction from service users for complaints, reduction in delays and extensions for complaints, provide examples of patient-led improvements and service transformation and increase the involvement opportunities for people with lived and living experience.
- In January 2022 we initiated a coproduction project with the complaints team, complainants, and complaints investigators across the trust, to undertake a root and branch review of the complaints process end to end, as we recognised that as an organisation, on the whole we were not meeting the needs of those that used the service. The result of this is a radical transformation of the Complaints service, which is currently in flight and will require new process, procedures, policies, and people.
- June '22 redesigned the complaints function. As part of this project created 3 new complaint liaison officer (band 5) roles (an investment of £98,496).





Other Feedback Mechanisms

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EPUT has a programme of work (led by the Director of Patient Experience) focused on transforming and improving how we put the people who experience our services, at the front and centre of everything we do.

- **I Want Great Care** (Launched January 2022) –programme to ensure patient / services users are able to access and give their feedback. IWGC is available for every service across our organisation and can be accessed online, by paper, on a tablet device, a mobile device, with a view to having SMS messaging in the near future to make it as easy as possible for people to provide feedback on their experiences.

- **Lived Experience Team** (established 2021) which is now a team of circa 100 people that have used our services working across the organisation to drive forward change that matters to the people and communities we serve. This team is growing on a weekly basis. Reward and Recognition Policy (Launched 2022) enabling the trust to reward and recognise the contributions of our Lived Experience Team in a mutual and reciprocal manner to our paid workforce.

- **Patient Led Assessments of Care Environments** (PLACE) across 62 sites.

- **Networks** - Throughout 2022 we have been creating a network of networks across our services to build a complex and integrated listening platform for our services, and service users. These include, The lived experience network, the PDCN network, the carers network, the lighthouse network, the LD and Autism network, and the diabetes network. The demand for service and service users specific networks is growing exponentially and we see this becoming more and more diverse.

- **Patient, Carer, and Family Collaborative** (EPUT Citizen Panel) Launches 2022 - which is co-chaired by the director of Patient Experience and one of our Principle Lived Experience Ambassadors. It is open to staff, patients, families, carers, services users, and organisational partners including other providers and VCSE.

- **Patient Safety Partner network** - we currently have 4 PSP's whom are members of our Lived Experience Team, that are working with the Patient Safety team and across the organisation to drive forward improvements to safety of our services for those that use them. Our aspiration is that this network will grow, and in the near future we will have PSP's operational across all of our place based care units.

- **Inpatient Forums** –Reinstated (post COVID-19 restrictions) the inpatient forums which will be facilitated by the Director of Patient Experience, and/or the patient experience team, and are a recurring event, perhaps running bi-monthly. This will be tied into the thematic reporting cycle to inform solutions, and 'you said we did' actions.

- **Inpatient Advocacy service** – a new initiative 2022 setting up an inpatient advocacy service, which will be a voluntary role, covered by our reward and recognition policy and fulfilled by our lived experience team. This role will be a mixture of peer support, advice, and liaison, for both patients and families. The inpatient advocates will attend the inpatient environments for a few hours each week and spend time talking to the patients and their families if they are there and have any questions. These individuals will have direct links to PALS and the Patient Experience Team and will be registered Trust Volunteers who have lived experience of Mental Health Services.

- **Ward based 'Community Meetings'** – service led forums for patients / service users to provide direct feedback to the team.

- **Board visits and informal visits across the Trust** – carried out by both Executive and Non-Executive Directors.

Seclusion and Long Term Segregation

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Policy and Procedure:

- Seclusion and Long-Term Segregation Policy and associated procedure. (CPG41) 2021 - 2024
- Therapeutic and Safe Interventions and De-escalation Procedure (RMPG05) 2021 - 2024
- Safety First Safety Always Strategy - Reducing Restrictive Practice Framework 2022 -2025 and Restrictive Practice Group in place to lead the programme of work.
- TASID (Mandatory Training) for identified staff - As at Sept. 22 TASID training compliance was 90%. Continuing to deliver recovery plan (following reduction in frequency during COVID-19 and the requirement to move back to annual refresher training as BAU).

Monitoring:

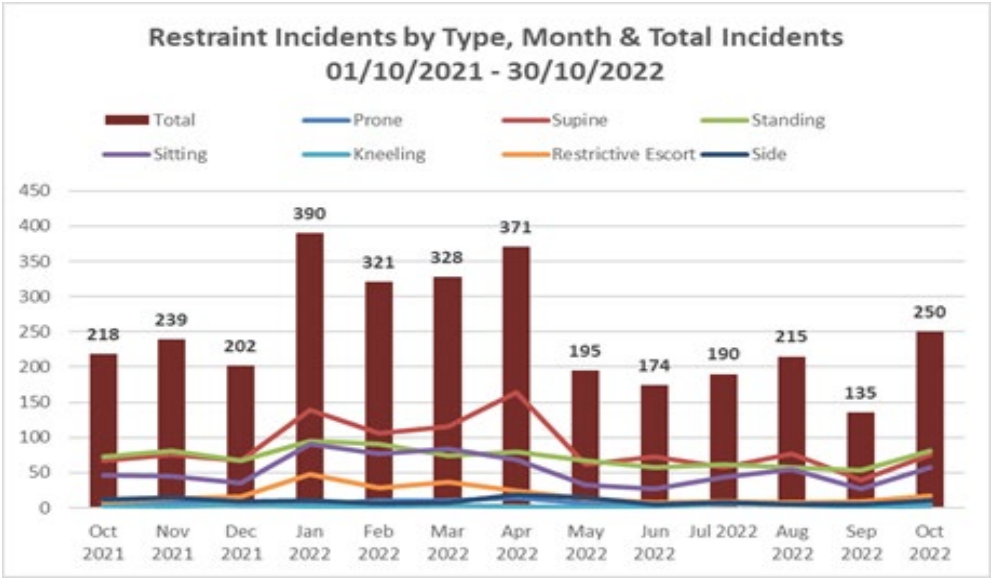
- Good reporting through Weekly Restrictive Practice Report to Executive Director of Operations and Operational Teams
- Restrictive Practice Sub Committee (Led by Assistant Director of Quality and Safety), meets monthly., reporting into Clinical Governance Quality Sub-Committee and the Quality Committee.
- Self-assessment against the Restraint Reduction Networks Checklist (A tool to support organisations to ensure that the use of restrictive practice is minimised and the misuse and abuse of restraint is prevented (completed in October '22)
- Annual Clinical Audit Seclusion and Long Term Segregation (Documentation Audit)

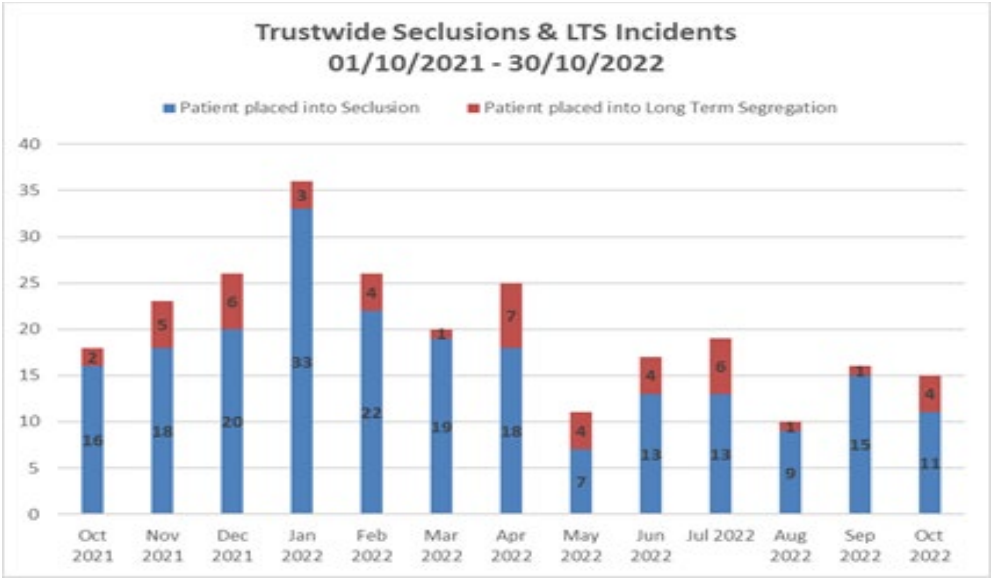
Analysis:

- 2021 /22 : Further work was undertaken to embed progress made as a result of the Restrictive Practice Inpatient Collaborative aimed at reducing levels of restraint and violence and aggression within our inpatient wards. Reducing restrictive practices is a necessity but the reduction of prone restraint was the priority due to the increased patient safety risk. Going forward our focus will include a reduction in seclusion and long term segregation. (Source: Quality Account 2021/22)
- Prone restraint significant reduced from April 2020 to March 2022 and continues to be sustained in 2022.
- Annual Clinical Audit Seclusion and Long Term Segregation - for 2021/22 noted that due to clinical pressures the audit was undertaken by the Clinical Audit Team (non clinical staff)– this audit therefore is limited in its scope and therefore to obtain a clinical audit opinion, a point prevalence audit of all patients in seclusion or long term segregation will be undertaken in December '22 and the outcome reported to the Quality Committee for assurance.

It is **good clinical governance** to routinely review processes (in particular given the reporting of restraint practices on the C4 dispatches programme)

- The Trust has initiated a project to explore the potential to utilise the CCTV and Body Worn Camera Video footage for learning with a clear focus on professional standards. This would both celebrate and share good practice, as well as the identification of lessons for improvement. The project group is currently piloting the concept with operational Directors. Nb. Some information governance considerations to be worked through.





Other Feedback Mechanisms

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EPUT has a programme of work (led by the Director of Patient Experience) focused on transforming and improving how we put the people who experience our services, at the front and centre of everything we do.

- **I Want Great Care** (Launched January 2022) –programme to ensure patient / services users are able to access and give their feedback. IWGC is available for every service across our organisation and can be accessed online, by paper, on a tablet device, a mobile device, with a view to having SMS messaging in the near future to make it as easy as possible for people to provide feedback on their experiences.

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Care Education and Treatment Review (CETRs)

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- Our CAMHS service follows NHS England Guidance and Toolkit.
- CAMHS respond to external processes and administration management for each individual who is subject to a CETR (noting this is a process we contribute to and do not lead).
- CETR requests is highlighted through the EPUT on admission process and through out admission.
- Documentation after CETR is shared with CAMHS to enable a link into our EPR.
- The Trust facilitates the process by ensuring a room is available, IT support to ensure access to the meetings.

Closed Cultures

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- The CQC published in May 2022 a report on Closed Cultures
- This project by the CQC sets out to identify inherent risk factors and warning signs of a closed culture.
- The likelihood that a service might develop a ‘closed culture' is higher if an inherent risk factors are present. Certain features of services will increase the potential for inherent risks.
- We will further embed the learning from the CQC guidance in our internal reviews and have a developed Culture of Care review early warning signs assessment.
- Work has been established to undertake these reviews using metrics and risk factors identified and will progress through our compliance function and leadership of the care units.

Advocacy Provision

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- There is an Independent Mental Health Advocacy (IMHA) provision which is commission by the Local Authority.
- Rethink Essex All ages Advocacy Service is the main provider across EPUT.
- With designated Independent Mental Health Advocates for each of the wards across Essex that fall under the Essex County Council.
- Leaflets for all advocacy provision is provided on each ward for display and awareness information about the right to access IMHA.
- Referrals are made directly with the service by individual wards, noting data is not collect on numbers of referrals. The Rethink services is looking at how this can be collated and shared.
- Independent Mental Capacity Advocate (IMCA) is available across all hospital sites.
- There is inconsistency across our wards in whether advocates visit in person and on a regular basis (note this may be a hangover from COVID restrictions).
- Working with the Rethink Essex All ages Advocacy Service who have proposed the following improvements:
    - Undertake and audit of their information that is available on the wards and refresh if needed
    - Designated advocates to book in and attend community meetings to raise awareness of the service
    - The offer of training to staff and student about advocacy.

Safeguarding

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Policy and Procedure:
The Trust has in place a safeguarding policies and procedures in place.

- Executive Nurse is responsible for the delivery of the Safeguarding Service
- Safeguarding Team led by an Associate Director fro Safeguarding – Tendayi Musubdire
- The Safeguarding Service includes Mental Capacity & Deprivation of Liberty Services, Domestic Abuse, MARAC, MAPPA, PREVENT and the Looked After Children Service, headed by Named Professionals and their teams.
- The service has a safeguarding duty system providing a reflective space to discuss and clarify safeguarding concerns and to provide support to practitioners on next steps. Further to this the service offers a single point of access to triage queries and provision of information.
- Safeguarding professionals within the Safeguarding Team are training to offer supervision across the Trust.
- Supervision – mandatory in children's services with three monthly sessions.
- Have a network of Safeguarding Champions – these staff act as conduit of information between the Safegaurding Team and their clinical area by raising awareness of safeguarding practice and initiatives and supporting the identification of team learning needs. Our champions attend events to update their knowledge throughout the year.
- Safeguarding Newsletter published monthly.
- Clinical staff received safeguarding training aligned to their job role. End Sept. '22 Safeguarding Adults level 3 training 89% and Safeguarding Children level 3 training 91%.
- All staff received Safeguarding Adults and Children level 1 training as part of mandatory training End Sept. '22 93%

Monitoring:
- Mental Health Act and Safeguarding Sub-Committee meets bi-monthly and is chaired by the Executive Nurse and has a non-executive director in the membership.
- Reporting to QC
- Safeguarding Annual report to the Board (September 2022)
- Feedback that we have a very open and transparent approach to safeguarding.

Forward Plan:
It is **good governance** to routinely review processes and a review of the Trust Safeguarding arrangements. The forward plan for 2022/23 is included within the annual report which was presented to the Board in Sept. '22.

Strengthening our position

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Freedom to Speak Up	Action	By Who
Governance • Freedom to Speak Up / Whistleblowing Policy and Procedure 2022- 2025	• Evaluation against the national Freedom to Speak Up Reflection and Planning Tool. • Review of the Freedom to Speak Up / Whistleblowing Policy and Procedure.	• Nesta Williams, Director of Workforce Transformation. • Elliott Judge, Principal F2SUG.
Freedom to Speak Up Guardian(s): • Principal Freedom to Speak Up Guardian (interim) – Elliott Judge from July '22 • Local Guardians (7)	• To substantively appoint to the Principle Freedom to Speak Up Guarding role. • Business case for investment to revise structure (Source ET 27/22/22) to establish additional FTSUP Guardians for MSE, W&NE and LB.	• Paul Scott, Chief Executive • Elliot Judge , Principal F2SUG
Education and Training: • Corporate Induction (all new starters) • Principal F2SUG attends regional and national networks.	• Review of F2SU training packages (supported by HR) – F2SU e-learning modules.	• Elliott Judge, Principal F2SUG (date)
Communication and Engagement: • Multiple access points: Email: f2su.eput@nhs.net Tel: 07814 226 709 • Dedicated intranet page Freedom To Speak Up (eput.nhs.uk) • F2SUG Reporting to Board of Directors (Quarterly)	• Development of F2SU Communication Strategy .	• Elliott Judge, Principal F2SUG (date)
Thematic Review of concerns raised. • Previous 2 years	• Develop a process to triangulate themes with those from other intelligence (patient safety activity, staff experience) • Benchmark reporting levels against peer organisations.	• Director of Patient Experience • Director of Patient Experience

Strengthening our position

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Complaints & Patient Feedback	Action	By Who
Governance • Complaints Handling Policy and Procedure	• Redesign the complaints process to be reflected in the Policy and Procedure.	• Complaints and PALS Manager.
Complaints Team • Complaints and PALS Manager • 5 new Complaint Liaison Officers	• Recruit to Band 5 Complaint Liaison Office roles.	• Complaints and PALS Manager.
• I Want Great Care	• Ensure all inpatient areas have access to Paper forms or IPADs to facilitate feedback	• Director of Patient Experience.
Thematic Review of concerns raised.	• Develop a process to triangulate themes with those from other intelligence (PALS and Complaints etc.) When there is enough data from IWGC The output of this would be a thematic report, identifying the themes of issues that need addressing. This can then be shared with the senior management teams to direct and focus our improvement work.	• Director of Patient Experience
Closed Cultures	• Embed the learning from the CQC guidance in our internal reviews and have a developed Culture of Care review early warning signs assessment.	• Executive Chief Nurse

Strengthening our position

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Seclusion and Long-Term Segregation	Action	By Who
• Seclusion and Long-Term Segregation Policy and associated procedure. (CPG41) 2021 - 2024 • Therapeutic and Safe Interventions and De-escalation Procedure (RMPG05) 2021 - 2024 • Safety First Safety Always Strategy - Reducing Restrictive Practice Framework	• Deliver Programme Reducing Restrictive Practice Framework 2022 – 2025 (continues to be included in Quality Account Priorities 2022/23)	• Restrictive Practice Group.
• Weekly Restrictive Practice Report • Restrictive Practice Group	• To consider whether additional information for the weekly data would benefit from showing number of 'patients stepped down from LTS, total number of patients in LTS and other sit rep information.	• Restrictive Practice Group
• Self-assessment against the Restraint Reduction Networks Checklist (A tool to support organisations to ensure that the use of restrictive practice is minimised and the misuse and abuse of restraint is prevented (completed in October '22) • Clinical Audit Plan: Annual Audit of the Seclusion and Long Term Segregation Policy and procedure. The audit checks for assurance that the policy and procured are embedded in clinical practice, implemented and monitored using the correct documentation.	• Deliver action plan arising from self assessment Oct 2022. • Undertake a point prevalence clinical audit of all patients in seclusion or long term segregation (December '22). The Restrictive Practice Group will focus on seclusion and long term segregation ensuring that point prevalence audits are supported with patient experience feedback and on site education and training delivered direct to teams.	• Restrictive Practice Sub-Committee • Restrictive Practice Sub-Committee
• No force first concept • Staff Training and trainers. • TASID (Mandatory Training)	• Restrictive Practices intranet page being developed • Deliver the recovery plan for TASID training	• Deputy Director for Quality & Safety (RP Group) • TASI Trainers

Strengthening our position

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Advocacy	Action	By Who
• Availability of advocacy information on wards to raise awareness with patients	• Undertake an audit of the information that is available on the wards (leaflets and posters) and update as required.	• Rethink Essex All Ages Advocacy Service
• Advocacy presence on the wards	• Designated IMHAs to book in and attend community meetings to raise awareness of service.	• Rethink Essex All Ages Advocacy Service and EPUT Ward Managers.
• Staff awareness	• Work with Rethink Essex All Ages Advocacy Service to provide awareness training with staff and students about advocacy.	• Rethink Essex All Ages Advocacy Service and EPUT Ward Managers.

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

Report Title:	**End of Life Care Annual Report**					
Executive/ Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Tracy Reed, Clinical Lead End of Life Care and Dr Fiona McDowall, Consultant Psychiatrist, Specialist End of Life Doctor					
Report discussed previously at:	Quality Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

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

Purpose of the Report		
This report provides the Board of Directors with the End of Life Annual Report for 2021/22.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Approve the End of Life Care Annual Report for 2021/22

Summary of Key Issues

Details of the End of Life care provided by EPUT as benchmarked against the EPUT Framework and national guidance documents related to End of Life Care. The report sets out the key elements of care and progress under headings which include:

- **The End of life subcommittee** meets monthly to support shared learning and information across all areas of the trust and representation from services across EPUT are represented. It provides an opportunity to review data from the end of life care dashboard and identify risks related to end of life care.
- **Policies and procedural guidance** updates of those documents that have been introduced or updated in line with national guidance and support ICB guidance where it has been introduced and ensure staff have accessibility to updated information to support safe practices. This year a number of documents have been updated including the **EPUT end of life care Framework 2022-24** which was updated to support changes in the National guidance Ambitions for Palliative and End of Life Care and Universal Principles of Advance Care Planning documents for all areas**.**
- **EOLC Champions** currently we have 62 champions who work across all areas, these include different grades, disciplines and roles within services. The group meet 4 times a year within a forum but updated information and communication is encouraged. All champions are encouraged to undertake end of life care training to fulfil this role and support competencies.
- **EOLC Competencies** a competency framework within the trust supports extended roles and the clinical lead supports the education and development of staff to achieve their competencies. They include syringe driver training, verification of expected death and senior clinical staff to support DNACPR conversations and implementation of DNACPR documents.
- **Clinical Audit** the trust participate in the NACEL audit the findings showed we were above national averages in care delivery for many elements. NACEL National recommendation is all staff undertake eolc training from Mental Health Trusts. The community audit undertaken of 52 eolc records was made easy to find the relevant data and information required to complete the audit and share information across services from the eolc templates and EPaCCs registers. The findings were pleasing as there was improvement on the previous year's audit even though we have audited more patient records this year increasing by 20 more sets of records. This also included the two nursing homes in SEE. The DNACPR audit also showed improvement of documentation and ensuring recording of conversations and inclusion of loved ones in conversation.
- **Patient Story** this story supports how services across the trust work together in identification and supporting those who are recognised as having a physical and mental health issue. It supports how services are able to link up within the integrated teams and work together to ensure best practice. This includes working with external partners including Primary care, social care and hospice.
- **NHSI and EOE end of life care collaborative** we are supporting all system partners to align services and practice. Sharing information and were asked to showcase at the East of England eolc collaborative meeting the developments we have made in Dementia and Frailty Services.
- **Mental Health** Tower Ward has continued to maintain their GSF status and support good practice for those who are eolc. The work with STaRS teams in North Essex has supported close working collaboratively with the Alzheimer's association and social care. EPUT are supporting St Helena Hospice to deliver joint training and support for advance care planning conversations in a timely way while people still have capacity.
- **Nursing Homes** both homes are now managed by one manager which has reduced variation in approaches to care. Patients are identified using the prognostic indicators and are added to the electronic EPaCCs Register so all community services have access to their preferences for care and eolc documentation, this supports patients holistic individualised care.
- **During Covid 19 pandemic and partnerships** The Clinical Lead and Specialty Doctor have continued to support the development and implementation of a wide range of initiatives including enhanced skills and guidance around early recognition of end of life and symptom management. The work across all areas continues with system partners to ensure patient choice and partnerships to support care for people identified as eol.

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

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

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

Acronyms/Terms Used in the Report			
EoLC	End of Life Care	**DNACPR**	Do Not Attempt Cardiopulmonary Resuscitation
PEACE	Proactive Elderly Advance Care Plan	**CCG**	Clinical Commissioning Group
TEP	Treatment Escalation Plan	**ICS**	Integrated Care System
CHS	Community Health Services	**MDT**	Multi-disciplinary Team
NACEL	National Audit of Care at End of Life	**GSF**	Gold Standards Framework
NICE	National Institute for Health and Care Excellence	**PPC**	Preferred Priorities for Care
PPD	Preferred Place of Death	**ESNEFT**	East Suffolk and North Essex NHS Foundation Trust
DIPC	Director of Infection Prevention and Control	**NEE Alliance**	North East Essex Alliance
LPA	Lasting Power of Attorney for health and welfare	**EPaCCs**	Electronic Palliative Care Co-ordination system
STaRS	Specialist Treatment and Recovery Service	**NHSI**	NHS Improvement National collaborative
PEoLC	P**alliative** and End of Life Care	**SEE**	South East Essex

Supporting Reports/ Appendices /or further reading
End of Life Annual Report 2021-22 End of Life Framework 2022-24 (on request)

Lead

Natalie Hammond
Executive Nurse

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END OF LIFE ANNUAL REPORT 2021-22

EPUT

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END OF LIFE ANNUAL REPORT

JULY 2021 - JULY 2022

Report prepared by:
Tracy Reed
Clinical Lead, End of Life Care

Dr Fiona McDowall
Old Age Psychiatrist

September 2022

CONTENTS

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INTRODUCTION

End of life care seeks to enhance the quality of life in the face of death by addressing the physical, psychological, social and spiritual needs of patients with life limiting diseases and their families. Good end of life care encompasses recognition of the dying phase, high quality coordinated care, carer support and advice delivered in a personalised, dignified and respectful manner. Approximately 500,000 people die in England each year, this rose to 695,000 in 2021. High quality end of life care is an indicator of how we care for sick and vulnerable people across health and social care services.

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

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

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

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

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

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

During 2021 and into 2022 we have continued to see service adaptions to ensure the best outcomes for people at end of life to provide the very highest care irrespective of diagnosis. In the past year, community health services have continued to see an increase in the number of people dying at home as more people are presenting later within services following on from the Covid 19 pandemic.

END OF LIFE SUBCOMMITTEE

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

- Clinical Lead, End of Life Care
- Specialty Doctor (consultant psychiatrist)
- End of Life Care Clinical Lead, Frailty and Urgent Care (GP)
- Integrated Services Manager, West Essex Community Health Services
- Head of Inpatient Services, West Essex Community Health Services
- Operational Service Manager, Mental Health Older Adult In-patients
- Associate Director, Dementia and Frailty, West Essex Mental Health Services
- Deputy Director of Integrated Services & Out of Hospital Care, South East Essex Community Health Services
- Integrated Services Manager, South East Essex Community Health Services
- Lead Nurse Palliative Care Team, South East Essex Community Health Services
- Operational Service Manager, Dementia & Older People's Community Mental Health (Mid & South Essex)
- Head of Patient Experience and Volunteers
- Head of Complaints and PALs
- Consultant Clinical Psychologist
- Senior Performance and Information Manager.

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

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

CLINICAL LEAD FOR END OF LIFE CARE AND SPECIALTY DOCTOR

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

COMPETENCIES

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

POLICIES AND PROCEDURAL GUIDELINES

Procedural Guideline for the care of the Deceased Patient

The guideline was revised in February 2022 it sets the standard for sensitive and compassionate communication with family members/significant others. Providing guidance on cultural and spiritual elements of care throughout end of life services. Sensitive care and support after death can be one of the most difficult and challenging aspects for clinical staff but, equally, the most rewarding. The aim of the guideline is to ensure that there is timely confirmation and notification of death by medical staff and that there is correct preparation of the deceased person's body for viewing by family members / significant others and dignified removal to the appropriate mortuary.

Advance Decisions and Advance Statements

The guideline was introduced to provide clarity to staff in relation to the process for advance decision making and advance statements and choice for adults within the care of EPUT. It supports safeguarding, mental capacity issues and person centred choices though the provision of guidance on the process and legislative requirements. This guideline updated in September 2022 and currently being reviewed to include updates related to changes in national guidance with the introduction of The Universal Principles of Advance Care Planning 2022. This has been updated and is currently undergoing the governance process to support the updates.

Verification of Expected Death (VOED)

The existing guideline was last reviewed in 2021. The training was adapted during the COVID19 pandemic to support staff competencies through a blended learning approach, including Train the Trainer to ensure that each team have staff available to support the increase in verification of death particularly within the community services. It is accompanied by a competency framework and a register of competent staff is maintained within each locality and service.

Subcutaneous Drug Administration in Community Health Services by Patients, Carers, Relatives

This was developed to support areas without 24 hour domiciliary services and rural localities. The operational guidance provides the legal and management information to support patients/carers/relatives to administer subcutaneous medication in the community in a timely way to manage symptoms. It also provided a way of reducing footfall during the COVID19 pandemic for patients who are vulnerable or at risk of infection. The guideline is robust in ensuring safe and effective practice and provides clear information and practical steps to ensure robust risk assessment whilst ensuring a person centred approach to patients, carers, relatives who wish to take on this element of care. This was recently updated as the pandemic continues and is now valid for another year.

Standard Operational Procedure - For Senior Clinician Competencies and Assessment of Do Not Attempt Cardiopulmonary Resuscitation

The introduction of this appendix to the do not attempt cardiopulmonary resuscitation guidelines (DNACRP) in 2022 provides a standard operating procedure for senior clinical staff competencies to support education, training and competencies to support senior clinical staff discussing and implementing DNACPR documents.

The standard operating procedure, training programme and competency framework has been developed in partnership with hospices across Essex and the clinical lead for end of life care to support all elements of education, training and competency framework.

End of Life Care Guidelines

The guideline was updated in 2022 to reflect the changes and updates from National Guidance. This includes the cultural and spiritual support of those receiving end of life care and supporting personalisation of care.

There was new guidance for deactivation of implantable cardioverter defibrillators so this element was reduced in the end of life guideline as a separate guidance now exists for deactivation of implantable Cardioverter defibrillators.

Operational Guideline for Deactivation of Implantable Cardioverter Defibrillators

The need for development of this as an independent guideline was increased during the Covid 19 pandemic with an increase of patients not being able to return to acute Trusts for deactivation.

In 2021 education and training were developed with the heart failure teams to support best practice and guidance for deactivation of this element of a pacemaker when someone is recognised as end of life.

END OF LIFE CARE CHAMPIONS

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

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

END OF LIFE CARE FRAMEWORK

The Trust End of Life Care Framework sets out clear guidance in accordance with the ambitions for palliative and end of life care and the National End of Life Care Strategy. These, together with NICE guidelines and quality standards support end of life care practices. The Framework has been reviewed in accordance with the new guidance issued in 2021 and the Trust End of Life Care Framework was updated in 2022.

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

1. Each person is seen as an individual	
Key Achievements	The systems in place to capture incidents, compliments and complaints have continued to be strengthened during 2021/22. The clinical lead is copied into any Datix or complaints in any of EPUT's services related to end of life care so that these can support lessons learned. The IWANTGREATCARE has been revised to include specific feedback and a post bereavement survey is now being used within our inpatient, nursing homes and specialist services. This is now captured within the end of life care dashboard reviewed monthly at the end of life subcommittee. The implementation of the West Essex Electronic Palliative Care coordination system in line with the established South East Essex system has seen shared data to coordinate patients recognised as end of life.
Areas to be progressed	Continue to strengthen processes to gain carer feedback within inpatient service and community services. Work with system partners to share locality learning and integration of services as a collaborative approach. The implementation of an Always Event to capture those aspects of the patient and family experience when patients interact with our teams and the health care delivery system. This has been on hold owing to the pandemic. We are currently working with the patient experience team to support the progression of this.

2. Each person gets fair access to care	
Key Achievements	The Clinical lead for end of life care and Specialty Doctor continue to have strong links with partner organisations. The growth of integrated collaboration of services within the Integrated Care Systems (ICS) have seen joint working to continue to develop services and provide fair access for all. These include local acute services, hospices and voluntary services in all locations across EPUT. Development and roll out of a guidance for STaRS teams to support integration of services and understanding of end of life care in North Essex. The dashboard, capturing quality and performance indicators has been further developed and seen a growth in recognition of dementia and frailty. This has been recognised at East of England and Nationally as the only Trust in the country capturing this. There have been extensive improvements across the systems in terms of psychological support with the development of level 4 services in West Essex. A number of business cases and collaboration has been developed to support service redesign in South East Essex.

	The development of an Electronic Palliative Care Co-ordination (EPaCCs) System in West Essex has seen a growth in integrated approaches and sharing of patient choice in line with the established EPaCCs in South East Essex.
Areas to be progressed	To further, develop the STaRS guidance to all areas across Essex.

3. Maximising comfort and wellbeing	
Key Achievements	Updates to the formulary and Medicine Management Guidance across the ICS is under review. This has included a number of documents that have been shared across the ICS. The do not attempt cardiopulmonary resuscitation competency training for senior clinical staff. The clinical lead was instrumental in supporting the development of the standard operating procedure and training. This has been supported by the Clinical Commissioning Group (CCG's) who have supported funding for staff to develop and attend training delivered in partnership with the hospices across Essex. They have also provided our training department with backfill funding to support the clinical lead and integrated care staff to support this initiative.
Areas to be progressed	Continued cascade end of life care competencies to all grades of staff in community services to ensure maximum update. Continued working in partnership with external stakeholders. This includes access to external training and development.

4. Care is co-ordinated	
Key Achievements	The Clinical Lead for end of life care and Specialty Doctor continue to have strong links with systems partners and attend the ICS meetings. Monthly multi-disciplinary meetings with primary and secondary care and hospices have been established to ensure an integrated approach and co-ordination of care. These now include ambulance services and Motor Neurone Disease Association (MNDA) input. Guidance has been rolled out for people with multiple organ failure who are on the caseload of the STaRS Team in North Essex. The EPACCs in West Essex and continued growth in South East Essex has allowed system sharing of patient choice.
Areas to be progressed	To continue with enhanced partnership working across systems to create best approaches with regard to advance care planning, individualised care plans and shared data.

5. All staff prepared to care	
Key Achievements	End of Life Care Champions are supporting staff at a local level. There are sixty two champions across services to support best practices and provide updates on end of life care. The ICS's are supporting training needs across localities. The competencies for EPUT have been adapted by some of the community providers. The Clinical lead is supporting sharing training and development of standard approaches to care. EPUT continue to have in-house training and a quarterly training report shows training delivered by clinical lead and numbers of staff attended.
Areas to be progressed	Continue the roll out of end of life care competencies for all grades of staff. Continue to expand the number of End of Life Care Champions. Continue to partnership work to support accessibility of end of life care training as an integrated approach.

6. Each community is prepared to help	
Key Achievements	The Trust participates in Dying Matters events on an annual basis. In 2021 this was undertaken via social media and virtually because of the COVID - 19 pandemic. There was the first Death Café held in EPUT in partnership with the Chaplaincy and Psychological services. There is continued partnership working across Essex. The End of Life Clinical Lead and Specialty Doctor are members of CCG, ICS and Alliance End of Life Care Groups. This has supported partnership collaboration and service redesign within Essex end of life care services.
Areas to be progressed	Public information relating to end of life care to be posted on the Trust Website and through social media to include blogs and sharing stories with staff and patient experiences. .

CLINICAL AUDIT

National Audit of Care at End of Life (NACEL)

The Trust continues to participate in NACEL. The standards focus on the quality and outcomes of care experienced by those in their last admission in acute and community hospitals throughout England and Wales. The audit monitors progress against the five priorities for care set out in One Chance to Get It Right and NICE Quality Standard 144, which address last days of life, within the context of NICE Quality Standard 12 (which addresses the last year of life).

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

The case note review considers patients who meet the following criteria:

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

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

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

NACEL in Mental Health Services

There were no deaths during the period stipulated by NACEL but EPUT participated in the staff survey. The feedback nationally from the Staff Surveys are suggesting that all staff in Mental Health across the country have access to mandatory or update training to support recognition of end of life care.

End of Life Care in EPUT – Community Health, Mental Health and Nursing Homes Audit Findings

An audit of 52 patient records were reviewed using an end of life care audit tool in line with the questions of the NACEL audit as a case note review of care. The aim was to establish that the services within EPUT delivering end of life care are supporting the requirements in line with best practice and national averages. Overall EPUT services are providing above the national averages for end of life services with many elements scoring 100%. The end of life care templates within the electronic databases are supporting record keeping. These made it easy to find the relevant data and information required to complete the audit and share information across services. The findings were pleasing as there was improvement on the previous year's audit even though we have audited more patient records this year increasing by 20

more sets of records.

Audit of Do Not Resuscitate Cardiopulmonary Arrest Orders

An audit of DNACPR for those at end of life was completed in December 2021. The purpose of the audit was to ensure the correct processes were in place to ensure a person centered approach to all decision making and supports the Care Quality Commissioning review in 2020 of DNACPR implementations.

The audit reviewed Sixty-two documents across both community health and mental health services:

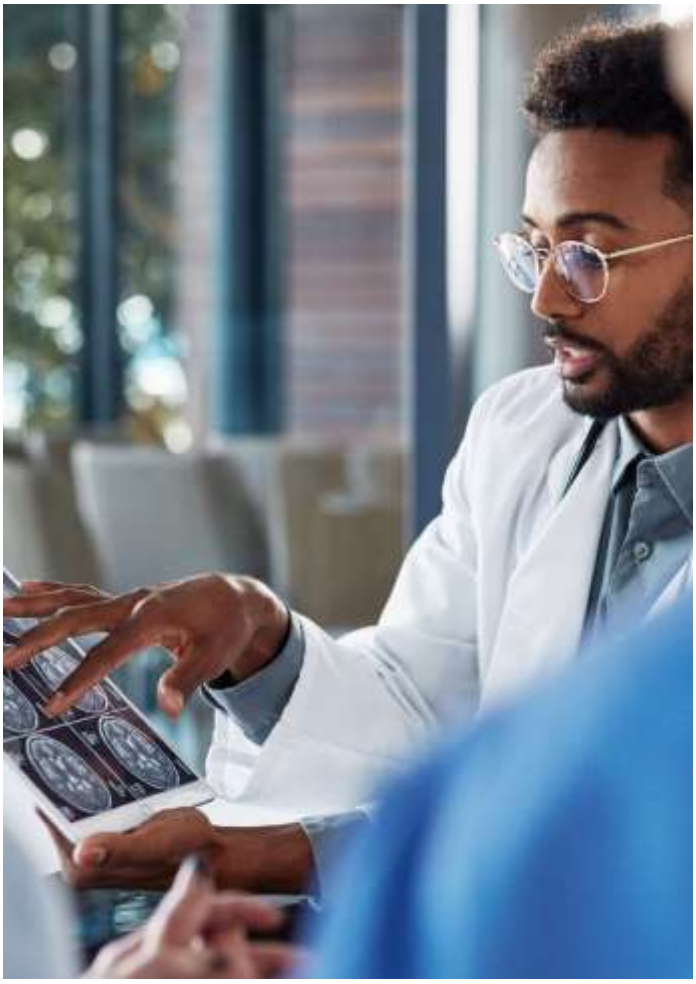
- Number of patients with a DNACPR when identified as end of life
- Number patients with a DNACPR at time of death
- Number of discussions held with patient and relatives/carers
- Number of discussions with a senior member of staff/MDT

Findings

Across EPUT services 100% of patients had a valid DNACPR form in place at the time of death, this is an increase in the 2020 audit. The audit found that there were extensive records within the end of life care template which has made the audit and finding of data more productive. There was evidence of conversations with patients, their significant others and those involved in their care to support the implementation of a DNACPR.

There was evidence documented in 100% of the records to support fair access to care and supportive conversations with evidence of an MDT approach to implement the DNACPR forms. The end of life care templates within all our electronic data bases have supported a more unified and accessible process of recording and finding the end of life care information.

The results are very positive that conversations and recognition of end of life care are happening in a timely and approach to support inclusion of those important to the patient and their loved ones.



PATIENT STORY / LIVED EXPERIENCE

A gentleman was admitted to a mental health adult ward following a bout of depression and an attempt on his life. He had been diagnosed with lung cancer which had contributed to his depression as he had lived experience of supporting his wife who had died of the same condition. The Clinical Lead for End of Life Care was contacted by the Psychologist for the ward asking to support and coordinate services by putting things in place for his discharge home. An MDT meeting was arranged to support discussions with the community services and the local palliative care provider from the hospice. The MDT included the team caring for him, his family and the individual, plus a representative from the community nursing team, palliative care team, ward psychology team and the clinical lead.

Discussions around his aspirations and expectations of going home and acknowledging what was important to him and his family and how his symptoms and care could be managed. Also what to expect and how best he could be supported at home. An advance care plan was made and the clinical lead and psychologist worked with him to develop and document advance care planning. This was supported by the teams for each element of services they worked alongside to also support a treatment escalation plan (PEACE document) to support escalation of symptoms and how to manage them. He was discharged home two weeks later with a care package, community teams supporting and handed back to his GP to support his care. A review of his care a month after discharge at the palliative and end of life care MDT with the Acute Trust and Hospice services indicated he was doing well coping at home. Although there were some signs of deterioration he was on the electronic palliative care coordination register so all services who have read access to the electronic data base were able to see what was in place and read his care plan both in and out of hours services. This provided information about what anticipatory medications and documents were in the home. These are also a clear record of discussions of process.

His main aim for care was to remain at home with his family and carers supporting him, as he feared suffering. He maintained his independence with this for six months post discharge and when he did decline, the treatment escalation plan recorded the discussions and aspirations of his personalisation. This enabled the service to wrap around his care needs together and he died peacefully at home with his family, which was his wish. The hospice at home team supported his care needs, the GP and community nursing team provided care at home. The community nurses were able to provide symptom management and ensure the pain and breathlessness he feared so much was managed and he was comfortable at home. At the time of death the nurses who knew him were able to verify him. This was important to the family as it provided a continuity of care. The community team received a card from his family thanking them for the care, dignity and compassionate approach and support they all received.

NHSI AND EOE END OF LIFE CARE COLLABORATIVE

The Clinical Lead for End of Life Care is a member of the NHSI PEoLC collaborative nationally, which supports shared best practice across a variety of settings. The work undertaken by the Trust in accordance with the Ambitions for End of Life Care has been presented nationally. EPUT have represented a sharing best practice event in Cambridge to show case the work that is currently being undertaken within the Dementia and Frailty services. The end of life care dashboards have been recognised locally within the ICS localities and nationally as best practice and the growth of identification of dementia and frailty are being showcased nationally as best practice. The integration of the mental health and physical health services is starting to show that the dashboard has more representation of dementia and frailty than cancer diagnosis.

The medical lead has also joined as a mental health member of the East of England strategic palliative and EOL meetings.

DEVELOPMENTS IN MENTAL HEALTH

The Gold Standard Framework process is now well established and Tower ward in Clacton has achieved accreditation. There is strong integration with the specialist teams and patients receive person centred approaches to their end of life care. The clinical lead continues to support patients whom are identified as end of life by supporting staff to care. Feedback from carers and relatives has been extremely positive.

A clinical pathway for patients under the care of STaRS (Specialist Treatment and Recovery Service) in the Northeast has been launched. This was developed jointly with support of Farleigh Hospice and has been showcased nationally. Work with the North Alliance has seen training and support available to all services who support STaRS and joint working with St Helena Hospice and ESNEFT who cover this locality.

The end of life lead and clinical lead are working with the NEE Alliance to restart Advance Care Planning meetings for patients soon after dementia diagnosis when they still have capacity to take part in these discussions. The local Alzheimer's society have agreed to work in partnership with EPUT and St Helena's Hospice to deliver this. An educational session will be delivered jointly by the hospice and EPUT for the Alzheimer's society to support them with this work. The clinics will be audited and feedback gathered for patients to evaluate the service and provide opportunities for service improvement.

DEVELOPMENTS WITHIN NURSING HOMES

The two nursing homes continue to have strong links with the specialist palliative care team and primary care within the South East Essex area. The two homes are now managed by the same manager, which has had benefits to reduce variations in end of life care. Patients are identified using the prognostic indicators and are added to the electronic EPaCCs Register. This incorporates all elements of advance care planning and patient choice is recorded. The shared data sharing has further strengthened joint working and coordinated care between Primary Care, the integrated teams and the care home staff.

CONTINUED SUPPORT DURING THE COVID-19 PANDEMIC AND PARTNERSHIPS

The COVID - 19 pandemic had required a re-focus of all services and the development of staff in 2019 so that they were able to provide the highest quality end of life care across all settings both to patients and carers/relatives. This has continued throughout 2021.

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

- Working with the integrated care systems in each of the localities across EPUT. This includes the Mid and South Essex (MSE), West Essex and Herts and the North Alliance. This supports a number of initiatives to support integrated partnership working. Including competencies and training for end of life care, Electronic palliative care co-ordination and dashboard – EPaCCs, Procedural guidance documents and aligning services. Learning from current services across the end of life care services in each of area.
- Electronic palliative care co-ordination and dashboard – EPaCCs in West Essex locality in line with the South East Essex model. Pilot of implementation of EPaCCs, which resulted in successful recruitment of a nurse to support this in the care co-ordination centre working as a member of the MDT.
- Development of Dependency guidance at end of life for the STaRS Team in North Essex to support best practice. Working with St Helena Hospice to deliver training to all the multi-professional agencies involved. There are plans to support future developments across all STaRS teams.
- Working with Herts Partnership to develop an Advance Care plan for those with a learning disability – (LD). This is supported by EPUT LD teams and has supported records and inclusion of end of life care conversations with people with LD and their families. Support for LD training on advance care planning and difficult conversations.
- Person centred approaches to care: complete roll out of Treatment Escalation Plans (PEACE documents) to record discussions and choices including PPC/PPD/DNACPR/Requesting treatment.
- Training relating to a number of aspects of end of life care delivered virtually and face 2 face to ensure end of life competencies for staff are met.
- Expert support/advice provided on a daily basis to clinical teams and staff members working outside of their usual area of expertise.

ABBREVIATIONS

EoLC	End of Life Care
PEACE	Proactive Elderly Advance Care Plan
TEP	Treatment Escalation Plan
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
CCG	Clinical Commissioning Group
ICS	Integrated Care System
CHS	Community Health Services
NACEL	National Audit of Care at End of Life
NICE	National Institute for Health and Care Excellence
MDT	Multi-disciplinary Team
GSF	Gold Standards Framework
PPC	Preferred Priorities for Care
PPD	Preferred Place of Death
DIPC	Director of Infection Prevention and Control
LPA	Lasting Power of Attorney for health and welfare
STaRS	Specialist Treatment and Recovery Service
ESNEFT	East Suffolk and North Essex NHS Foundation Trust
NEE Alliance	North East Essex Alliance
EPaCCs	Electronic Palliative Care Co-ordination system
NHSI	NHS Improvement National collaborative
PEoLC	Palliative and End of Life Care

END OF LIFE ANNUAL REPORT 2021-22

Essex Partnership University NHS Foundation Trust

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

Tel: 0300 123 0808

@EPUTNHS

		Agenda Item No: 7d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

Report Title:	Learning from Deaths – Summary of Quarter 1 2022/23 Data and Learning					
Executive/ Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Michelle Bourner, Project Co-ordinator					
Report discussed previously at:	Learning from Deaths Oversight Group Learning Oversight Sub-Committee Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Project reports only:	
If this report is project related please state whether this has been approved through the Transformation Steering Group	Not applicable

Purpose of the Report		
This report presents to the Board of Directors: • Information relating to the context of mortality data and surveillance for Q1 2022/23 under the Trust's new Learning from Deaths arrangements; • Data relating to deaths recorded on the Trust Incident Management system, Datix, for Q1 2022/23 (1st April – 30th June 2022) together with updated information on the progress of mortality reviews for 2021/22, 2020/21, 2019/20 and 2018/19; and • Learning and action as a result of reviewing deaths since the last report to the Board of Directors.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

1. The Trust implemented a new Learning from Deaths Policy and Procedural Guidelines from 1st April 2022. The attached report provides information relating to the context and impact of these arrangements on the collation and reporting of data enabling mortality surveillance.

2. The report also presents information that the Trust is nationally mandated to report to public Board meetings on a quarterly basis – i.e. the number of deaths in scope, the number reviewed and the assessment of problems in care; as well as the learning realised from reviewing deaths. Additional information is also included to provide assurance on inpatient / nursing home deaths and on the timeliness of learning from deaths processes within the Trust.

3. The new learning from deaths arrangements include a new definition for deaths included in scope for consideration for **mandatory** individual mortality review in the Trust (and thus also included within data reporting). This is detailed in paragraphs 2.1 – 2.2 of the attached report. In addition to these mandatory requirements, services are being encouraged to report on the Trust's Incident Management system, Datix, all deaths that are reported to them / brought to their attention. This increases the Trust's ability to learn from deaths locally, to undertake mortality surveillance and identify potential learning opportunities. There were a total of **99** deaths reported on Datix for Q1 (including those not mandated for report). Full details are included in Section 3 of the attached report.

4. Of the 99 deaths reported on Datix in Q1, 4 were inpatient deaths and 6 were nursing home deaths. 3 of the 4 inpatient deaths and all 6 of the nursing homes deaths have been confirmed as due to natural causes. There was one inpatient death which was due to unexpected unnatural causes and this death is subject to a comprehensive Patient Safety Incident Response Framework (PSIRF) investigation.

5. The attached report includes details of the level ("Stage") of review to which deaths are being subjected and the timeliness of completion of those reviews. This is being closely monitored on a monthly basis by the new Learning from Deaths Oversight Group and any concerns addressed.

6. The breakdown of the level of review to which deaths are being subjected indicates an increase in the proportion of deaths being subjected to a Stage 2 Clinical Case Note Review and a decrease in those being closed at Stage 1 desktop review or investigated at Stage 3 (Patient Safety Incident Response Framework – PSIRF - arrangements), as compared to the previous mortality review arrangements. This is an intended outcome of the new arrangements as it enhances the ability to learn from deaths. This has required an increase to the number of clinicians able to undertake such Case Note Reviews – to this end, a training session and support information has been delivered. All Stage 2 Clinical Case Note Reviews for Q1 have now been commissioned and will be completed in early 2023.

7. The attached report also includes details of the profile of problems in care scores assigned to deaths in scope. This indicates that the significant majority of deaths under the previous Mortality Review arrangements (2017 – 2022) have been assessed as having no problems in care (score 6). Under the new Learning from Deaths arrangements, the previous 6 point scale for assessing problems in care has been replaced with the Royal College of Psychiatrists structured judgement review tool version which requires determination of whether a death was "more likely than not to have resulted from problems in care delivery or service provision" by EPUT. Details are included in the attached report.

8. The Learning from Deaths Oversight Group also oversees information on deaths of patients under the EPUT element of the Essex Drug and Alcohol Partnership (EDAP) services. This information is

included in the Q1 data in the attached report. It should be noted that these deaths are all subject to a collaborative multi-agency review process.

9. All learning disability and autism deaths are subject to review under the national LeDeR mortality review processes – again data is included in the attached report.

10. As the scope of deaths included has changed from the previous mortality review arrangements (see bullet point 3 above), there is no historic data prior to Q1 2022/23 against which to make comparisons. As a result, the data for Q1 has also been analysed using previous scope arrangements in order to provide assurances that the Trust is not experiencing increases in death numbers across key services against historic data. This is detailed in Section 4 of the attached report. This indicates that figures for Q1 are in line with quarters not impacted by COVID-19 in previous years.

11. The analysis of progress in completion of open mortality reviews for deaths occurring in previous years indicates that 48 death reviews have been concluded since the last report to the Board of Directors. There are now 34 deaths remaining open under the previous mortality review arrangements. 9 of these are being reviewed under PSIRF arrangements (7 in progress and 2 stopclocked); 11 of these are being subjected to a Grade 2 case note review (9 of which are part of a thematic review of non-patient safety incident deaths of individuals with Severe Mental Illness (SMI) being undertaken in January); and 14 are subject to further information / query prior to closure.

12. Details of learning themes since the last report to the Board of Directors are included in the attached report, together with examples of actions taken in response to learning themes. A full report on learning from deaths is presented to the Learning Oversight Sub-Committee on a monthly basis. From next month, this report will also incorporate learning from LeDeR, EDAP and end of life death reviews. Consideration is being given to the inclusion of learning from reviews of deaths undertaken under PSIRF to provide a holistic overview of all learning.

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

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

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

Acronyms/Terms Used in the Report			
LDOG	Learning from Deaths Oversight Group	MRSC	Mortality Review Sub-Committee
EPUT	Essex Partnership University NHS Foundation Trust	LOSC	Learning Oversight Sub-Committee
LeDeR	National Mortality Review Programme for Learning Disability Deaths	SMI	Severe Mental Illness
PSIRF	Patient Safety Incident Response Framework	MSEMHS	Mid & South Essex Mental Health Services
NEEMHS	North East Essex Mental Health Services	WEMHS	West Essex Mental Health Services
SEECHS	South East Essex Community Health Services	WECHS	West Essex Community Health Services
CAMHS	Child and Adolescent Mental Health Services	LD	Learning Disability
EDAP	Essex Drug and Alcohol Partnership		

Supporting Reports/ Appendices /or further reading

Attached –

Report on Mortality Data and Learning from Deaths for Q1 2022/23

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

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

Lead

Natalie Hammond
Executive Nurse

Agenda item: 7d
Board of Directors Part 1
30 November 2022

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

LEARNING FROM DEATHS
PUBLICATION OF MORTALITY DATA AND LEARNING
QUARTER 1 2022/23

1.0 PURPOSE OF REPORT

1.1 This report sets out:

- Information relating to the context of mortality data and surveillance for Q1 2022/23 under the Trust's new Learning from Deaths arrangements;
- Data relating to deaths recorded on the Trust's incident management system, Datix, for Q1 2022/23 (1st April – 30th June 2022) together with updated information on the progress of mortality reviews for 2021/22, 2020/21, 2019/20 and 2018/19; and
- Learning and action as a result of learning from deaths since the last report to the Board of Directors.

2.0 Q1 2022/23 MORTALITY DATA – CONTEXT

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

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

2.2 In addition, deaths of clients under the care of services provided by EPUT as part of the drug and alcohol services care pathway (EDAP) are subject to specific reporting and mortality review processes including a collaborative multi-agency review. These deaths are therefore also included within mortality surveillance data.

2.3 Regardless of the above mandatory requirements for a formal review, services are being encouraged to report on Datix all deaths that are reported to them / brought to their attention. This increases the Trust's ability to learn from deaths locally and to undertake mortality surveillance and identify potential learning opportunities. These reported deaths are also included in the data for Q1 2022/23.

2.4 As the scope of deaths included has changed from the previous mortality review arrangements, there is no historic data prior to Q1 2022/23 against which to make comparisons. As a result, the data for Q1 has been analysed in its totality under the new arrangements (detailed in Section 3 of this report), as well as using previous scope arrangements in order to provide assurances that the Trust is not experiencing increases in death numbers across key services against historic data (detailed in Section 4 of this report). A decision will be taken in due course in terms of the period of time analysis will be undertaken under both methodologies (ie at what point the Trust is satisfied that there is sufficient historic data under the new arrangements to provide assurances).

3.0 Q1 2022/23 MORTALITY DATA – NEW SCOPE AND ARRANGEMENTS

3.1 There were a total of **99 deaths** reported on Datix for Q1 2022/23 under the new arrangements (including those not falling within the scope for mandatory reporting) as follows:

Table 1: Total deaths reported on Datix - Q1 2022/23

Quarter	MSEMHS	NEEMHS	WEMHS	SEECHS	WECHS	CAMHS	Specialist	LD	EDAP
Q1 2022/23	46	23	9	2	3	0	2	3	11

3.2 Of the 99 deaths reported in Q1, 4 were inpatient deaths and 6 were nursing home deaths. 3 of the 4 inpatient deaths and all 6 of the nursing homes deaths have been confirmed as due to natural causes. There was one inpatient death which was due to unexpected unnatural causes and this death is subject to a comprehensive Patient Safety Incident Response Framework (PSIRF) investigation.

3.3 The most recent data indicates that the following Stages of review are being applied to the 99 deaths:

Table 2: Breakdown of level ("Stage") of review Q1 2022/23 deaths being subjected to

Level of review	Number of deaths Q1	As a percentage of total deaths Q1
Closed at Stage 1	43	43%
Awaiting Stage 1 review to be completed	7	7%
Automatically referred for a Stage 2 review	15	15%
Manually referred for a Stage 2 review	11	11%
Review taking place under PSIRF processes	9	9%
Review taking place under EDAP processes	10	10%
Review taking place under LeDeR	3	3%
Under determination	1	1%

These are at differing points of approval by Quality & Safety Groups and should there be changes to levels of review agreed, updated information will be included in future reports.

3.4 The above table indicates an increase in the proportion of deaths being subjected to a Stage 2 Clinical Case Note Review and a decrease in those being closed at Stage 1 desktop review or investigated at Stage 3 (ie under full PSIRF arrangements), as compared to the previous mortality review arrangements. This is an intended outcome of the new arrangements as it enhances the ability to learn from deaths. This has required an increase to the number of clinicians able to undertake such Case Note Reviews – to this end, a training session and support information has

been delivered. All Stage 2 Clinical Case Note Reviews for Q1 have now been commissioned and will be completed in early 2023.

3.5 **LeDeR reporting -** All learning disability identified deaths in Q1 have been reported to the national LeDeR programme.

3.6 **Problems in care assessment -** Under the new Learning from Deaths arrangements, the previous 6 point scale for assessing problems in care has been replaced with the Royal College of Psychiatrists structured judgement review tool version which requires determination of whether a death was "more likely than not to have resulted from problems in care delivery or service provision" by EPUT. All deaths closed at Stage 1 are automatically deemed to be less likely than not to have resulted from problems in care. The likelihood of deaths having resulted from problems in care is assessed as part of the Stage 2 review and PSIRF review processes – as such, any deaths subject to Stage 2 or PSIRF review processes have not yet been determined. The current position is as follows:

Table 3: Breakdown of whether Q1 2022/23 deaths deemed more likely than not due to problems in care by EPUT

Q1 deaths deemed less likely than not to be due to problems in care by EPUT	Q1 deaths deemed more likely than not be to due to problems in care by EPUT	Q1 deaths for which problems in care assessment under determination
50 (51%)	-	49 (49%)

4.0 Q1 2022/23 MORTALITY DATA – PREVIOUS SCOPE AND ARRANGEMENTS (FOR BENCHMARKING AND ASSURANCE PURPOSES)

4.1 An analysis has been undertaken of the Q1 data using the previous "scope" categories and reporting groupings, in order to identify any trends of potential concern in relation to death numbers in established categories (as historic data under the new groupings does not yet exist). This indicates that reported numbers of deaths are in line with numbers reported under the previous arrangements and that the service breakdown also remains consistent with previous months. The only potential outlier was the number of learning disability deaths reported in Q1 2022/23 which, at only 3 deaths, appears low in comparison to previous quarters. The learning from deaths lead for Learning Disability Services was therefore requested to validate this data and has confirmed it to be correct.

4.2 Details of the Q1 deaths which fall within the previous scope are as follows:

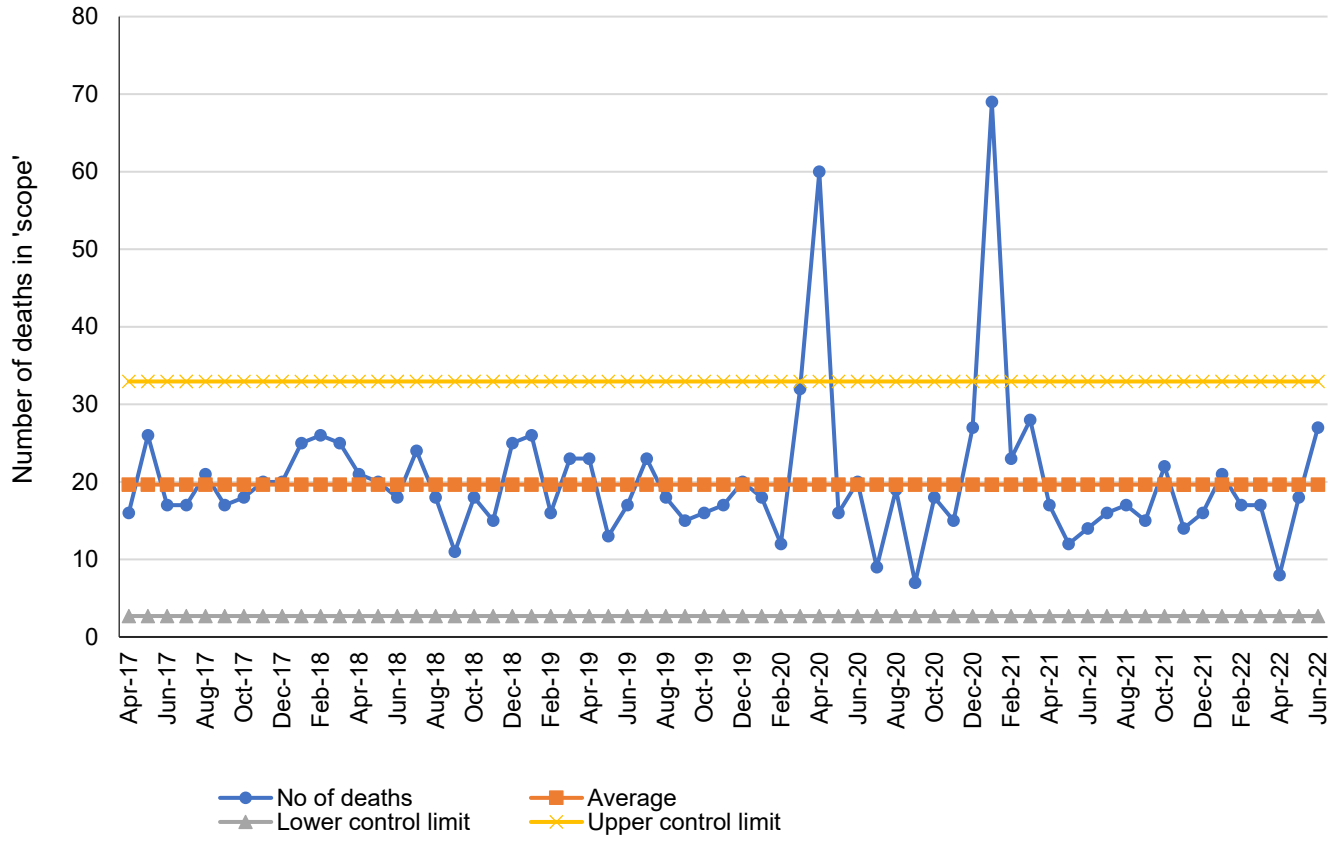
Table 4: Q1 2022/23 falling within previous Mortality Review Policy scope

Period	Total 2018/19	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	Total 2019/20	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	Total 2020/21	2021/22 Q1	2021/22 Q2	2021/22 Q3	Jan 2022	Feb 2022	March 2022	2021/22 Q4	Total 2021/22	April 2022	May 2022	June 2022	2022/23 Q1
Deaths in scope	235	53	56	57	62	228	96	35	60	120	311	43	48	50	21	17	17	55	196	8	18	27	53

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

eliminated. Figure 1 below indicates that the number of deaths in scope in Q1, using the previous scope, fall within control limits.

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



5.0 UPDATE ON PROGRESS ON CLOSURE OF DEATHS IN PREVIOUS YEARS (2017/18 – 2021/22)

5.1 The following tables outlines progress in closing deaths in previous years:

Table 5: Closed deaths 2018/19 – 2021/22

Year	Total deaths	Total closed	*(Figure in previous quarterly report)*	Closed at Grade 1 (DPRG)		Closed at Grade 2 (CNR)		Closed at Grade 3 (CIR)		Closed at Grade 4 (SI/PSIRF)		Under determination
2017/18	248	248	*(248)*	148	60%	11	5%	1	0.5%	88	35%	0
2018/19	235	235	*(234)*	148	63%	18	8%	0	0%	69	29%	0
2019/20	228	228	*(228)*	145	64%	16	7%	1	0.5%	66	29%	0
2020/21	311	307	*(301)*	226	73%	9	3%	0	0%	72	23%	1
2021/22	195	165	*(124)*	118	61%	1	0.5%	0	0%	46	24%	13

Table 6: Deaths remaining open 2018/19 – 2021/22

Year	Total deaths	Total open	*(Figure in previous quarterly report)*	Open Grade 2 (CNR)		Open Grade 4 (SI/PSIRF)		Open queries	
2017/18	248	0	*(0)*	0	0%	0	0%	0	0%
2018/19	235	0	*(1)*	0	0%	0	0%	0	0%
2019/20	228	0	*(0)*	0	0%	0	0%	0	0%
2020/21	311	4	*(10)*	*3	1%	0	0%	1	0.5%
2021/22	195	30	*(72)*	*8	4%	**9	5%	13	7%

* 9 of these to be included in thematic review of non-patient safety incident deaths of people with SMI – to be undertaken January 2023

** 7 = PSIRF in progress and 2 = stopclocked PSIRF

5.2 The following table outlines the current position in terms of "problems in care" scores under the previous arrangements for deaths occurring 01/04/18 – 31/03/22. All outstanding scores deemed as under determination are being pursued and an update will be given in the next report to the Board of Directors.

Table 7: Problems in care scores breakdown 2018/19 – 2021/22

Score	2018/19 Number	2018/19 (as a %)	2019/20 Number	2019/20 (as a %)	2020/21 Number	2020/21 (as a %)	2021/22 Number	2021/22 (as a %)
6 - definitely less likely than not	194	83%	176	77%	256	82%	119	61%
5 - slight evidence	22	9%	29	13%	23	7%	1	0.5%
4 - not very likely	11	5%	16	7%	8	3%	0	0%
3 - probably likely	6	3%	4	2%	0	0%	0	0%
2 - strong evidence	1	0.5%	0	0%	0	0%	0	0%
1 - definitely more likely than not	0	0%	0	0%	0	0%	0	0%
Under determination	1	0.5%	3	1%	15	5%	30	15%
PSIRF not scored	N/A	N/A	N/A	N/A	9	3%	45	23%
TOTAL	235	-	228	-	311	-	195	-

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

5.4 Those deaths assessed with a score lower than a 6 all had action plans associated with the findings of the review / investigation and their implementation was monitored.

5.5 Under the new Patient Safety Incident Response Framework (PSIRF), investigations focus on quality learning outcomes and no "score" is allocated. This is reflected in the 2020/21 and 2021/22 columns in the table above.

6.0 LEARNING

6.1 This section details learning themes emerging since the last report to the Board of Directors, together with examples of actions taken in response to learning themes.

6.2 A full report on learning from deaths is presented to the Learning Oversight Sub-Committee on a monthly basis. From next month, this report will also incorporate learning from LeDeR, EDAP and end of life death reviews. Consideration is being given to the inclusion of learning from reviews of deaths undertaken under PSIRF to provide a holistic overview of all learning.

6.3 Learning themes emerging from Stage 1 reviews so far relate to:

- Confirmed cause of death often not available at point of Stage 1 review which can sometimes make it difficult to draw conclusions;
- Physical health conditions being the main cause of the significant majority of deaths with many of the deaths being expected deaths / deaths of service user on end of life care pathways;
- Communication – within teams, between teams (including between physical and mental health teams) and between partner agencies;
- Referrals;
- Risk assessments; and
- Record keeping

These have been shared monthly with the learning team for inclusion in the Trust's Culture of Learning work (see paragraph 6.5 below).

6.4 It should be possible to identify themes emerging from Stage 2 reviews in the early 2023, once these have been completed and subject to the scrutiny and approval governance process.

6.5 Positive progress has been made in terms of embedding the Trust's learning culture since the last report to the Board of Directors – an update in terms of learning from all Trust incidents, including deaths, is detailed below:

6.5.1 The EPUT Culture of Learning (ECOL) represents our commitment to excellence and our willingness to learn from the experience of others. The concept enables us to identify and share learning through safe, effective and constructive pathways, ensuring this learning is embedded and sustained at all levels within the organisation. The framework will enable us to achieve the Safety First, Safety Always Strategy outcomes.

6.5.2 The Culture of Learning work programme aims to facilitate learning by promoting a fair, open, and compassionate culture that moves away from a blame approach. It enables the belief that 'incidents cannot simply be linked to the actions of individuals involved but rather the system in which the individuals were working'. Looking at what was wrong in the systems and processes helps organisations learn lessons that can prevent incidents from reoccurring.

6.5.3 The Trust implemented the Patient Safety Incident Response Framework in May 2021, as an early adopter. In August 2022, the PSIRF guidance was published with the aim for all NHS organisations to implement the Framework by Autumn 2022. EPUT are supporting other organisations with their implementation plan.

The methodology of ensuring learning is systems based and incorporates human factors has been defined within the new guidance. The method used is Safety Engineering Initiative for Patient Safety (SEIPS) and this has been incorporated within the PSIRF templates used by the Trust.

6.5.4 Thematic analysis and review is an integral component of PSIRF. With the increase in resource in the Patient Safety Incident Management (PSIM) Team, the number of thematic reviews which will be undertaken will increase, which in turn will lead to the Safety Improvement Plans (SIP) being developed. Each of the key priorities under the Trust's Patient Safety Incident Response Plan (PSIRP)

will have a SIP associated to the risk element which had been determined, such as transfer of care, disengagement, falls to name a few. The SIP will be monitored by the PSIM Team and assurance will be provided through weekly Executive Team reports, Executive Assurance Group meetings, and the Learning Oversight Collaborative.

The SIP template is being trialled at present for the following themed areas:

- Falls which resulted in head injury
- Ligature risk reduction

These followed thematic review of incidents which were reviewed/investigated under PSIRF.

6.5.5 Learning from incidents under PSIRF or from Mortality Review has been enhanced in the last quarter with the introduction of the Learning Collaborative Partnership (LCP) Group. LCP members bring monthly learning from events to the group for discussion and inclusion within 5 Key Messages and the Lessons Identified Newsletter. This is shared via Wednesday Weekly, in Quality and Safety meetings, via LOSC and is published on the intranet with banners and pop-ups to promote the learning. Feedback has suggested the newsletter is well received, staff feel it contains an appropriate amount of information and is easy for them to read and access.

6.5.6 With the introduction of the Lessons Team, processes are being formed as to how second line assurance testing is completed to ensure learning identified is embedded in practice and can be considered as “lesson learnt”.

6.5.7 In addition, when a new and significant learning opportunity is available and requires wide cascade, the Lessons Team work with Subject Matter Experts to collate key information for Safety Action Alerts.

7.0 ACTION REQUIRED

7.1 The Board of Directors is asked to:

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

Report prepared by: Michelle Bourner, Learning from Deaths Co-ordinator
On behalf of: Natalie Hammond, Executive Nurse (13 November 2022)

		Agenda Item No: 7e
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

Report Title:	**Final Charity Accounts 2021/22**					
Executive/Non-Executive Lead:	Trevor Smith, Executive Chief Finance and Resources Officer					
Report Author(s):	Clare Barley, Head of Financial Accounts					
Report discussed previously at:	n/a					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	✓

Risk Assessment of Report		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
Does this report mitigate the Strategic risk(s)?	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*	n/a	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

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

Purpose of the Report		
To approve the final Charity Annual Report and Accounts for 2021/22, including the review of going concern.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. Approve the final Charity Annual Report and Accounts for 2021/22
3. Approve the Letter of Representation for signing by the Chair of the Audit Committee and Executive Chief Finance and Resources Officer
4. Approve the going concern concept as the basis of accounts preparation
5. Request any further information or action.

Summary of Key Issues
The auditors work around the Charity Annual Report and Accounts for 2021/22 is now complete and a copy is attached at appendix 1. Draft and final versions of these accounts have been reviewed by the Audit Committee and are now recommended for approval by the Board. In line with the 2011 Charities Act, a full audit was not required for the 2021/22 accounts and the Trust's external auditors completed an independent examination rather than a full audit. The examination identified that in order to comply with section 3.36 of the Charities SORP (Statement of Recommended Practice) the Trust was required to restate comparator information to account for a prior period misstatement of £1,480 in respect of investment income, plus a low level of rounding. This had previously been reported as an unadjusted misstatement in the 2020/21 accounts due to it being below materiality. However, due to a reduction in the materiality threshold applied to the 2021/22 examination (arising from reduced level of income received in the year), the prior period misstatement was material in the current year. A note to this effect has been included as note 1.8 to the accounts. In addition to the above, a number of minor typographical and rounding issues were addressed as part of the auditors work. As part of the annual accounts process, the Trust is required to confirm that the Charity continues as a going concern. The financial position of the Charity is reviewed by the Charitable Funds Committee, with the current fund value as at the end of October 2022 totalling £1 million. The Charitable Funds Committee have not raised any concerns around the future financial viability of the charity and as such, the Audit Committee recommend the Board of Directors approve the going concern concept as the basis for preparing the accounts. The Trust is also required to submit a Letter of Representation to the Auditors. A copy is attached at appendix 2 for the Boards approval. Following formal approval by the Board of Directors and the signing of the necessary certificates and Letter of Representation, the Auditors will sign their certificate for inclusion in the final document. The audited accounts will then be submitted to the Charity Commission by the deadline of 31st January 2023.

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

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

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

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

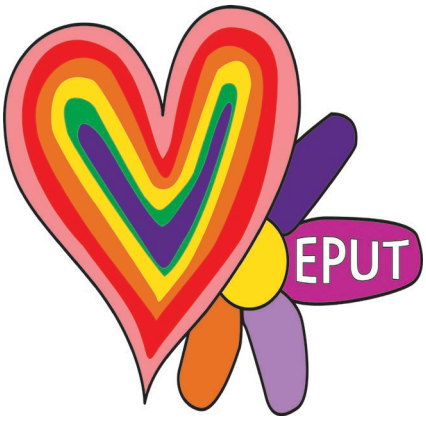
Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
Appendix 1 – Final Charity Annual Report and Accounts 2021/22 Appendix 2 – Letter of Representation

Lead
Trevor Smith **Executive Chief Finance and Resources Officer**

Essex Partnership University NHS
NHS Foundation Trust Charities

Annual Report and Accounts 2021-22



ANNUAL REPORT AND ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2022

CHARITY INFORMATION

Name: Essex Partnership University NHS Foundation Trust Charities

Trustees: The Board of Directors of Essex Partnership University NHS Foundation Trust

Charity Number: 1053793

Charity Offices:
Essex Partnership University NHS Foundation Trust
Head Office
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Independent Examiners:
Ernst & Young LLP
400 Capability Green
Luton
LU1 3LU
United Kingdom

Bankers:
Lloyds Banking Group
34 High Street
Grays
Essex
RM17 6LX

Investment Brokers:
BlackRock Investment Manager (UK) Ltd
33 King William Street
London EC4R 9AS

M&G Securities Limited
Laurence Pountney Hill
London EC4 0HH

CCLA Investment Management
80 Cheapside
London EC2V 6DZ

REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2022

1. INTRODUCTION

The Essex Partnership University NHS Foundation Trust Charities (referred to as the Charity for the purpose of this document) was renamed from the legacy organisations name (South Essex Partnership University NHS Foundation Trust Charity) on the 1st April 2018, as a result of the merger of the former North Essex Partnership University NHS Foundation Trust and the South Essex Partnership University NHS Foundation Trust and their associated Charities.

The purpose of this report is to inform users of the accounts on the structure, policy and objectives, and governance arrangements of the Charity. The report also covers funding arrangements and a high level financial review for the year.

2. GOING CONCERN

These accounts have been prepared on the basis that the Charity is a going concern. This means that the assets and liabilities of the Charity reflect the ongoing nature of the Charity's activity.

3. SCOPE

The objective of the Charity is that the funds are made available to benefit the patients and staff of the Essex Partnership University NHS Foundation Trust (the Trust), or for any other NHS organisations on behalf of whom the Trust administers funds.

The Charity is sub-divided into a number of linked funds, each of which has a specific purpose and this determines the type of expenditure that can be incurred. Each linked fund is further broken down into smaller funds which are assigned an individual fund number. Each fund has a designated fund manager who is responsible for approving expenditure against the fund, monitoring fund levels and co-ordinating fund raising activities where appropriate in accordance with the scheme of delegation.

4. OBJECTIVES AND STRATEGY

The objective of the Charity during the current and future years is to support the needs of patients and staff of the Trust, in improving standards of care and facilities, within the scope of provision included above.

In seeking to achieve the Charity's objective, the Charity actively encourages donations and fundraising.

5. FUNDS

Unrestricted funds are those which are not subject to any specific restriction, but can be used in accordance with the general purpose of the Charity, to improve standards of care and facilities for patients and staff within the scope of the Charity.

Restricted funds are funds which are subject to specific restrictions, over and above the general purpose of the Charity.

6. STRUCTURE AND GOVERNANCE

The charitable trust, which is an umbrella Charity, is an unincorporated body, with each separate restricted and unrestricted fund within the charitable trust being governed by its own model declaration of trust. The model declaration of trust sets out the specific or general purpose of the fund by way of its objects. This structure enables donations received into the restricted funds to be used for the purpose intended by the donors and those donations given for general purposes to be controlled.

The Charitable Funds Committee has delegated authority from the Board of Directors to approve applications for funds up to £10,000 in accordance with agreed criteria and the Charities objects. This Committee is overseen and monitored by the Board of Directors. The Corporate Trustee for the Charity is the Essex Partnership University NHS Foundation Trust, with responsibility for the management of the Charity undertaken by the Board of Directors. Any provision for training and induction of Trustees is therefore covered under the ongoing requirement of the Board of Directors.

7. RESERVE POLICY

Fund managers are encouraged to use the funds available to them. The Trustees aim to ensure the value of the overall fund value is maximised in line with the Investment Policy and will ensure that the capital value of endowment funds are maintained in perpetuity. The funds will continue to be used to improve the standards of care and facilities provided to patients and staff.

8. INVESTMENT POLICY

The Charity has an investment policy which aims to achieve a split of funds between investment in the unit trust and deposit style investments. This is maintained in order to meet the spending plans of the organisation. This also provides detail around the Charities corporate, social and ethical responsibilities in terms of where investments are made.

Funds are currently invested with the following investment managers:

BlackRock Investment Management
M&G Securities Ltd
CCLA Investment Management

The Committee is responsible for reviewing and updating this Investment Policy on a regular basis.

9. RISK STATEMENT

The risk to the Charity is that equity investments may be adversely affected by a material fall in stock market values. The Committee will continue to monitor risks at its meetings, and obtain professional advice where appropriate with respect to its investments.

10. FUNDING

Income is received from direct contributions from the public, in addition to income from dividends and interest receivable. In addition funds are generated from fund raising activities. During 2021/22, the Trust received £47,000 in grants, £42,000 from NHS Charities Together and £5,000 from the Essex Association of Local Councils.

Each fund receives a proportion of dividends and interest received from the investments in accordance with the average fund value during the year. This basis of apportionment is also applied to capital losses/gains, administration expenses and the management fees of the investment managers. The Committee consider this apportionment equitable.

The investments are made in accordance with the Trustee Act of 2000. The investment advisers have been instructed to exclude any direct investment in the tobacco industry, as this is considered inappropriate for an NHS Charity.

The Charity also follows the 2017 Money Laundering, Terrorist Financing and Transfer of Funds Regulations which came into force on the 26 June 2017 (superseding the 2007 Regulations). These regulations aim to ensure that there are robust arrangements in place to ensure incoming resources, especially cash donations, are not the proceeds of crime.

11. FINANCIAL REPORT FOR THE YEAR

The attached accounts give full details of the income and expenditure for the year and the value of the assets and liabilities at the year end. The information below is given to supplement these formal accounts.

The value of the Charitable Funds as at 31 March 2022 was £1,140,000 (2020/21: £1,040,000). The net movement in value is an increase of £100,000 (2020/21: £164,000) which was attributable to;

1. Unrealised gain on investment which amounted to £76,000 (2020/21: £184,000)
2. Total expenditure of £95,000 (2020/21: £259,000)
3. Total income of £119,000 (2020/21: £239,000)

The direct charitable expenditure is charged to the accounts on an accrual basis, and was in line with the objectives of the Charity. The total expenditure for the year of £95,000 can be further analysed as follows,

- Expenditure on patient welfare of £60,000 including an additional palliative care support service, cycling sessions, music therapy, games and leisure activities and improvements to outside areas
- Expenditure on staff welfare of £1,000 including courses and books
- Expenditure on fundraising activities £1,000
- Expenditure on support costs of £33,000.

The General Charitable Fund does not directly employ any staff; however a governance (support) cost to cover staff time was made by Essex Partnership University NHS Foundation Trust. Governance costs are charged across the funds based on the proportion of funds held, and are considered each year by the Charitable Funds Committee.

12. **OPEN ARTS PROJECT**

Open Arts is a charitable community arts and mental health service managed by the Trust, which helps to improve and maintain mental health and wellbeing. Open Arts is not funded by the NHS but operates completely on external funding, donations and fundraising by participants, volunteers and local businesses.

During this past year, the Open Arts service continued to adapt its delivery, the health and wellbeing of participants and volunteers has always been at the forefront. Open Arts provides structure, which for many is also a safety net. Knowing that activities and weekly contact continues to be a regular weekly occurrence, has been a lifeline to many of our participants, and continues to help them to manage their mental health. Open Arts continued delivering:

3910 Client Studio, Course 'In the Open Arts' sessions/Zoom Sessions

9322 hours of Open Arts delivery

860 hours Volunteer time

8000 Estimated People Attending Community Engagement Activities

As a result of Open Arts participation, substantial benefits have been reported, including improved mental health, increased social activity, greater confidence and self-esteem, reduced use of mental health services and increased take up of wider community based opportunities.

'*Open Arts have helped me no end before pandemic and during lockdown. The current situation of opening up feels me with great anxiety and stress but we are working through it. Open Arts have brought me out of some deep dark places; I struggled to return to 'interaction/socialisation' from a "severe nervous breakdown" I lost who I was...just a depressed amoeba. Through all the work THEY DID, I am a person again. Art, a sunshine attitude and a friendly and compassionate team taylor make the experience for your needs. Thank you Open Arts. Thank you to the Staff and Volunteers who work tirelessly to provide a safe, warm and caring atmosphere for us to thrive' Sarah,* Open Arts studio member

'*Open Arts is such a marvellous organisation-Where you can learn to recover at your own pace without the normal pressure or the stigma mental health can bring. Open Arts also gives everyone the help and assistance to learn to be kind to yourself and aid recovery at their own pace through artwork'.*

'I'm extremely thankful and grateful that I found Open Arts. Thank you Open Arts!' Julie, Open Arts participant

A heartfelt thank you to the Open Arts team; our artists and volunteers, friends, members and participants. For the funding and support received from NHS Charities Together, Leigh on Sea Lions Club, The Augustine Courtauld Trust, Essex Association Of Local Councils Grant, the Co-op local communities fund and EPUT.

If you can help support Open Arts or would like information on how you can, please contact Epunft.open.arts@nhs.net or call Jo Keay Open Arts manager on 07580 982462 www.openartsessex.orgIf you can help support Open Arts or would like information on how you can, please contact Epunft.open.arts@nhs.net or call Jo Keay, Open Arts manager on 07580 982462 www.openartsessex.org

You can donate online via CAF www.cafonline.org search for **Essex Partnership NHS Foundation Trust Charities or 1053793.** Please make sure you type **For Open Arts** in the message box. Thank you.

A summary of the income streams and resources expended relating to Open Art is detailed below;

Statement of Financial Activities	
	2021/22
Incoming resources from;	**£**
Various donation	7,534
Investment income	1,042
Grant Income	5,000
Gain from investment valuation	1,652
Total income	**15,228**
Resources expended on	
Charitable fund activities	(6,593)
Administration and other cost	(815)
Total expenditure	**(7,408)**
Net income/(expenditure) for the yea	**7,820**
Fund balance at the beginning of the yea	20,230
Fund balance at the end of the year	**28,050**

13. THE TRUSTEES

The Trustees for the Charity for the year ended 31 March 2022 are as follows:

Professor Sheila Salmon	-	Trustee
Paul Scott	-	Trustee
Alexandra Green	-	Trustee
Trevor Smith	-	Financial Trustee
Dr Milind Karale	-	Trustee
Nigel Leonard	-	Trustee
Professor Natalie Hammond	-	Trustee
Sean Leahy	-	Trustee
Janet Wood	-	Trustee
Alison Davis	-	Trustee (until 30/04/2021)
Amanda Sherlock	-	Trustee
Manny Lewis	-	Trustee
Dr Rufus Helm	-	Trustee
Dr Alison Rose-Quirie	-	Trustee (until 31/10/2022)
Dr Mateen Jiwani	-	Trustee
Loy Lobo	-	Trustee

All appointments to the Board of Directors of the Essex Partnership University NHS Foundation Trust Board are also the appointed Trustees of the Essex Partnership NHS Foundation Trust General Charitable Fund. Non-Executive Directors are normally appointed for a fixed term of three years.

14. ADMINISTRATION ARRANGEMENTS

The Trust holds bi-monthly Board of Directors meetings, which include an update from the Charitable Funds Committee at least twice a year. The day-to-day management of the restricted funds has been delegated to Fund Managers who have delegated authority to approve expenditure of up to £5,000 or the balance of fund (whichever is lower).

The Board of Directors has delegated the management of the unrestricted funds to the Chief Executive of the Trust.

The Board of Directors has retained approval of expenditure commitments of a recurring nature and approval of expenditure over £10,000, with the Charitable Funds Committee approving expenditure of between £5,000 and £10,000.

15. INDEPENDENT EXAMINERS

NHS Funds held on Trust are subject to the 2011 Charities Act, which superseded the 2006 Charities Act and states that all Charities with a gross income of more than £25,000 are required to have some form of external scrutiny of their accounts. In addition, if the Charity has gross income in excess of £1 million in the period of account, or if its gross income exceeds £250,000 and the aggregate value of assets (before deduction of liabilities) exceeds £3.26 million, then the accounts will be subject to a full audit.

For the year ended 31 March 2022 the Charities income was below the £1 million threshold and as such the annual report and accounts will not therefore be subject to a full audit. However, due to the Charities having income in excess of the £25,000 threshold, they will instead be subject to an independent examination as required by the Charities Act 2011.

16. ACKNOWLEDGEMENTS

The Trustees acknowledge the generous contributions and donations made by the public, as well as the time and commitment of staff.

17. APPROVAL

This report was approved by the Trustees and signed on their behalf.

Professor Sheila Salmon
Chair

Date:

Statement of Trustees' Responsibilities

The Trustees are responsible for:

- keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the funds held on trust and to enable them to ensure that the accounts comply with requirements in the Charities Act 2011;
- establishing and monitoring a system of internal control; and
- establishing arrangements for the prevention and detection of fraud and corruption.

The Trustees are responsible for the preparation of financial statements in accordance with the Charities Statement of Recommended Practice (FRS 102) Accounting and Reporting by Charities for each financial year. The Charity Commission directs that these accounts give a true and fair view of the financial position of the funds held on trust, in accordance with Charities SORP (FRS 102). In preparing these accounts the Trustees are required to:

- apply on a consistent basis, accounting policies laid down by applicable accounting standards;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.
- prepare the accounts on the going concern basis unless it is inappropriate to presume that the Charity will continue in operation.

The Trustees confirm that they have met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 1 to 13 attached, have been compiled from and are in accordance with the financial records maintained by the Trustees.

By Order of the Trustees

Signed:

Chair …… Date:

Financial Trustee …… Date:

Independent examiner's report to the trustees of Essex Partnership University NHS Foundation Trust General Charitable Fund

I report on the accounts of the Charity for the year ended 31 March 2022**,** which are set out on pages 2 to 13.

Responsibilities and basis of report

As the charity trustees of the Charity you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the Act').

I report in respect of my examination of the Charity's accounts carried out under section 145 of the 2011 Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5)(b) of the Act, which are available in the Charity commission guidance for independent examination of charity accounts: Directions and guidance for examiners.

Independent examiner's statement

I have completed my examination. I confirm that no material matters have come to my attention which gives me cause to believe that in, any material respect:

- the accounting records were not kept in respect of the Charity as required by section 130 of the Charities Act; or
- the accounts did not accord with the accounting records; or
- the accounts did not comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Use of our report

This report is made solely to the trustees, as a body, in accordance with our engagement letter dated 25 January 2020. The examination has been undertaken so that we might state to the trustees those matters that are required to be stated in an examiner's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the trustees as a body, for this examination, for this report, or for the statements made.

Name: Debbie Hanson
For and on behalf of Ernst & Young LLP
Relevant professional qualification or body: CIPFA

Address: 400 Capability Green, Luton, LU1 3LU

Date:

FUNDS HELD ON TRUST ACCOUNTS 2021/22

The accounts of the funds held on Trust by Essex Partnership University NHS Foundation Trust

Foreword

These accounts have been prepared by the Trust under section 98(2) of the National Health Service Act 1977 (as amended) in the form which the Secretary of State has, with the approval of the Treasury, directed.

The Essex Partnership University NHS Foundation Trust is the corporate trustee of the funds held on trust under paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990. The Trustees have been appointed under s11 of the NHS and Community Care Act 1990.

The Essex Partnership NHS Foundation Trust Charitable Funds Held on Trust are registered with the Charity Commission. The main purpose of the charitable funds held on trust is to apply income for any charitable purpose relating to the National Health Service wholly or mainly for the services provided by the aforementioned organisations.

If you require any further information regarding these accounts please contact:

The Executive Chief Finance Officer
Essex Partnership University NHS Foundation Trust
Trust Head Office
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Telephone: 01268 739666

Trevor Smith
Financial Trustee

Statement of Financial Activities for the Year ended 31 March 2022

	Note	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**Total Funds £000**	*Restated '2020/21 Total Funds £000*
Incoming Resources from:						
Donation, grant and legacies	2	63	12	-	75	*200*
Other trading activities	3	3	-	-	3	*2*
Investment income	4	17	24	-	41	*37*
Total income		**83**	**36**	**-**	**119**	***239***
Resources Expanded on:						
Charitable activities	5	(61)	(34)	-	(95)	*(259)*
Total expenditure		**(61)**	**(34)**	**-**	**(95)**	***(259)***
Net gain/(losses) on investments	6	33	43	-	76	*184*
Net income/(expenditure)		**55**	**45**	**-**	**100**	***164***
Reconciliation of funds						
Total fund balance brought forward		404	608	28	1,040	*876*
Total fund balance carried forward		**459**	**653**	**28**	**1,140**	***1,040***

The statement of financial activities includes the income and expenditure account.
The notes are at pages 5 to 13 and form part of this document.

Balance Sheet as at 31 March 2022

	Note	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**Total Funds 2021/22 £000**	***Restated Total Funds 2020/21*** *£000*
Fixed Assets						
Investments	7	430	612	26	1,068	*992*
Total fixed assets		430	612	26	1,068	*992*
Current Assets						
Debtors	8	1	-	-	1	*2*
Short term investments & deposits	9	4	7	-	11	*11*
Cash at bank and in hand	10	29	41	2	72	*47*
		34	48	2	84	*60*
Current Liabilities						
Creditors: Amounts falling due within one year	11	(5)	(7)	-	(12)	*(12)*
Net current assets		29	41	2	72	*48*
Total assets less current liabilities		459	653	28	1,140	*1,040*
Creditors: Amounts falling due after more than one year		-	-	-	-	-
Provisions for liabilities and charges		-	-	-	-	-
Total Net Assets		459	653	28	1,140	*1,040*
The funds of the charity						
Total Restricted funds	12	-	653	-	653	*608*
Total Unrestricted funds	12	459	-	-	459	*404*
Total Endowment funds	12	-	-	28	28	*28*
Total charity funds		459	653	28	1,140	*1,040*

The notes are at pages 5 to 13 form part of this document.

Signed:

Date:

Statement of Cash Flow at 31 March 2022

	Note	2021/22 Total Funds £000	*Restated 2020/21 Total Funds £000*
Cash flows from operating activities			
Net cash provided by/(used in) operating activities	10.2	(16)	*(61)*
Cash inflow/(outflow) from other activities	12	-	*-*
		(16)	*(61)*
Cash flows from investing activities			
Dividends, interest from investments	4	41	*37*
Proceeds from sale of investments	7	-	*-*
Purchase of investments		-	*-*
Net cash provided by/(used in) investing activities		41	*37*
Cash flows from financing activities			
Repayment of borrowings		-	*-*
Cash flows from borrowings		-	*-*
Net cash provided by/(used in) financing activities		-	*-*
Change in cash and cash equivalents during the year		25	*(24)*
Cash and cash equivalents at the beginning of the year		47	*71*
Cash and cash equivalents at the end of the year		72	*47*

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.1 Accounting Policies

The financial statements have been prepared under the historical cost convention and in accordance with the Statement of Recommended Practice issued in 2015 - Accounting and Reporting by Charities (FRS 102), and with accounting standards and policies for the NHS approved by the Secretary of State.

There have been no changes to accounting policy for the 2021/22 financial year.

1.2 Incoming Resources

a) All incoming resources are included in full in the statement of financial activities as soon as the following three factors can be met:

i) entitlement - arises when a particular resource is receivable or the Charity's right becomes legally enforceable;
ii) certainty - when there is reasonable certainty that the incoming resource will be received;
iii) measurement - when the monetary value of the incoming resources can be measured with sufficient reliability

b) Gifts in Kind

i) Assets given for distribution by the Charity are included in the Statement of Financial Activities only when distributed.
ii) Assets given for use by the Charity (e.g. property for its own occupation) are included in the Statement of Financial Activities as incoming resources when receivable.
iii) Gifts made in kind but on trust for conversion into cash and subsequent application by the Charity are included in the accounting period in which the gift is sold.

In all cases the amount at which gifts in kind are brought into account is either a reasonable estimate of their value to the Charity or the amount actually realised. The basis of the valuation is disclosed in the annual report.

c) Intangible Income

Intangible income (eg the provision of free accommodation) is included in the accounts with an equivalent amount in outgoing resources, if there is a financial cost borne by another party. The value placed on such income is the financial cost of the third party providing the resources.

1.3 Resources Expended

The Funds Held on Trust account is prepared in accordance with the accruals concept. A liability (and consequently, expenditure) is recognised in the accounts when there is a legal or constructive obligation, capable of reliable measurement, arising from a past event.

Resources expended are split into two main categories being the costs of generating funds and the actual costs of charitable activities. The costs of generating funds are the costs associated with generating income for the Funds Held on Trust. A grant is any payment which is made voluntarily to any institution or to an individual in order to further the Charity's objectives, without receiving goods or services return.

The cost of activities in the furtherance of charitable activities is expenditure incurred on the provision of services or goods. Support costs are an integral and material part of the costs of activities in the furtherance of charitable activities and/or expenditure incurred in paying grants. Management and administrative expenditure includes direct and indirect costs (as distinct from directly pursuing charitable activities). Direct costs include those of external and internal audit and legal advice for trustees, the indirect costs include office and communication costs.

1.4 Tangible Fixed Assets and Donated Assets

The General Charitable Fund has no retained fixed assets or donated assets.

1.5 Investment Fixed Assets

Investment fixed assets are shown at market value.

Quoted stocks and shares are included in the balance sheet at mid-market price, excluding dividend.

Other investment fixed assets are included at trustees' best estimate market value.

Unrealised and realised gains and losses are shown in the statement of financial activities and represent the difference between the market value and the original purchase cost.

1.6 Structure of Funds

Where there is a legal restriction on the purposes to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are classified as designated funds. The major funds held within these categories are disclosed in note 11.

As at 31 March 2022 the Charity held one endowment fund.

1.7 Pension Contributions

There have been no pension contributions made by the Charity in the financial year ended 31 March 2022.

1.8 Prior Year Adjustments

The restatement of the 2020/21 accounts relates to the receipt of investment income of £1,480 received post 31st March 2021 in respect of the 2020/21 financial year. This was an unadjusted misstatement at the 2020/21 year end due to the value being immaterial.

However, due to a reduction in materiality for the 2021/22 financial year, the 2020/21 primary statements and related notes have now been adjusted for the above, plus roundings.

	Originally Stated 2020/21	*Restatement*	*Restated Amount 2020/21*
Statement of Financial Activities:	*£000*		*£000*
Investment Income	35	2	*37*
	1,038	2	1,040
Statement of Financial Position:			
Debtors	-	2	*2*
Total Net Assets / Total Charity Funds	1,038	2	*1,040*
Split by:			
Total Restricted Funds	607	1	608
Total Unrestricted Funds	403	1	404
Total Endowment Funds	28	0	*28*

1.9 Pooling Scheme

The General Charitable Fund is a Charitable Fund Umbrella which comprises general and specific purpose funds. As such funds are pooled for investment purposes. The funds included within the General Charitable Fund are as follows,

Essex Partnership University NHS FT General Fund
District Nurses Fund
Mental Health Charity
Primary Care Charity
Continuing Care Services Fund
Psychiatric Research Fund
Primary Care Trust Staff Welfare Fund
Mental Health Research Foundation
Learning Disabilities Psychiatry Academic and Research Foundation
The Margaret Ethel Bolton Fund
Cancer Care General Fund
Child Health Directorate Fund
Cancer Relief Fund

The scheme was registered with the Charity Commission on 18 December 2002.

1.10 Consolidation of Charity Accounts with EPUT Annual Accounts

IAS 27 on Consolidation and Separate Financial Statements, requires consolidation of a group of entities under the control of a parent where there exists the power to govern the financial and operational policies of an entity so as to obtain benefits from its activities. The Essex Partnership University NHS Foundation Trust is the corporate Trustee for the Charity and hence controls it. The purpose of the Charity is to assist NHS patients, and hence the Trust benefits from its activities. As such, IAS27 would normally be applicable in the preparation of the Trust's main accounts and the Charity would be consolidated.

However, IAS1 on Presentation of Financial Statements confirms that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material. The net assets of the Charity represent 1% of the Trust's total assets employed, and are therefore not considered to be material in the context of the Trusts main accounts. The Audit Committee have noted and approved that the Charity Accounts will not be consolidated into the main Trust accounts for 2021/22. This is subject to an annual materiality review.

Note 2 Analysis of donations and legacies

				2021/22				2020/21
	Unrestricted £000	Restricted £000	Endowment £000	**Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*Total £000*
Donations	21	7	-	**28**	*25*	*2*	*-*	*27*
Legacies	-	-	-	**-**	*1*	*-*	*-*	*1*
Grant income	42	5	-	**47**	*172*	*-*	*-*	*172*
	63	12	-	**75**	*198*	*2*	*-*	*200*

Note 3 Analysis of income from other trading activities

				'2021/22				2020/21
	Unrestricted £000	Restricted £000	Endowment £000	**Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*Total £000*
Income from other fundraising activities	2	-	-	**2**	*2*	*-*	*-*	*2*
Other Income	1	-	-	**1**	*-*	*-*	*-*	*-*
	3	-	-	**3**	*2*	*-*	*-*	*2*

Note 4 Analysis of income from investments

				'2021/22				Restated 2020/21
	Unrestricted £000	Restricted £000	Endowment £000	**Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*Total £000*
BlackRock Investment	3	4	-	**7**	*3*	*4*	*-*	*7*
M&G Charities	11	16	-	**27**	*10*	*13*	*-*	*23*
COIF Charities Investment Fund	3	4	-	**7**	*3*	*4*	*-*	*7*
	17	24	-	**41**	*16*	*21*	*-*	*37*

Note 5 Analysis of expenditure on charitable fund activities

	Unrestricted £000	Restricted £000	Endowment £000	'2021/22 Total £000	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2020/21 Total £000*
Patients Welfare & Amenities	45	15	-	**60**	*113*	*14*	*-*	*127*
Staff Welfare & Amenities	1	-	-	**1**	*100*	*-*	*-*	*100*
Support Cost (see note 5.1)	14	19	-	**33**	*13*	*18*	*-*	*31*
Fundraising Expenditure	1	-	-	**1**	*1*	*-*	*-*	*1*
	61	34	-	**95**	*227*	*32*	*-*	*259*

Note 5.1 Analysis of support cost by type

	Unrestricted £000	Restricted £000	Endowment £000	'2021/22 Total £000	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2020/21 Total £000*
Audit fee	3	3	-	**6**	*2*	*3*	*-*	*5*
Admin fee	11	16	-	**27**	*11*	*15*	*-*	*26*
	14	19	-	**33**	*13*	*18*	*-*	*31*

Note 5.2 Analysis of support cost by activities

	Unrestricted £000	Restricted £000	Endowment £000	'2021/22 Total £000	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2020/21 Total £000*
Patients Welfare & Amenities	13	19	-	**32**	*7*	*18*	*-*	*25*
Staff Welfare & Amenities	1	-	-	**1**	*6*	*-*	*-*	*6*
	14	19	-	**33**	*13*	*18*	*-*	*31*

Note 6 Gain/(losses) on investments revaluation

	Unrestricted £000	Restricted £000	Endowment £000	'2021/22 Total £000	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2020/21 Total £000*
BlackRock Investment	7	9	-	**16**	*18*	*24*	*-*	*42*
M&G Charities	17	22	-	**39**	*43*	*57*	*-*	*100*
COIF Charities Investment Fund	9	12	-	**21**	*18*	*24*	*-*	*42*
	33	43	-	**76**	*79*	*105*	*-*	*184*

Note 7 Fixed Asset Investments

Note 7.1 Changes in Fixed Asset Investments

	Unrestricted £000	Restricted £000	Endowment £000	**2021/22 Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2020/21 Total £000*
Market Value at 1 April	397	569	26	**992**	*306*	*475*	*27*	*808*
Transfers/Disposals	-	-	-	**-**	-	-	-	-
Dividends re-invested	-	-	-	**-**	-	-	-	-
Net Gain/(Loss) on Revaluation	33	43	-	**76**	*79*	*105*	*-*	*184*
Total Market Value of Fixed Asset Investments	**430**	**612**	**26**	**1,068**	***385***	***580***	***27***	***992***

Note 7.2 Analysis of Fixed Asset Investments by Investment Manager

	Unrestricted	Restricted	Endowment	**2021/22 Total**	*Unrestricted*	*Restricted*	*Endowment*	*2020/21 Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
BlackRock Investment Managers (UK) Ltd	93	131	5	**229**	*83*	*124*	*6*	*213*
M & G Securities Ltd	230	327	14	**571**	*207*	*310*	*15*	*532*
CCLA Investment Management	107	154	7	**268**	*96*	*144*	*7*	*247*
Total Market Value of Fixed Asset Investments	**430**	**612**	**26**	**1,068**	***386***	***579***	***28***	***992***

Note 8 Analysis of recievables due within one year

	Unrestricted £000	Restricted £000	Endowment £000	2021/22 Total £000	Unrestricted £000	Restricted £000	Endowment £000	Restated 2020/21 Total £000
Sundry Debtors	1	0	-	1	*1*	*1*	-	*2*
Value as at 31 March	**1**	**0**	**-**	**1**	***1***	***1***	**-**	***2***

Note 9 Short term investments & deposits

	Unrestricted £000	Restricted £000	Endowment £000	2021/22 Total £000	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2020/21 Total £000*
COIF Charities deposits funds	4	7	-	11	*4*	*7*	-	*11*
Value as at 31 March	**4**	**7**	**-**	**11**	***4***	***7***	**-**	***11***

Note 10 Analysis of cash and cash equivalent by fund type

	Unrestricted £000	Restricted £000	Endowment £000	2021/22 Total £000	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2020/21 Total £000*
Cash at bank and in hand	29	41	2	72	*19*	*27*	*1*	*47*
Value as at 31 March	**29**	**41**	**2**	**72**	***19***	***27***	***1***	***47***

Note 10.1 Analysis of cash and cash equivalents

	2021/22	*2020/21*
	£000	*£000*
Cash at bank	69	*44*
Cash in hand	3	*3*
Value as at 31 March	**72**	***47***

Note 10.2 Reconciliation of net income/(expenditure) to net cash flow from operating activities

	2021/22 £000	***Restated 2020/21 £000***
Net income/(expenditure) for the year as per the SoFA	100	*164*
(Gain) and losses of investment	(76)	*(184)*
Dividends, interest from investments	(41)	*(37)*
(increase)/decrease in stocks	-	*-*
(increase)/decrease in debtors	1	*(1)*
increase/(decrease) in creditors	-	*(3)*
Net cash provided by (used in) operating activities	(16)	*(61)*

Note 11 Analysis of Creditors

				2021/22				*2020/21*
	Unrestricted	Restricted	Endowment	**Total**	*Unrestricted*	*Restricted*	*Endowment*	*Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
Amounts falling due within 1 year:								
Intercompany creditors	1	1	-	**2**	*1*	*1*	-	*2*
Accruals	4	6	-	**10**	*4*	*6*	-	*10*
Total Creditors	**5**	**7**	**-**	**12**	***5***	***7***	**-**	***12***

Note 12 Reconciliation of fund balance at 31 March 2022

	Restated Balance at 31/03/2021	**Income**	**Expenditure**	**Unrealise gain(losses)**	**Balance at 31/03/2022**
	£000	**£000**	**£000**	**£000**	**£000**
Restricted funds	608	36	(34)	43	653
Unrestricted funds	404	83	(61)	33	459
Endowment funds	28	-	-	-	28
Total funds as per balance sheet	1,040	119	(95)	76	1,140

Note 13 Trustee and Related Party Transaction

Essex Partnership University NHS Foundation Trust is the Corporate Trustee (the Trust) of the Essex Partnership NHS Foundation Trust General Charitable Fund (the Charity). During the year the Charity paid £26,788 to the Trust, to cover costs incurred by the Trust in administering the Charity, on its behalf.

During the year none of the Trustee Board members or parties related to them has undertaken material transaction with the Charity.

Note 14 Trustees Remuneration and Benefits

There was no remuneration or other benefits paid to Trustees during the year.

Note 15 Staff Cost and Other Benefits

The Charity does not directly employ any staff. As such, there were no staff costs or other staff benefits incurred during the year.

Note 16 Contingencies

There are no contingent losses or gains known by the Trustees.

Note 17 Commitments, Liabilities and Provisions

There are no commitments, liabilities or provisions known by the Trustees.

Note 18 Post Balance Sheet Events

There are no post balance sheet events for the reporting period.

Essex Partnership University
NHS Foundation Trust

30 November 2022

The Lodge Trust HQ Runwell
Lodge Approach
Wickford
Essex
SS11 7XX

Tel: 01268 739666

Email:Trevor.Smith9@nhs.net

Debbie Hanson
Associate Partner
Ernst & Young LLP
400 Capability Green,
Luton
Bedfordshire LU1 3LU

Dear Debbie

This letter of representations is provided in connection with your independent examination of the financial statements of Essex Partnership University NHS Foundation Trust Charities ("the Charity") for the year ended 31 March 2022. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to complete your independent examination as to whether there are matters to which attention should be drawn to enable a proper understanding of the financial statements to be reached.

We understand that the purpose of your independent examination of our financial statements is to report whether any matter has come to your attention which gives you reasonable cause to believe that in any material respect:

- the accounting records were not kept in respect of the Charity as required by section 130 of the Charities Act; or
- the accounts did not accord with the accounting records; or
- the accounts did not comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give 'true and fair' view which is not a matter considered as part of an independent examination.

We understand that this examination is substantially less than an audit and involves an examination of the accounting records and related data to the extent you considered necessary in the circumstances and is not designed to identify – nor necessarily be expected to disclose – all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

A. **Financial Statements and Financial Records**

1. The Trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

2. We have fulfilled our responsibilities, as set out in the engagement letter dated 25 January 2020, for the preparation of the financial statements in accordance with the Charities SORP and UK Generally Accepted Accounting Practice (UK GAAP).

3. We acknowledge, as trustees of the Charity, our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair view of the financial position and financial performance of the Charity in accordance with the Charities SORP and UK Generally Accepted Accounting Practice (UK GAAP), and are free of material misstatements, including omissions. We have approved the financial statements.

4. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements.

5. We have disclosed to you any significant changes in our processes, controls, policies and procedures that we have made to address the effects of the COVID-19 pandemic and the effects of the conflict and related sanctions in Ukraine, Russia and/or Belarus on our system of internal controls.

6. There are no unadjusted audit differences identified during the current audit and pertaining to the latest period presented.

B. **Non-compliance with laws and regulations, including fraud**

1. We acknowledge that we are responsible to determine that the Charity's business activities are conducted in accordance with laws and regulations and that we are responsible to identify and address any non-compliance with applicable laws and regulations, including fraud.

2. We acknowledge that we are responsible for the design, implementation and maintenance of internal controls to prevent and detect fraud.

3. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

4. We have no knowledge of any identified or suspected non-compliance with laws or regulations, including fraud that may have affected the Charity (regardless of the source or form and including without limitation, any allegations by "whistleblowers"), including non-compliance matters:

    - Involving financial improprieties

    - Related to laws or regulations that have a direct effect on the determination of material amounts and disclosures in the Charity's financial statements

    - Related to laws and regulations that have an indirect effect on amounts and disclosures in the financial statements, but compliance with which may be fundamental to the operations of the Charity's business, its ability to continue in business, or to avoid material penalties

    - Involving management, or employees who have significant roles in internal control, or others

    - In relation to any allegations of fraud, suspected fraud or other non-compliance with laws and regulations communicated by employees, former employees, analysts, regulators or others.

C. **Information Provided and Completeness of Information and Transactions**

1. We have provided you with:

    - Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;

- Additional information that you have requested from us for the purpose of the independent examination; and

- Unrestricted access to persons within the entity from whom you determined it necessary to obtain evidence.

2. All material transactions have been recorded in the accounting records and are reflected in the financial statements, including those related to the COVID-19 pandemic, and including those related to the conflict and related sanctions in Ukraine, Russia and/or Belarus.

3. We have made available to you all minutes of the meetings of trustees or subcommittees of trustees (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the period to the most recent meeting on the following date: 28 July 2022.

4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Charity's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related balances due to or from such parties at the period end. These transactions have been appropriately accounted for and disclosed in the financial statements.

5. We have disclosed to you, and the Charity has complied with, all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.

6. From 26th January 2022, the date of our last management representation letter, through the date of this letter we have disclosed to you, to the extent that we are aware, any (1) unauthorised access to our information technology systems that either occurred or is reasonably likely to have occurred, including of reports submitted to us by third parties (including regulatory agencies, law enforcement agencies and security consultants), to the extent that such unauthorized access to our information technology systems is reasonably likely to have a material effect on the financial statements, in each case or in the aggregate, and (2) ransomware attacks when we paid or are contemplating paying a ransom, regardless of the amount.

D. **Liabilities and Contingencies**

1. All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the financial statements.

2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal counsel.

3. We have recorded and/or disclosed, as appropriate, all liabilities related to litigation and claims, both actual and contingent, and have not given any guarantees to third parties.

E. Going Concern

1. There are no matters of which we are aware that are relevant to the Charity's ability to continue as a going concern, including significant conditions and events, our plans for future action, and the feasibility of those plans.

F. **Subsequent Events**

1. There have been no events, including events related to the COVID-19 pandemic, and including events related to the conflict and related sanctions in Ukraine, Russia and/or Belarus, subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

G. **Other information**

1. We acknowledge our responsibility for the preparation of the other information. The other information comprises the Annual Report and Accounts 2021-22.

2. We confirm that the content contained within the other information is consistent with the financial statements.

H. Climate-related matters

1. We confirm that to the best of our knowledge all information that is relevant to the recognition, measurement, presentation and disclosure of climate-related matters has been considered and reflected in the financial statements.

2. The key assumptions used in preparing the financial statements are, to the extent allowable under the requirements of Charities SORP and UK Generally Accepted Accounting Practice (UK GAAP), aligned with the statements we have made in the other information or other public communications made by us.

I. Reporting to regulators

1. We confirm that we have reviewed all correspondence with regulators, in England and Wales, which has also been made available to you, and the serious incident report guidelines issued by the Charity Commission (updated in 2017). We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the signing of the balance sheet.

Yours faithfully

Trevor Smith
Executive Chief Finance Officer

Janet Wood
Non Executive Director / Chair of Audit Committee

NHS
Essex Partnership University
NHS Foundation Trust

Board Assurance Framework – November 2022

Agenda item #8a

CONTENTS

Board of Directors 30 November 2022

NHS
Essex Partnership University
NHS Foundation Trust

Introduction

The Board has overall responsibility for ensuring systems and controls are in place and are sufficient to mitigate any significant risks, which may threaten the achievement of the Strategic Objectives.

The Board Assurance Framework is the overarching report relating to Strategic risks and Corporate risks.

The BAF outlines key strategic risks, linked to the strategic objectives. The risks (where appropriate) have a strategy underpinning them and will have longer-term actions with deliverables.

The Board of Directors may wish to undertake deep dives on individual strategic risks. The Executive Team may delegate Strategic risks to specific Committees for oversight and scrutiny.

Following review by the Executive Board Assurance Framework Group (EBAF), held Tuesday 22 November '22 the updated board assurance risk framework (BAF) is presented to the Board of Directors for information.

EPUT Board is asked to receive the BAF report and note:

The two new risks approved by the Executive BAF Group (Slide 10)

- CRR96 Loggists – SRO being Executive Director Major Projects
- CRR99 Safeguarding Referrals – SRO being Executive Nurse

The change to SRO for risk CRR81 - Ligature from the Executive Chief Finance Officer to the Executive Chief Operating Officer. And that no risk closed during the period.

The progress against risk actions (noting the source of updates being increasing derived from Groups/ Committee business). The Board is asked to note this is September '22 data, with October '22 data being populated after Board Assurance Committees this month. Any requests for further information will be taken forward by the EBAF Group and Board Committees.

Corporate Impact Assessment	
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	

02 - BAF Dashboard November 2022

EPUT

Strategic Risks

NHS
Essex Partnership University
NHS Foundation Trust

Existing Risks	Recommended New Risks	Recommended for Downgrading	Recommended for Closure
8	0	0	0

Risk Score Increases	Risk Score Decreases	No change in Risk Score	Risks Reviewed by owners	On RR more than 12 months
0	0	8	1	6

% Risks with Controls Identified	% risks with assurance identified	% risks with actions overdue
100%	100%	0%

ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score 20+ (Existing risks)								
SR1	1	Safety	Safety, Experience, Compliance, Service Delivery, Reputation	NH	5x4= 20	20 → 20 → 20	Rising demand for services; Government MH Recovery Action Plan; Covid-19; Challenges in CAMHS & complexities; Systemic workforce issues in the NHS	• Zero never events and safety alert breaches in year • Safety dashboard integration with I want Great Care has been passed to the IWGC optimisation project team • BSOG has continued to receive updates on progress with Safety First, Safety Always Strategy • Framework to stand up Safety Actions Command Call (SACC) has been established
SR2	2	People	Safety, Experience, Compliance, Service Delivery, Reputation	SL	5x4= 20	20 → 20 → 20	National challenge for recruitment and retention	• Meeting targets for turnover (although this is increasing), starters and sickness • Since November 2021 there have been 147 successful bank to permanent transitions • Time to care moving into phase 2 – implementation • Developing staffing plan for mental health inpatients
SR4	All	Demand and Capacity	Safety, Experience, Compliance, Service Delivery, Reputation	AG	5x4= 20	20 → 20 → 20	Covid-19. Long-term plan. White Paper. Transformation and innovation National increase in demand on services	• Meeting target for Adult Delayed Transfers of Care and less discharges and less long-stays in September • Increased Activity Coordinators on the wards • After action review completed following Opel 4 status in August '22 and learning being embedded into work streams • GIRFT workshop held re urgent care pathway
SR7	All	Capital	Safety, Experience, Compliance, Service Delivery, Reputation	TS	5x4= 20	20 → 20 → 20	The need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	• Re-forecast exercise including sign off from project leads and a revised spend profile in train

Strategic Risks

NHS
Essex Partnership University
NHS Foundation Trust

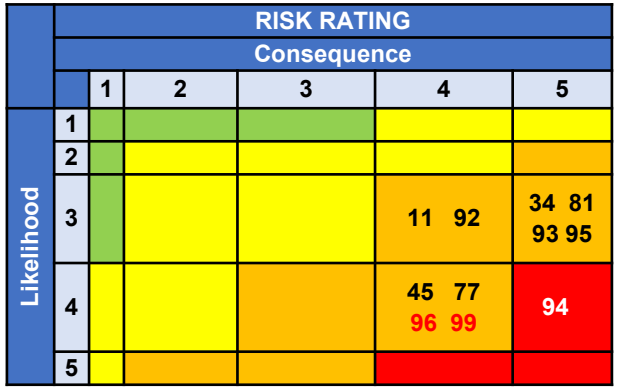
ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score <20 (Existing risks)								
SR3	All	Systems and Processes/ Infrastructure	Safety, Compliance, Service Delivery, Experience, Reputation	ZT/TS	5x3=15	15 15 15	Capacity and adaptability of the support service infrastructure including Estates & Facilities, ITT /Digital Systems, Estates, Finance, Procurement and Business Development/ Contracting to support frontline services. Recovery from HSE and Covid-19. Need to release clinical time.	• Electronic Patient Record business case submitted and approved by the Executive Team • 3i system review underway • Draft restructures for Finance and Resources, and Strategy Transformation and Digital out to consultation November '22, with implementation January 2023 • Phase 2 of Time to Care programme
SR5	1	Independent Inquiry	Compliance, Reputation	NL	5x3=15	15 15 15	Government led independent inquiry into Mental Health services in Essex	• Phase 2 collection of evidence • Documentary evidence provided • Focus on hearing evidence from families, friends and carers of inpatients who died during the period and others with lived experience of Essex MH services drawing to close • Inquiry Team has written to all current EPUT staff and some historic staff asking for them to come forward and speak with them • Inquiry inviting specific members of staff to attend evidence sessions
SR6	All	Cyber Attack	Safety, Compliance, Service Delivery, Experience, Reputation	ZT	5x3=15	15 15 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	• Following a national cyber incident the finance system was unavailable between 9 Aug and 2 Sep. '22 Business continuity plans were successfully deployed. Following reconnection focus on restoration • A request to reduce the risk score was not approved by EBAF. It was noted that our response to the threat in Aug was robust and that significant actions have been taken, and are being taken,. However, it was felt that these do not reduce the overall risk of cyber attacks from other sources.
SR8	All	Use of Resources	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x3=15	15 15 15	The need to devolve financial management and ensure EPUT makes effective and efficient use of its resources.	• £2.3m below plan but £1.3m of under-delivery relates to a single scheme expected to deliver later than planned • Forecast break-even position and continues to assess risks and opportunities

Corporate Risks

Essex Partnership University NHS Foundation Trust

Existing Risks	Recommended New Risks	Recommended Downgrading from SRR to CRR	Recommended Downgrading From CRR to DRR	Recommended for Closure
9	2	0	0	0

Risk Score Increases	Risk Score Decreases	No change in Risk Score	Risks Reviewed by owners	On RR more than 12 months
0	0	9	3	8



% Risks with Controls Identified	% risks with assurance identified	% risks with actions overdue
100%	100%	TBC

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR94	Engagement and supportive observation	Safety, Compliance	AG	5x4=20	20 20 20	CQC found observation learning not embedded	• Project complete and new Policy and Procedure launched with revised training material • Pilot of e-observations completed and approved for roll out. • 23 wards scored 100% in Tendable observation audit with 7 wards scoring 90% or above (10 wards did not complete) • Observation and engagement focus in Dispatches Documentary and subsequent CQC inspection.
CRR11	Suicide Prevention	Safe	MK	4x3=12	12 12 12	Implementation of suicide prevention strategy	• Zero instances of preventable deaths • 19.3% downward trend in instances of self-harm • 95% patients have personal safety plan
CRR34	Suicide Prevention - training	Safe	MK	5x3=15	15 15 15	Implementation of suicide prevention strategy	• Trainers recruited • 95% staff completed dedicated suicide prevention training
CRR45	Mandatory training	Safe	SL	4x4=16	16 16 16	Training frequencies extended over Covid-19 pandemic leaving need for recovery	• Attained a further 12 month's TASI accreditation from British Institute of Learning Difficulties (BILD). • September mandatory training 92.5% and 90.2% (against targets of 85% and 90%) • Increased number of TASI trainers
CRR77	Medical Devices	Safe, Financial, Service Delivery	NH	4x4=16	16 16 16	Number of missing medical devices compared to Trust inventory	• A number of actions in place to address internal audit recommendations.

Corporate Risks

NHS
Essex Partnership University
NHS Foundation Trust

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Existing Risks cont'd							
CRR81	Ligature	Safe, Compliance, Reputation	AG/TS	5x3=15	15 → 15 → 15	Patient safety incidents	• Ligature rate remains in line with national benchmark • Ligature Risk Reduction Group has been reviewed with increased clinical representation • Basildon awarded Best External Environment in Best Patient Safety Initiative • September ligature training on target at 90% • Project continuing to look at electronic solution for actions • Phase 4 Capital Projects Programmes Group agreed funding • Garden Standards group continuing
CRR92	Addressing Inequalities	Experience	SL	4x3=12	12 → 12 → 12	Staff Experience	• EDI plan in development with four strategic pillars: culture and leadership, talent management and acquisition; recruitment and retention, and data • EDI plan aligned to vision and values, and objectives • WRES and WRDS action plans signed off by executives
CRR93	Continuous Learning	Safety, Compliance	NH	5x3=15	15 → 15 → 15	HSE and CQC findings highlighting learning not fully embedded across all Trust services	• Discussions on joint development of ELIMS. • Accessing a trial pack from 03/10 from Allocate for safety dashboard • Lessons SOP circulated for comments • Quality Academy established • Life QI introduced, • PDSA (Plan, Do, Study, Act) key approach
CRR95	Delivery of new vaccination programme	Service Delivery, Financial	NL	5x3=15	15 → 15 → 15	Vaccination focus has changed	• Autumn vaccination programme underway with all vaccination centre and delivery • models open • Confident of achieving the activity target for the number of vaccines • Supporting care homes and housebound
CRR96	Loggists	Compliance	NL	4x4=16	16	Major incident cover	• New risk • Cover has been provided up to now but there is a need to extend identified pool of loggists and out of hours cover
CRR98	Safeguarding Referrals	Safety	NH	4x4=16	16	Escalation from operations and high increase in referrals	• New risk • Risk has been managed well so far but unlikely to be sustainable

03 - New Risks Approved November 2022

EPUT

New Risks approved

NHS
Essex Partnership University
NHS Foundation Trust

ID	Title	Impact	Lead	IRS	Potential Risk	Context	Key Controls and Assurances	Gaps
Executive – Executive Nurse								
CRR99	Safeguarding Referrals	Safety	NH	IRS 4x4 = 16 Target 4x2=8 Date TBC	If EPUT is unable to manage the increase in safeguarding referrals then it may not adequately assess patients' needs resulting in compromised patient safety, wellbeing and compliance with safeguarding best practice and regulation	Need to manage safeguarding referrals. Identification of Care Co-ordinator posts to investigate but unable to recruit Increased S42 work National, local and societal context (Post COVID) Risk score is high based sustainability of current demand response.	Team establishment Trust safeguarding team Safeguarding policies and procedures Prioritisation and management systems Process for oversight of S17, S47 and MARAC Safeguarding training Robust caseload management Monthly safeguarding reports Datix reporting Monitoring – safeguarding supervision improved. Duty team picking up overflow of demand to respond to S17 and S47	Operational capacity to manage safeguarding demand Increased complexity cases Challenge to meet timeframe and compliance with policy Double recording – safeguarding forms do not populate within system
Executive Director of Major Projects								
CRR96	Number of Loggists	Compliance	NL / NJ	IRS 4x4 = 16 Target 4x1=4 March 23	If EPUT is unable to increase the number of trained loggists and hours of availability then there may be a suboptimal level of cover during a major incident resulting in the use of untrained loggists or no log of decisions or actions	Low number of loggists currently available No training available currently in region Risk score based on untrained loggists and likelihood of availability out of hours for a major incident being high.	Pool of trained loggists including Emergency Preparedness Resilience and Response (EPRR) team and Executive Director executive Assistants All EPRR incidents have been logged to date. Some logging has been undertaken by staff who are untrained.	Not enough loggists to cover a sustained period of active major incident and available out of hours No training currently available from region to increase trained loggist pool.

04 - Risks Closed November 2022

EPUT

Nil Closed

05 – Strategic Risks

November 2022

EPUT

SR1: Safety

Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT does not invest in safety or effectively learn lessons from the past (***Cause***), then we may not meet our safety ambitions (***Effect***), resulting in a possibility of experiencing avoidable harm, loss of confidence and regulatory requirements (***Impact***).

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

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

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	C5 x L2 = 10 (Mar '23)

Risk Appetite:
Risk Tolerance:

Progress since last report:

- Progress report to Board Safety Oversight Group in November 2022 highlighted good progress on delivering the strategy
- The financial agreement to automate Health Roster data to the Safety dashboard submitted end October 22
- Safety dashboard integration with I Want Great Care passed to IWGC optimisation project team
- EPUT and MASS Cohort plc negotiating and seeking mutual agreement on delivery of ELIMS (technical development paused at this stage)
- Framework for Lessons Team to stand up Safety Action Command Call (SACC) approved by ECOL steering group

Key Gaps in Assurance

- Reduction in Patient Safety Incidents (Sep 22 remains below reduction target)
- No Harm / Low Harm incidents >93% (Sep 22 - 77% MH and 71.4% CHS
- Decrease in incident reporting September 29.8%

Executive Responsible Officer:
Natalie Hammond, Executive Nurse
Executive Committee: ESOG
Board Committee: BSOG, Quality Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Refresh Patient Safety Incident Response Plan	TBC (When data Available)	Moriam Adekunle Director of Safety and Patient Safety Specialist	Road Map
2. Deliver the Patient Safety Incident Response Plan	March 2023	Moriam Adekunle Director of Safety and Patient Safety Specialist	Controls
3. Deliver the Patient Safety Strategy (Safety First Safety Always)	End March 2023	Natalie Hammond Executive Chief Nurse	Road Map / Control
4. Culture of Learning Programme	Ongoing	Moriam Adekunle	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Patient Safety Team and Culture of Learning Team	Team in place	Report Safety First Safety Always – Leadership	PSIRF pilot feedback
Learning Collaborative Partnership	Established		
Safety First Safety Always Strategy	ESOG Reporting	Annual Report to TB 0 Never events YTD 0 safety alert breaches YTD	
PSIRF; Complaints; Claims; Safety First Safety Always Strategy	Policy Register	PSIRF reports/ risk management reports/ complaints reports/ ESOG reporting cycle / Clinical Audits	IA Reviews inc PSIRF May 22 and Medical Devices Feb 22 Fundamental Standards CQC Benchmarking from NRLS
Range of learning platforms in place – thematic analysis/ EPUT Lab/ Quality Academy/ Lunchtime Learning/ Key messages / Quality and Safety Champions Network	Have been running and scheduled for future	Learning collaborative partnership Group	
Intensive Support Groups			
Nurse Advocates/ RISE leadership	12 nurses completed advocate training		
PMO Support	Overall portfolio status		
Capital investment in patient safety	Progress on delivery of essential safety improvements		CQC CAMHS inspection safety improvements
Insight into wellbeing		Reports to ESOG and QC Culture of Learning progress report	

SR2: People

Essex Partnership University NHS Foundation Trust

At a Glance:

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

Likelihood based on: Establishment of existing and new roles verses the vacancy factor and shift fill rate. [add some statistics)
Consequence based on: Impact of staffing levels on service objectives; length of unsafe staffing (days) through the sit rep return; staff morale; availability of key staff; attendance at key training.

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	C5 x L3 = 15 (Mar '23) C5 x L2 = 10 (Mar '24)

Risk Appetite: TBC
Risk Tolerance: TBC

Progress since last report:

- Meeting targets for turnover (although this is increasing), starters and sickness
- Since November 2021 there have been 147 successful bank to permanent transitions
- Time to care moving into phase 2 – implementation
- Developing staffing plan for MH inpatients – both recruitment and retention, temp staffing and cultural improvements. PT March 23

Key Gaps in Assurance

- Team staff increasing to 8.9% in sept 2022. Escalated to inadequate in performance report following sharp increased in the number of Shift Framework breaches (September 358 up from 296 in August)
- Vacancy rate increasing (Sep 17.4%)
- Sickness above target (Sep 6.3%)
- Supervision below target (Sep 67.9%)
- Appraisal below target (Sep 76.3%)

Executive Responsible Officer: Sean Leahy, Executive Chief People Officer
Executive Committee: Executive Team
Board Committee: People, Equality and Culture Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
Rolling recruitment programme	Ongoing	Matt Gall, Associate Director Resourcing	Control
Deliver International Recruitment Programme	December 2022 / Ongoing	Marcus Riddell, Senior Director of OD	Control
Bank/Agency Conversion Programme	Ongoing	Matt Gall, Associate Director Resourcing	Control
Student Recruitment	Ongoing	Annette Thomas-Gregory Director of Education & Learning	Control
Apprenticeship Programme Relaunch	October 2022	Annette Thomas-Gregory	Control
Time to Care Programme	December 2023	Paul Scott, Chief Executive	Control
Refresh and Deliver Recruitment/ Retention Strategy	December 2022	Matt Gall, Associate Director Resourcing	Road Map / Control
Develop People Commitments (strategic plan)	December 2022	Marcus Riddell, Senior Director of OD	Road Map
Employee experience road map	October 2022	Lorraine Hammond Director Employee Experience	Road Map

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
HR Team and People and Culture Directors	Team in place		
HR Policies	Policy Register	IA Reviews Workforce Reports to PECC	Ofsted inspection on 27th-29th July 2022 scoring good in all domains
Workforce Plans and strategies	Workforce Safeguards Workforce Establishment Reviews	Workforce Safeguards Workforce Establishment Reviews Workforce Reports to PECC	CQC inspections NHSE Workforce Returns System Workforce Returns / benchmarks
Rolling recruitment programme	Recruitment team	Workforce Reports to PECC	
Retention programme	People and culture directorate	Reports to F&PC and PECC Turnover rate in performance report Safer staffing data	
Sit Rep Meetings	Staffing Sit-Rep	Quality and performance reports	CQC inspections
Use of Bank and Agenda Staff (when needed)	Staffing Sit-Rep	Workforce Reports to PECC	CQC inspection reports Use of Resources Assessment
Recruitment Branding	Branding in place from March '22	Direct Hire Numbers within the Workforce reporting to PECC	
Staff wellbeing	Engagement Champions	0 bullying and harassment incidents Turnover rate below target and starters above target	Pulse Survey
Data reporting	Staffing sitrep	Safety huddle report to ESOG	Increase in Pulse responses and key themes identified

SR3: Systems and Processes/ Infrastructure

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

If our systems, processes and infrastructure do not continue to adapt to support clinical services(***Cause***), Then we may not have the right facilities/ resources to deliver safe, high quality care (***Effect***), Resulting in not attaining our safety, quality/ experience and compliance ambitions(***Impact***).

Likelihood based on:
Consequence based on:

Initial risk score	Current risk score	Target risk score
C5 x 3L = 15	C5 x L3 = 15	C5 x L2 = 10 (Mar '23)

Risk Appetite: TBC
Risk Tolerance: TBC

Progress since last report:

- Following a national cyber incident the finance system was unavailable between 9 Aug and 2 Sep. BCPs successfully deployed. Following reconnection focus on restoration.
- EPR submission to Executive Team
- 3i system review underway
- Draft restructure for both Executive portfolios out to consultation on 23 November for 30 days with expected implementation January 23

Key Gaps

- Teams not fully established
- Information governance training 92.9% September (target 95%)

Executive Responsible Officer: Trevor Smith, Executive Chief Finance and Resources Director & Zephan Trent, Executive Director Strategy Transformation and Digital
Executive Committee: Executive Team, ESOG
Board Committee: BSOG, Finance and Performance Committee, Audit Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
Fully recruit to all finance, resources, strategy, transformation and digital systems teams including agreeing portfolios and jointly funded posts	January 2023	Trevor Smith, Executive Chief Finance and Resources Director& Zephan Trent, Executive Director Strategy Transformation Digital	Control - Full establishment
Develop EPUT Strategy	October 2022	Zephan Trent, Executive Director Strategy Transformation Digital	Roadmap
Develop Commercial Strategy	December 2022	Liz Brogan, Director of Contracting & Service Development Lauren Gable, Director of Finance Commercial	Roadmap
Develop Estates Strategy	December 2022	Charles Hanford Director of Estates and Facilities	Roadmap
Deliver Interim Digital Strategy	March 2027	Zephan Trent, Executive Director Strategy Transformation Digital	Control
Deliver on the Target Operating Model	End March 2023	All Executives	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Digital Systems, Estates and Facilities, Contracting and Business Development, Finance Teams	Establishment Support services		
Interim Digital Strategy Range of corporate, finance and IG policies Information Governance Framework		EOSC, Information Governance Sub-Committee, Digital Strategy Group Capital Group and PMO	NHS Digital Information Governance Toolkit
Information Governance Training		IG Training compliance reporting via Accountability Framework	
Investment in PMO, Capital Programme, E-expenses system, HIE		Weekly PMO/ ITT integration meetings Capital Planning Group	Access to data and services across system
Audit programme/ ISO in place		Audit Committee Internal Audit	CQC CAMHS inspection highlighted effectiveness of HIE BSI data external assessment

SR4: Demand and Capacity

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

If we do not effectively address demands (***Cause***), Then our resources may be over-stretched(***Effect***), Resulting in an inability to deliver high quality safe care, transform, innovate and meet our partnership ambitions (***Impact***).

Likelihood based on:
Consequence based on: Mismanagement of patient care and length of the effects.

Initial risk score	Current risk score	Target risk score and timescale
C5 x 4L = 20	C5 x L4 = 20	TBC

Risk Appetite: TBC
Risk Tolerance: TBC

Progress since last report:

- Therapeutic offer on wards increased with activity co-ordinators
- After action review completed following August OPEL 4 and learning being embedded into workstreams
- All individuals with extended LOS have a clear treatment plan
- September 22 93 discharges, 22 of whom were long-stay
- Adult DTOC Sep 22 1.7%
- Sep 22 reduction in out of area bed days at 757
- System escalation of delayed transfers of care meetings and the joint inpatient and community review meetings all well established

Key Gaps:

- September 2022 ALOS increased slightly to 52.2 and remains outside benchmark
- September 2022 94.9% Bed Occupancy remains above target
- High demand for inpatient admissions

Executive Responsible Officer: Alex Green, Executive Chief Operating Officer
Executive Committee: SMT
Board Committee: BSOG, Quality Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
Recruitment and Development of the Care Unit leadership structures.	December 2022	Milind Karale, Executive Medical Director Natalie Hammond, Executive Chief Nurse	Control
Embedding of Care Units (Operational and governance structures)	September 2022	Alex Green, Executive Chief Operating Officer	
Development of individual Care Unit Service Strategies	September 2022	Zephan Trent Executive Director Strategy Transformation & Digital	Road Map
Implement Service Delivery Strategy	March 2023	Alex Green, Executive Chief Operating Officer	Control
Model service need (population health / bed model)	TBC	Zephan Trent, Executive Director Strategy Transformation & Digital (Supported by KPMG)	Control
Time to Care Programme	December 2023	Paul Scott, Chief Executive	Control
MH EUC Project (MSE)	Ongoing	Alex Green, Executive Chief Operating Officer	Control
Purposeful admission group	Ongoing	Alex Green, Executive Chief Operating Officer	Control
Develop clear road map for portfolio	March 2023	Alex Green, Executive Chief Operating Officer	Roadmap
Smart V1 reporting	TBC	Zephan Trent	Assurance
GIRFT	March 2023	Alex Green, Executive Chief Operating Officer	Control
Exploration of Community virtual ward model to support Clozapine initiation and titration	March 2023	Alex Green	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Operational staff	Establishment		
Integrated Director posts covering Mental Health and physical health	Establishment		
Target operating model/ care unit development, Accountability Framework, Safety First, Safety Always Strategy, Flow and Capacity Policy, MAST roll out	Dedicated discharge coordinator	Accountability meetings	
MH UEC Project, MSE Connect Programme, Partnerships, Time to Care initiative, New ways of working and new digital solutions	Flow and Capacity Project	Purposeful admission steering group Mthly inpatient quality and safety group	Provider Collaborative(s) MH Collaborative Whole Essex system flow and capacity group
Service dashboards Daily sit reps	Updated OPEL framework DTOC 1.7% in Sep 22	Performance and Quality Report to Accountability Meetings and F&PC	
Skilled temporary workforce via Trust Bank	Bank establishment		
Business Continuity Plans	Emergency Planning		

SR5: Independent Inquiry

NHS
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NHS Foundation Trust

At a Glance:

If EPUT is not open, transparent and has the correct governance arrangements in place (Cause) then it may not embed the learning from past failings (Effect) resulting in undermining our Safety First, Safety Always Strategy (Impact)

Likelihood based on:
Consequence based on:

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L3 = 15	C5 x L2 = 10 Target December 23

Risk Appetite: TBC
Risk Tolerance: TBC

Progress since last report:

- Essex Mental Health Independent Inquiry still in phase 2, collecting evidence from a range of people
- Documentary evidence continues to be provided by the Trust
- Inquiry focus on hearing evidence from families, friends, and carers of inpatients who died during the relevant period and others with lived experience of Essex Mental Health services drawing to a close
- The Inquiry Team have written to all current EPUT staff, and some historic staff, asking them to come forward and speak to them
- The Inquiry also inviting specific members of staff to attend evidence sessions

Key Gaps:
MOU and ISP in draft

Executive Responsible Officer: Nigel Leonard, Executive Director, Major Projects
Executive Committee: SMT
Board Committee: BSOG, Audit Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
Carry out internal audit on learning	March 23	BDO	Assurance
Respond to information requests	Ongoing	Gill Brice, Project Director	Control
Learning log in place	Ongoing	Gill Brice, Project Director	Assurance
Project Plan in place	Ongoing	Jade Line, Project Manager	Control
Deep dive into sample of deaths in scope over 20 year period	Completed	Inquiry Response Team	Assurance
Deep dive in 13 prevention of future death notices	Completed	Inquiry Response Team	Assurance
Project plan in place	Ongoing	Jade Line, Project Manager	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Project Team Independent Director and Clinical Advisor	Establishment	EOC and Audit Committee oversight	Independent Director and Independent Clinical Advisor in place
Internal methodology for working with inquiry	In place	In place and used for reporting Project Group overseeing	As above
Inquiry Terms of Reference MOU and Information Sharing Protocol	In draft		
Learning Log	Log in place	In place and used for reporting to ET Audit Committee and BOD	
Exchange portal in place to safely transfer information to the inquiry	Data protection impact assessment	Reporting in place	Independent Director and Clinical Advisor

SR6: Cyber Security

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At a Glance:

If we experience a cyber-attack (***Cause***), then we may encounter system failures and downtime(***Effect***), **r**esulting in a failure to achieve our safety ambitions, compliance, and consequential financial and reputational damage (***Impact***).

Likelihood based on: Prevalence of cyber alerts that are relevant to EPUT systems.
Consequence based on: assessed impact and length of downtime of our systems

Initial risk score	Current risk score	Target risk score
C5 x L4 = 20	C5 x L3 = 15	C4 x L3 = 12 Inherent ongoing risk

Risk Appetite:
Risk Tolerance:

Progress since last report:

- Following a national cyber incident the finance system was unavailable between 9 Aug and 2 Sep. BCPs successfully deployed. Following reconnection focus on restoration.
- IT security health check and penetration testing report with no critical issues identified
- Business case to Digital Strategy Group to support release of revenue for procurement recommending option to agree immediate procurement and offset through end of year non-recurrent revenue
- As above for replacement of smartphones than can no longer receive software (IOS) updates
- Upgrade of legacy windows and SQL server versions underway with expected completion Feb 23

Key Gaps:

- Audit recommendations to be completed
- Cyber essentials plus re-certification – see progress and actions

Executive Responsible Officer:
Zephan Trent, Executive Director Strategy Transformation and Digital
Executive Committee: IG Steering Group, Digital Strategy Group
Board Committee: Finance and Performance Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
Appoint to Cyber Governance Manager	March 23	BDO	Assurance
Complete recommendations from internal audit	March 23	Adam Whiting Deputy Director, ITT and BAR	Controls and Assurance
Develop business continuity plan and disaster recovery for each system (using third party)	March 23	Adam Whiting Deputy Director, ITT and Business Analysis and Reporting	Controls and Assurance
Take actions to meet gaps identified in Cyber Essentials Accreditation – 1) replacement of desktops and laptops that cannot support latest version of Windows	March 23	Adam Whiting Deputy Director, ITT and Business Analysis and Reporting	Controls and Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place – two appointments to be made	New Cyber Governance Manager post to act in independent role Existing Cyber Security Manager role	IGSSC	NHS Digital Data Security Protection Toolkit (DSPT) Cyber Essentials Accreditation
Range of policies and frameworks in place	Virtual and site audits Compliance with mandatory training	IGSSC; BDO internal audit May 22 – overall Moderate Confidence level Medium	As above MSE ICS IG & Cyber Levelling Up Project (annual)
Investment in prioritisation of projects to ensure support for operating systems and licenses			
IG & Cyber risk log	Risk working group 2022 complete – highlighted no risks vulnerabilities	IGSSC and Digital Strategy Group	DSPT Areas identified for upcoming BDO Audit
Business Continuity Plans and National Cyber Team processes		Successfully managed Cyber incident	Annual Testing as part of DSPT NHS Digital Data Security Centre, Penetration Testing, Cyber Essentials+
CareCert notifications from NHS Digital	Monitored and acted upon within 24 hours of their announcement	Reported to IGSSC	NHS Digital

SR7: Capital Resource

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

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

Likelihood based on: percentage of capital programme unable to deliver / deferred
Consequence based on: what not delivered and the impact on the strategic plans.

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	TBC

Risk Appetite: TBC
Risk Tolerance: TBC

Progress :

- Reforecast exercise undertaken including sign off from project leads and revised spend profile
- A number of tenders for material schemes were approved at September Board and are now progressing

Key Gaps

- Key strategies to be developed
- Capital annual plan £12.3m YTD spend £3.2m. £4.9m behind plan.

Executive Responsible Officer: Trevor Smith, Executive Chief Finance and Resources Officer
Executive Committee: Executive Team
Board Committee: Finance & Performance Committee

Actions

Action	By When	By Who	Purpose
Develop Estates Strategy (co-dependent on Clinical Strategy)	End Dec 2022	Charles Hanford – Director of Estates & Facilities	Road Map
Develop Digital Strategy (co-dependent on Clinical Strategy)	Ongoing	Jan Leonard – Director of IMT	Road Map
Develop a medical devices replacement programme	Ongoing	Natalie Hammond – Executive Chief Nurse	Road Map
Horizon scan to maximise opportunities both regional and national to source capital investment	Ongoing	Simon Covill – Director of Finance	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Finance Team (Response to new resource bids and financial control oversight)	Team in place		
Purchasing / tendering policies	Policy Register	IA reviews	
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2022/23	Capital Project Group Reporting - £14.3m	Capital Resource reporting to Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£New resource secured	Capital Resource reporting to Finance & Performance Committee	
ICS representation re: financial allocations and MH/Community Services	ECFO or Deputy Attendance at ICS Meetings		
	CEO or Deputy membership of ICB		

SR8: Use of Resources

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

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

Likelihood based on: EPUT financial risk and opportunities profile
Consequence based on: assessed impact on long financial model for EPUT and the System

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L3 = 15	TBC

Risk Appetite: TBC
Risk Tolerance: TBC

Progress since last report:
- Delivered £3.3m of efficiencies
- Forecast break-even position and continue to assess risks and opportunities.

Gaps:
- Improve financial maturity
- £2.3m below plan. £1.3m of under-delivery relates to a single scheme expected to deliver later than planned

Executive Responsible Officer: Trevor Smith, Executive Chief Finance and Resources Officer
Executive Committee: Executive Team
Board Committee: Finance & Performance Committee

Actions

Action	By When	By Who	Purpose
Improve financial maturity (Training and development for budget holders and business partners)	End March 2023	*Lauren Gable Finance Director*	*Control*
Efficiency workshops to identify remaining efficiency savings	End May 2022 (delayed due to additional national planning activities now Sept '22)	*Simon Covill Director of Operational Finance*	*Control*
Deliver Financial Efficiency Target (All Budget Holders)	End Mar 2023	*Trevor Smith Executive Chief Finance Officer*	*Control*
In year forecast outturn (FOT) and risk and opportunities assessments	End Sept 2023 (monthly thereafter)	Simon Covill	Assurance
Deliver Operational Plan 2022/23	End March 2023	Alex Green / Trevor Smith	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Finance Team (Response to new resource bids and financial control oversight)	Team in place		
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Policy Register	IA reviews	Budgetary Management Internal Audit substantial assurance
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2022/23		Capital Plan and Group	
Fully identified efficiency target		Reporting to ET, F&PC and BOD	
Finance reporting	ECFO or Deputy Attendance at ICS Meetings	Capital Group, EOSC, F&PC Accountability Meetings	Nationally mandated controls
	CEO or Deputy membership of ICB		

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06 – Corporate Risks

November 2022

EPUT

CRR94: Engagement and Supportive Observation

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

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

Initial risk score	Current risk score	Target risk score
C5 x L4 = 20	C5 x L4 = 20	C5 x L2 = 10

Progress since last report:
- E-Observation pilot continuing
- 78% wards scored above 90% in June Tendable Audits (7% below 90% and 15% did not complete audit)

Key Gaps:
- Some wards do not have Oxehealth for electronic recording
- Tendable audits not routinely reported on
- Culture piece needed
- Mitigating actions related to staff
- Agreed to work up an additional risk on leadership and separately on fundamentals of care

Executive Responsible Officer: Chief Operational Officer

Executive Committee: Executive Operational Committee
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
E-Observation Pilot, outcome to be reported to ET	Ongoing	Jan Leonard	Control
Undertake annual audit using data from Tendable Follow up clinical audit in Q2	December 22	Katy Stafford	Audit recommendations
Enhance with planned staffing improvements enabled by digital tools, engagement with AHPs and improved oversight through the Accountability Framework	Ongoing	Jan Leonard/ Katy Stafford	Assurance
Review on line training	September 22	Katy Stafford	Control
Collation of learning	Ongoing	Katy Stafford	Control
Development of KPIs	September 22	Richard James / Katy Stafford	Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Engagement and Observation Project	Project Group	Plan Complete and Group Closed	
Revised Observation and Engagement Policy		CG&QC Accountability Meetings	
Weekly ward huddles		Tendable Audits	
Electronic observation recording tool	In trial stage		
Comprehensive audits using Tendable	Audit Results via weekly huddles	June 2022 – 25 wards scored 100%	
Observation and Engagement E-Learning and Training Videos			

CRR11: Suicide Prevention

NHS
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NHS Foundation Trust

At a Glance:

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

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L3 = 12	C4 x L2 = 8 March 2023

Progress since last report:

- Working with Human Engine to further review strategy to bring in SMART principles.
- Review of Suicide Prevention Group underway.
- Have identified 4 key priorities which are being monitored.
- Self Harm pilot project underway at a number of wards with enhanced funding to support utilisation of sensory approaches and increased activity coordinators. Positive initial feedback
- Preparing comms for suicide prevention awareness day
- New draft strategy to address gaps around accountability and priorities to be highlighted

Key Gaps:

- Strategy requires refresh – in draft

Executive Responsible Officer: Executive Medical Director

Executive Committee:
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Implementation of revised strategy, work plan and dashboard	March 2023	Nuruz Zaman	Roadmap
Align with Safety First Safety Always Strategy	March 2023	Nuruz Zaman	Clear strategic direction
Focus groups with patients and families and Research into family involvement in suicide	March 2023	Matt Sisto	Control
Implement outcome measures	March 2023	Nuruz Zaman	Assurance
Review approach to Safer Wards and Ligature risk	March 2023	Angie Butcher	Control
Introduce self-harm reduction pilot project	March 2023	Diane Lucky	Control
Comms and Engagement over September / October to mark Suicide Awareness Day and MH Awareness Day	Sept / Oct 2022	Nuruz Zaman / Comms	Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Identified Medical Lead			
Support in place via Human Engine			
Suicide Prevention Strategy 2021-23	Suicide prevention group	Overseen by Mortality Sub-Committee	Feedback from ICS leads
Ongoing communication and engagement with staff	Breaking the Silence Safety Plans		
Local reflective sessions			
Oxehealth digital monitoring			
Suicide prevention training			
Suicide prevention outcome measures	Zero instances of preventable deaths 19.3% downward trend in instances of self-harm		

CRR34: Suicide Prevention - Training

NHS
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At a Glance:

If EPUT does not train and support staff effectively in suicide prevention; then staff may not have the necessary skills or confidence to support suicidal patients; resulting in self-harm or death and a failure to achieve our safety first, safety always strategy

Initial risk score	Current risk score	Target risk score
C3 x L3 = 9	C5 x L3 = 15	C3 x L2 = 6

Progress since last report:
- Trainers recruited
- Continuing comms to encourage staff to complete training
- Linking with Francis Stevens to develop training trajectory

Key Gaps:
- Training attendance
- Quality Improvement Project currently on hold due to staff changed in senior nursing team
- Communications regarding training licence cover – licences withdrawn from 10 trainers

Executive Responsible Officer: Executive Medical Director

Executive Committee:
Board Committee: .Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Refresher course required due to attrition	Ongoing	Nuruz Zaman	Control
Move to STORM training	Dec 22	Nuruz Zaman Annette Thomas-Gregory	Control
Explore training offers and frequency	Ongoing	AT-G	Control
Develop improvement trajectory and report on suicide prevention training	Ongoing	Nuruz Zaman AT-G	Assurance
Develop a quality improvement project to address the barriers on completing the suicide prevention training	Ongoing	Nuruz Zaman	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Trainers	Recruited		
Suicide prevention strategy	Sets out training requirements overseen by Suicide Prevention Group	Reporting to Mortality Sub-Group Annual Report	
Virtual training offer			

CRR45: Mandatory Training

Essex Partnership University NHS Foundation Trust

At a Glance:

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

Initial risk score	Current risk score	Target risk score
C4 x 3L = 12	C4 x L3 = 12	C4 x L2 = 8

Progress since last report:

- Attained a further 12 month's TASI accreditation from British Institute of Learning Difficulties (BILD), which EPUT is part of
- September 22 mandatory training 92.5% and 90.2% (above target)
- August saw 87 courses running with 1428 seats available and a 92% uptake. Overtime paid to people completing mandatory training.
- Approval to recruit 2 additional TASI trainers

Key Gaps:
IG Training Sep 22 92.9% against 95% target (improvement on August)
Face to face course attendance

Executive Responsible Officer: Director of People and Culture

Executive Committee: Executive Operational Team.
Board Committee: People and Culture Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Implement recovery plan	Ongoing	Training Team	Assurance
Review mandatory training policy	October 22	Annette Thomas-Gregory	Control
Work to give flexible workers equal priority on mandatory training	TBC	Training Team	Control
Increase TASI trainers			Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Training Team	Established		
Induction and Training Policy	Policy system		
Training Tracker	Managers check and provide oversight.	Reporting of training to PECC	
Training recovery plan		Sept training compliance above target	
Training days created for staff			
Monthly reporting to ET		Accountability. F&PC and PECC	

CRR77: Medical Devices

NHS
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At a Glance:

If EPUT does not track missing/ unregistered medical devices or address the clinical rationale/ pathway; then unsafe, non-serviced, non-calibrated and inappropriate devices may be in use; resulting in a failure to achieve our safety first, safety always strategy

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L4 = 16	C4 x L2 = 8 March 2023

Progress since last report:

- Concerns around resource available and seeking additional project team support.
- Medical device asset register currently being cleansed

Key Gaps:
Resource and capacity
No capital replacement programme in place

Executive Responsible Officer: Executive Chief Nursing Officer

Executive Committee:
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Complete actions from recommendations in internal audit report	March 2023	Nick Archer	Assurance
Options appraisal for Capital replacement programme and Medical device replacement strategy	March 2023	Nick Archer / TBC	Control (Resource)
Options appraisal EPUT management of Medical Devices inc resource needed	March 2023	Nick Archer / TBC	Control (Clear resource)
Review Althea contract reporting	March 2023	Nick Archer / TBC	Assurance
Trailing process of reminder email to services before Althea visits	March 2023	Nick Archer / TBC	Control (Innovation)
Review of Policy and Procedure to ensure clear process and monitoring set out	March 2023	Nick Archer / TBC	Control (Policy)
Medical Device Management training	March 2023	Nick Archer / TBC	Control (training)

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Corporate Nursing Team and Datix Team including Head of Deteriorating Patient and Clinical Governance	Established		
Medical Devices Group	Established and meets regularly	Overseen by Medical Devices Group	
Althea contract for device maintenance	Monthly KPI Report	Overseen by Medical Devices Group	
Procurement process in place Medical Devices Policy	Asset Register	Medical Devices Group oversee	Internal Audit Report Q4 2021/22 (Moderate / Limited Assurance)
Asset Register			
Incident Reporting			
BCPs in place			

CRR81: Ligature

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NHS Foundation Trust

At a Glance:

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

Initial risk score	Current risk score	Target risk score
C4 x L3 = 12	C5 x L3 = 15	C4 x L2 = 8

Progress since last report:

- LRRG Terms of reference – revitalised to improve clinical representation
- Integration of policy into approved one-page template
- Basildon awarded Best External Environment in Best Patient Safety Initiative
- September 22 ligature training on target at 90%
- Ligature rate audits (benchmark 42 per 10,000 beds) 45.5 (consistent trend in line with benchmark)
- ELFT independent review action plan – Sep 22 all actions bar 1 complete
- Discussions have taken place regarding a solution for the front-end electronic audit system
- Phase 4 CPPG agreed revenue funding and LRRG approved immediate completion of 52 high priority hinges
- Lakes user group established
- Business case drafted for review of Tidal training

Key Gaps:

- DTAs not in place in Brockfield House
- Ligature actions on 2 systems
- Ongoing issues with PFI provider
- Review of remaining 40 high priority hinges November 22

Executive Responsible Officer: Executive Chief Finance Officer / Executive Chief Operating Officer

Executive Committee: Executive Safety Oversight Group
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Completion of ELFT Independent review Action Plan	March 2023	Jane Cheeseman/ Comfort Sithole	Assurance
Identify right system for recording ligature actions (overseen by Project Group)	March 2023	Project Group	Control
Ensure EPUT environments meet environmental standards and Review environmental risk stratification document	Ongoing	Charles Hanford	Control
Review standards on outdoor garden furniture to avoid raised fittings ligature risk		Charles Hanford	Control
Further roll out of DTA to bedroom doors	March 23	Charles Hanford Anthony Flaherty	Control
Increase awareness and ownership of ligature reduction work	March 2023		Control
Review of Tidal training to see if this could be brought in-house	March 2023	Jane Cheeseman/ Comfort Sithole	Control
Develop robust and systemic processes for disseminating learning related to ligature reduction. Link to Culture of learning project	December 22	Jane Cheeseman/ Comfort Sithole	Assurance
Develop KPIs and dashboard to highlight progress on ligature reduction	September 22	Nicola Jones Richard James	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Ligature / Patient Safety Leads in Estates, H&S and Compliance Team	Established		
Ligature Project Group	Established		
Ligature Policy and Procedure	Ligature wallet audits	Overseen by LRRG ESOG and BSOG top priority	Internal Audit 2021 (all actions complete) ELFT Review (actions open)
Ligature Training	71 staff trained via TIDAL (as at July 2022)		
Trend analysis		Incident Rate below benchmark of 42 (39.42 for Aug 2022)	

CRR92: Addressing Inequalities

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

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

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C4 x L3 = 12	C3 x L2 = 6

Progress since last report:

- An EDI plan is currently being developed with four strategic pillars:
- This EDI plan is aligned with the Trust's strategic vision, values and objectives and about everyone taking an active role to reduce inequalities, respecting one another and building an open and equitable culture within our organisation that celebrates diversity
- WRES and WRDS action plans signed off by executives

Key Gaps:
EDI Team gap in resource

Executive Responsible Officer: Executive Director of People and Culture

Executive Committee: Equality and Inclusion Sub-Committee
Board Committee: People and Culture Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Establishment of EDI and Employee experience team	Dec 2022	Loraine Hammond	Control
Improve EDI learning offer for EPUT	June 2023	Lorraine Hammond	Control
Working on staff safety and closer alignment with LSMS	March 2023	Lorraine Hammond / Nicola Jones	Control
Develop culture which brings EDI into all Trust work streams	Ongoing	Lorraine Hammond	Control
Complete WDRES Action Plan	June 2023	Lorraine Hammond	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Employee Team including Director	Established		
Equality and Inclusion Policies	Policy System		
Range of equality networks and staff engagement methods	Established	Equality and Inclusion Sub-Committee	WRES and WDES (actions identified)
RISE Programme			Positive staff feedback
Champions Toolkit and monthly newsletter			
The Grill			

CRR93: Continuous Learning

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

If EPUT does not continuously learn and improve
then patient safety incidents will occur
resulting in failure to achieve our safety strategy ambitions
and maintain or improve CQC Good ratings

Initial risk score	Current risk score	Target risk score
C5 x L3 = 15	C5 x L3 = 15	C5 x L2 = 10

Progress since last report:

- 60% reduction in conduct cases for 2021/22
- Financial agreement to automate health roster data into safety dashboard submitted end October. Safety Dashboard integration with I Want Great Care now passed to the IWGC optimisation project team
- EPUT and MASS Cohort plc negotiating and seeking mutual agreement on the delivery of ELIMS.
- Streamlined decision monitoring tool has continued offline testing prior to being added onto the Datix incident form
- Framework for the lessons team to stand up the Safety Action Command Call (SACC) approved by ECOL
- Revised dif2 and local lessons log to promote recording and embedding of lessons identified through local investigation published on 7 November

Key Gaps:

- Embedding new processes
- Review of complaints

Executive Responsible Officer:
Executive Chief Nursing Officer

Executive Committee: Executive Safety Oversight Group.
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
Stakeholder communications plan and series of workshops scheduled and developing	Ongoing	Moriam Adekunle	Control
Review Human Engine process maps to incorporate into patient safety incident team standard operating procedure	Ongoing	Moriam Adekunle	Control
Review and explore learning from other organisations including non-NHS	March 23	Moriam Adekunle	Control
Develop new safety dashboard to go live status	Dec 2022	Moriam Adekunle	Control
Develop Lessons Identified Management System (ELIMS)	TBA	Moriam Adekunle	Control and Assurance
Review PSIRF process	March 23	Moriam Adekunle	Control
Establish Governance structure for Learning Lessons	March 23	Moriam Adekunle	Control
Develop and embed Quality and Safety Champions Network	Dec 2022	Moriam Adekunle	Assurance
Develop learning information sharing	TBA	Moriam Adekunle	Control
Link into UCL partnership who are implementing a range of collaboratives as part of MH Safety Programme	TBA	Moriam Adekunle	Control
Systems – monitoring of new L3 process within Datix, review early adoption and ensure any required improvements are documented and actioned	TBA	Moriam Adekunle	Control
Develop QI methodology	TBA	Moriam Adekunle	Control
Improve consistency of team meeting agendas across specialist services inpatient wards	Jan 23	Scott Huckle	Control
Develop and socialise staff behaviour framework	Oct 22	MA	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Patient Safety Team	Established		
Quality and Safety Champion Network			
Learning Collaborative partnership meeting and Learning Oversight Committee		Reporting to Quality Committee	
Adverse incident policy inc PSIRF SOP	Policy system		
Range of initiatives via culture of learning project			Internal audit completed – awaiting results
Tackling bullying and harassment in the NHS	Pilot launching Nov 22 and integrate into ways of working by March 23. Funding granted		

CRR95: Delivery of new vaccination programme

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NHS Foundation Trust

At a Glance:

If EPUT is uncertain of its role and available budget to deliver the autumn vaccination programme
then then there may be significant cost and workforce shortfalls resulting in a challenge to delivering future programmes and potential reputational damage

Initial risk score	Current risk score	Target risk score
C5 x L3 = 15	C5 x L3 = 15	C5 x L2 = 10

Progress since last report:

- Autumn programme underway
- All vaccination centre and other delivery models open
- Supporting care homes and the housebound
- Project team confident of achieving activity target for number of vaccines

Key Gaps:

Executive Responsible Officer:
Executive Director of Special Projects

Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

Action	By When	By Who	Gap: Control or Assurance
Work with each system to develop system plans and joint vaccination programme	September 2022	Nigel Leonard	Roadmap
Review delivery models and associated costs	September 2022	Nigel Leonard	Delivery model and costings

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Mass Vaccination Team		Project Board	
Internal plan to reduce direct and in-direct costs			
Block contract (with marginal rate tolerances) for activity between September and December 2022. Contract proposal £3m to perform 255,000 vaccinations			

CRR96: Loggists

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NHS Foundation Trust

At a Glance:

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

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L4 = 16	C4 x L1 = 4 March 23

Progress since last report:
All EPRR incidents logged to date, even if by untrained loggists

Key Gaps:
- Insufficient loggists to cover significant period and none available out of hours
- No training currently available from region
- Some logging has been undertaken by staff who are untrained

Executive Responsible Officer:
Executive Director of Major Projects

Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

Action	By When	By Who	Gap: Control or Assurance
Train more loggists	Once training available from region	Nicola Jones	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Pool of trained loggists including EPRR team and Executive Director PA's	All EPRR incidents have been logged to date	Command structure	

CRR99: Safeguarding Referrals

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

If North East Care Unit is unable to manage the increase in safeguarding referrals then it may not adequately assess patients' needs resulting in compromised patient safety, wellbeing and compliance with safeguarding best practice and regulation

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L4 = 16	C4 x L1 = 4 March 23

Risk score is high based on only just being managed at present but is not sustainable. Safeguarding discussing with operational senior managers how to address the risk and resources to mitigate it.

Progress since last report:

Key Gaps:

- Challenge to meet timeframe and compliance with safeguarding policy
- Safeguarding forms do not populate within system. Double recording
- Datix do not close after completion and populate across systems
- Increase in safeguarding Datix (July 22)
- Increase in referrals, reliance on duty team results in less availability for other demands, increased demand results in less time for other clinical work

Executive Responsible Officer:
Executive Director of Major Projects

Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

Action	By When	By Who	Gap: Control or Assurance
Continue additional hours	Ongoing	Team	Control
Review issue related to Datix sign-off risk		Datix Team	Control
Build supervision structure into new Perinatal Social Worker roles		Caroline Bogle	Control
Develop stepped model of safeguarding involvement		Tendayi Musundire	Control
Perinatal Social Workers to support development of role		Lynn Prendergast	Control
Undertake internal consultation on complex cases		Caroline Bogle	Control
Develop local system to monitor child safeguarding case involvement		Tendayi Musundire	Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Team establishment			
Trust safeguarding team			
Safeguarding policies and procedures			
Prioritisation for oversight of S17, S47 and MARAC requests in place for perinatal social work team – attendance at appointments and involvement in reports as well as attendance at statutory meetings on behalf of doctors	In place		
Safeguarding training			
Robust caseload management	Team managers monitor safeguarding caseloads		
Monthly safeguarding reports	Reporting in place		
Datix reporting	Datix investigation		
Monitoring – safeguarding supervision improved. Duty team picking up overflow of demand to respond to S17 and S47 requests (perinatal)			

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07 – Risk Movement November 2022

EPUT

Risk Movement and Milestones

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NHS Foundation Trust

Strategic Risk Movement – two year period (December 20 – November 22)

Risk ID	Initial Score	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Risk ID
SR1 Safety	20											New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR1
SR2 People	20											New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR2
SR3 Infrastructure	15											New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR3
SR4 Demand	20											New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR4
SR5 Inquiry	20	20	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR5
SR6 Cyber	12	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	15↑	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	12↓	SR6
SR7 Capital	20																				New	20↔	20↔	20↔	20↔	SR7
SR8 Resources	15																				New	15↔	15↔	15↔	15↔	SR8

Strategic Risk Milestones – two year period (December 20 – November 22)

Risk ID	Initial Score	Time on SR/ old BAF	Dec 20	Jan 21	Feb 21	Mar 21	Apr 22	May 21	Jun 21	Jul 21	Aug2 1	Sep2 1	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Risk ID
SR1 Safety	20	>6 months											New	20													SR1
SR2 People	20	>6 months											New	20													SR2
SR3 Infrastructure	15	>6 months											New	15													SR3
SR4 Demand	20	>6 months											New	20													SR4
SR5 Inquiry	20	>1 year	20					15↓						SR													SR5 (BAF54)
SR6 Cyber	12	>2 years													CRR	15										12	SR6 (CRR40)
SR7 Capital	20	<6 months																				New					SR7
SR8 Resources	15	<6 months																				New					SR8

Risk Movement and Milestones

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Corporate Risk Movement and Milestones – two year period (December 2020 – November 22)

Risk ID	Initial Score	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May22	Jun 22	Jul 22	Aug 22	Sep22	Oct 22	Nov22	Risk ID
CRR11	16	12↔	12↔	12↔	12↔	12↔	12↔	12↔	8↓	12↑	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	CRR11
CRR34	9	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	15↑	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR34
CRR45	12	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR45
CRR77	16				New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR77
CRR81	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR81
CRR92	20			New	20	20↔	16↓	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	CRR92
CRR93	15				New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR93
CRR94	16								New	16	16↔	16↔	16↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	15↓	CRR94
CRR95	20																				15	15↔	15↔	15↔	15↔	CRR95
CRR96	16																								16	CRR96
CRR99	16																								16	CRR99
Risk ID	Initial Score	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May22	Jun22	Jul 22	Aug 22	Sep 22	Oct22	Nov 22	Risk ID

Risk ID	Initial Score	Time on CRR or old BAF	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug21	Sep21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Risk ID
CRR11	16	> 2 years								8	12																CRR11
CRR34	9	> 2 years									15																CRR34
CRR45	12	> 2 years																									CRR45
CRR77	16	>1 year						16																			CRR77
CRR81	12	> 2 years																									CRR81
CRR92	20	>1 year			New	20		16								12											CRR92
CRR93	15	>1 year				New	15																				CRR93
CRR94	16	>6 months								New	16				20											15	CRR94
CRR95	20	<6 months																				15					CRR95
CRR96	16	New																								16	CRR96
CRR99	16	New																								16	CRR99
Risk ID	Initial Score	Time on CRR or old BAF	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug21	Sep21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep22	Oct 22	Nov 22	Risk ID

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08 – Useful Information

November 2022

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Executive Lead Dashboard

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Director of Governance and Corporate Affairs	Executive Director of People and Culture	Executive Medical Director	Executive Director of Major Projects and Programmes
Nil	1 Strategic Risk 2 Corporate Risks • SR2 People (Risk Score 20 no change) ↔ • CRR45 Mandatory training (Risk Score 16) ↔ • CRR92 Addressing inequalities (Risk Score 12) ↔	0 Strategic Risks 2 Corporate Risks • CRR11 Suicide Prevention (Risk Score 12) ↔ • CRR34 Suicide Prevention – training (Risk Score 15) ↔	1 Strategic Risk 2 Corporate Risk (1 x New) • SR5 Independent Inquiry (Risk Score 15) ↔ • CRR95 Delivery of new vaccination programme (Risk Score 15) • CRR96 Loggists (Risk Score 16) NEW

Executive Director of Nursing	Executive Chief Finance Officer	Executive Director of Strategy and Transformation	Executive Chief Operating Officer
1 Strategic Risk 2 Corporate Risk • SR1 Safety (Risk Score 20) ↔ • CRR93 Continuous Learning (Risk Score 15) ↔ • CRR77 Medical Devices (Risk Score 16) ↔	3 Strategic Risks 1 Corporate Risk • SR3 Systems & Processes/ Infrastructure (Risk Score 15) ↔ • CRR81 Ligature (Risk Score 15) ↔ • SR7 Capital (Risk Score 20) ↔ • SR8 Revenue (Risk Score 15)	1 Strategic Objective SR6 Cyber Attack (Risk Score 15) ↔ SR3 Systems & Processes/ Infrastructure (Risk Score 15) ↔	1 Strategic Risk 1 Corporate Risk • SR4 Demand and Capacity (Risk Score 20) ↔ • CRR94 Engagement and supportive Observation (Risk Score 20) ↔ • CRR81 Ligature (Risk Score 15) ↔ • CRR99 Safeguarding referrals (Risk Score 16) NEW

Acronyms

Essex Partnership University NHS Foundation Trust

BAF	**Board Assurance Framework**	**SR**	**Strategic Risk**
SO	Strategic Objective	**CRR**	Corporate Risk Register
RR	Risk Register	**DRR**	Directorate Risk Register
ICS	Integrated Care System	**F&PC**	Finance & Performance Committee
QC	Quality Committee	**PECC**	People & Culture Committee
IGDSPT	Information Governance Data Security & Protection Toolkit	**EOSC**	Executive Operational Sub Committee
BOD	Board of Directors	**ESOG**	Executive Safety Oversight Group
EERG	Estates Expert Reference Group	**LRRG**	Ligature Reduction Group
MHA	Mental Health Act	**HSSC**	Health Safety Security Committee
ECC	Essex County Council	**CQC**	Care Quality Commission
CxL	Consequence x Likelihood	**CRS**	Current Risk Score
SMT	Senior Management Team	**HSE**	Health & Safety Executive
CAS	Central Alert System	**NHSE/I**	NHS England/ Improvement
PMO	Project Management Office	**ESR**	Electronic Staff Record
EFIN	Electronic Finance Record	**TBA**	To be advised or agreed
PFI	Private Finance Initiative	**NHSPS**	NHS property services
CMO	Chief Medical Officer	**EDS**	Equality and Diversity Standards
BAU	Business as Usual		

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THANK YOU

EPUT

Agenda Item No: 8bi

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	30 November 2022

Report Title:	**Audit Committee Assurance Report**					
Executive/ Non-Executive Lead:	Janet Wood, Chair of the Audit Committee					
Report Author(s):	Carol Riley, Audit Committee Secretary					
Report discussed previously at:	Assurance Reports provided to the Board following Audit Committee Meetings.					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

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

Purpose of the Report		
This report is provided by the Chair of the Audit Committee, a sub-committee of the Board of Directors to provide assurance to Board members that the duties of the Audit Committee which include Governance, Risk Management and Internal Control have been appropriately complied with.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 To confirm acceptance of assurance given in respect of risks and actions identified
3 To Request any further information or action.

Summary of Key Issues

The following provides a list of items discussed at two meetings held since the last report, with further details provided in the main report:

Meeting held on the 23 September 2022

- Internal Audit (including LCFS)
- External Audit
- Clinical Audit Assurance on Process and Delivery
- Cyber Security – Alert Monitoring and Assurance
- Governance Update
- National Cost Collection
- Annual Review of Standing Orders
- Annual Review of Scheme of Reservation and Delegation
- Internal Review of HMFA Checklist
- Draft Charity Accounts 2021/22
- Losses and Special Payments
- Waiver of Standing Orders
- Statement of Financial Position Write Offs/Write Backs/impaired Debts Write Offs
- Audit Committee Chair's Annual Report – April 2021 to March 2022

Meeting held on the 17 November 2022

- Internal Audit (including LCFS)
- External Audit
- Cyber Security
- Governance Update
- Directors Expenses
- Annual Review of Governance Arrangements re System Working
- Losses and Special Payments
- Waiver of Standing Orders
- Write Offs
- Protocol for Changes to in year Revenue Financial Forecast

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 Documents and/or Further Reading

Main Report
Appendix 1 – Audit Committee Chair's Annual Report

Lead

Janet Wood
Non-Executive Director
Chair of Audit Committee

Agenda Item: 8bi
Board of Directors Part 1
30 November 2022

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

AUDIT COMMITTEE ASSURANCE REPORT

1.0 PURPOSE OF REPORT

This report is provided by the Chair of the Audit Committee, a sub-committee of the Board of Directors to provide assurance to Board members that the duties of the Audit Committee which include Governance, Risk Management and Internal Control have been appropriately complied with.

2.0 EXECUTIVE SUMMARY

Audit Committee Meeting 23 September 2022 & 17 November 2022

The Audit Committee met on the 23 September 2022 and the 17 November 2022. At the meeting held on the 23 September 2022 the minutes were approved of the 7 July 2022. At the meeting held on the 17 November 2022 the minutes were approved of the 23 September 2022. These minutes are available to Board members on request.

At the meeting held on 23 September 2022 the following matters were discussed:

1. **Internal Audit**

Internal Audit Progress Report
The following reports have been finalised:

- 2021/22 SFIs and Waivers – Moderate assurance issued.
- 2022/23 KFS Budget Management – Substantial assurance issued.

Local Counter Fraud Service Progress Report

Referrals
The Committee received an update on the current investigations/referrals.

NHSCFA Exercise
The NHSCFA are due to publish its findings from two national proactive exercises which relate to Covid19 and the purchase order v non purchase order expenditure. Once published we will be able to see how the Trust compares with other organisations.

2. **External Audit**

Trust's Charitable Fund Accounts 2021/22
The above accounts are in the process of being reviewed.

External Annual Audit Report
The above report is due to be presented to a forthcoming Council of Governors meeting.

3. **Clinical Audit Assurance on Process and Delivery**
Following the above audit CAD have developed an action plan which has resulted in all actions being closed.

4. **Cyber Security – Alert Monitoring and Assurance**

An update was provided with regards to the existing and new cyber risks. It was noted that the Board Assurance Framework (BAF) cyber security risk rating has been reduced from 15 to 12.

Members were informed of a recent cyber incident on the 4 August 2022 with regards to Advanced eFinancials which affected the Trust's finance and procurement systems. The Trust's contingency plans were put into place. Following a reassessment of the cyber risk and successful testing connectivity to Advanced eFinancials was re-established.

5. **Governance Update**
Phase 1 of the Committee review is on target and is due to go 'live' in October 2022. It was noted that the document is to be signed off and presented to the Board of Directors in November 2022 for ratification.

6. **National Cost Collection**
National Cost Collection was submitted on the 10 August 2022. NHS England have confirmed that there are no issues identified and no further submission is required.

7. **Annual Review of Standing Orders**
The Committee approved the minor changes to the above and agreed to recommend the Standing Orders to the Board for approval. It was noted that the Standing Orders may be subject to further review following the publication of the Code of Governance.

8. **Annual Review of Scheme of Reservation and Delegation (SORD)**
No changes were made to the above. However, it was noted that following publication of the Code of Governance, once published, this may impact on the SORD which may require changes.

The Committee approved the revised SORD to be presented to the Board of Directors for approval.

9. **Annual Review of Standing Financial Instructions (SFIs) and Detailed Scheme of Delegation (DSoD)**
The Committee approved the changes to the above and agreed to recommend the SFIs and DSoD to the Board for approval.

10. **Internal Review of HFMA Checklist**
The Committee approved the terms of reference for the above. It was noted that the self-assessment was approved by the Executive Operational Committee on the 16 August 2022. Internal Audit review is to take place by the 30 November 2022. Completion of any improvement plans by the 31 January 2023. A report is due to be presented to the Audit Committee in January 2023.

11. **Draft Charity Accounts 2021/22**
The Committee approved the above.

12. **Losses and Special Payments**
The Committee noted losses and special payments of £35,814.

13. **Waiver of Standing Orders**
During the period 1 June 2022 to 31 August 2022 competitive quotations were waived on 23 occasions totalling £825k (including VAT).

14. **Statement of Financial Position Write Offs/Write Backs/Impaired Debts Write Offs**
The Finance Department has completed a review of the debts and ledger balances at the end of Month 5. The total amount to be written off is £1,284.23. It was noted that these had not been provided for previously and that there would be a charge in 2022/23.

The write offs mainly relate to low value salary overpayments. It was noted that HR is escalating this issues through the Accountability Framework meetings going forward.

15. **Audit Committee Chair's Annual Report – April 2021 to March 2022**

The above report was discussed and noted. The report is attached at appendix 1.

At the meeting held on 17 November 2022 the following matters were discussed

1. **Internal Audit**

Internal Audit Progress Report

The following reports have been finalised:

- Site Visits – moderate/limited
- Patient Safety – substantial/moderate
- HFMA Financial Sustainability

Internal Audit Progress Report 2021/22
The following report has been issued in draft:

- Business Continuity Planning

Local Counter Fraud Service Progress Report

Referrals
The Committee received an update on the current investigations/referrals.

Fraud Awareness Week
LCFS will be hosting three online 'drop in' fraud awareness sessions. This would be promoted via Communications.

It was noted that Mandate fraud is increasing within the NHS. A training session is in the process of being arranged for finance staff.

NHSCFA Exercise Findings – NHS Procurement and Covid 19
The Trust showed a higher than average percentage of non Purchase Orders compared to Acute Trusts. However, the Trust compared average for Mental Health organisations. The Committee were assured that there was a robust control system for these orders.

There were no specific issues or recommendations for the Trust with regards to Covid 19 contracting.

2. **External Audit**

Charitable Fund Accounts 2021/22
The above accounts are in the process of being reviewed.

3. **Cyber Security**
An update was provided with regards to existing and new cyber risks. There are currently no critical penetration issues to report.

4. **Governance Update**
The Committee received a comprehensive update on governance arrangements. A review of the Trust's leadership and governance is due to take place in 2023 which will be undertaken by an external facilitator.

5. **Directors Expenses**
Directors expenses for the first half of the 2022/23 financial year total £2,264 were noted.

6. **Annual Review of Governance Arrangements re System Working**
The Audit Chair has engaged with the Audit Chair of the MSE.

7. **Final Charity Accounts 2021/22**
The Committee approved the above accounts and recommended to the Board for formal approval.

8. **Losses and Special Payments**
As at the end of Month 7, the Trust is reporting losses and special payments of £35,991.

9. **Waiver of Standing Orders**
During the period from 1 September 2022 to 31 October 2022 competitive quotations were waived on twenty occasions totalling £762k (including VAT).

10. **Write Offs**
As at the end of Month 7 the total write offs were £12,728.32. Of this £10,061.27 has already been provided for as part of last financial year, with the balance of £2,667.05 to be charged into 2022/23.

The report was discussed and noted.

11. **Protocol for changes to in year Revenue Financial Forecast**
The Committee were informed of the changes to in-year revenue financial forecast' protocol which was introduced nationally in early November 2022

3.0 MANAGEMENT OF RISK

The Audit Committee is not responsible for managing any of the Trust's significant risks (as identified in the Board Assurance Framework).

4.0 NEW RISKS

There are no new risks that the Audit Committee has identified that require adding to the Trusts' Assurance Framework, nor bringing to the attention of the Board of Directors.

5.0 ACTION REQUIRED

The Board of Directors is asked to:

1 Note the contents of the report
2 To confirm acceptance of assurance given in respect of risks and actions identified
3 To Request any further information or action.

Janet Wood
Non-Executive Director
Chair of Audit Committee

Appendix 1

		Agenda Item No: 20
SUMMARY REPORT	**AUDIT COMMITTEE PART 1**	**Meeting: 23.09.22**

Report Title:	**Audit Committee Chair's Annual Report for the Accounting Period April 2021 to March 2022**					
Executive/Non-Executive Lead:	Janet Wood					
Report Author(s):	Janet Wood					
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	x
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	x
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	x
	SR6 Cyber Attack	x
	SR7 Capital	
	SR8 Use of Resources	x
Does this report mitigate the Strategic risk(s)?	Yes/ **No**	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	Yes/ **No**	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
To provide an annual review of the work of the Audit Committee	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Audit Committee is asked to:

1. Approve the contents of this report.

Summary of Key Issues

This report provides the Board of Directors with a review of the progress undertaken in dealing with Audit Committee matters covering the 2021/22 financial year.

The Audit Committee is comprised of four Non-Executive Directors, with myself as Chair.

Apart from the Committee's regular work which is identified in a later section, there were five areas which required additional input from the Committee.

Governance arrangements
In line with best practice the Trust has been reviewing governance arrangements. The Audit Committee has received regular updates on progress and been able to participate in the review. Areas covered include, the Risk and Assurance Management Framework (including risk appetite), Standing Committee review and the Accountability Framework. Once any new arrangements are in place they are reviewed for effectiveness.

Adapted Financial Regime
The Audit Committee has received assurance updates on the governance arrangements for funding and reporting under this regime. We have also been assured on arrangements for working with system partners on the funding arrangements.

Continuous Learning
The Audit Committee reviewed the Director of Safety plans to ensure safety issues that require embedding of learning are being taken forward in a systemic and sustainable way.
Progress against these plans is monitored by the Board Safety Oversight Group (Audit Chair in attendance). A reviews of arrangements is included in 2022/23 Internal Audit Programme.

Independent inquiry
The Audit Committee has taken on a governance oversight role in relation to the Essex Mental Health Independent Inquiry. Members are regularly updated on progress by both the Project Director and Independent Director, covering information requests, project plan, risks, learning and costs.

External Audit Tender
A market testing process for external audit services took place in March 2022, with EY being appointed following an evaluation panel consisting of Audit Committee members, governors and officers of the Trust.

Regular Work and Other Issues
During the year some new areas of regular reporting have been added to the workplan of the Audit Committee in line with suggested best practice:

- Sustainability assurance and compliance (ISO 1400!)
- Clinical negligence (NHS resolution scorecard)
- Conflicts of interest
- Cyber security – alert monitoring and assurance

The remaining work of the Audit Committee can be summarised as follows:

- consideration and agreement of the Trust's external and internal audit plans
- reviews of internal and external audit reports
- consideration of the Trust's financial accounts before presentation to the Trust Board
- receiving the Annual Governance statement from the Chief Executive
- twice yearly review of risk management and assurance arrangements
- consideration of the Trust's charitable fund accounts for presentation to the Board
- consideration of the annual audit results report issued by the Trust's external auditors
- monitoring of recommendations from both internal audit and external audit reports
- review of the Standing Financial Instructions and related documents
- reviewing bad debt write offs and waivers to standing orders and standing financial instructions
- the receipt and debate of regular assurance reports
- receipt and debate of counter fraud reports from the counter fraud specialist
- receipt and debate of local security management services reports
- Clinical Governance, Clinical Audit, whistleblowing and Freedom to Speak Up reports presented to the Committee as appropriate
- Approval of financial policies and procedures
- regular review of the Audit Committee's terms of reference
- regular update on the Audit Committee Chair's activities

- Review the use of management consultants, legal advisors, losses and compensations and Directors expenses

The Audit Committee Chair continues to meet with the Trust's Accountable Officer regularly to discuss any issues arising from Audit Committee meetings. The Audit Committee Chair also meets with the appropriate Directors to review matters associated with assurance in relation to patient safety, quality, risk and assurance and governance. The Audit Committee Chair also meets regularly with both sets of Auditors for private discussions.

Relationship to Trust Strategic Priorities	
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	✓

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			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 Documents and/or Further Reading
None

Lead
 Janet Wood **Chair of the Audit Committee**

		Agenda Item No: 8bii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

Report Title:	**Finance & Performance Committee Assurance Report**					
Executive/ Non-Executive Lead:	Loy Lobo Chair of the Finance & Performance Committee					
Report Author(s):	Amy Tucker Senior Performance Manager					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	Listed in BAF report	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
Does this report mitigate the Strategic risk(s)?	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		

Purpose of the Report		
This report provides the Board of Directors that the Finance & Performance Committee (FPC) is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objective and impact on quality are being managed effectively.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance provided
3 Request any further information or action

Summary of Key Issues

Quality & Performance

During the October meeting the Executive Chief Operations Officer advised performance had been stable in September however the number of inadequate measures rose from 5 to 6, with the addition of temporary staffing. The Associate Director of Flow and Operational Transformation also attended the meeting and gave a presentation on current inpatient flow and capacity challenges along with what mitigations are in place.

In the November committee meeting the Executive Chief Operations Officer reported a very challenged position for October regarding inpatient capacity. Assurance was provided that there are multiple work streams underway in November which will be fed back in the next committee meeting in January.

Contracting

For the September contracting update the paper was agreed as read and questions were answered by the Director of Contracting on the subject of the service model for Survivors of Sexual Assault. An action was agreed to be taken away by the Director of Contracting and the Chair, to explore what digital solutions could be used within the model.

The October contracting update was again provided by the Director of Contracting and summarised that there have been three awards of contracts.

Finance M7

Within this update the Director of Finance reported year to date there is a deficit of £2.1m, which is £0.2m behind plan. The year-end revenue forecast remains to deliver a breakeven position consistent with plan.

Year to date the Capital spend is £4.3m, this is £4.9m behind plan.

Tenders for key schemes are now approved and will enable acceleration of expenditure in future months. Capital leads continue to forecast that the capital plan will be delivered in full and the Trust continues to participate and support the ICS Financial Recovery Programme. The Trust and ICS has begun their 23/24 planning process.

Thurrock Community Diagnostic Centre

In October the Director of Commercial Finance advised this business case has involved a long engagement with the system and now has a development proposal for the Thurrock Community Hospital site. Work on this site redevelopment is in the pipeline to begin in March 2023.

An action was agreed for the Chief Finance Officer to contact system colleagues for their attendance at a future meeting to update the committee on this development.

Capital Group (CPPG)

The Director of Finance informed members in October that a bid for the revenue consequences of capital investments had been submitted to the Regional office. In addition, the Trust is working on a carbon reduction application (SALIX bid) relating to the Thurrock site and elimination of gas to heat pump solutions.

Any Risks or Issues

There were no risks identified as requiring addition to the risk register in either the October or the November meetings.

Any Other Business

There was no other business.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Loy Lobo **Non-Executive Director** **Chair of the Finance and Performance Committee**

FINANCE AND PERFORMANCE COMMITTEE ASSURANCE REPORT

1.0 PURPOSE OF REPORT

This report is provided by the Chair of the Finance and Performance Committee, Loy Lobo to provide assurance to Board members that the performance operational, financial and governance as at month 6 September 2022 and month 7 October 2022 were subject to appropriate and robust scrutiny.

The Finance and Performance Committee (FPC) is constituted as a standing committee of the Board of Directors. The Board of Directors has delegated responsibility to this committee for the oversight and monitoring of the Trust's financial, operational and organisational performance in accordance with the relevant legislation, national guidance, the Code of Governance and current best practice from 1 April 2017.

The Committee is required to ensure that risks associated with the performance and governance arrangements of the Trust are brought to the attention of the Board of Directors and/or to provide assurance that these are being managed appropriately by the Executive Directors.

2.0 QUALITY AND PERFORMANCE REPORT

This report covers the position for month 6 (September -22) and month 7 (October-22).

In October 2022 there were 6 areas of inadequate performance (6 in September):

- Safer Staffing
- CPA Reviews
- Inpatient MH Capacity (Adults)
- Out of Area Placements
- Psychology
- Temporary Staffing

During the October meeting the Executive Chief Operations Officer advised performance had been stable however the number of inadequate measures rose from 5 to 6, with the addition of temporary staffing. Assurance was provided that HR Business Partners were working with leadership teams to reduce their agency cap and framework breaches. The Associate Director of Flow and Operational Transformation also attended the meeting and gave a presentation on current inpatient flow and capacity challenges along with what mitigations are in place.

In the November committee meeting the Executive Chief Operations Officer reported a very challenged position regarding inpatient capacity, particularly for out of area placements and average length of stay. Assurance was provided that there are multiple work streams underway in November which will be fed back in the next committee meeting.

Discussions within this update covered topics of workforce, the setting of new KPI's from ICB's, continued high demand for inpatient beds, and initiatives such as Time to Care and Getting it Right First Time (GIRFT).

The Chair of the Committee thanked the Executive Chief Operations Officer for an in depth conversation on performance and acknowledged the Trust will likely be operating at peak pressure for a while to come.

3.0 CONTRACTING

For the September contracting update the paper was agreed as read and questions were answered by the Director of Contracting on the subject of the service model for Survivors of Sexual Assault. An action was agreed to be taken away by the Director of Contracting and the Chair, to explore what digital solutions could be used within the model.

The October contracting update was again provided by the Director of Contracting and summarised that there have been three awards of contracts. These were the Op Courage Integrated Veterans Mental Health Service, Essex Sexual Health Service, and the provision of psychiatry at HMP Bedford and Yarl's Wood Immigration Removal Centre.

The Chair of the committee thanked the Director of Contracting for their update on these successful bids.

4.0 FINANCIAL UPDATE M7

The Director of Finance gave an update as to the month 7 (October 22) financial position for the Trust.

This update reported year to date there is a deficit of £2.1m, which is £0.2m behind plan. The year-end revenue forecast remains to deliver a breakeven position consistent with plan.

The Trust's payment performance was impacted by a Cyber incident however 'in month' performance will continue to be the focus.

Year to date the Capital spend is £4.3m, this is £4.9m behind plan.

Tenders for key schemes are now approved and will enable acceleration of expenditure in future months. Capital leads continue to forecast that the capital plan will be delivered in full and the Trust continues to participate and support the ICS Financial Recovery Programme. The Trust and ICS has begun their 23/24 planning process.

Committee members acknowledged this current position and thanked the Director of Finance for their update.

5.0 THURROCK COMMUNITY DIAGNOSTIC CENTRE

In October the Director of Commercial Finance advised this business case has involved a long engagement with the system and now has a development proposal for the Thurrock Community Hospital site.

This proposal outlines the partial redevelopment of the site and would bring an enhancement to staff currently working there as well as those who will work within the new centre. Work on this is in the pipeline to begin in March 2023.

The Chair of the committee thanked the Director of Commercial Finance for the proposal and praised the good work done to get the case this far.
An action was agreed for the Chief Finance Officer to contact system colleagues for their attendance at a future meeting to update the committee on this development.

6.0 CAPITAL GROUP (CPPG)

The Director of Finance informed members in October that a bid for the revenue consequences of capital investments had been submitted to the Regional office. In addition, the Trust is working on a carbon reduction application (SALIX bid) relating to the Thurrock site and elimination of gas to heat pump solutions.
This is currently in the application stage and a further update will be advised once this progresses.
Members advised it was good to see plans for a move to green energy and the Chair thanked the Director of Finance for their report.

7.0 ANY RISKS OR ISSUES

There were no risks identified as requiring addition to the risk register in either the October or the November meetings.

8.0 Any Other Business

There was no other business.

Report prepared by:

Amy Tucker
Senior Performance Manager
On behalf of:

Loy Lobo
Non-Executive Director
Chair of the Finance and Performance Committee

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 8biii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

Report Title:	**Quality Committee Report**					
Executive/ Non-Executive Lead:	Rufus Helm, Committee Chair & Non-Executive Director					
Report Author(s):	Matt Rangué, Quality Project Lead					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

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

Purpose of the Report		
This report provides the Board of Directors with assurance on actions being taken by sub-committees to progress key aspects of the quality agenda and identify any risks associated with the current pressures on services.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3 Request any further information or action

Summary of Key Issues
The Quality Committee has reviewed the work of the sub-committees and all performance and quality dashboards accountable to the Committee. This report is presented to the Board of Directors as assurance of the review and challenge initiated. This report confirms that the Quality Committee has received assurance that all work streams are in place and actions are being taken to mitigate risks.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report

Lead
Rufus Helm Non-Executive Director Chair of the Quality Committee

Agenda Item: 8biii
Board of Directors Meeting Part 1
30 November 2022

QUALITY COMMITTEE REPORT

1.0 PURPOSE OF REPORT

This report provides the Board of Directors with assurance on actions taken by the Quality Committee, to progress key aspects of the quality agenda.

2.0 EXECUTIVE SUMMARY

This report provides a summary of discussions and issues identified as well as assurances provided at the November meeting. Please note that there was no meeting held in October due to system pressures.

2.1 COMMITTEE MEETING HELD ON 10 November 2022

2.1.1 Sub-Committee Combined Assurance Report

The Quality Committee received the new assurance report format, which was well received, enabling more succinct focus on the key themes affecting quality and safety across the Trust. Members noted that the report will develop further as risks and quality priorities change, however recommended additional scrutiny, including improved narrative for reporting overdue actions to clarify whether an overdue action poses any risk. Links will also be made to the safety dashboard and patient experience measures to ensure continuity of information available to the Committee for scrutiny.

Assurance reporting was received from 12 of the 13 sub-committees. No assurance report was available from the Multi-Professional Education Sub-Committee as meetings had been suspended following Covid-19 pandemic prioritisation, however the Committee was assured that this Sub-Committee has reformed and will be holding its next meeting in December.

The Committee also noted that there will be further streamlining of reports received now that the Suicide Prevention Group and the Learning from Deaths Oversight Group will report directly into the Learning Oversight Sub-Committee. This offers the additional assurance that the organisation scrutinises and learns from all deaths associated with the organisation.

2.1.2 End of Life Annual Report

The End of Life Annual Report was presented to the Committee and it was noted that the CQC had rated this service as ‘outstanding’ overall in the caring and responsive domains.

It was also noted that the End of Life Team continues to provide an excellent and innovative service despite the significant challenges they have faced throughout the pandemic, and also recognised the service as one of the Trust's key successes and the support necessary to maintain high standards of care in a challenging and changing health system.

2.1.3 Care Quality Commission (CQC) Compliance Report

The CQC Compliance Report was presented and approval was sought for an extension, until December 2022, for two CAMHS actions M2 and M5. Committee members expressed their disappointment at the delay in delivery of these actions, but following assurance of no impact to the Trust, the extension was agreed on the understanding that they will be completed by December 2022.

The Committee challenged how the Compliance Team will ensure that the use of the CQC Quality Standards are embedded into reporting and learning from incidents, and were informed that a Communication Plan on CQC regulatory changes is currently being put into place.

The Committee noted and supported the role of the newly appointed Deputy Directors of Quality and Safety which will ensure good quality governance arrangements are maintained operationally, especially important in ensuring that the story of quality, safety and patient experience is consistent from Ward to Board.

The Committee noted the areas for improvement from CQC and were assured by the immediate actions undertaken in response. Clarification was sought in regard to the Trust's position on Oxevision and consent. It was noted that the Trust's Standing Operational Procedure (SOP) was reviewed following the recent release of the national policy and in response to challenge from a small number of patients. The SOP was in line with national guidance and revision strengthened the emphasis on the importance of Oxevision as a safety measure and tool. Committee members were assured that the Trust is maintaining its position, as an organisation, on the approach with implicit consent and that areas within the SOP have been strengthened. The SOP will be presented to the Committee next month following final sign off.

2.1.4 Mortality Data and Learning Quarterly Report

The report presented to the Committee detailed changes within the Learning from Deaths Policy and Procedural Guideline, and it was noted that the process is creating an aggregated repository of information of organisational learning, and that as this learning is presented at local care units, there is greater opportunity for ownership and embedding of learning outcomes.

It was also noted that the higher proportion of deaths being investigated at stage 2, clinical note review, assures the Committee the process enables greater scrutiny of care. Additionally, the Committee supported the learning outcome element of reviews being brought to the forefront.

The Committee confirmed that deaths are still required to be reported publically, however this is in a simplified form that will require careful explanation of data to avoid misunderstanding and confusion.

2.1.5 System Partnership and Engagement Project

The Committee received and discussed an update on the implementation of the System Partnership and Engagement Project. The update included progress in achieving project objectives to improve the experience and care of people living with a mental illness when using the physical health services and their physical health when using mental health services.

The Committee noted the project report, its relevance in the context of increasing number of people living with a mental illness, and requested additional outcome measures for monitoring success.

2.1.6 Ligature Risk Update

The Committee received assurance from the Ligature Risk Update Report. There continues to be a strong focus on mitigating ligature risk and a reduction in the number of ligature incidents in the second quarter which offers additional assurance of the effectiveness of actions being taken to reduce risk.

2.1.7 Emergency Planning Preparedness and Resilience Report (EPPR)

The Committee received the report noting the substantial assurance for incident management.

2.1.8 Infection Prevention and Control (IPC) Board Assurance Framework

The IPC Board Assurance Report was received and noted. The Committee challenged the decision to reinstate mask wearing across the Trust, as this appears to be out of step with other organisations. Assurance was given that on risk assessment the increased number of Covid-19 cases justified the action to protect the service and workforce capacity from outbreaks in clinical areas.

2.1.9 Patient and Carer Experience Annual Report

The Patient and Carer Experience Annual Report was presented and Committee members acknowledged the success in implementing the 'Working with People and Communities Framework', and the position the Trust has as system leader within the MSE ICB, and commended the approach of building relations with service users based on trust, the development of networks for the Lighthouse Service, the network for carers, and the practical approach being taken to user engagement at the Linden Centre.

The Committee requested additional assurance that a strategic approach is being taken to the development of patient and carer experience, and assurance was received

that whilst the existing aspirations of the 'Working with People and Communities Framework' have been met, further development can now be achieved through the new Deputy Director of Quality and Safety roles, which will also enable a touch point for user experience across all services.

3.0 RISKS AND REFLECTIONS

3.1 Reflection on risks, issues or concerns:

- There were no risks for escalation to the CRR or BAF
- There were no risks or issues to be raised with other standing committees
- There were no recommendations to the Audit Committee linked to the internal audit programme

3.2 Reflections on areas of good practice:

- Significant improvement in volunteer participation in Trust activities
- Structure and outputs from the End of Life service is commendable

4.0 DISCUSSION ON OUTCOMES AND REFLECTIONS ON DECISIONS MADE

4.1 What Went Well

- Attendance and engagement from the new Deputy Directors of Quality & Safety at today's meeting

5.0 RECOMMENDATIONS/ACTION REQUIRED

The Board of Directors is asked to:

1. Receive and note the contents of the report
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3. Request any further information or action.

Report prepared by:

Matt Rangué, Quality Project Lead

On behalf of:

Rufus Helm, Quality Committee Chair and Non-Executive Director

		Agenda Item No: 8biv
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	30 November 2022

Report Title:	**People, Equality and Culture Committee**					
Executive/Non-Executive Lead:	Manny Lewis, Chair of the People Equalities and Culture Committee					
Report Author(s):	Manny Lewis, Chair of the People Equalities and Culture Committee					
Report discussed previously at:	Not previously discussed.					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber-Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	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*	N/A	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Project reports only:	
If this report is project related please state whether this has been approved through the Transformation Steering Group	No

Purpose of the Report		
This report provides the Board of Directors with details that the People Equality and Culture Committee (PECC) is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objectives are being managed effectively.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Receive and note the contents of the report

2 Accept the Assurance provided

Summary of Key Issues

The People, Equality and Culture Committee (PECC) met on the 24 November 2022, the meeting was quorate by means of delegated membership and the minutes of the meeting held on 22 September 2022 were approved as an accurate reflection of the meeting.
The focus of the Committee was on employee experience and wellbeing as part of a structured approach to reviewing and addressing the Trust's workforce issues.

The Committee received reports on the following:

- **Emergent & Topical issues**

The Committee was briefed on:

a) International recruitment – as a result of the need to carefully consider the lessons learned it was agreed that any new business case for a further phase of recruitment would be approved by formal delegated authority via the Finance and Performance Committee.

b) Corporate preparation for the forthcoming national industrial action by nurses.

c) The Trust's unsuccessful ROATP (Register of Apprenticeship Training Providers) application and the need to resubmit in April 2023. The process exposed capacity issues in the L&D team and the Executive Team will be reviewing the implications for our current trainee commitments.

- **Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) Action Plans** – Following the Executive Team consideration, the Committee approved the action plans.

  The objectives for the Action Plans are:

  a) To improve BME and Disabled staff representation across the organisation, in particular at senior levels.

  b) Reduce the gaps in experiences between white staff and BME staff / disabled and non-disabled staff.

  c) Support managers to understand structural and individual acts of discrimination, including racism d. Valuing and actively promoting the voice of BME and Disabled Staff within decision-making.

  Key activity for the WRES Action plan includes:

  (i) An MSE ICS led bullying and harassment workshop pilot targeted at Operational Middle Managers in EPUT as part of the Civility and Respect bid which will increase awareness and confidence for managers to take action when staff are reporting incidents.

(ii) Implementation of the Behaviours Toolkit to support the development of positive workplace culture.

(iii) Continuation of the 'RISE Programme', targeted at BME staff bands 2 – 8a, which will increase career progression and development for BME staff across the Trust.

(iv) Review of ED&I training offering to ensure that all staff are educated and equipped with the right tools to deliver this agenda effectively.

Key activity for the WDES Action plan include:

a) Working with Inclusive Employers (an agency that provides additional support to disabled candidates to complete their application as well as preparation for interviews, to recruit candidates with a disability.

b) Review the Reasonable Adjustment Policy to ensure there is a consistent approach for all managers to support staff across the Trust.

c) Implementation of the new Zero Tolerance Policy outlining a clear process to allow effective targeting of repeat offences and ensuring appropriate action is taken to hold patients and carers to account.

The committee also approved a specific bullying and harassment action plan.

- **Time to Care Programme** – Following the mobilisation of the programme, the Chief Executive presented the second report from the Time to Care Programme Steering Group. The committee noted that the programme has reached the end of the discovery phase and was now entering phase 2 which was about delivering change and building sustainable capability. This would involve developing a new staffing model, introducing new processes, system improvements, and changes to ways of working and building improvement foundations across EPUT. The committee noted the current key risks were the production of the future state staffing model and the demand and capacity model, both as a result of the need to integrate and produce accurate Trust wide data. The focus of the programme did however exclude some important areas of organisational development – such as the need to invest significantly in our L&D structures including mandatory training compliance, training facilities and apprenticeship support. These were critical to enable the Trust to meet its future staffing requirements and a separate programme of work will be needed to address these. The committee welcomed the level of commitment to change that had emerged and also challenged how new standards set out by TTC would be consistently applied – compliance will need real staff understanding of the requirements as well as rigorous management.

- **Freedom to Speak Up Service** – a review of the Trust's FTSU arrangements has been undertaken by the interim F2SU Principal Guardian. A number of improvements have been made including a redesigned process for action following a person speaking up, a revised notification document, updated training plans and an updated FTSU policy & procedure. In addition a new communications strategy will help draw attention to this important process. The committee welcomed the report.

- **Guardian of Safe working** – The Committee noted a report that gave assurance on the safe rostering of trainee doctors and received confirmation that trainee doctors are generally working within the terms & conditions of their contract.

- **Annual Staff Survey update –** The Quarter 2 quarterly pulse survey was presented. The committee received assurance that the varying staff responses and comments were actively

considered by Service Heads. The national annual staff survey is currently being undertaken.

- **Mapping the Employee Journey**
  This was an important piece of work to review how well the Trust manages the employment process through the key stages of attracting, on-boarding, developing, engaging, rewarding and transitioning our staff. The steps in the journey have been mapped and then on an evidence basis, they will each be given a RAG rating with improvement actions identified. The Committee welcomed the initiative and looked forward to receiving the outputs. The Committee particularly asked that retirement and reengagement be looked at as a process that is not currently working smoothly.

- **Staff Health & Well Being – Staff Support**
  A report was considered on the level of demand for the Hear For You confidential staff support service which had received 3640 calls over the last 18 months and 39000 web page hits. The demand for the Employee Assistance Programme was also noted.
  The committee endorsed the need for a strong health & wellbeing strategy and plan across the Trust given the pressures on staff.

- **Workforce Dashboard –** the employee relations metrics were noted.

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

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

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

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

Acronyms/Terms Used in the Report			
FTSU	Freedom to Speak Up	LD	Learning and Development
ROATP	Register of Apprenticeship Training Providers	TTC	Time to Care
ICS	Integrated Care System	MSE	Mid and South Essex NHS Foundation Trust
EDI	Equality, Diversity, Inclusion		

Supporting Reports/ Appendices /or further reading
None

Lead
Manny Lewis **Non-Executive Director** **Chair of the People, Equality and Culture Committee**

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Agenda Item No: 8c

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	30 November 2022

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

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

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

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

Recommendations/Action Required

The Trust Board is asked to:

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

Summary of Key Issues

The main report provides details of:

- Ligature Risk Reduction
- EPUT Culture of Learning
- Mental Health Emergency Department
- International Recruitment

- Safety Strategy Update

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Main Report

Lead
Professor Sheila Salmon **Chair of the Trust**

Agenda Item: 8c
Board of Directors Part 1
30 November 2022

BOARD SAFETY OVERSIGHT GROUP REPORT

This report is provided as assurance to the Trust Board on the continued progress of projects, programmes and other activities linked to the safety priorities within the safety strategy.

In this period the key areas of focus for the ESOG and BSOG have been spotlight reports on ligature risk reduction, EPUT Culture of Learning and progress against our overall Safety Strategy in preparation for the full report in January.

Ligature Risk Reduction

Work continues on the ligature risk reduction programme with continued focus on the environment of the in-patient estate, improvement of ligature related training programmes, consideration of a robotic process automation (RPA) solution to synchronise our incident reporting and facilities management systems, and ensure policies related to ligature risk are easily understandable and accessible to all:

Environment

An updated completed environmental works is included in Part 2 of this report.

Training

Working in collaboration with Psychology and OTs, the Ligature Risk Reduction Training Working Group have presented a proposal to the Ligature Risk Reduction Group (LRRG) to bring TIDAL training in house. Incorporating the feedback from LRRG, the team are now completing an options appraisal to be included in a business case to explain the need for, and justify investment in, an in-house practical training programme for Ligature Risk Awareness and Management. The Ligature Risk Awareness and Management Training will incorporate therapeutic and practical training in order to equip and skill all staff working within inpatient areas to be confident in identifying and managing ligature risks.

Systems

Concerns have been raised by our Digital team regarding the use of an RPA link between DATIX (risk management system) and 3i (facilities management system). This is due to the current systems requiring considerable human input and reporting variables which presents a challenge for an RPA solution. This has resulted in the decision to delay the work pending a broader estates systems review which has commenced.

Policy

The Policy working group presented their 'policy on a page' template to clinical and operational colleagues and feedback has been incorporated. Further socialisation of this document revealed that a similar process was being undertaken through the ECOL programme, 'Policy at a glance' and work is now underway to resolve any duplication and plan next steps.

EPUT Culture of Learning (ECOL)

Negotiations are underway following receipt of a proposal from MASS Cohort plc on the high-level contractual details for the development of EPUTs Lessons Identified Management Systems (ELIMS). Once an agreement has been reached this will be submitted to the Digital Steering Group and the Transformation Steering Group prior to being presented to the Executive Team for approval.

The team have been finalising the Patient Safety Incident Response Framework (PSIRF) process maps and how that integrates with ELIMS whilst also planning for a method to automate thematic reviews of patient safety incidents. A streamlined decision monitoring tool (DMT) has been developed and is undergoing offline testing to ensure all requirements are captured before being added to Datix. Once testing is complete, the DMT will then be added to the Datix incident form for the Patient Safety Incident Management (PSIM) Team and available for use by the Clinical Review Group. Safety Improvement Plans (SIPs) have been developed for Ligature Risk Reduction and falls with the draft templates to be reviewed at the next Learning Oversight Sub-Committee (LOSC).

Work has continued on Phase 2 of the safety dashboard which will now incorporate user interface refinements, procurement of an Automatic identification System (AIS) pack and is planned to go live in mid-November. Further sessions on the technical development of the automation of Health Roster data into the safety dashboard are underway and the team will work with Matrons and Service Managers to develop the manager's summary pages.

Work has continued with engagement from key stakeholders on the lessons standard operating procedure with final approval anticipated at the next Learning Oversight Sub-Committee (LOSC) at the end of November.

We have commenced the development of an implementation plan based on findings following the successful comms survey which took place across September. The script for an induction video has now been finalised and a videographer identified.

The training team have commenced DATIX and SEIPS training to all frontline teams and continue to work with MASS Cohort Plc to develop an e-learning package 'Delivery of Trust Culture of Learning' which will be reviewed and then uploaded to our OLM system.

Mental Health Urgent Care Department

Development continues of our new service within the urgent care pathway to support increasing system pressures in the MSE System.

The full business case received approval from the Finance and Performance Committee, our Executive Team, and the Trust Board in late September. Following this approval, the team have continued on the formation of a comms and marketing plan, a review of EPR documentation requirements and collation/creation of job descriptions for the core team.

Due to operational pressures and unforeseen events, the planned move of the Mental Health Assessment Unit to Grangewater encountered delays. This milestone was on the critical path for the programme timeline and the impact has led to a change in the expected completion date from 27 Feb 2023 to 13 March 2023.

The contractors have been engaged to complete the required estates work and they now have access to the site and have commenced the strip out and construction of internal walls. The design team have developed the 1:50 drawings and the programme forums are supporting active discussion around the service and clinical model.

International Recruitment

The EPUT international recruitment of nurse's campaign has now on-boarded and welcomed 10 nurses in 2021 and 149 nurses in 2022. 62 nurses have completed their training and passed their OSCE exam, five of these nurses are RMHN's. A remaining 36 nurses are required to arrive in December in order to meet our projected target of 195.

The project remains at "amber" status due to the risks which are under management by the Steering Group.

Safety Strategy Update

Over the last six months ESOG and BSOG have been presented monthly updates on our progress against the Safety First, Safety Always strategy. Each month the updates have covered one of the seven priorities from the strategy. As part of this work we have also highlighted projects and initiatives which were not originally stated in the safety strategy although contribute to its objectives.

The Transformation Team have pulled together an overall storyboard which highlights the projects and activity under each of the seven priorities and their associated benefits and measurable/KPIs. This will enable us to clearly demonstrate the significant progress made and also our continued areas of focus. EPUT's Marketing and Communications team have now been engaged and are working on the final deliverables which will be presented at the January Board meeting.

Report prepared by

Richard James,
Director of Transformation

On behalf of

Professor Sheila Salmon,
Chair

		Agenda Item No: 8d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

Report Title:	**Risk Management and Assurance Framework 2020 – 2023 (Interim Update September 2022)**					
Executive/Non-Executive Lead:	Denver Greenhalgh, Senior Director of Governance and Corporate Affairs					
Report Author(s):	Susan Barry Head of Assurance					
Report discussed previously at:	Executive Operational Committee and the Audit Committee.					
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 EPUT Strategic and Corporate Risk Registers	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	N/a	
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		
Risk Management and Assurance Framework (RMAF) 2020-23 for approval, following 2022 update to reflect changes within the Trust. The RMAF was reviewed by both the Executive Operational Committee and the Audit Committee and is now presented to the Board of Directors for approval (as a matter reserved for the Board).	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required
The Board of Directors is asked to: 1. Approve the Risk Management and Assurance Annual Report 2020-23 (interim update September 2022).

Summary of Key Issues

Introduction

The purpose of the EPUT Risk Management and Assurance Framework (RMAF) is to ensure EPUT follows best practice guidance for the management of Risk. The RMAF takes account of recommendations from independent reviews and assessments in the systems and processes underpinning our management of risk and robust assurance arrangements. It reflects NHS England / Improvement (NHSE/I) Well Led Framework, Code of Governance and Department of Health and Social Care (DHSC) requirements (approval process) and guidance. As part of Trust internal controls, it underpins all EPUT activities with clear risk and escalation processes to ensure the Board of Directors remains sighted on significant risks.

A full review of the RMAF is undertaken 3 yearly with interim reviews annually or following significant change throughout the lifetime of the framework.

Risk Management and Assurance Framework 2020-2023 (Interim update 2022)

A thorough refresh of EPUT's Board Assurance Framework, introduction of Accountability Framework and introduction of a new electronic Risk Register (Radar) has necessitated a review of its Risk Management and Assurance Framework during its final year of existence. The review takes account of many changes, including the structure of EPUT risk registers, format and reporting of the Board Assurance Framework.

An internal audit in Q4 2022/23 will provide a management opinion in relation to risk maturity and we will take any recommendations to strengthen our controls or implementation into the full review in 2023.

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

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

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

Acronyms/Terms Used in the Report			
BAF	Board Assurance Framework	SRR	Strategic Risk Register

SO	Strategic Objective	CRR	Corporate Risk Register
ICS	Integrated Care System	F&PC	Finance & Performance Committee
QC	Quality Committee	PCC	People & Culture Committee
IGDTS	Information Governance Digital Toolkit Standards	EOSC	Executive Operational Sub Committee
BOD	Board of Directors	ESOG	Executive Safety Oversight Group
EERG	Estates Expert Reference Group	LRRG	Ligature Reduction Group
BSOG	Board Safety Oversight Group	DRR	Directorate Risk Register
MHA	Mental Health Act	HSSC	Health Safety Security Committee
ECC	Essex County Council	CQC	Care Quality Commission

Supporting Documents and/or Further Reading

Risk Management and Assurance Framework 2022-2023

Lead

Denver Greenhalgh
Senior Director of Governance and Corporate Affairs

Essex Partnership University
NHS Foundation Trust

RISK MANAGEMENT AND ASSURANCE FRAMEWORK

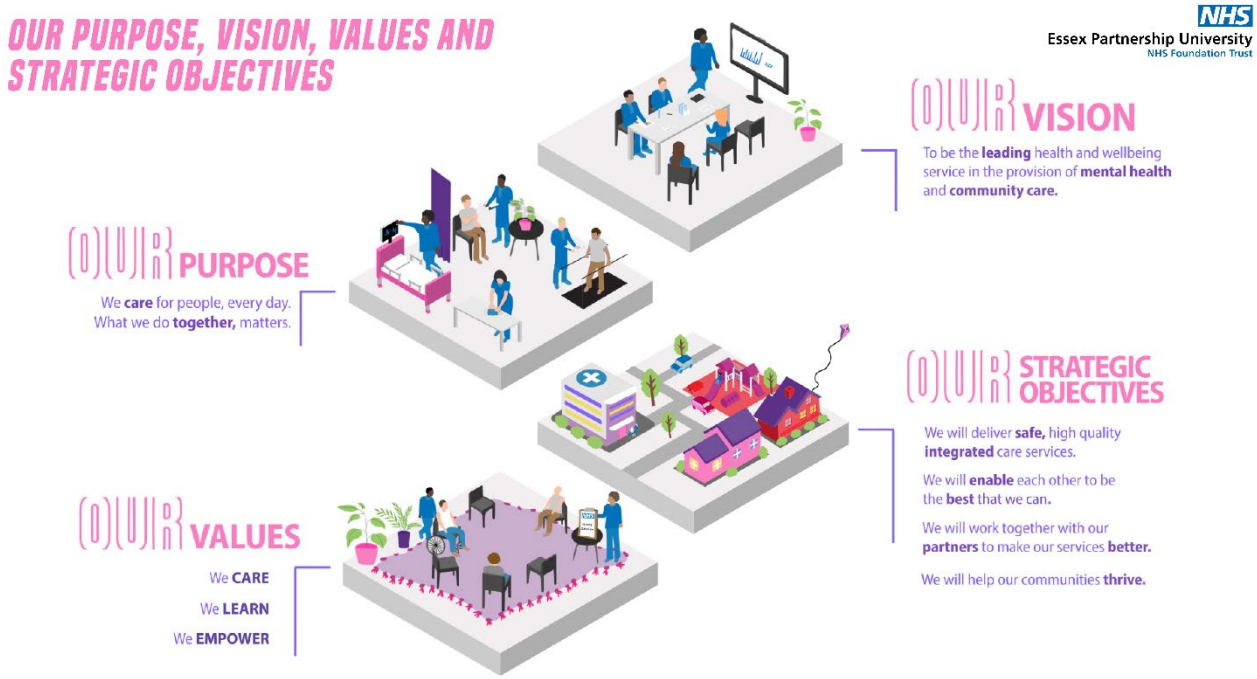
2020/23

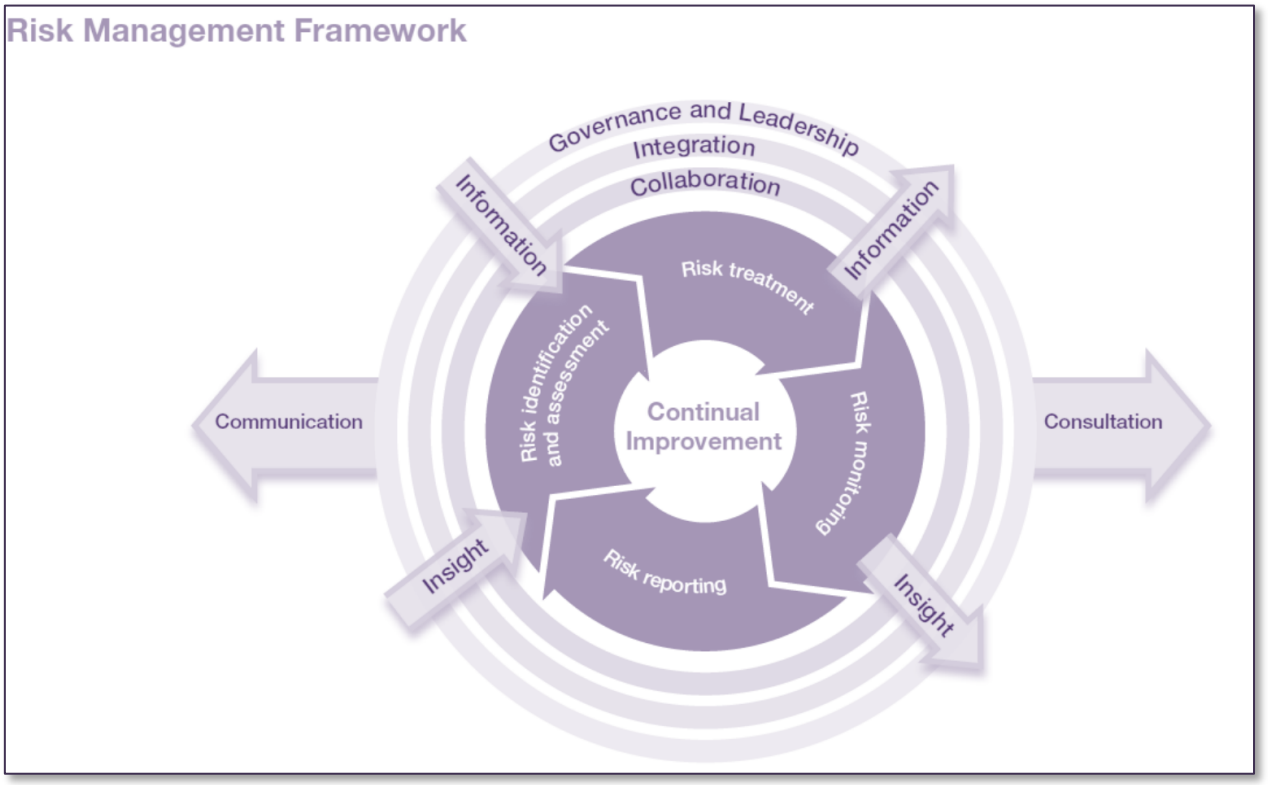
September 2022

Framework Author	Susan Barry, Head of Assurance
Date Last Reviewed	September 2022

Contents

RISK MANAGEMENT AND ASSURANCE FRAMEWORK 2020/2023 September 2022





1.0 Introduction

Risk management is a statutory requirement and a fundamental part of an integrated approach to governance, essential to EPUT's ability to provide health services to the public as well as employ significant numbers of staff and discharge its partnership functions within local health and social care systems. This framework enables a common approach to risk management activities in the Trust.

The Risk Management and Assurance Framework underpins the achievement of the Trust's objectives. EPUT is committed to delivering safe, high quality integrated care services whilst enabling all staff to be the best they can be, working together with partners for better services and help our communities thrive. In order to achieve its objectives EPUT's Board of Directors must be confident in its systems of internal control and be cognisant of the risks facing the Trust through evidence from the Board Assurance Framework and to make decisions based on the management of risk.

The Board of Directors' commitment ensures that risk management forms an integral part of EPUT's values, practices, planning and activities. Risk management is not a separate programme of work at any level of the organisation. The Trust's risk management arrangements will encompass all stakeholders, internal and external.

Internal control mechanisms will assess risk and measure the effectiveness of risk management plans and processes through:

- Accurate, timely and effective reporting including the categorisation of likelihood and consequence of risks
- Application of preventative risk management processes to facilities, equipment and clinical practice
- Safe systems of work that protect patients, visitors and staff
- There will be a degree of integrity of Directorate Risk Management through the Accountability Framework in relation to assumptions underpinning identified risks, their ratings and plans for dealing with them
- A process of scrutiny and assurance of allocated risks relevant to EPUT's corporate risk register and standing committees of the Board

An interim review of the Risk Management and Assurance Framework has been undertaken in August 2022 to reflect the improvement project that has been running to review and improve the EPUT Board Assurance Framework (BAF). As part of this project risk assessments have been undertaken against the Strategic Objectives and a new style BAF document has been developed. The next phase of the project is to bring on line an electronic risk register.

2.0 Purpose and Aims

2.1 Purpose

The purpose of the Risk Management and Assurance Framework is to outline how EPUT leads, directs and controls risks to its objectives in order to comply with terms of authorisation, Health and Safety legislation and delivering its strategic objectives.

2.2 Aims

The overall aim of the framework is to ensure continuous improvement in the quality of care delivery to our patients ensuring maintenance of a safer environment for all, reduce losses to the Trust to a minimum and enable achievement of organisational objectives. Management of risks is everyone's responsibility in order to inform operational decision making, improve safety and quality, and deliver high quality care and services.

Essex Partnership University NHS Foundation Trust aims to:

- Embrace an integrated approach to all risk management
- Identify and control risks that adversely affect operational capability
- Manage risk in accordance with best practice and a continuous, systematic approach to risk assessment trust-wide
- Prevent loss, disruption, damage or injury and maximise resources by reducing the cost of risk
- Provide and maintain a safe and secure environment for all
- Encourage and support innovation/ service development within a risk management framework
- Protect the Trust's services, resources and reputation through evaluation, control, elimination or transfer of risks, and ensuring open and explicit acceptance of remaining risks with mitigation in place
- Create awareness and a proactive approach to the importance of risk management
- Ensure risk management systems and processes are clear and understood by all staff
- Develop all staff to ensure knowledge and skills in risk management appropriate to their role
- Establish and maintain clear roles, responsibilities and reporting lines for risk management
- Provide opportunities for shared learning on risk management
- Anticipate and respond to changing legislative and regulatory requirements
- Share risk data with stakeholders in an appropriate form
- Promote a risk intelligent culture (see 2.3).

2.3 Risk Intelligent Culture

The Board of Directors is responsible for advising management on risk culture and overseeing efforts to maintain that culture. EPUT demonstrates the following characteristics in its drive for a risk intelligent culture:

- Alignment of risk management and assurance with EPUT's vision, values, strategic and corporate objectives, interests, and ethics
- Consider risk in all activities, from strategic planning through to day-to-day business, across the Trust
- Continuously improve the Trust's collective management of risk through a culture of safety, fairness and learning
- Strive to use a common risk language to promote shared understanding on risk and empower people to be open and honest
- Focus Board meeting agendas, discussion and decision making on risks to organisational objectives
- A Strategic Risk Register to reflect risks to strategic objectives
- A Corporate Risk Register to reflect risks to corporate objectives
- Directorate / Care Unit Risk Registers to reflect risks to directorate objectives
- Run a common thread through all risks to ensure identification of the right owner, and identification of the right actions to the right individual(s)
- An Accountability Framework to ensure personal and collective responsibility for management of risk with a proactive approach to empowering others when necessary
- Encourage challenge at all levels of the organisation and to ensure people feel comfortable challenging others and for those challenged to respond positively

3.0 Risk Appetite

There must be a balance between risk appetite and risk tolerance. Risk appetite is the level of risk required to achieve strategic objectives without compromising delivery of safe, high quality care to patients/ service users**.**

The Trust must take risks in order to achieve its aims and deliver beneficial outcomes to patients/ service users and all its stakeholders. The following principles are observed:

- Risks will be taken in a considered and controlled manner
- Exposure to risks will be kept to a level deemed acceptable by the Board

- The acceptable level (target risk score) may vary from time to time (see Appendix 1)
- Some particular risks with a high target risk score may be accepted because:
    - the likelihood of the risk occurring is sufficiently low
    - they have the potential to enable realisation of considerable reward/ benefit
    - they are considered too costly (financial and other) to control given other priorities
    - the cost (financial and other) of controlling them would be greater than the cost of the impact should they materialise
    - there is only a short anticipated period of exposure to them
    - they are considered essential to achieving the Trust's objectives

- All reasonable efforts will be taken within the context at the time to ensure that risks are managed if they have a high target risk score and have the potential to have a significant impact on the patient/ service user or staff experience, the Trust's reputation, financial or operational viability, our ability to deliver core services, deliver value for money without compromising safety, or to comply with law and regulation

The Trust Board of Directors have developed a draft risk appetite for the Trust against the new Strategic Objectives. This attached as appendix 1 and is subject to further review.

4.0 Definitions A-Z

Acceptable risk/ tolerable risk: based on the following principles:

- Tolerability does not mean acceptability – it refers to a willingness to live with risk to secure certain benefits, but with the confidence that it is appropriately controlled. (see Appendix 2)
- To tolerate a risk does not mean to disregard it, but rather that its review aims to reduce further risk.
- It is reasonable to accept a risk that under normal circumstances would be unacceptable if all other alternatives would create a greater risk.

Action/ task owner: risks will have actions that will mitigate it and the risk owner will delegate actions/ tasks to specific owners to ensure their delivery and report on progress.

Adverse event: the unintentional harm, suffering or loss from an activity, situation or event
Assumption: Assumption in the risk management context means identifying what it is we should be doing as an optimum or the best outcome within the Trust. By knowing what the assumption is, it is possible to identify the risks and then assess the likelihood of the risk materialising.

Assurance framework: identifies the objectives that may be at risk due to inadequacies in the operation of controls or where there is insufficient assurance. Assurance is a general term for the confidence derived from objective information over the successful conduct of activities, the efficient and effective design and operation of internal control, compliance with internal and external requirements, and the production of insightful and credible information to support decision-making. Confidence diminishes when there are uncertainties around the integrity of information or of underlying processes.
Clinical practice risk: risks to individual patients may occur at any time during their care episodes. Assessment of risks and the process for documenting the outcome of any risk assessment is set out in clinical policies and procedures.

Consequence: the impact, outcome, or outcome component of a risk.
Controls: Controls are checks and balances such as committees, systems, policies or people which act to minimise or reduce either the impact (consequence) or likelihood (or both) of risks. Controls may comprise a number of individual actions that need to be taken together to become effective.
The Trust must ensure that there are controls in place to manage identified risks. Risk Registers will document controls in place. Controls must map to each risk. A number of controls may mitigate one risk.

Some of these controls may only be effective when operating in conjunction with other controls and one control may relate to more than one risk.

Assessment and evidencing of controls regularly may determine whether there are any gaps. This will ensure that the Trust is confident that the action it is taking is enough to mitigate against the risks and/or agree further action required.

Controls assurance: Assurance is a general term for the confidence derived from objective information over the successful conduct of activities, the efficient and effective design and operation of internal controls, compliance with internal and external requirements, and the production of insightful and credible information to support decision-making.

Corporate risk register: a robust method of risk assessment and management to meet the Trust's corporate objectives including structured assurance of effective risk management.
Financial risk: a weakness in financial control that may result in a failure to maintain assets, adversely affecting the Trust's viability and capability in providing services.

Governance: Governance is a system by which organisations direct and control, define accountabilities, relationships and distribution of rights and responsibilities throughout the organisation. This includes establishing, supporting and steering the risk management framework.

Hazard: anything with the potential to cause harm.
Internal Control: Internal control is the dynamic and iterative framework of processes, policies, procedures, activities, devices, practices, or other conditions and/ or actions that maintain and/ or modify risk. Internal controls permeate and are inherent in the way the organisation operates and cultural and behavioural factors may influence.

Likelihood: the probability of a risk occurring or recurring on a scale of 1-5.
Mitigating action: A mitigating action is a specific action, project, activity, or process taken to reduce or eliminate risk and the potential impact of that risk. Constant review and challenge of mitigating actions is imperative. Mitigating actions may become controls or assurance once are complete.

Operational risk: risks that compromise the day-to-day delivery of clinical care and services.
Patient safety incident: unintended or unexpected event, which could have or did lead to harm for one or more patients receiving healthcare. It is a specific type of adverse event.
Performance risk: the ability of the Trust to deliver high quality care for patients in accordance with its business plan and Care Quality Commission standards.

Reputational risk: a risk from negative publicity that may affect public confidence in the Trust.

Risk

- Risk is the effect of uncertainty on organisational objectives. The usual articulation of a risk is cause (if), potential event (then) and consequence (resulting in). A cause is an element which, alone or in combination has the potential to give rise to risk
- An event is an occurrence, change or a set of circumstances. Sometimes the expectation of an event does not materialise and the unexpected may materialise. Events can have multiple causes and consequences and can affect more than one organisational objective.
- The consequence should the event happen is the outcome of an event affecting organisational objectives, which can be certain or uncertain, can have positive or negative, direct or indirect effects on objectives, can be expressed qualitatively or quantitatively, and can escalate through a cascade or cumulative effect.

Risk assessment: a process by which information gathering about an event, process, organisation or service area, enables identification of existing risks/ hazards, the consequences and the likelihood of harm and what control measures are in place or need to be put in place.

Risk assessors: those who have the knowledge, skills and experience to undertake risk assessments.

Risk domains: Risk domains will identify the consequences of a risk

Risk management: Risk management is the co-ordinated activity designed and operated to manage risk and exercise internal control within an organisation.

Risk owner: all risks will have a risk owner who is responsible for ensuring management of the risk, including ongoing monitoring; ensuring controls are in place to mitigate the risk, and reporting overall risk status. Risk owners will escalate risks where appropriate in line with the risk escalation process.

Risk rating: the 5 x 5 matrix (consequence x likelihood) will determine the risk rating as an initial score before mitigation, a current score (current risk or exposure) and a target score on full mitigation of the risk.

Risk register: a repository for all risks (electronic or manual) with prioritisation according to the risk rating.

Strategic risk: risks associated with the Trust's ability to achieve its strategic objectives

5.0 Embedding a risk management culture

The Trust provides training for all Board members, Executives, senior managers and other staff to ensure the development of a risk management culture, supported by effective assurance systems. This process starts at induction through the risk management presentation, and will continue through training programmes, for example management development training programme, mandatory and core training, workshops, seminars, policies and procedures, etc. The Induction, Mandatory and Essential Training Policy will confirm what aspects of risk related training are mandatory. Individual risk management policies will identify training required associated with its implementation.

Job descriptions will contain a statement to the effect that all staff working in, or for the Trust have a responsibility to participate in the risk management programme. All post-holders have a responsibility to assess all risks to systems, processes and environment and contribute to the clinical and corporate governance agendas as appropriate.

All employees must be aware of the responsibilities placed upon them under the Health and Safety at Work Act (1974) to ensure that the agreed safety procedures provide a safe environment for patients/ service users, employees and visitors

'Risk management' training is provided to the Board of Directors through the Board Development Programme.

The Trust will increase awareness and knowledge amongst all staff groups about the risk management arrangements and accountability framework in place.

Committee Structures will enable the identification of new potential risks through information presented to and discussed in the meeting.
Key objectives will include:

- A clear structure and robust leadership to deliver risk management trust-wide
- Embed risk management processes, policies and procedures trust-wide
- Review risk oversight functions through the Trust's Audit Committee
- Provide role specific risk management training/ awareness
- Integrate risk management into business as usual and delivery of high quality care
- Ensure risk management maturity through the internal audit programme
- Develop an implementation plan for actions by the Assurance Team to support the embedding of risk management principles across EPUT

6.0 Roles, Responsibilities and Accountability

6.1 Roles and Responsibilities

The Board of Directors demonstrates its commitment to risk management through the way it conducts its business and through the endorsement of the Risk Management and Assurance Framework. It delegates authority to its Audit Committee to act on its behalf.

Management of risk is everyone's responsibility at all levels of the organisation. All job descriptions will include a statement that requires the post-holder to 'assess all risks to systems, processes and the environment, and contribute to the clinical and corporate governance agenda as appropriate'.

Individuals and staff groups	
Chief Executive	• The Chief Executive is the responsible officer for EPUT and is accountable for ensuring that the Trust discharges its legal duty for all aspects of risk • As Accountable Officer, the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the Annual Governance Statement. Operationally, the Chief Executive delegates responsibility for implementation of risk management.
Non-Executive Directors	• Non-Executive Directors chair Trust Board Committees. They are accountable to the Board through the Chair and play an essential role in ensuring robust and effective governance and risk arrangements.
All Executive and Non-Voting Directors	• All Executive Directors will own, review, scrutinise and agree potential risks identified by their Directorate and make recommendation to the Executive Team for the escalation of risks for inclusion on the Strategic Risk Register and Corporate Risk Register as appropriate • They are accountable to the Chief Executive and contribute to the structure and ongoing review of the Board Assurance Framework • The fundamental role is to provide leadership on all aspects of risk management and implementation of the Risk Management and Assurance Framework supported by governance managers
Director of Risk and Compliance	• The Director of Risk and Compliance is responsible for ensuring that assurance and risk management systems are in place in the Trust and that these are adequately supported and resourced. • In addition, the post holder is responsible for co-ordinating and supporting the development of the assurance systems within the Trust ensuring that there is appropriate liaison with the Audit Committee, internal audit function and other external assessors such as the CQC and NHS England/ Improvement. • The post also has specific responsibility for managing risk associated with litigation, compliance, violence and aggression, EPRR and health and safety.
Operational and Corporate Directors	• All Directors are accountable for implementing and monitoring any identified and appropriate 'risk management control measures' within their designated area(s) of responsibility.
Managers	• In the identification of significant risk situations where local control measures are potentially inadequate, managers are responsible for bringing these risks to the attention of the appropriate lead Director. All high risks are to be escalate to Executive Directors/ Directors/ Associate Directors at the earliest opportunity for review and validation. • Managers must also ensure staff attend appropriate risk training, carry out risk assessments, and actively promote the upward reporting of all incidents and near misses in accordance with the Adverse Incident Policy and Procedure. • Managers are required to review and monitor Directorate /Care Unit Risk Registers and to:

Individuals and staff groups	
	○ Identify, assess and manage clinical and non-clinical risks/ hazards in their Directorate areas for inclusion in the Directorate /Care Unit risk register ○ Ensure team members are aware of the key objectives of the Risk Management and Assurance Framework ○ Encourage the continual analysis of risk in their area, update their Directorate risk assessments and risk registers accordingly through quality and governance reporting arrangements • Ensure team members (including new starters and contractors, agency and temporary staff) are aware of risks affecting service users, staff, visitors/ public, and the Trust as well as the necessary control measures to manage those risks ○ Involve team members in the development of recommendations to change practice • To implement changes to practice as a result of risk assessments and investigations into incidents (including Serious Incidents), complaints, and claims
All staff (including contractors, bank and agency)	Employees will be aware that they have a duty under legislation to take reasonable care for their own safety and the safety of all others who may be affected by the Trust's business, which includes the following responsibilities: • Identify (and report to their Manager) risks/ hazards that could cause harm arising out of work activities • Be aware of organisational and health and safety risk assessments and the necessary control measures (e.g. policies, procedures, training, safe systems of work etc.) to reduce risks identified and ensure they participate in the process and controls as indicated • Be aware of what should be reported as an incident or near miss, how to report it, implement any necessary changes following an investigation into incidents, complaints or claims and embed learning • Work within their area of competence and identify (to their Manager or Professional lead) any development or training needs and to follow Trust and/or Professional policies, procedures, protocols, care pathways etc. which deliver good quality outcomes for service users • To participate in mandatory training, 1:1 support and clinical supervision in line with Trust standards • All high rated risks must be communicated to the service lead at the earliest opportunity via line manager reporting arrangements
Associate Director, Risk and Compliance	• To be responsible for development and implementation of assurance and risk management systems in the Trust and that these are adequately supported and resourced. • To be responsible for the development of the Trust's Risk Management policies and procedures that ensure risk management arrangements within the Trust operate effectively • To be responsible for the development of good governance processes that supports the risk and compliance agendas throughout the Trust. • To be responsible for the development of a culture of positive risk management and compliance culture through training, awareness, communication and organisational development processes. • To ensure that all risk and compliance processes maximise high quality, safe patient care and minimise bureaucratic impact on front-line staff. • Develop policies, systems and processes and effectively implement various non-clinical risk assessment processes, such as ligature, general work place risk assessments, pregnant workers, violence and aggression etc. • The development and implementation of systems and processes that ensure patients and staff are cared for and work in a safe environment. This will include responsibility for accident and incident reporting, health and

Individuals and staff groups	
	safety, local security management (excluding physical environment) and organisational resilience. • The analysis, identification of trends, hotspots and areas of significant clinical and non-clinical risk in relation to Risk Management within the Trust and for reporting and escalation of risk to the Senior Management Teams, Executive Team, Board of Directors and relevant Committees. • On-going development of the incident reporting system.
Head of Assurance	• Oversee the day-to-day management and co-ordination of the risk management system, providing support and expert advice on risk management issues trust-wide • Provide Board Assurance Framework and Risk Register reports as required to the Executive Team • Provide Board Assurance Framework reports bi-monthly to the Board of Directors • Provide assurance report to Executive Team • Provide quarterly reports to all Standing Committees on the Board Assurance Framework • Provide risk register reports to Accountability Framework Meetings, Service Management Teams and other operational/ quality and safety meetings as appropriate, with summaries • Author/ review the Risk Management and Assurance Framework and develop/ manage the Implementation Plan annually • Author and present Annual Risk Management and Assurance Report to Audit Committee and provide progress reports • Maintain InPut page for Assurance • Align all Directorate Risk Registers with Executive Director portfolios
Risk Specialists	In addition to those responsibilities listed above, the Trust has a number of risk specialists who have specific responsibility for particular risk areas; these fall within a range of Trust policies and procedures available on InPut. Examples of specialists include: • Risk Management/ Health & Safety • Claims • Complaints • Clinical Audit • Estates Compliance/ Fire Safety • Infection and Prevention Control

6.2 Committee Roles and Responsibilities

An annual effectiveness review takes place on the role and remit of Board Committees in line with their terms of reference in preparation for an annual report to the Board of Directors. There are three tiers of Committees under the Board of Directors:

- Tier 1 - Board Standing Committees with delegated responsibility from the Board of Directors
- Tier 2 - Executive Committees/ Sub-Groups with responsibility for monitoring the effectiveness of risk management for specific areas e.g. patient safety; patient experience; clinical effectiveness
- Tier 3 - Trust-wide groups that lead and provide operational assessment, management and monitoring of specific risk areas e.g. Mental Health Act and Safeguarding; Clinical Governance and Quality; Information Governance

Specialist Committees are responsible for identifying trends from individual risks reported across the organisation and where appropriate escalating these to Lead Directors or the appropriate Board Standing Committee or sub-committee.

6.3 Supporting Policies and Procedures

A range of policies and procedures is in place, together with operational clinical guidelines associated with risk management, underpinning principles set out in this framework, and supporting its implementation. These are in the Policy section of the Trust intranet. EPUT ensures the review of all policies in accordance with the level of risk with which they are associated.

Testing and implementation of policies and procedures linked to monitoring is part of any policy review/ development in order to ensure risk mitigation of non-compliance with policy.

6.4 Other Risk Related Reporting Arrangements

Apart from identified Committees that have oversight and scrutiny, there are monitoring and control decisions taken by other Committees and by Operational and Executive Directors that will ensure appropriate management of all risks.

The Board of Directors, together with its Standing Committees and sub-committees, receive routine reports detailing the management of risks and resources on a regular basis to an agreed schedule throughout the year. Examples include integrated performance reports and financial reports.

The Board also receives reports related to external inspections or assessments from, for example, NHS England/ Improvement and the Care Quality Commission.

All written reports to the Board of Directors and Standing Committees will confirm the implications of the content of the report on the Trust. This will include any impact on:

- Risk mitigation
- The financial position
- Patient safety and quality issues
- The level of internal or external assurance provided
- Any implications for the Trust's Governance arrangements

7.0 Board Assurance Framework

7.1 Board Assurance Framework

The Board Assurance Framework is the reporting mechanism for risk registers, made up of the highest level of risks to the Trust's objectives. Presentation of a detailed Board Assurance Framework will take place monthly to the Executive Team with a more succinct version going to the Board of Directors at its bi-monthly meeting.

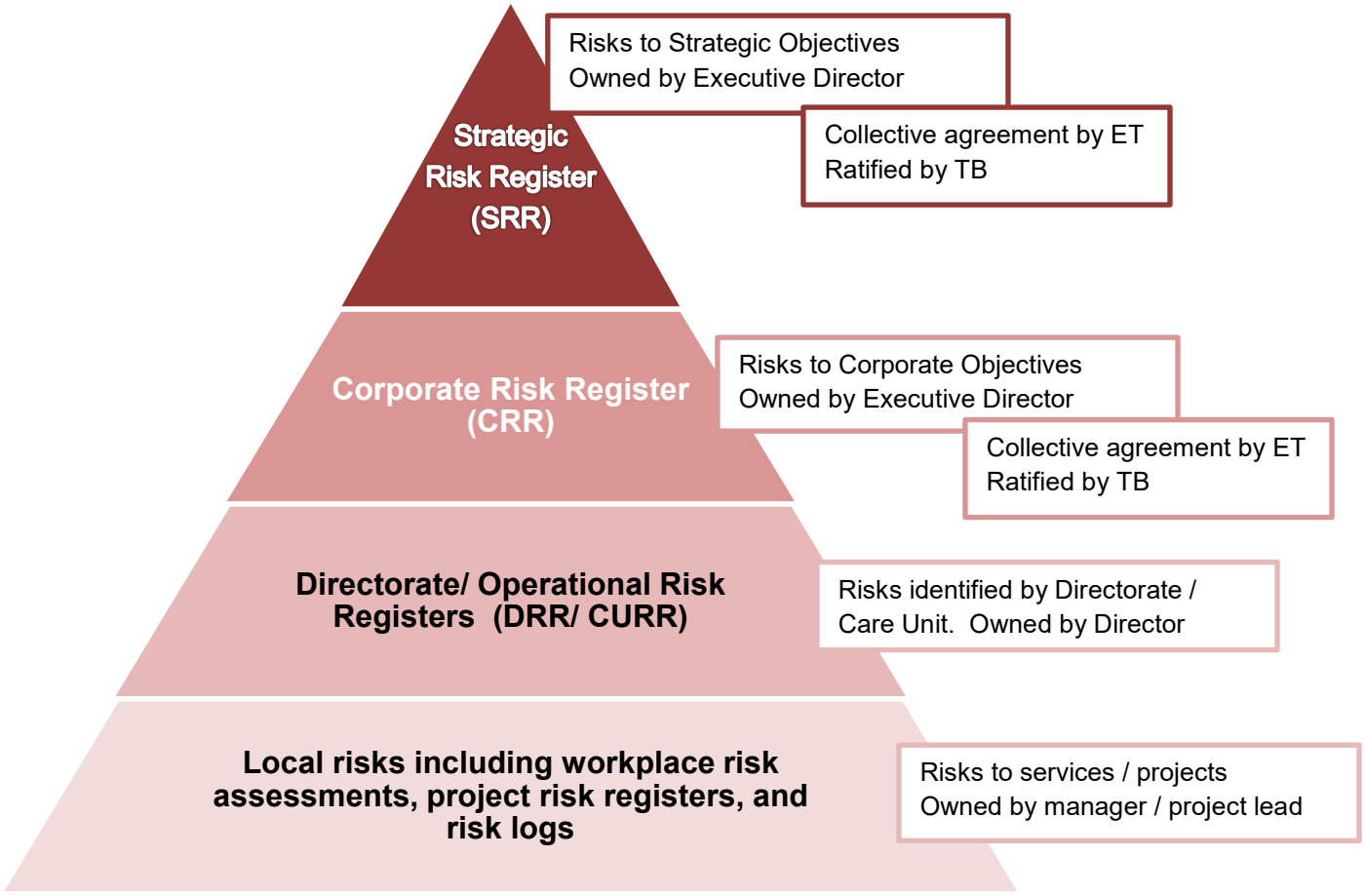
7.2 Electronic Risk Register

An electronic risk register from Radar Healthcare is an investment to move from manual Excel spreadsheets to a more modern system. For the duration of this interim Risk Management and Assurance Framework, the electronic risk register is in its implementation phase. The aim will be to enable direct access to leads for updating and managing risks and tasks/ actions.

7.3 Risk Register Structure

The Trust is required to identify its main risks and manage them by recording and detailing actions on a risk register. For many of the risks, it is possible to put adequate control measures in place to prevent a major risk to the Trust's organisational objectives. For others, additional resources and actions may be required to manage and reduce the risk.

There are four tiers of risk registers within the Trust as outlined in the diagram below:



The Strategic and Corporate Risk Registers are Trust wide registers and will have an appropriate Executive Director lead, whose responsibility it will be to ensure monthly review and update. In some cases there will a lead with other supporting Executives.

In addition to the risk registers in the diagram above other high-level risk registers may be in place at any one time, for example in relation to the Mass Vaccination Programme.

7.4 Strategic Risk Register

The strategic risk register contains high-level risks to the organisation's strategic objectives. For the most part, a Strategy will underpin each risk with the expectation that they are slow burn in terms of mitigating and reaching their target score and timescale. Strategic risks will have an Executive Director lead although in some instances there may be more than one if there is a crossover of portfolios.

There will be collective agreement by the Executive Team and ratification from the Board of Directors for any risk escalation to the Strategic Risk Register or any de-escalation to the Corporate or Directorate/ Care Unit Risk Registers. Strategic risks will be the subject of regular reviews and updates from key Committees, Groups and individual Executive Directors of no less than bi-monthly.

7.5 Corporate Risk Register

The strategic risk register contains high-level risks to the organisation's corporate objectives. There will be a golden thread running through the levels of risk registers within the organisation to ensure that there is a link from all strategic objectives, through corporate objectives and to Directorate risks. Corporate risks will have an Executive Director lead and may have delegation to direct reports within a portfolio.

There will be collective agreement by the Executive Team and ratification from the Board of Directors for any risk escalation to the Corporate Risk Register and any de-escalation from the Strategic Risk Register. Operational risks should normally sit on a Directorate/ Care Unit Risk Register unless they

constitute a risk to strategic or corporative objectives. Corporate risks will be the subject of regular reviews and updates from key Committees, Groups, individual Executive Directors and/ or their direct reports of no less than bi-monthly.

7.6 Directorate Risk Registers

Executive Directors for Corporate Services will have a Directorate Risk Register associated with their portfolio. They will delegate responsibility for management of Directorate level risks. Delegates will have sufficient seniority to ensure follow through of the mitigation plan and to identify/ request additional resources if necessary. Directorate risks will be the subject of at least bi-monthly reviews and updates from Directors and their direct reports as well as relevant Tier 3 Committees/ groups as appropriate.

7.7 Operational Risk Registers

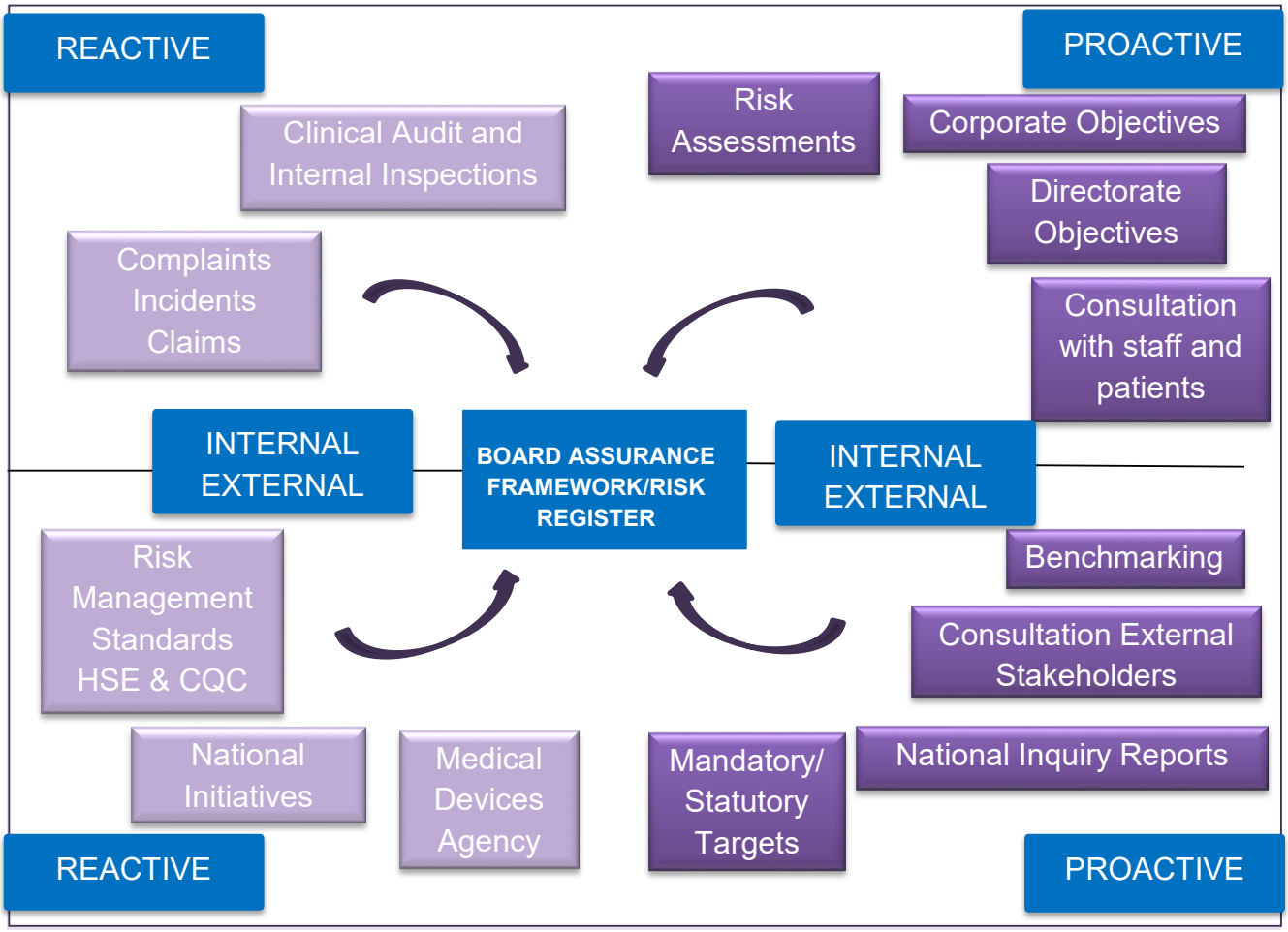
Operational Directorate Risk Registers will sit with the Trust's Care Units, each of which has a Director with delegated responsibility for risk management from the Executive Chief Operating Officer. Delegates will have sufficient seniority to ensure follow through of the mitigation plan and to identify/ request additional resources if necessary. Care Unit risks will be the subject of at least bi-monthly reviews and updates from Directors and their direct reports as well as relevant Tier 3 Committees/ groups as appropriate.

Care Unit risk registers are subject to Accountability Framework meeting reporting on a monthly basis for a summary of risks together with a review status.

8.0 Risk Management Process

8.1 Identification of Risk

Risk identification involves a systematic review of all current and planned activities to achieve organisational objectives. The principle of embedding reviews in all organisational processes drives a mature risk intelligent culture. The diagram below demonstrates the proactive and reactive identification of risks:



Key questions to address are:

- What could go wrong and at what point during the activity?
- How could it happen and why?
- What could be the impact?
- Whom might it affect?

Avoid confusion between risks and issues by remembering the following:

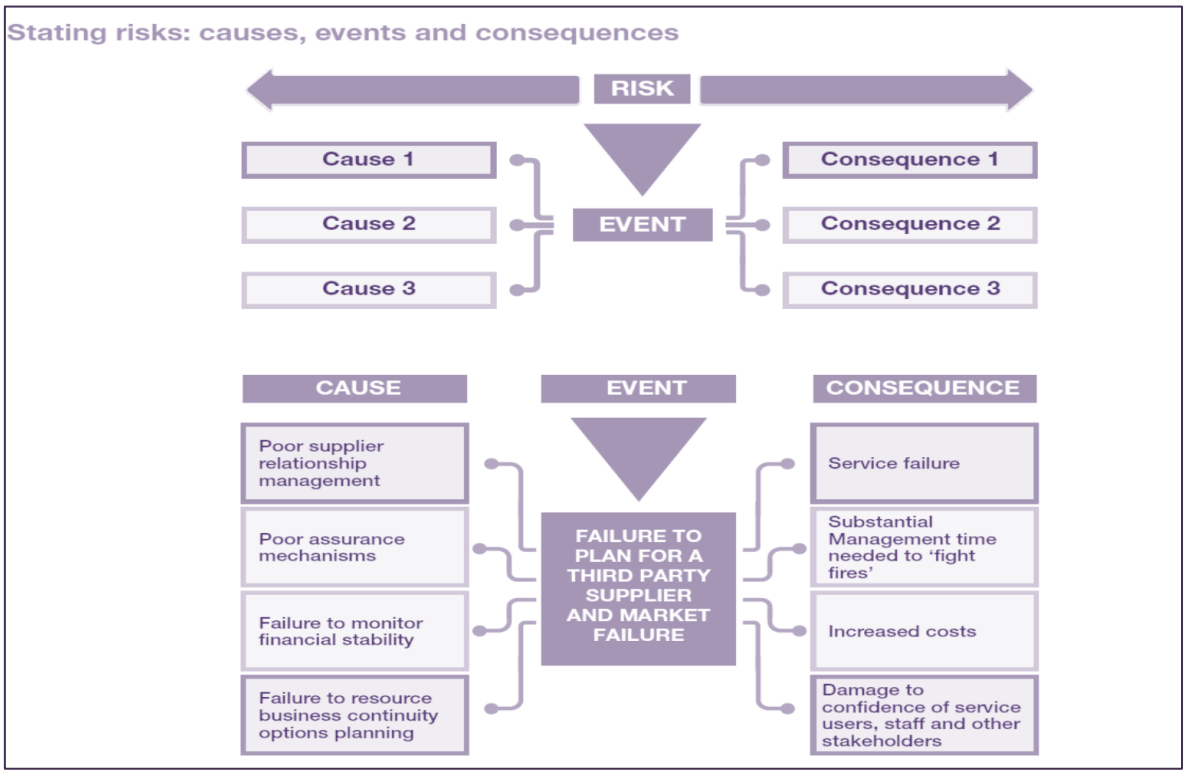
- Risks are things that might happen and prevent us achieving objectives, or otherwise impact on the success of the Trust
- Issues are things that have occurred and were not planned, requiring management action

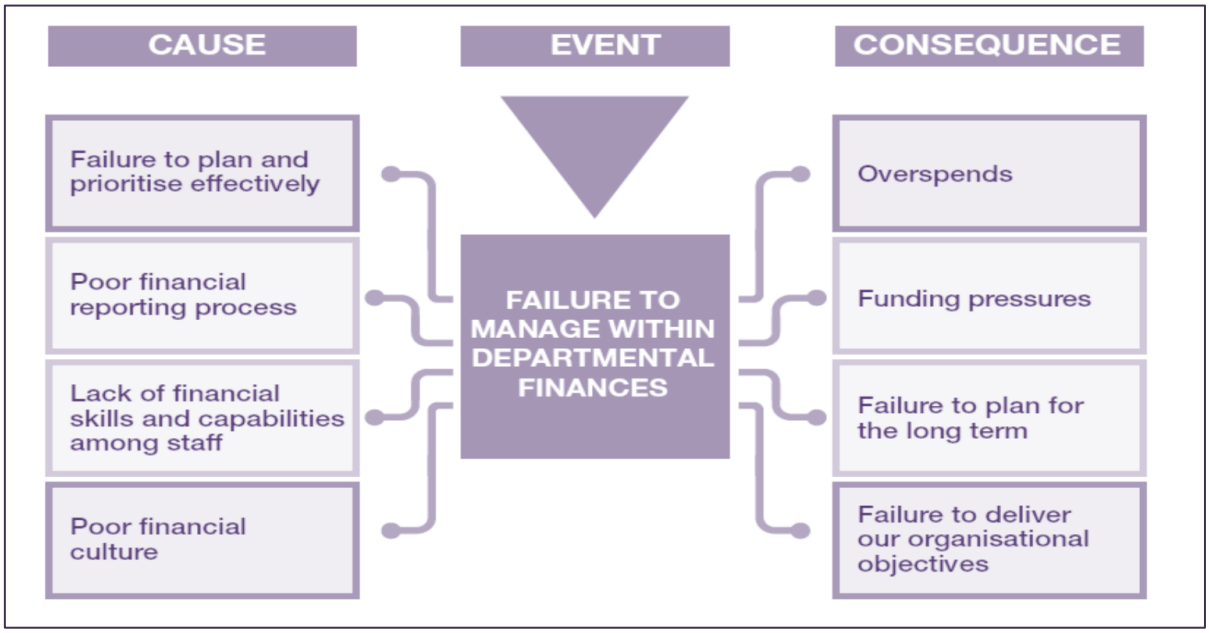
A consistent and objective approach to risk assessment will enable appropriate risk management. See Appendix C for the risk assessment form for use prior to recording on the electronic risk register (Radar).

8.2 Articulating a risk

Following identification of a risk, the next step is to articulate it. A clear, concise and consistent risk descriptor will enable controls, actions and contingency plans to reduce the likelihood of risk materialisation.

The terminology “If” (the cause) “then” (the event) “resulting in” (effect or consequence) will articulate the risk in this manner. See the illustration below.





8.3 Risk Scoring

The Trust uses a single methodology for risk scoring known as the '5 x 5' risk matrix (see below). It provides a guide to assist the risk assessment process.

Likelihood	Consequence				
	1	2	3	4	5
1	Low (1)	Low (2)	Low (3)	Medium (4)	Medium (5)
2	Low (2)	Medium (4)	Medium (6)	Medium (8)	High (10)
3	Low (3)	Medium (6)	Medium (9)	High (12)	High (15)
4	Medium (4)	Medium (8)	High (12)	High (16)	Extreme (20)
5	Medium (5)	High (10)	High (15)	Extreme (20)	Extreme (25)

A consequence score x a likelihood score will give a total score and the above matrix shows where the risk sits as low, medium, high or extreme risk as a RAG rating and identifies the level of authority for risk management. Any score of 25 or with a likelihood of 5 would normally mean that risk materialisation thus turning the risk into an issue.

8.4 Steps for determining strategic risk scores (consequence x likelihood)

Consequence (impact) on the trust	
Level	*Example of description*
1	▪ **Negligible** ○ no service disruption ○ no workforce shortages or implications ○ no obvious harm to patients or staff ○ low financial loss (up to £200,000)
2	▪ **Low** ○ temporary service disruption with minimal operational impact ○ some workforce shortages with minimal impact on service delivery ○ minimal harm to patients or staff ○ increased level of care 1-7 days ○ adverse publicity unlikely ○ financial loss £200,001 - £500,000
3	▪ **Moderate** ○ temporary service disruption with operational impact ○ workforce shortages which marginally impact on service volume medical intervention required ○ local adverse publicity possible ○ financial loss £500,001 - £2,500,000
4	▪ **Severe** ○ temporary significant service disruption ○ workforce shortages with significant impact on service volume suicide/incident rates which significantly exceed national average ○ increased level of care over 15 days ○ national adverse publicity ○ financial loss £2,500,001 - £6,500,000
5	▪ **Extreme** ○ total service failure ○ high profile death, permanent illness or disability due to significant clinical failure ○ significant multiple injuries ○ extended service closure ○ protracted national adverse publicity ○ financial loss over £6,500,001

Likelihood of risk occurring	
Level	*Detail description examples*
1	• **Rare** – may occur only in exceptional circumstances (up to 20%)
2	• **Unlikely** – could occur at some time (21% to 40%)
3	• **Possible** – might occur at some time (41% to 60%)
4	• **Likely** – will probably occur in most circumstances (61% to 80%)
5	• **Almost certain** – is expected to occur in most circumstances (81% to 100%)

8.5 Determining risks from Corporate Objectives

All risks originating from Corporate Objectives will utilise the following process, with the same likelihood table and scoring matrix in 8.4 above.

Domains	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical /psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work An event which impacts on more than one but less than 10 patients / members of staff	Minor injury or illness, requiring minor intervention Requiring time off work for more than three days Increase in length of hospital stay by one-three days An event which impacts on more than 10 patients/staff	Moderate injury requiring professional intervention Requiring time off work for four-14 days Increase in length of hospital stay by four-15 days RIDDOR/ agency reportable incident An event which impacts on more than 20 patients/ staff	Major injury leading to long-term incapacity/ disability Requiring time off work for more than14 days Increase in length of hospital stay by more than15 days Mis-management of patient care with long-term effects An event which impacts on more than 50 patients / staff	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on more than 100 patients / staff
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential independent review) Repeated failure to meet internal standards Major patient safety implications if findings not acted upon	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted upon Inquest / ombudsman inquiry Gross failure to meet national standards

Domains	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Human resources/ organisational development/ Staffing/ competence	Short-term low staffing level that temporarily reduces service quality (less than1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (more than one day) Low staff morale Poor staff attendance for mandatory/ key training	Uncertain delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (more than five days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objective/ service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance / statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommend-ations / improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with less than three days service well below reasonable public expectation	National media coverage with more than days service well below reasonable public expectation MP concerned (questions in the House) Total loss of public confidence

Domains	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Business objectives/ projects	Insignificant cost increase/ schedule slippage	Less than five per cent over project budget Schedule slippage	Five–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading more than25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss less than 0.1 per cent of budget Claim less than £100,000	Loss of 0.1–0.25 per cent of budget Claim(s) between £100,000 and £250,000	Loss of 0.25–1.0 per cent of budget Claim(s) between £250,000 and £1 million	Uncertain delivery of key objective / Loss of 1.0–3.0 per cent of budget Claim(s) between £1m and £3m Purchasers failing to pay on time	Non-delivery of key objective/ Loss of more than3 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) more than£3 million
Service/ business interruption /Environmental impact	Loss/ interruption of more than one hour Minimal or no impact on the environment	Loss/ interruption of more than one day Minor impact on environment	Loss/ interruption of more than one week Moderate impact on environment	Loss/ interruption of more than one month Major impact on environment	Loss/ interruption of more than three months Catastrophic impact on environment

8.6 Determining risks from Care Unit/ Directorate Objectives

The risk matrix in 8.5 applies to Directorate Objectives except for the Finance domain score adjustments to reflect the local nature of the risk as follows. The same likelihood table and scoring matrix in 8.4 above is applicable.

Domain	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Finance including claims	Small loss less than 0.1 per cent of budget Claim less than £20,000	Loss of 0.1–0.25 per cent of budget Claim(s) between £20,000 and £40,000	Loss of 0.25–1.0 per cent of budget Claim(s) between £40,000 and £60,000	Uncertain delivery of key objective/Loss of 1.0–3.0 per cent of budget Claim(s) between £60,000 and £80,000	Non-delivery of key objective/ Loss of more than3 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) between £80,000 and £100,000

8.7 Classification of risks

Risk classification will either be Strategic, Corporate or Care Unit/ Directorate. See sections 7.4 – 7.7 for more detail.

8.8 Control Identification

Risk assessment requires the identification of controls to mitigate or reduce the risk. Controls are measures that will minimise the likelihood or severity of a risk. Effective controls always reduce the probability of a risk occurring. If it does not then the control is inadequate; they should always improve resilience. Control measures will take account of any relevant legal requirements that establish the minimum levels of risk control. There are four types of risk control:

Types of risk control	
Eliminate	Remove the risk completely
Substitute	Pass the risk to a third party, to bear or share the impact
Contain	Reduce the likelihood and/or the impact or establish a contingency to be enacted should the risk materialise
Sanction	Tolerate or accept the risk, subject to monitoring

Any gaps in controls will form risk tasks/ actions (see risk assessment form) with clear identification of a lead and completion date. Regular monitoring of risk tasks/ actions will be part of regular risk reviews.

When identifying controls to mitigate the risk the following should be considered:

- **Prevention / Treatment**: what resources are available, what policy is in place, are there technical or innovations that can be used, what investment is needed
- **Detection**: how do you know if the risk is materialising
- **Contingency**: what is in place as contingency if the risk materialises

8.9 Controls Assurance

If a control is in place, it is imperative that positive assurance demonstrates its effectiveness. Assurances can be from a variety of sources, such as:

- Management reports
- Internal and external audit
- Other external assessors such as the Care Quality Commission

There are 3 levels of controls assurance:

- 1st line – Management has primary ownership, responsibility and accountability for identifying, assessing and managing risks
- 2nd line - Functions and activities that monitor and facilitate the implementation of effective risk management practices and facilitate the reporting of adequate risk related information up and down EPUT
- 3rd line - Internal Audit (carried out by appointed Auditors external to the Trust but still referred to as internal auditors)

Gaps in assurance should be clear and appropriate actions put in place to mitigate and close those gaps.

It is not always possible to identify and implement actions that fully eliminate or minimise a risk. In this case, it is imperative that there is understanding of the significance and acceptance through the appropriate level of authority to agree a residual risk.

8.10 Recording of Risks

The Trust is currently transitioning from a manual set of risk registers held in Excel/Ward documents to a new Electronic risk register in Radar.

The Assurance Team will carry out an initial population and management of the electronic risk register, as follows:

Phase One	Strategic Risks (August 2022)
Phase Two	Corporate Risks (September 2022)
Phase Three	Directorate Risks (Corporate) (October 2022)
Phase Four	Care Unit Risks (Operational) (December 2022)

A standard operating procedure will be agreed which will outlined roles and responsibilities for updating the electronic risk register, process for updating and process for reporting from. It is planned that this will 'go live' across the organisation by April 2023. At this time Executive and Non-Executive Directors, Directors and Managers with risk management responsibility will be able to access the risk register at any time and make updates as appropriate.

For the duration of manual risk registers recording of risks will continue through the Assurance Team reviews with the appropriate Director/ Manager and submission of the risk assessment form.

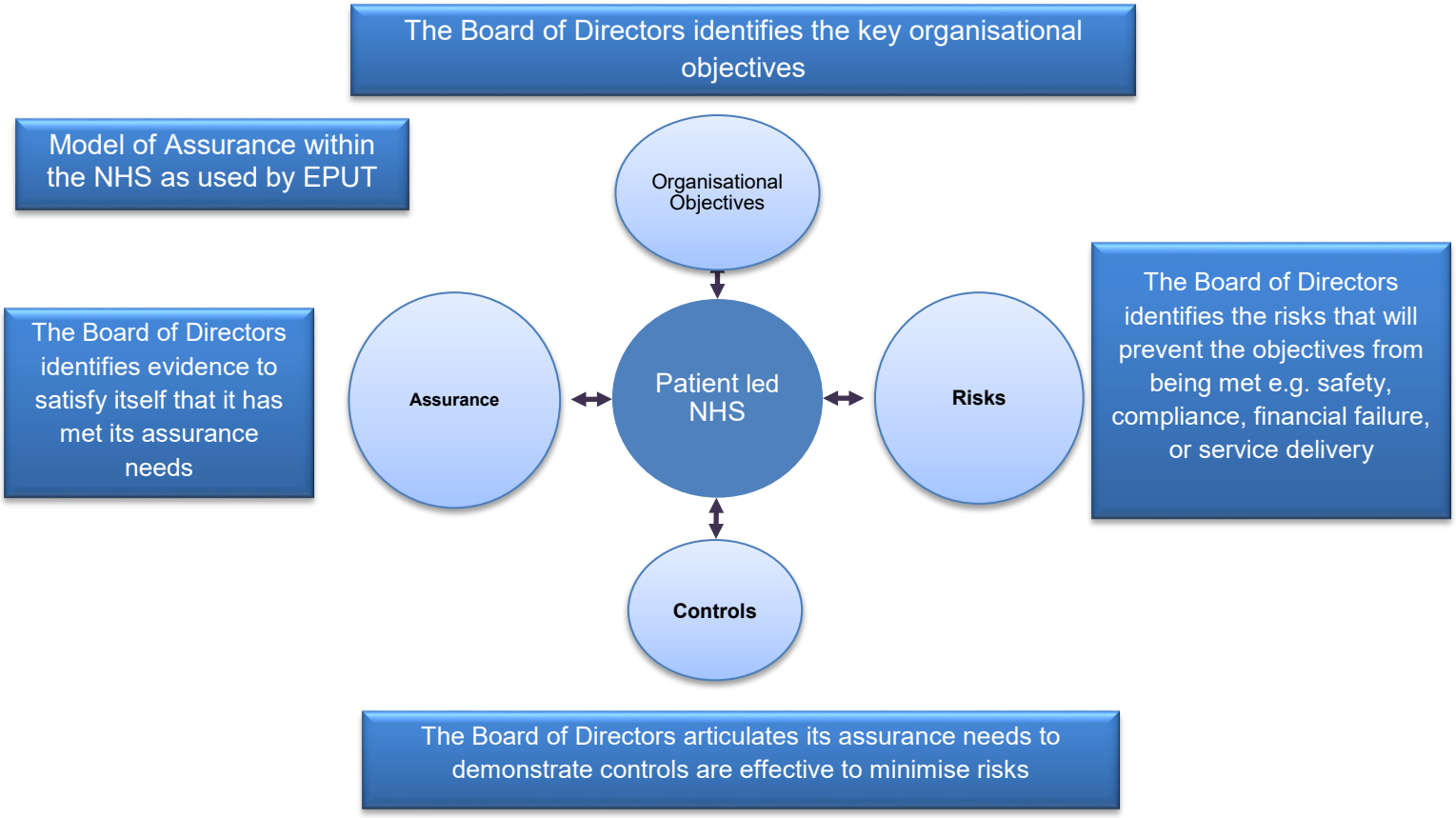
8.11 Approval and Escalation of Risks

Approvals for all risk escalations to the Corporate and Strategic Risks Registers will be via the monthly Executive Team Board Assurance Framework Report. Bi monthly Board Assurance Framework reports to the Board of Directors will provide ratification.

Approvals for all Directorate or Care Unit risks will be via use of the risk assessment form with sign off by the line manager, risk owner and Directorate/ Care Unit. See Appendix 4 for flow chart.

9.0 Assurance

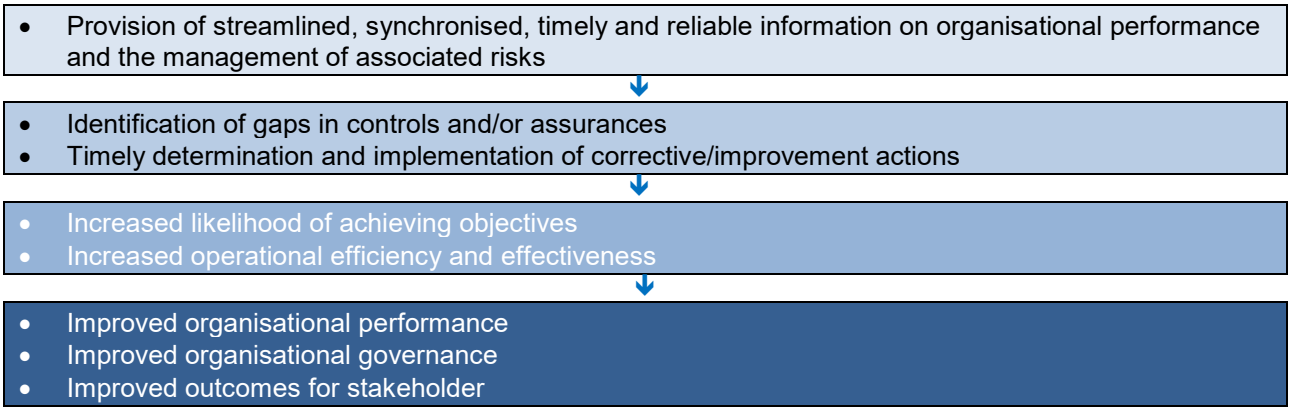
9.1 Model of assurance



All members of the Board of Directors are involved in the evaluation of assurance including by virtue of delegation to standing Committees as per the EPUT scheme of delegation.

9.2 Benefits

The Good Governance Standard for Public Services states that a governing body should ensure that the organisation operates an effective system of risk management. In applying this system, the organisation should put in place a framework of assurance from different sources, to show that risk management processes, including responses, are working effectively. The benefits of an assurance framework are:



9.3 Principles

EPUT's assurance systems will enable the Board of Directors and senior managers to review corporate governance, risk management and systems of internal control to address any weaknesses identified. Methodology aligns with principles defined in the HM Government Orange Book – Management of Risk – Principles and Concepts (updated February 2020).

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/866117/6.6266_HMT_Orange_Book_Update_v6_WEB.PDF

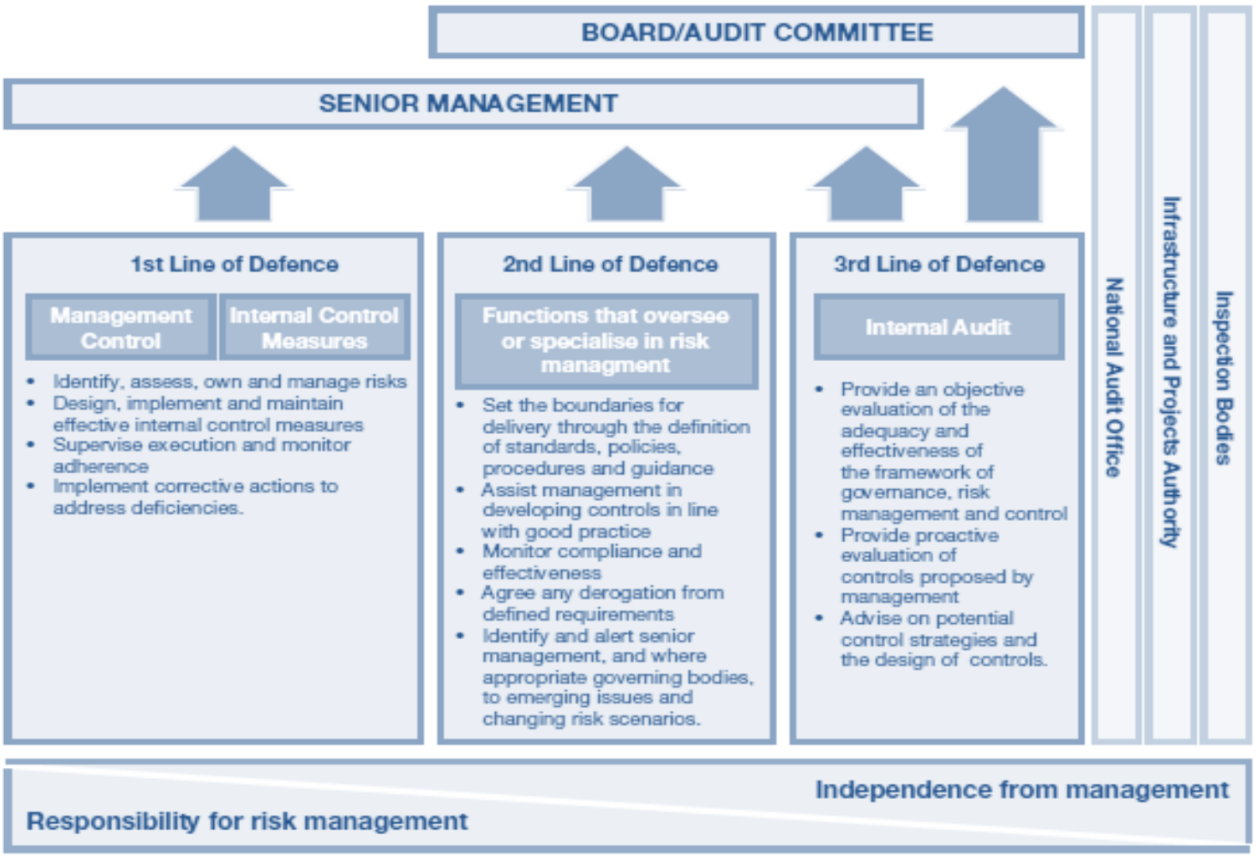
The key principles and their application within EPUT are below:

Main principle	Supporting principles
Governance and Leadership	
Risk Management shall be an essential part of governance and leadership, and fundamental to how the organisation is directed, managed and controlled at all levels	• Define risk appetite, culture, communicate, promote and assess • HR policies and performance systems encourage and support desired risk behaviours and discourage inappropriate risk behaviours • Determine the nature and extent of the principal risks to achieving objectives in a proportionate manner • Board and governance forums support the management of risks and integrate with discussion on other matters • Support decision making • Defined, co-ordinated and documented authority, responsibility and accountability for risk management and internal control • Designated lead positioned and supported to exercise objectivity and influence effective decision making • Assess and support skills, knowledge and experience or risk specialists • Demonstrate commitment to risk management
Integration	
Risk Management shall be an integral part of all organisational activities to support decision-making in achieving objectives	• Consider risks when setting and changing strategy and priorities • Assess risks within options appraisals for policies, programmes and projects • Identify and consider emerging risks

Main principle	Supporting principles
	• Assess risks to public within policy development and implementation • Recognise national and system wide risk register risks in risk assessments and discussions
Collaboration and Best Information	
Risk Management shall be collaborative and informed by the best available information and expertise	• Support the delivery of services through an aggregated view of the risk profile of the organisation • Gather and include views of external stakeholders within risk considerations • Communicate and consult to assist stakeholders to understand risks • Use function and professional expertise to inform strategies, plans, programmes, projects and policies • Expert functions and professions inform identification, assessment and management of risks and design/implementation of controls • Communicate functional standards and monitor adherence across the organisation
Continual Improvement	
Risk management shall be continually improved through learning and experience	Risk management shall be continually improved through learning and experience
Risk Management Processes	
Risk Management processes shall be structured to include: • Risk identification and assessment to determine and prioritise how the risks should be managed • The selection, design and implementation of risk treatment options that support achievement of intended outcomes and manage risks to an acceptable level • The design and operation of integrated, insightful and informative risk monitoring • Timely, accurate and useful risk reporting to enhance the quality of decision-making and to support management and oversight bodies in meeting their responsibilities	• Use risk categories to facilitate identification of risks • Set risk criteria to support consistency and understanding • Highlight limitations and influences associated with information and evidence used with risk assessments • Identify and assess interdependencies between risks or possible combinations of events • Use dynamic assessment of risks and consideration of mitigating actions to reflect new or changing risks or operational efficiencies • Assess exposure to principal risks to inform options for selection and development of internal controls • Balance new or additional controls against costs, efforts and disadvantages • Design and test contingency arrangements to support continuity, incident, crisis management and resilience • Define and communicate nature, source, format and frequency of information required to support monitoring of risk management and internal control • Highlight and escalate new and changing principal risks • Use comprehensive assurance activities to achieve objective and support effective management • Disclose fair, balanced and understandable risk management and internal controls in annual report

9.4 Levels, values and sources of assurance

There are three lines of defence in determining levels, values and sources of assurance as illustrated by the diagram below



All reports to the Board of Directors and Standing Committees have an assurance level assigned (aligned to the three lines of defence above) approved by the Executive Director submitting the report. Where a report has been scrutinised and approved through multiple oversight Committees including Members, Governors and Non-Executive Directors, Assurance Level 3 may apply.

First line of defence	
Management has primary ownership, responsibility and accountability for identifying, assessing and managing risks	• Respond to risks through internal controls on a day-to-day basis and for implementing corrective actions • Use a cascade structure to design, operate and improve processes, policies, procedures, activities, devices, practices, or other conditions and/or actions that maintain and/or modify risks and supervise their effectiveness • Ensure compliance through managerial and supervisory controls and highlight any breakdown in control, variations in or inadequate processes and unexpected events, supported by routine performance and compliance information
Second line of defence	
Functions and activities that monitor and facilitate the implementation of effective risk management practices and facilitate the reporting of adequate risk related information up and down EPUT	• Clinical Audit - The universally accepted definition for both national and local clinical audit as defined by the National Institute for Health and Care Excellence (NICE) in their 'Principles for Best Practice in Clinical Audit' NICE, 2002 is: 'A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery.' • Other methods bring expertise, process excellence, and monitoring alongside the first line of defence to help ensure risk is effectively managed – examples would be internal compliance inspections, reviews or assessments carried out against standards, policy and/or regulatory considerations across EPUT
Third line of defence	

Internal audit (carried out by appointed Auditors external to the Trust but still referred to as internal auditors)	• The internal audit function will use a risk-based approach to its work, providing an objective evaluation on behalf of the Audit Committee of how effectively EPUT assesses and manages its risks, including the design and operation of the first and second lines of defence. It should encompass all elements of the risk management framework and include in its potential scope all risk and control activities. It may also provide assurance over the management of cross-organisational risks and support the sharing of good practice between organisations, subject to considering the privacy and confidentiality of information • The scope of each review is agreed in advance with relevant Directors and aligns to the Internal Audit plan agreed by the Audit Committee

The following factors may influence the value and level of assurance:

Age	The time elapsed since assurance obtained
Durability	Whether it endures as a permanent assurance on an historic matter e.g. auditors report on financial statements, or work that loses relevance over the passage of time e.g. clinical audit
Relevance	The degree to which assurance aligns to a specific area or objective over which it is required
Reliability	Trustworthiness / dependability of the source of assurance
Independence	The degree of separation between the function over which assurance is sought and the provider of assurance
Outcome	The level of assurance given within the external report may be positive or negative

In addition to the three lines of defence described above there are a range of other sources of assurance that support EPUT's understanding and assessment of its management of risks and operation of controls, including:

External Auditors	Primarily the National Audit Office (NAO) who have a statutory responsibility for certification audit of the financial statements However, external audit as appointed by EPUT will fulfil the statutory functions in relation to providing an opinion on the Annual Accounts of the Trust. Audit professionals undertake their work in accordance with specific laws and accounting / auditing standards. They are completely separate from and independent of the organisation.
Value for Money studies	Also undertaken by the National Audit Office, which Parliament use to hold government to account for how it spends public money
Infrastructure and Projects Authority	Arrange and manage independent expert assurance reviews of major government projects that provide critical input to HM Treasury business case appraisal and financial approval points
Stakeholder feedback	Valuable assurance is provided to the organisation through feedback from stakeholders, including patients, visitors, staff, Governors, Trust members, and partner organisations such as Local Authorities and Commissioners. The view of our carers and service users are captured through mechanisms such as: • Patient Experience Team • Public Board meetings • Planning events • Patient/ service user surveys • Carer surveys • Complaints • Healthwatch • EPUT public website • Patient engagement events • Local Equality and Diversity forums • Members meetings

	• Council of Governors meetings

10.0 Links

As risk management is an integral part of the activity of all Trust functions, this framework will need to be read in conjunction with Trust Strategies, other supporting frameworks, policies and procedures, and in particular, the Safety First, Safety Always Strategy.

11.0 Monitoring, Review and Audit

The key to effective monitoring of the Trust's risks is the availability of relevant, accurate, and timely information. The Strategic Risk Register, Corporate Risk Register and Directorate/ Care Unit Risk Registers will provide a basis for the holistic assessment of risk performance by the Trust Board of Directors and its Standing Committees.

The Audit Committee is responsible for overseeing the implementation of this framework and taking all actions associated with risk management and assurance processes. The Committee will monitor progress at least every six months or at the request of the Chair. In addition, it will receive an Annual Report. Exception reporting will take place to the Board of Directors

The Audit Committee acts as a co-ordinator of external sources of assurance, namely internal and external audit. The Audit Committee will use these services to contribute to the monitoring of the assurances and will provide resources to assist in providing assurances of controls through the Annual Audit Plan.

The organisation will monitor the effectiveness of the implementation of this Framework using audit. Internal Audit will carry out a review of the risk management arrangements, usually on an annual basis to support annual governance and self-certification arrangements and production of the Annual Governance Statement.

The framework will be in place for a three-year period with an annual review

Monitoring Committee Structure	
Board of Directors	• The Audit Committee will inform and advise The Board of Directors on the soundness and effectiveness of systems and processes in place for meeting its objectives and delivering appropriate outcomes including independent assurance. The Board of Directors will achieve this by: • Taking a strategic view of risks and leading the assessment and management of risk • Ensuring clear accountability for managing risks using managers equipped with the relevant skills and guidance to perform their roles effectively and efficiently • Ensuring roles and responsibilities for risk management support effective governance and decision-making at each level with appropriate escalation, aggregation and delegation • Determining and continuously assessing the nature and extent of the principal risks to achieving Trust objectives and ensuring planning and decision-making reflect the assessment • On-going monitoring of the effectiveness of the resulting Board Assurance Framework. To receive a detailed BAF report at each Board meeting to ensure management of risks through appropriate controls and evidenced through robust assurances. Identify further strategic risks for inclusion in the BAF • Ensuring that its Standing committees complete and report on their specific responsibilities as defined in this document and their Terms of Reference • Review annually risks to be carried forward to the following year's Strategic Risk Register and Corporate Risk Register • Undertake training in risk management on an annual basis • Using horizon scanning to identify emerging sources of uncertainty, threats and trends • Assessing compliance with the Corporate Governance Code including explanations of any departures within the governance statement of EPUT's annual report and accounts
Audit Committee	• The Audit Committee independently monitors and reviews the establishment and maintenance of an effective system of integrated governance, risk management, and internal control across the whole organisation's activities (both clinical and non-clinical), that support the achievement of the organisation's objectives. • Where appropriate the Audit Committee will, through its independence, facilitate and support the attainment of effective governance processes. • The Audit Committee receives an Annual Risk Management and Assurance Report that describes the achievements made in developing the Board Assurance Framework and that this is properly utilised by the Standing Committees of the Board of Directors and by the Executive Directors to identify and adequately manage risks and identify mitigating actions. • The Audit Committee supports the Board in its role of leading the assessment and management of risk by: o Understanding EPUT's strategy, operating environment and associated risks o Understanding the role and activities of the Board in managing risk o Discussing EPUT's policies, attitude to and appetite for risk o Understanding the risk management framework o Critically challenging and reviewing the risk management framework to evaluate how well it is working o Critically challenging and reviewing the adequacy and effectiveness of control processes in responding to risks within EPUT's governance, operations, compliance and information systems
Standing Committees	• Standing Committees will take responsibility for overseeing the management of various risk and assurances processes used by the Trust. They ensure that sub-committees and individuals manage risk and provide assurances relating to the achievement of the organisational objectives at an operational level. They will implement controls and take action to minimise risks. They will scrutinise the risks (hotspots) and variations to performance highlighted by the Executive Operational Sub-Committee, seeking assurance that the risks are clearly articulated and mitigating action has or is taken by Executive Directors. They will also identify any

Monitoring Committee Structure	
	further risks to performance as a result of consideration of reports provided and to monitor progress made with implementing action to address identified risk. • Each Standing Committee has its own Terms of Reference to which it will operate and manage the review and scrutiny of risks. • Standing Committees have a range of sub-Committees (referred to as Tier 3) reporting to them, having their own Terms of Reference and managing risks appropriate to them.
Executive Team	• The Executive Team is a sub-Committee of Finance and Performance and will receive the detailed Board Assurance Framework and/or risk register reports a minimum of bi-monthly • The Executive Team will make decisions on changes to risk scoring and ratification by the Board of Directors via the CEO. • The Executive Team has the responsibility of regularly overseeing the progress and developments within individual Directorate/ Care Unit Risk Registers to an approved reporting schedule and review risks rated at 8 and above. • This review will ensure that the contents of the Directorate/ Care Unit Risk registers are accurate, relevant, and comprehensive, and that the risks are being managed at an appropriate level within the organisation. • The Executive Team will provide the forum for Executive Directors to discuss and review risks identified through operational reports, SMT minutes, Directorate/ Care Unit Risk Registers, and risk assessments for potential escalation to the Strategic and Corporate Risk Register • The Executive Team will identify hotspots from performance reports to escalate to a risk register • The Executive Team will make decisions on and take to the Board for ratification of new risks, movement of risks and closure of risks as required
Specialist Committees	• A range of specialist Committees, such as Health, Safety and Security, Fire Safety, and Information Governance, exist to review specific risk issues, advise on the management of risks, and escalate risks as appropriate in line with the Trust's approved governance structure • Specialist Committees will also be responsible for identifying risks from trends from across the organisation and will be responsible for escalating those trends which are increasing in potential severity or which are likely to pose a threat to other Directorate objectives or to the Trust's organisational objectives to the appropriate Board Standing Committee • Understand and utilise the concept of risk stratification in order to prioritise and programme any works required to mitigate risks
Accountability Framework Meetings	• Care Unit Accountability Framework Meetings will receive a risk register report highlighting the most significant risks • The Accountability Framework Meeting is responsible for seeking assurance that risks are being managed
Operational Groups	• Service Management Teams (SMT)/ Care Unit Groups, and Governance Committees will be responsible for identifying local risks, agreeing Directorate Risk Registers, reviewing and challenging mitigating actions, and monitoring implementation. • Directorate/ Care Unit Risk Registers will be composed of local risks that the Directorate has identified. • Service Management Teams and operational management teams will need to manage these risks and agree to escalate any local risks which are increasing in potential severity or which are likely to pose a threat to other Directorate objectives or to the Trust's organisational objectives to the Executive Team. • SMTs will be responsible for ensuring that DRR's are kept up to date and that the information contained in them is accurate and relevant and will review monthly through delegated leads.

Appendix 1

EPUT Risk Appetite

Aim

The aim of the EPUT risk appetite is to provide a decision making tool which assists in understanding the level of risk that EPUT is willing to accept while pursuing our Strategic Objectives and before any action is determined to be necessary in order to reduce the risk. The risk appetite is critical for successful risk management and facilitates effective decision making and strategic alignment of decisions with organisation strategy. The risk appetite will further develop into a decision making tool for use at all levels of the organisation.

EPUT's statement of risk appetite follows in depth discussion with the Executive Team and Board of Directors. EPUT will undertake reviews of its risk appetite regularly and a full review of risk appetite will coincide with the annual review of EPUT's Risk Management and Assurance Framework.

Risk Appetite Statement

- EPUT will take risks in order to achieve our vision, purpose and values and deliver beneficial outcomes to patients/ service users and all stakeholders.
- The definition of risk appetite in the context of EPUT is the type and amount of risk we are willing to accept in order to achieve our strategic objectives without compromising delivery of safe, high quality care to patients/ service users.
- Articulation of risks will enhance EPUT decision-making by focusing on strategy and objectives to enhance long-term sustainability. Risk appetite will be an integral part of EPUT decision-making.
- The Board of Directors will agree the approach to incorporate appetite into decision-making. The decision-making approach will be anticipatory of emerging risks to enable agility and resilience.
- EPUT will anticipate and understand risks in order to embrace change and be agile in challenging times. We will drive innovation though a culture of continuous learning and improvement of services whilst considering the significance and potential impact of any risks created. EPUT must understand the changing health and care landscape and its reaction to it.
- We will know the amount of risk we are willing to take when considering strategies and objectives. The choice of strategy and objectives will be significant factors to providing high quality, safe care.
- EPUT will balance the relationship between acceptable risk, value for money and reward. Our strategy precedes our objectives that link to decision-making around vision, purpose and values.
- We will avoid conflict by aligning risk appetite with the development of strategy and business plans.
- Understanding our vision, purpose and values will enable the building of strategies that inform risk. EPUT will be aware of emerging risks throughout the life of its strategy and may review strategy accordingly.
- Knowing our capabilities will drive our values and we will have a reduced appetite for any loss of those capabilities.
- We will use risk appetite to develop tolerances, measures, key performance indicators, and triggers, in order to monitor performance in business as usual.
- Tolerance refers to the boundaries of acceptable variations in performance versus objectives. Tolerance will apply to significant objectives, will cascade through the Trust to provide guidance for business as usual, and will support the understanding of appetite.

EPUT Domains	Impact
Safety	Impacts on the safety and wellbeing of service users, staff, and visitors
Compliance	Impacts on the conformance with legislative obligations, statutory duties, compliance with regulatory requirements, quality/ professional standards and audit recommendations
Service Delivery	Impacts on the intended, expected, contracted and continuous delivery of services (including business continuity)
Experience/ Quality	Impacts on the experiences of service users, carers, staff and visitors and service user outcomes, staff wellbeing and environmental sustainability
Financial	Impacts on financial autonomy and sustainability
Reputational	Impacts on the reputation amongst stakeholders, the wider community and general public

EPUT Risk Appetite					
Safety	**Compliance**	**Service Delivery**	**Experience/ Quality**	**Financial**	**Reputational**
Open	**Moderate**	**Open**	**Moderate /**	**Open**	**Open**
EPUT maintains sound strategic direction incorporating a commitment to safe, high quality delivery within an integrated care system. EPUT has a sound basis for partnership and integrated working, with an open and honest approach to its safety ambitions. EPUT demonstrates a sound basis for investment in and focus on early intervention and prevention.	EPUT will strive to ensure a maximum limit of no more than 'challenging external recommendation or improvement notice'. Any enforcement action, prosecution, improvement notices, low performance ratings and critical reports imposed on EPUT can have a negative effect on the workforce and we may not be able to recruit the calibre of staff that we need to meet our vision, values and objectives.	EPUT will empower managers and selected staff and give others latitude to mitigate any risk of unsafe staffing levels and very low morale. EPUT demonstrates close partnership working to deliver integrated services, sharing of risks and working together in challenging times. Positive staff experience by means of EPUT empowering/ valuing staff has a positive impact on patient/ service user/ carer experience.	Quality and experience with EPUT demonstrating a preference for mainly evidence based practice, underpinned by a sound basis in strategic direction. **Ambitious** Enabling widespread empowerment to EPUT staff reinforces the use of initiative, high morale, and willingness to go the extra mile. Sound strategic direction; with particular focus on our strategic risks in order to mitigate any worst-case scenario Underpinned by an accountability framework, fairness, just and learning culture	EPUT demonstrates its ability to balance the need to make fast, informed decisions on its commitment to deliver safe, high quality services. EPUT demonstrates its ability to make decisions that impact positively on staff wellbeing in challenging times. EPUT demonstrates trust in partnerships in relation to maintaining financial integrity and autonomy and has contingency plans in place through sound programme management. EPUT demonstrates commitment to its population by sound investment and management of finance and resources.	EPUT demonstrates confidence in its commitment to safety first, safety always and its ability to put safety above reputation. EPUT demonstrates its ability to put the safety and wellbeing of its staff above reputation. EPUT demonstrates its ability to encompass integrated and system working to collectively maintain public confidence in services. EPUT demonstrates to the public it is honest and open approach to its commitment to safety first, safety always.

Appendix 2

Risk Tolerance Levels

Domains	Risk Tolerances				
	Averse	Vigilant	Moderate	Open	Ambitious
SAFETY	Minimal injury requiring no/minimal intervention or treatment No time off work An event which impacts on more than one but less than 10 patients / members of staff	Minor injury or illness, requiring minor intervention Requiring time off work for more than three days Increase in length of hospital stay by one-three days An event which impacts on more than 10 patients/staff	Moderate injury requiring professional intervention Requiring time off work for four-14 days Increase in length of hospital stay by four-15 days RIDDOR/ agency reportable incident An event which impacts on more than 20 patients/ staff	Major injury leading to long-term incapacity/ disability Requiring time off work for more than14 days Increase in length of hospital stay by more than15 days Mismanagement of patient care with long-term effects An event which impacts on more than 50 patients / staff	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on more than 100 patients / staff
QUALITY/ EXPERIENCE	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry Loss/ interruption of more than one hour Minimal or no impact on the environment	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved Loss/ interruption of more than one day Minor impact on environment	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential independent review) Repeated failure to meet internal standards Major patient safety implications if findings not acted upon Loss/ interruption of more than one week Moderate impact on environment	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report Loss/ interruption of more than one month Major impact on environment	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted upon Inquest / ombudsman inquiry Gross failure to meet national standards Loss/ interruption of more than three months Catastrophic impact on environment
SERVICE DELIVERY	Short-term low staffing level that temporarily reduces service quality (less than1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (more than one day) Low staff morale Poor staff attendance for mandatory/ key training	Uncertain delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (more than five days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objective/ service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
COMPLIANCE	No or minimal impact or breach of guidance / statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations / improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Domains	Risk Tolerances				
	Averse	Vigilant	Moderate	Open	Ambitious
REPUTATION	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with less than three days Service well below reasonable public expectation	National media coverage with more than three days Service well below reasonable public expectation MP concerned (questions in the House) Total loss of public confidence
FINANCIAL	Small loss less than 0.1 per cent of budget Claim less than £100,000 Insignificant project cost increase/ schedule slippage	Loss of 0.1–0.25 per cent of budget Claim(s) between £100,000 and £250,000 Less than five per cent over project budget plus schedule slippage	Loss of 0.25–1.0 per cent of budget Claim(s) between £250,000 and £1 million Five–10 per cent over project budget plus schedule slippage	Uncertain delivery of key objective / Loss of 1.0–3.0 per cent of budget Claim(s) between £1m and £3m Purchasers failing to pay on time Non-compliance with national 10–25 per cent over project budget Schedule slippage and key project objectives not met	Non-delivery of key objective/ Loss of more than3 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) more than £3 million Incident leading to more than 25 per cent over project budget Schedule slippage and key project objectives not met

Appendix 3

Risk Assessment Form – expand sections as required

Ward or Team:	**Directorate:**
Name of person completing:	**Title of person completing:**
Date risk identified:	**Target risk date:**
Accountable Manager:	**Manager/ Director responsible for risk:**

Risk Description	
Risk Title:	
Summary of risks/ hazards:	
Context:	
Cause:	If
Event:	Then
Effect:	Resulting in

Controls				
Current Controls List the current controls already in place to mitigate the risk Consider Resources, Policy/Process, Innovation, Technology, Investment, Detection and Contingency	**Gaps in controls** list the gaps in controls that need to be put in place to mitigate the risk	**Controls Assurance** list the evidence that the above controls are in place and effective		
		Level 1 Function/ Department	**Level 2** Organisational Oversight	**Level 3** Independent Assurance

Negative Assurance: list any evidence for lack of management or reduction in mitigation

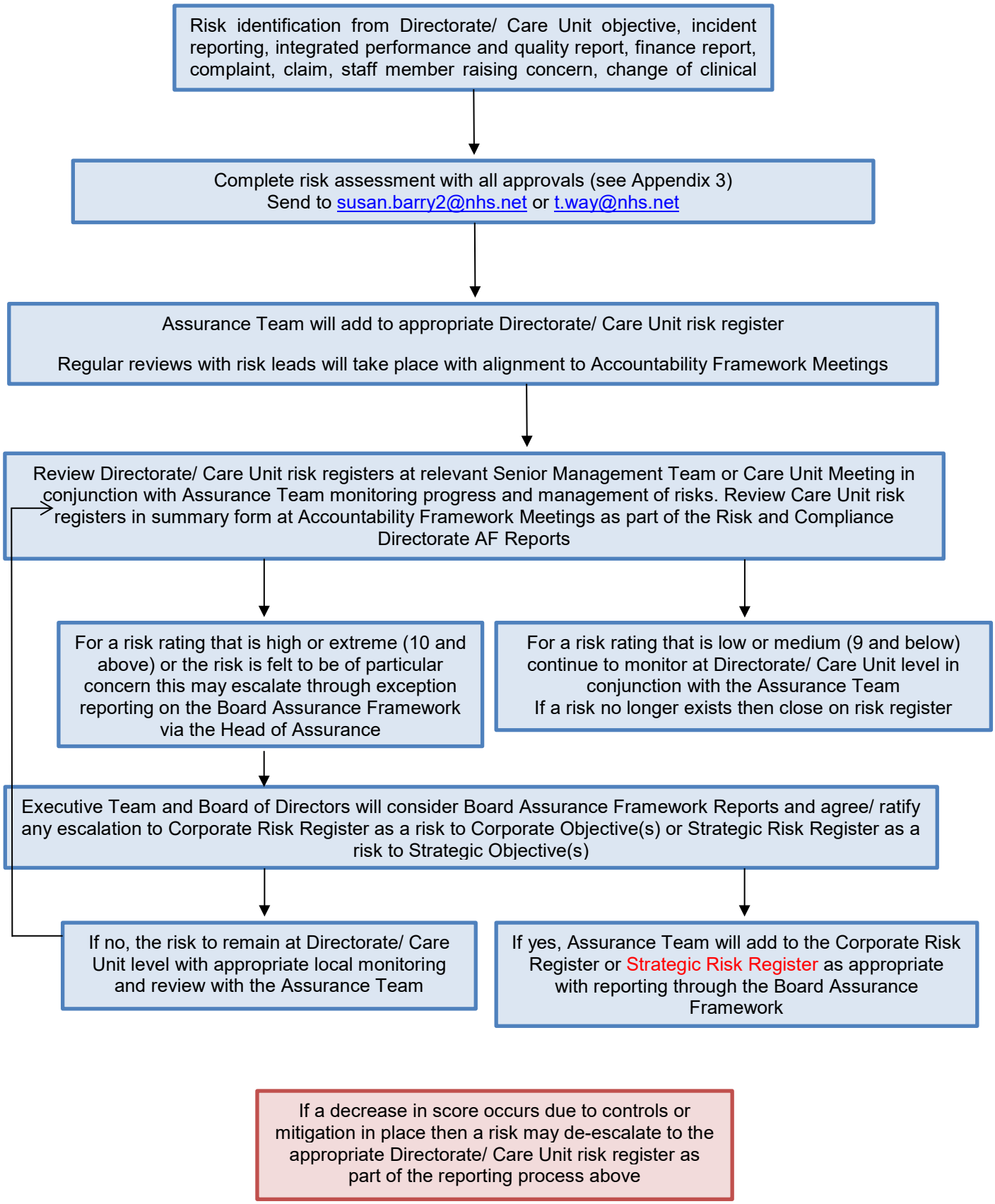
Actions/ Tasks to mitigate the risk, provide assurance or implement a control		
Action	**By Whom**	**Completion Date**

Risk Rating:		
Level of Risk	**Care Unit/ Directorate: Yes/ No**	**For Escalation to Corporate Risk Register: Yes/ No**
Initial Risk Score before mitigation – consequence x likelihood		
Current Risk Score – consequence x likelihood		
Target Risk Score following all mitigation – consequence x likelihood		

Approvals:	
Line Manager – name and date	
Risk Owner – name and date	
Care Unit/ Directorate approval – state meeting and date at which approval given	

Appendix 4

Local Risk Assessment and Escalation Process



If a decrease in score occurs due to controls or mitigation in place then a risk may de-escalate to the appropriate Directorate/ Care Unit risk register as part of the reporting process above

		Agenda Item No: 9(i)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

Report Title:	**Ligature Risk Management Q2 Report**					
Executive/ Non-Executive Lead:	Alex Green, Executive Chief Operating Officer					
Report Author(s):	Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Ligature Risk Reduction Group (LRRG) Health, Safety and Security Committee (HSSC) Executive Operational Team (EOT) Quality Committee (QC)					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	CRR81 - 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	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	~~Yes~~/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes~~/ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

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

Purpose of the Report		
This report provides the Board of Directors with: • An update and assurance on the key risks associated with ligature from a fixed point within the Trust's in-patient estate and activities that were undertaken within the Trust for Q2. • An outline of activities planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's in-patient estate.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance given in respect of actions identified to mitigate risks
3 Request any further information or action

Summary of Key Issues

Independent Assurance

- Recommendations from the East London NHS Foundation Trust (ELFT) peer report continue to be taken forward. The developed action plan continues to be monitored bimonthly by the Ligature Risk Reduction Group (LRRG) and currently, 10 actions have been fully addressed with 1 remaining in progress.
- Testing against the CQC briefing guide for inspection teams continues to be taken forward.

Governance

- A review of the current membership and structure of LRRG is being undertaken to ensure an effective focus and support of clinical assessment and management of ligature risks.
- All Mental Health and Learning Disability wards have received a Ligature Environmental Risk Assessment in the last 12 months and received a 6 month follow up review which continues to focus on clinical risk management and staff coaching.
- Action required following a ligature risk assessment is recorded and monitored. Any extreme and high risk overdue actions are discussed in detail monthly and followed up by members of LRRG.
- Partial reviews of the Policy and Procedure were undertaken and approved in Q2 to incorporate learning and reflect agreed standards.
- There remains an open risk around ligature risk reduction in the corporate risk register (CRR81). The action plan continues to be monitored and has been revised to reflect the changes in focus of the Ligature Risk Reduction Group.

Continuous Learning

- Following the successful establishment of a networking forum with other Trusts, the group has met thrice and continues to work towards its aims to provide an opportunity for Mental Health Trusts risk management and clinical teams to work collaboratively in the reduction, response and learning from ligature risk incidents.
- The monthly EPUT staff ligature forum continues successfully with positive feedback being received from attendees.
- During the Q2 reporting period, 1st July 2022 – 30th September 2022, LRRG continued to receive incident analysis and identified learning in conjunction with national and local safety alerts.

Enhancing Environments

- The LRRG continues to develop the agreed risk reduced environmental standards that inform the Trust's investment and patient safety improvement works programme
- The Trust Ligature risk reduction project is continuing with a clear project plan monitored by the Executive Safety Oversight Group.

Culture - Staff Training

- TIDAL ligature risk assessment training: This EPUT bespoke training continues to provide ligature risk assessment training to staff.
- E-learning "Preventing Suicide by Ligature": The online training continues to be mandatory for staff and compliance is monitored monthly at LRRG.

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		**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	LRRG	Ligature Risk Reduction Group
EERG	Estate Expert Reference Group	ELFT	East London Foundation Trust
CRR	Corporate Risk Register	LD	Learning Disability
MH	Mental Health		

Supporting Reports/ Appendices /or further reading
Ligature Q1 Report

Lead
Alex Green **Executive Chief Operating Officer**

Agenda Item: 9i
Board of Directors Part 1
30 November 2022

LIGATURE RISK MANAGEMENT – Quarter 2

1.0 INTRODUCTION

This report provides an update and assurance the of the work that has been undertaken and areas that are planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate.

The Trust is committed to continuously improving systems and processes that facilitate robust risk identification and management; carrying out patient safety improvement works to create safer physical environments; and to creating a risk aware culture.

The Board of Directors has identified the potential risk associated with this agenda as one of the most significant potential risks that may prevent achievement of the Trust strategic objectives and this potential risk is therefore recorded in the Corporate Risk Register (CRR81). A robust action plan is in place to mitigate this potential risk. Reports on the action that has been taken are provided regularly to the Board of Directors.

This report aims to assure members that the focus on mitigating this potential risk continues to be a priority.

Whilst this report does confirm that the focus on mitigating risk continues to be strong and that progress continues to be made, members are reminded that managing ligature risk associated with the physical environment must be considered in the wider context of care provision that includes training, staffing, security, patient risk assessment, patient engagement, observation and care planning.

It also has to be recognised that the Trust's inpatient environments, consistent with many providers of mental health services, will rarely be entirely free of fixed ligature points. This is because most physical environments were not designed to mitigate the potential risks being identified currently, and/or there are no design solutions to eliminate identified potential risk entirely from all infrastructure, fixtures and fittings.

2.0 INDEPENDENT ASSURANCE

2.1 ELFT Review

The action plan that was developed following the peer review with East London NHS Foundation Trust (ELFT), continues to be monitored bimonthly by the LRRG. 10 actions have been fully addressed with 1 remaining in progress and this continues to be reviewed and monitored bimonthly by LRRG.

2.2 CQC New Inspection Criteria

Work continues to be undertaken in regards to the self-assessments against the revised CQC Brief Guide to assessing Ligature Anchor Points and Ligatures criteria. The action plan that was developed to test EPUT's systems and processes against this guide is monitored bimonthly by LRRG. At the end of Q2, 15 of the 20 actions were fully addressed and completed.

3.0 GOVERNANCE

3.1 Ligature Risk Reduction Group

A further review of the current membership and structure of LRRG is being undertaken to ensure an effective focus and support of clinical assessment and management of ligature risks.

The Estates Expert Reference Group, chaired by the Executive Chief Finance Officer, meets monthly to oversee a wide range of environmental patient safety improvement works identified as a result of ligature risk assessments and setting of agreed standards by the Ligature Risk Reduction Group.

The ligature project supported by the Performance Management Office is continuing with updates reported to Estates Risk Reduction Group (ERRG), LRRG and Executive Safety Group. The chart below outlines the current Governance arrangements for the project group feeding into Trust committees:

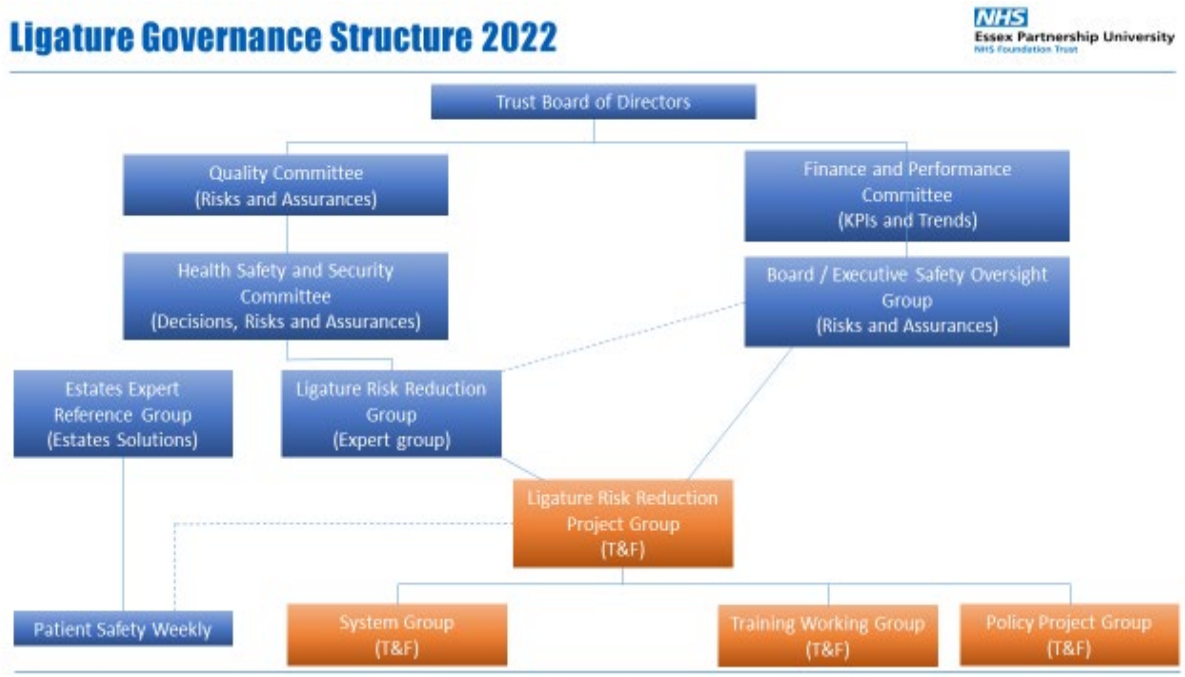


Figure 1: Governance Structure

Quarterly Ligature reports are shared with the Trust Quality Committee and Trust Board of Directors to provide assurance reporting and risk escalation

3.2 Policy and Procedure

Partial reviews of the Policy and Procedure were undertaken and approved in Q2 to incorporate learning and to reflect agreed standards. Appendices 5 and 9 were reviewed and approved by LRRG and Health, Safety and Security Committee (HSSC). Work continues with the Project Management Team to further review the policy and building a 'policy on a page' template with the aim to make the policy easily accessible to staff.

3.3 Ligature Environmental Risk Assessment

All Mental Health and Learning Disability wards have received a Ligature Environmental Risk Assessment in the last 12 months and received a 6 month follow up review which focuses on clinical risk management and staff coaching.

Compliance checks within the Risk team continue to ensure all ligature risk assessment tools and reports are completed correctly and in line with policy.

Action required following a ligature risk inspection is recorded and monitored on a database held by the Risk Team through to completion. There is a significant decrease in open actions and this is due to focused work that is being carried out to address open and overdue actions by the Risk and Estates Teams.

Each month, any extreme and high risk overdue actions are discussed in detail and followed up by members of LRRG.

3.4 Co-production

The protocol to safely include a person with lived experience (PWLE) as part of the ligature inspection team has recently been reviewed with the Patient Experience team. This is part of the work currently underway to progress the initiative to include a PWLE on the annual full ligature inspections. This is currently being reviewed, along with the current protocol.

3.5 Corporate Risk Register, (CRR81)

The Trust continues to have an open risk on the corporate risk register around Ligature risk reduction, CRR81. The action plan has been reviewed and updated to reflect ongoing learning, changes in focus and within the terms of reference of the Ligature Risk Reduction Group. Thus the focus of the action plan is on risk awareness, clinical risk management as well as the physical environment.

4.0 CONTINUOUS LEARNING

4.1 Estates and Facilities/National Patient Safety Alerts (NatPSA)

There have not been any NatPSA or Estates and Facilities Patient Safety Alerts directly relating to ligature risks issued in Q2.

4.2 Learning Forums

The Trust's approach to identifying and mitigating potential risk is constantly subject to reflection and review, informed by independent review (as detailed above), incident data and internal scrutiny. The Compliance team have set up a local networking ligature forum with leads from neighbouring trusts to enable wider learning and sharing of ligature awareness. To date the group has meet twice and continues to work towards its aims to provide an opportunity for Mental Health Trusts risk management and clinical teams to work collaboratively in the reduction, response and learning from ligature risk incidents.

Following LRRG approval, the internal monthly EPUT Ligature Forum that is aimed at providing a platform to share learning and deliver coaching, continues to be held monthly. The forum has been successfully held three times and has had good attendance by trust staff. The discussed topics thus far have been well received with attendees providing positive feedback. The review of the forum will be undertaken in the autumn and reported to LRRG.

4.3 Ligature Incident Data

A bi-monthly report is presented to LRRG detailing ligature incidents involving a fixed anchor point within EPUT's inpatient wards. This report facilitates discussion with the wider Multi-Disciplinary Team (MDT) represented within the group to identify learning.

To compliment this, a quarterly incident report is presented to LRRG providing an overview of ligature incidents in which a mental health inpatient has attempted/succeeded self-harm. The report details incidents using both a secured point to fix a ligature and an unsecured ligature. This increases understanding of incidents and any emerging trends in order to increase learning and adopt safer practices.

Good practice and lessons continue to be identified from reported incidents with a common theme pertaining to the following:

- Appropriateness of implemented technology.
- Quick response of staff to incidents thereby facilitating effective patient safety.
- Consistent approach to risk required.
- Staff awareness.

Learning is identified and shared in detail at LRRG.

5.0 ENHANCING ENVIRONMENTS

Setting Environmental Standards

The LRRG has, and continues to develop agreed risk reduced environmental standards that inform the Trust's investment and patient safety improvement works programme and these are appended to the Ligature Risk Management Policy and Procedure. The environmental standards are updated to take into account all known safety alerts and ligature learning. In Q2, the standards were reviewed to reflect agreed standards.

Ligature Risk Reduction Project

The trust Ligature Risk Reduction management project group continues with a clear project plan monitored by the Executive Safety Oversight Group.

Initially, the primary focus of the Ligature Risk Reduction project was to address environmental concerns, which has seen significant progress. As the project progresses, focus is now on environment, policy and training as it was recognized that the environment alone was not a significant factor in the majority of incidents . Working Groups were been established for each of the identified areas and leads assigned. In order to drive this work forward, leads have been identified for each area and Short Life Working Groups were been established.

6.0 CULTURE – STAFF TRAINING

We continue with the aim to develop a culture of risk awareness and continuous learning when incidents happen. An essential part of developing this culture is having robust training programmes for staff. As such all staff working within a mental health / learning disability inpatient setting are required to complete the ligature awareness on-line training package “Preventing Suicide by Ligature” on an annual basis.

Overall Trust compliance with training as of the end of September 2022 has increased to 90%. The compliance of staff training is monitored monthly by the LRRG and any potential risk is escalated should the figures be below the Trust’s target.

The trust continues to offer staff the bespoke TIDAL ligature risk assessment training. From May 2022, this training was extended to now include those of a Band 4 and above to increase ligature awareness of our staff across the inpatient mental health wards. The training is delivered over 2 full days by TIDAL Training; attendees include clinical staff, members of the risk team and estates staff who undertake ligature risk assessments. To date 96 staff have been trained as follows:

- 68 Clinical staff
- 13 Estates staff
- 15 Corporate/Risk Staff

Of the 96 staff who have completed the training, 68 are clinical staff, this breaks down into the core services as:

Core Service	No. of Staff Trained
Acute Wards for Adults of Working Age	26
Secure Wards - Forensic Inpatient	17
Wards for Older People with Mental Health problems	12
CAMHS	7
Rainbow Unit	1
Wards for People with Learning Disability or Autism	2
Liaison Service	3

Table 1: Breakdown of clinical staff trained per core services

The overall aim of the sessions is to equip and skill staff members to be confident in identifying ligature risks and to continue to monitor and update risk assessments for their individual work areas.

The uptake of this training is also monitored via LRRG where operational leads are advised of the need to ensure more staff enrol on the training. The next TIDAL training session is booked for November 2022.

7.0 CONCLUSION

The summary of information provided in this report is by its nature only a snapshot of the work that is taking place by frontline clinical staff, risk and estates specialists and the wider leadership team.

The focus on mitigating ligature risks continues to be strong and progress continues. However, it should be recognised that managing ligature risk associated with the physical environment must be considered in the

wider context of care provision that includes training, staffing, security, patient risk assessment, patient engagement, observation and care planning

It is intended that the information provides sufficient assurance that the Trust continues to take action and mitigating the risk of ligature seriously.

8.0 ACTION REQUIRED

The Board of Directors are asked to:

1 Note the contents of this report
2 Confirm acceptance of assurance given in respect of actions identified to mitigate risks
3 Request any further information or action

Report Prepared By

Nicola Jones
Director of Risk and Compliance

On behalf of

Alex Green
Executive Chief Operating Officer

		Agenda Item No: 10a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

Report Title:	CQC Compliance Update					
Executive/Non-Executive Lead:	Denver Greenhalgh, Senior Director of Corporate Governance and Corporate Affairs					
Report Author(s):	Alison Buckland Compliance Officer					
Report discussed previously at:	Executive Operational Team Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
The purpose of this report is to: 1. Provide an update on the key CQC related activities being undertaken within the Trust. 2. Provide details of CQC guidance/updates received.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to

1. Receive and note the content of the report.

Summary of Key Issues

- EPUT is registered with the CQC.
- The CQC are actively inspecting our adult mental health services.

- We continue to have in place the intensive support group meeting weekly, with membership from all MH wards and Specialist Service wards to ensure actions are taken across the Trust.
- We continue to progress the CAMHS action plan with 20 (80%) individual 'must do' actions complete; 5 (20%) ongoing and 2 (8%) approved for extension by the Quality Committee to December 2022 (noting overdue their original stated deadline).
- One enquiry has been received by the Trust from the CQC in this period.
- One Mental Health Act CQC inspection during September 2022, none have taken place during October 2022.
- We are readying the organisation for the change over to the new CQC Quality Statements, which will replace the Key Line of Enquire from January 2023.

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

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

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	EPUT	Essex Partnership University Trust
CAMHS	Child and Adolescent Mental Health Service	EOT	Executive Operational Team
PICU	Psychiatric Intensive Care Unit	CCG	Clinical Commissioning Groups
MHA	Mental Health Act		

Supporting Documents and/or Further Reading
Main Report

Lead
Denver Greenhalgh **Senior Director of Governance and Corporate Affairs**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC COMPLIANCE UPDATE

1.0. INTRODUCTION

The purpose of this report is to provide an update on the key Care Quality Commission (CQC) registration requirements and related activities within the Trust. The report provides details of guidance/updates that have been received since the previous report.

2.0. CQC REGISTRATION REQUIREMENTS

2.1 Registration

EPUT is fully registered with the CQC.

3.0. CQC INSPECTIONS

3.1. Galleywood Ward & Willow Ward October 2022

The CQC undertook an unannounced inspection of Willow ward on 5 October and Galleywood ward on 6 October following advanced notification by the Trust of the allegations included within the Channel 4 Dispatches documentary. As a consequence of these concerns the CQC considered that there was a need for significant improvement and under a section 29A notice asked the Trust to make improvements by the 18 November 2022. The Trust fully complied and reported back to the CQC.

On Tuesday 22 November 2022, the CQC commenced an unannounced inspection of the following core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Mental health crisis services and health-based places of safety
- Substance misuses services
- Community-based mental health services for adults of working age

In response to the CQC inspection the Inpatient Clinical Support Group has been escalated to an intensive support group, meeting weekly. The group membership includes all mental health wards and Specialist Service wards to ensure actions are taken across the Trust. The group will continue to meet weekly and work on improvements, while the Trust awaits the CQC report. Initial focus has been on the actions to address immediate issues and working through to understand why these issues have been found. The group have identified a number of work streams already in place within the Trust to address some of these issues, including:

- Safer Staffing Project
- Time to Care
- Oxevision Project
- E-Observation Pilot

3.2. CAMHS March 2022

The CAMHS improvement planning group has continued to meet to take forward the actions. The table below summarises progress with the actions identified to address the CQC 'must do, recommendations. Each recommendation has a number of specific actions that address the overall recommendation.

As of November 2022, 20 (80%) individual 'must do' actions are reported as being complete; 5 (20%) individual actions are in progress and are not yet due for completion and 2 (8%) individual 'must do' actions were approved for extension by the Quality Committee to December 2022 (noting that these were overdue their original stated deadline).

The CAMHS improvement planning group will continue to meet monthly to provide oversight and support to the delivery of the action plan. The CAMHS improvement planning group is committed to delivering the action plan by December 2022

3.3. CQC Mental Health Act (MHA)

The CQC have undertaken 1 MHA inspection during September 2022 to Ruby Ward and none during October 2022. Following each inspection a monitoring report is received by the ward with recommendations for improvement. All wards develop action plans to address these recommendations supported by the MHA Office.

3.4 CQC Enquiries

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

On 25 October the Trust received an enquiry from the CQC, regarding concerns raised by a family member of a former patient. A response for each of the concerns raised was provided to the CQC on 27 October and confirmation that the Trust is undertaking a PSII into the death of the patient named in this enquiry.

4.0. ANNUAL PROGRAMME 2022

The Trust annual plan to promote and monitor adherence to the fundamental standards of care (CQC registration requirements) has been developed for 2022/23. The following key activity has taken place in October 2022:

4.1. Themes for Focus

The Compliance Team have continued to use analysis from a range of data sources to identify what key themes will be focused on in this period. No new themes were identified in the period.

4.2. Ward / Service Focus

The internal ward heat map document which reviews multiple sources of data has been used to identify key wards/services for focused support. The table below summarises the heat map findings for this period:

Level	Descriptor	Map
Level 1 (score 0-11)	Review for good practice	36 wards
Level 2 (score 12-15)	Ward Review via Accountability Meetings	7 wards

Level 3 (score 16-19)	Compliance Team to visit and consider deep dive	3 wards
Level 4 (score 20+)	Compliance Team to visit and consider Rapid Response	0 (zero) wards scoring at level 4

5.0. TRUST COMPLIANCE PROGRAMME

5.1 Ongoing programme of ward/service visits to test compliance with the fundamental standards of care

The Compliance Team visit schedule has been paused since September to enable the Compliance team to focus on the implementation of the new CQC Framework and Quality Statements.

The Compliance Team continue to support Quality Assurance visits and undertake any risk focussed visits to support the Services.

The Compliance team supported Willow Ward and Galleywood Ward, following the unannounced CQC inspection, during October.

5.2 New CQC Approach to Regulation

The CQC has been working with health and social care providers and professionals, the public and other stakeholders to develop a new regulatory model. This has included publication of a new Single Assessment Framework, Quality Statements (replaced current Key Lines of Enquiry) and introduced 6 evidence categories that the CQC will use to organise their findings.

The Compliance Team are taking forward this piece of work using the structure and timeframe stated in appendix 1.

6.0. CQC GUIDANCE / UPDATES

6.1 The CQC are Proposing Changes to the way they Publish Reports and Ratings

The CQC is proposing changes to the way they publish reports and ratings following their assessments of health and social care providers. These updates include the layout of reports on their website, sections and information on how they've assessed providers.

The CQC is aiming to make their reports more accessible to more people, to provide more up-to-date information about services regularly, to help service improve and effectively represent the information they have gathered.

The CQC proposed changes will include a summary about people's experience of the service, a scoring for each quality statement and the ability to navigate through the report online, to enable better navigation of the reports. A rating scale graphic and where the service sits within it will would also be included within these proposed changes as well as a score for the service and the banding for its rating.

The proposed changes will be implemented from October, following assessments using the CQC new approach.

7.0. ACTION REQUIRED

The Board of Directors is asked to:

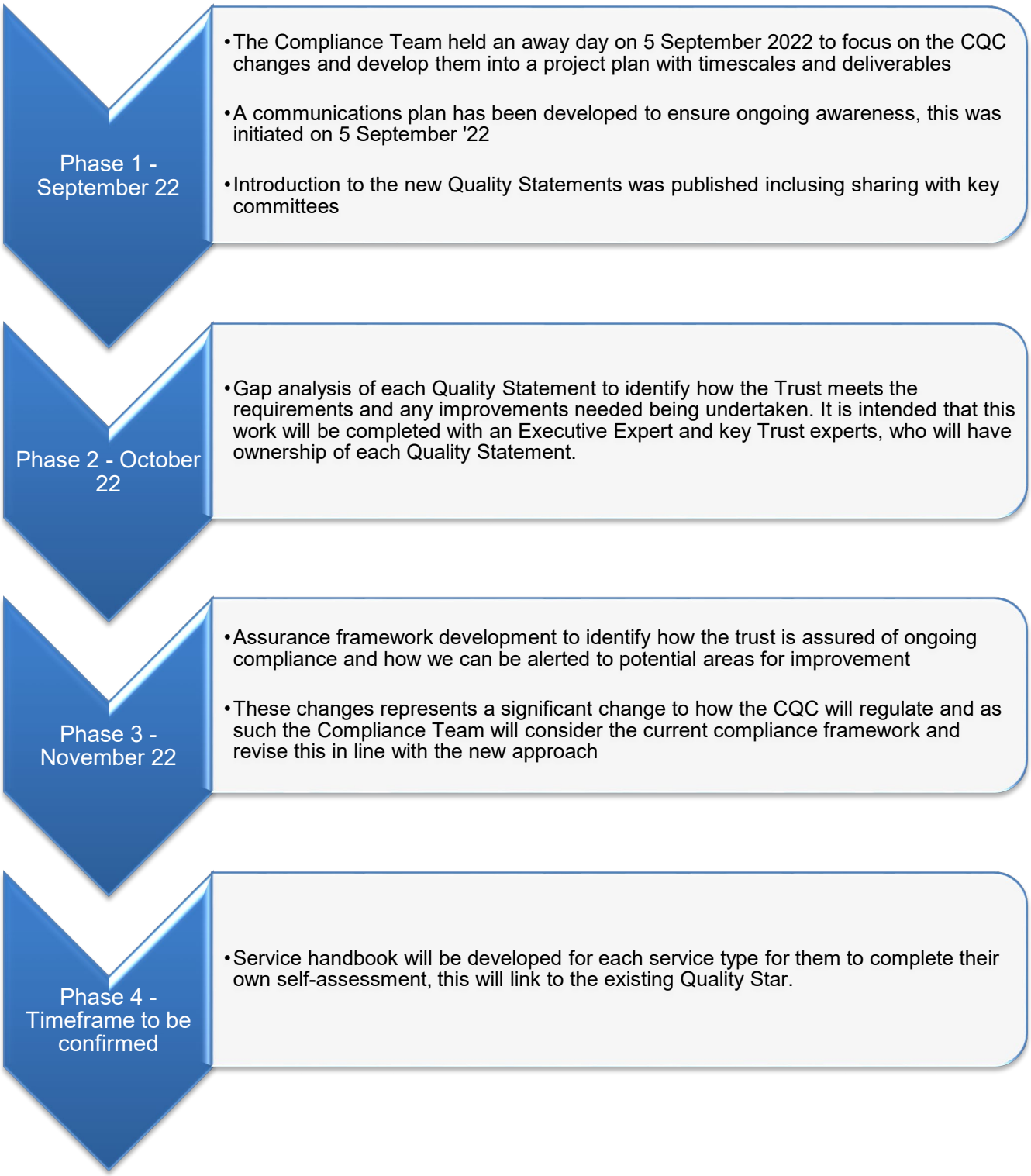
1. Received and note the content of the report

Report Prepared by:

Alison Buckland
Compliance Officer

On behalf of:
Denver Greenhalgh
Senior Director of Governance and Corporate Affairs

Appendix 1:
Single Assessment Framework, Quality Statements programme



		Agenda Item No: 10b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

Report Title:	**Safe Working of Junior Doctors Quarterly Report (July – September 2022)**					
Executive/ Non-Executive Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr Sethi, Consultant Psychiatrist					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

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

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

Recommendations/Action Required

The Board of Directors is asked

1. Note the content of the report.

Summary of Key Issues

The main report provides further details to the following areas of note:

- There are 5 Exception Report raised by trainees. All the issues have been resolved.
- No fines were issued in this quarter.
- There are gaps in the on call rota which are filled by MTI and LAS doctors. The gaps in the rota are much less in this quarter due to better recruitment in August 2022 rotation.
- Refurbishment work at Basildon and Rochford Doctor's room is still pending. Estates are aware.

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

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

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

Acronyms/Terms Used in the Report			
MTI	Medical Training Initative		
LAS	Locum Appointment Service		

Supporting Reports/ Appendices /or further reading
Main Report

Lead

Dr Milind Karale
Executive Medical Director

Agenda Item: 10b
Board of Directors Part 1
30 November 2022

SAFE WORKING OF JUNIOR DOCTORS QUARTERLY REPORT (JULY – SEPTEMBER 2022)

1.0 PURPOSE OF REPORT

The purpose of this report is to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.

2.0 EXECUTIVE SUMMARY

This is the twenty first quarterly report submitted to the Board on safe working of junior doctors for the period 1 July 2022 to the 30 September 2022. The Trust has established robust processes to monitor safe working of junior doctors and report any exceptions to their terms and conditions.

Exception Reporting: (5 Exception reports in this quarter)

07,08 & 11July 2022: FYI trainee raised exception reports on support due to staff shortage i.e lack of Consultant on the ward, Senior doctor being on leave for 3 weeks, Junior doctor being off sick. The matter was resolved after escalating to the relevant Clinical Tutor and Clinical Director. Support was put in place and time off in lieu was given.

12 July 2022: FY1 trainee worked an additional 30 minutes on the ward due to staff shortage. Time off in lieu was given.

22 July 2022: CT1 worked 1 hour extra on the ward due to staff shortage (colleague's annual leave and sick leave). Time off in lieu was given.

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on the 3rd August 2022.

Doctors in Training Data

Total number of posts	144
Number of doctors in training posts (total inclusive of GP and Foundation)	133
Number of doctors in psychiatry training on 2016 Terms and Conditions	79
Total number of vacancies	10
Total vacancies covered LAS/ MTI/Agency	6
Total gaps	4

Agency

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

Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy/Maternity/ sick/COVID	126	126	0	1481.5	1481.5
Total	126	126	0	1481.5	1481.5

Actions taken to resolve issues:

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

1. Rolling adverts on NHS jobs. Few International doctors who were appointed have started their posts.
2. Emails are sent to former GP and FY trainees if they would like to join the bank to do on-calls, this is now part of the termination process for GP's and FY's so they can express an interest in covering extra shifts when they leave EPUT.
3. 11 Fellows under the EPUT Advanced Fellowship programme have been appointed last year
4. The CT and ST posts recruitments were far better during the August 2022 rotation and hence there are less gaps in the rota as compared to the previous quarter.

Fines: None

Issues Arising:

1. Doctors room refurbishment at Basildon and Rochford site are still pending, Estates are aware and are in liaison with the trainee representatives.
2. Funding money from Health Education England is still available to spend by trainees on both Rochford and Basildon site, trainees have been urged to spend their money by end of this year.

3 Action Required

The Board of Directors is asked

1. Note the content of the report.

Report prepared by:

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

On behalf of

Dr. Milind Karale
Executive Medical Director

Oct 2022

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Agenda Item No: 10c

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	30 November 2022

Report Title:	**Standing Orders for the Practice and Procedures of the Council of Governors**					
Executive/ Non-Executive Lead:	Denver Greenhalgh, Senior Director of Governance and Corporate Affairs					
Report Author(s):	Chris Jennings, Assistant Trust Secretary					
Report discussed previously at:	Council of Governors 7 November 2022.					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

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

Purpose of the Report		
Presentation of the Standing Orders for the Practice and Procedures of the Council of Governors following annual review.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to

1 Note the annual review and approve the Standing Orders for the Practice and Procedures of the Council of Governors.

Summary of Key Issues
The Standing Orders for the practice and procedures of the Council of Governors are reviewed on an annual basis as part of maintaining good governance. The Board is asked to note the following amendments: • Removal of references to Monitor where appropriate and being replaced by NHS England. • Replacement of masculine language to be gender neutral for clarity, inclusion and equality. The procedural document has been reviewed and approved by the Council of Governors at its meeting held on 7 November 2022.

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Appendix 1: Standing Orders for the practice and procedures of the Council of Governors (as revised).

Lead

Denver Greenhalgh
Senior Director of Governance and Corporate Affairs

STANDING ORDERS FOR THE PRACTICE AND PROCEDURES OF THE COUNCIL OF GOVERNORS

POLICY REFERENCE NUMBER:	TB02
VERSION NUMBER:	6
KEY CHANGES FROM PREVIOUS VERSION	Minor amendments, including removal of references to Monitor and the "he" pronoun.
AUTHOR:	Trust Secretary's Office
CONSULTATION GROUPS:	Board of Directors Council of Governors CoG Governance Committee
IMPLEMENTATION DATE	April 2017
AMENDMENT DATE(S)	September 2018, September 2019, November 2019, September 2020, September 2021, November 2022
LAST REVIEW DATE	September 2022
NEXT REVIEW DATE	September 2023
APPROVAL BY COUNCIL OF GOVERNORS	7 November 2022
RATIFIED BY	
COPYRIGHT	

POLICY SUMMARY
The purpose of the Standing Orders for the Council of Governors is to set out the practice and procedures of the Council in order to maintain good standards of governance.
The Trust monitors the implementation of and compliance with this policy in the following ways:
Monitoring of implementation and compliance with the Standing Orders for the Council of Governors will be undertaken by the Trust Secretary.

Services	**Applicable**	**Comments**
Trustwide	✓	
Essex MH&LD		
CHS		

The Director responsible for monitoring and reviewing this policy is the Chief Executive Officer

CONTENTS

Regulatory Framework

Essex Partnership University NHS Foundation Trust (the Trust) is a public benefit corporation. It was established on 1st April 2017, following the grant of an application pursuant to Section 56 of the National Health Service Act 2006 (the 2006 Act), by Monitor (now part of NHS England).

The functions of the Trust are conferred by this legislation and the Trust will exercise its functions in accordance with the terms of its provider licence (no: 120163) and all relevant legislation and guidance.

These standing orders add clarity and detail where appropriate. Nothing in these standing orders shall override the Trust's constitution, the National Health Service Act 2006, the Health & Social Care Act 2012 and the Health and Care Act 2022.

The Trust's standing orders and wider governance arrangements are further supported by various policies and procedures.

The principal place of business of the Trust is The Lodge, Lodge Approach, Wickford, Essex SS11 7XX.

1. INTERPRETATION

1.1 Save as otherwise permitted by law, at any meeting of the Council of Governors the Chair of the Trust shall be the final authority on the interpretation of these standing orders (on which they should be advised by the Trust Secretary).

1.2 Any expression to which a meaning is given in the National Health Service Act 2006 or regulations made under it shall have the same meaning in these standing orders and in addition:

1.2.1 **2006 Act** means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

1.2.2 **2012 Act** means the Health & Social Care Act 2012.

1.2.3 **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

1.2.4 **Board of Directors** or **Board** or **Board Member** or **Member of the Board** means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body in accordance with the constitution. This term is used interchangeably with the term **Director**.

1.2.5 **Chair of the Board** or **Chair of the Trust** means the person appointed under paragraph 28 of the constitution by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from a meeting or is otherwise unavailable or such other Non Executive Director as may be appointed as acting Chair in accordance with these SO.

1.2.6 **Chief Executive** is the person appointed as the Chief Executive Officer (the Accounting Officer) of the Trust under paragraph 31 of the constitution.

1.2.7 **Committee** means a committee appointed by the Council of Governors.

1.2.8 **Committee members** means persons formally appointed by the Council of Governors to sit on or to chair specific committees.

1.2.9 **Constitution** means the Trust's constitution which has effect in accordance with Section 56(11) of the 2006 Act.

1.2.10 **Council of Governors** or **Council** means the Council of Governors of the Trust as described in paragraphs 14 and 18 of the constitution.

1.2.11 **Directors** means the Executive and Non-Executive members of the Board of Directors.

1.2.12 **Executive Director** means a member of the Board of Directors, including the Chief Executive, appointed under paragraph 31 of the constitution.

1.2.13 **Lead Governor** is the person appointed by the Council of Governors in accordance with the *NHS Foundation Trust Code of Governance* (July 2014).

1.2.14 **Licence** means the Trust's provider licence (no: 120163) issued by NHS England (Monitor) on 1st April 2017.

1.2.15 **Motion** means a formal proposition to be discussed and voted on during the course of a meeting.

1.2.16 **Non-Executive Director** means a member of the Board of Directors, including the Chair, appointed by the Council of Governors under paragraph 28 of the constitution.

1.2.17 **SOs** mean these Standing Orders (for the Council of Governors).

1.2.18 **Trust** means Essex Partnership University NHS Foundation Trust.

1.2.19 **Trust Secretary** means a person appointed by the Chair and Chief Executive as the Trust Secretary.

1.2.20 **Vice-Chair** means the Non-Executive Director appointed under paragraph 30 of the constitution.

1.2.21 **Working days** a day that is not a Saturday or Sunday, Christmas Day, Good Friday or any day that is a bank holiday.

1.3 Words importing the plural shall import the singular and vice-versa.

1.4 Any reference to an Act shall, where appropriate, include any Act amending or consolidating that Act and any regulation or order made under any such Act.

2. COUNCIL OF GOVERNORS ROLES AND RESPONSIBILITIES

2.1 The purpose of these SOs is to ensure that the highest standards of corporate governance and conduct are applied to all Council meetings and associated deliberations.

2.2 The roles and responsibilities of the Council which are to be carried out in accordance with the Trust's constitution, license and the *NHS Foundation Trust Code of Governance* (July 2014) (and any subsequent versions) are:

General Duties

2.2.1 To hold the Non-Executive Directors individually and collectively to account for the performance of the Board, including ensuring that the Board acts so that the Trust does not breach the terms of its licence. "Holding the Non-Executive Directors to account" includes scrutinising how well the Board is working, challenging the Board in respect of its effectiveness, and asking the Board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the Trust, questioning Non-Executive Directors about the performance of the Board and of the Trust and making sure to represent the interests of the Trust's members and of the public in doing so.

2.2.2 To represent the interests of the members of the Trust and the interests of the public.

Chair and Non-Executive Directors

2.2.3 To approve the policies and procedures for the appointment and removal of the Chair and/or Non-Executive Directors in accordance with any guidance issued by NHS England and on the recommendation of the Council's Nominations Committee.

2.2.4 To appoint and remove the Chair and other Non-Executive Directors. The Council should only exercise its power to remove the Chair or any other Non-Executive Directors after exhausting all means of engagement with the Board.

2.2.5 To approve the policies and procedures for the appraisal of the Chair and Non-Executive Directors on the recommendation of the Council's Remuneration Committee. The performance of Non-Executive Directors should be subject to regular appraisal and review. All Non-Executive Directors should be submitted for re-appointment at regular intervals. The Council should ensure planned and progressive refreshing of the Non-Executive Directors.

2.2.6 To decide the remuneration, allowances and other terms of office for the Chair and Non-Executive Directors having regard to the recommendations of the Council's Remuneration Committee. Professional advisers should be consulted to market test the remuneration levels of the Chair and other Non-Executives Directors at least once every three years and when there is a material change to the remuneration of the Chair or another Non-Executive Director.

Chief Executive

2.2.7 To approve the appointment of the Chief Executive of the Trust.

Auditors

2.2.8 To approve the criteria for the appointment, removal and re-appointment of the auditor.

2.2.9 To appoint, remove and reappoint the auditor having regard to the recommendation of the Trust's Audit Committee.

Strategy Planning

2.2.10 To provide feedback to the Board on the development of the strategic direction of the Trust, as appropriate.

2.2.11 To collaborate with the Board in the development of the Trust's forward plan.

2.2.12 Where the forward plan contains a proposal that the Trust will carry out activities other than the provision of goods and services for the purpose of the NHS in England, to determine whether it is satisfied that the carrying out of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and notify its determination to the Board.

2.2.13 Where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purpose of the NHS in England, approve such a proposal.

2.2.14 To approve entering into any significant transactions (as defined under paragraph 49 and Annex 9 of the constitution) in accordance with the 2006 Act and the constitution.

2.2.15 When appropriate, to make recommendations for the revision of the constitution and approve any amendments to the constitution in accordance with the 2006 Act and the constitution.

2.2.16 To receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council.

Representing Members and the Public

2.2.17 To prepare and from time to time review the Trust's membership engagement strategy and policy.

2.2.18 To notify NHS England, via the Lead Governor, if the Council is concerned that the Trust is at risk of breaching the terms of its licence, and if these concerns cannot be resolved at local level.

2.2.19 To report to the members annually on the performance of the Council.

2.2.20 To promote membership of the Trust and contribute to opportunities to recruit and engage members in accordance with the membership strategy.

2.2.21 To seek the views of stakeholders and feedback to the Board.

2.3 All business shall be conducted in the name of the Trust.

3. THE COUNCIL OF GOVERNORS

3.1 Composition of the Council

The composition of the Council shall be in accordance with paragraph 14 of the constitution.

3.2 Appointment of the Chair

The Chair is appointed by the Council as set out in paragraph 28 of the constitution.

3.3 Terms of Office of the Chair

The provisions governing the period of tenure of office of the Chair are set out in Board of Directors SO 2.8.

3.4 Role of the Chair

3.4.1 The Chair is not a member of the Council. However, under the regulatory framework, they preside at meetings of the Council and holds a second or casting vote.

3.4.2 Where the Chair has died or has ceased to hold office, or where they are unable to perform their duties as Chair owing to illness or any other cause, and there will be an absence of a Chair for less than 3 months the Vice-Chair of the Board shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these SOs shall, so long as there is no Chair able to perform their duties, be taken to include references to the Vice-Chair.

3.4.3 Where an absence of the Chair has or will exceed a period of 3 months the Council at a general meeting shall appoint one of the Non-Executive Directors as the acting Chair. Before a resolution for such an appointment is passed, the Board shall be entitled to advise the Council of the Non-Executive Director (who may be the Vice-Chair) who is recommended by the Board of Directors for that appointment. This recommendation will not, however, be binding upon the Council of Governors; it will be presented to the Council of Governors at its meeting before it comes to its decision. The Vice Chair shall act as Chair until an appointment of an acting Chair is made by the Council.

3.5 Role of the Lead Governor

3.5.1 The Lead Governor shall be appointed by the Council.

3.5.2 The Lead Governor will facilitate communication between NHS England and the Council where Governors have concerns about the leadership provided to the Trust by the Board or in circumstances where it would be inappropriate for the Chair to contact NHS England, or vice versa (for example, regarding concerns about the appointment or removal of the Chair).

3.5.3 Having a Lead Governor does not prevent any other Governor from making contact with NHS England directly if they feel this is necessary. However, any Governor should consider contacting the Lead Governor prior to contact with NHS England. For the avoidance of doubt, a person holding the role of Lead Governor shall not assume greater power or responsibility than other Governors. Where the Trust chooses to broaden the Lead Governor's role, the Chair and the Council should agree what powers should be included.

3.6 Termination of Office and Removal of Governors

Paragraphs 16, 17 and Annex 6 paragraph 5 of the constitution sets out the period of tenure of office of Governors and provisions relating to the termination or suspension of office of Governors.

3.7 Vacancies amongst Governors

3.7.1 Where a vacancy arises amongst the appointed Governors, the Trust Secretary shall request that the appointing organisation appoints a replacement.

3.7.2 Where a vacancy arises amongst the elected Governors within the first 24-months of their term of office, the Trust Secretary shall offer the next highest polling candidate in the election for that post the opportunity to assume the vacant office for the unexpired balance of the retiring member's term of office. If that candidate does not wish to fill the vacancy, it will then be offered to the next highest polling candidate and so on until the vacancy is filled.

3.7.3 Where the vacancy cannot be filled, consideration will be given for holding a by-election, based on cost of the election and the proximity of any by-election to other elections to the Council of Governors.

3.8 Appointment and Powers of Vice-Chair

3.8.1 The Council at a general meeting shall appoint one of the Non-Executive Directors as a Vice-Chair in accordance with paragraph 30.1 of the constitution and, in similar manner, shall remove any person so appointed from that position and appoint another Non-Executive Director in their place.

3.8.2 In line with paragraph 30.2 of the constitution, before a resolution for any such appointment is passed, the Board may decide which of the Non-Executive Directors it recommends for that appointment; the Chair shall advise the Council of the recommendation from the Board which will not be binding upon the Council but will be presented to the Council at its meeting before it comes to a decision.

3.8.3 Subject to SO 3.4.2 and SO 3.4.4 in the absence of the Chair, the Vice-Chair shall be the acting Chair of the Trust.

3.8.4 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Council may then appoint another Vice-Chair in accordance with paragraph 30.1 of the constitution and SO 3.8.

4. MEETINGS OF THE COUNCIL

4.1 Subject to SOs 4.2.1 and 4.2.2 below and any other provisions of these SOs, the Council may only exercise any powers and make decisions when in formal session. The Council may be advised by committees appointed by the Council but may not devolve any decision making powers to these committees, which, for the avoidance of doubt, shall operate as working groups of the Council.

4.2 Admission of the Public and the Press

4.2.1 The meetings of the Council shall be open to members of the public and the press.

4.2.2 Members of the public and the press may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Council will resolve that:

"In accordance with paragraph 34.1 of the constitution and paragraph 13(2) of Schedule 7 of the 2006 Act, the Council of Governors resolves that there are special reasons to exclude members of the public from Part 2 of this meeting having regard to commercial sensitivity and/or confidentiality and/or personal information and/or legal professional privilege in relation to the business to be discussed."

4.2.3 The Chair may exclude any person from a meeting of the Council if that person is interfering with or preventing the proper conduct of the meeting.

4.2.4 Nothing in these SOs shall require the Council to allow members of the public to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council.

4.2.5 Matters discussed at a meeting following the exclusion of the public and representatives of the media shall be confidential to the Council and shall not be disclosed by any person attending the meeting without the consent of the Chair of the meeting.

4.2.6 All decisions taken in good faith at a meeting of the Council or of any committee shall be valid even if there is any vacancy in its membership or it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

4.3 Calling Meetings

4.3.1 Ordinary meetings of the Council shall be held at such times and places or via digital platforms as the Council may determine.

4.3.2 There shall be not less than four meetings in any year except in exceptional circumstances.

4.3.3 Meetings of the Council may be called by the Trust Secretary, or by the Chair. Not less than one-third of the Governors in office can requisition the Trust Secretary to call a meeting at any time by giving written notice to the Trust Secretary stating the business to be considered at the meeting.

4.4 Notice of Ordinary Meetings

4.4.1 The Trust Secretary shall give to all Governors at least 10 (ten) working days written notice of the date and place of every ordinary meeting of the Council.

4.4.2 Agendas will be sent to Governors not later than three (3) working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, save in the case of the need to conduct urgent business under a meeting called under paragraph 4.5.1.

4.4.3 A notice or other document(s) to be served upon a Governor under these SOs shall be delivered by hand or sent by post to the Governor at the place of residence which he shall have last notified to the Trust, or where sent by email, to the address which he shall have last notified to the Trust as the address to which a notice or other document may be sent by electronic means.

4.4.4 A notice or other document(s) where delivered by hand or sent by post shall be presumed to have been served on the next working day following the day it was sent and where it was sent by email at the time at which the email is sent.

4.4.5 Failure to serve notice and supporting papers on any Governor shall not affect the validity of an ordinary meeting.

4.4.6 Save in the case of urgent meetings, for each meeting of the Council a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's office and on the Trust's internet site for general access at least three working days before the meeting.

4.5 Notice of Urgent/Extraordinary Meetings

4.5.1 At the request of the Chair or not less than one-third of Governors, the Trust Secretary shall send written notice of a meeting to all Governors as soon as possible after receipt of such a request. The Trust Secretary shall give Governors as much notice of the meeting as is practicable in light of the urgency of the request.

4.5.2 If the Trust Secretary does not call a meeting of the Council of Governors within ten (10) working days of receiving a requisition from Governors pursuant to SO 4.3.3, the Governors who made the requisition may convene the meeting themselves by giving written notice to all Governors; this notice must be signed by all of the Governors who signed the requisition. A meeting called under this SO may only consider the business set out in the requisition.

4.5.3 In the case of a meeting called under SO 4.4.2, 4.4.3 or 4.5.1, the notice shall be signed by the Chair or by at least one-third of Governors in office.

4.5.4 No business at a meeting called under SO 4.4.2, 4.4.3 or 4.5.1 shall be transacted at that meeting other than that specified in the notice. Agendas will be sent to Council members three (3) working days before the meeting and supporting papers, shall accompany the agenda, save in the case of urgent meetings.

4.5.5 In the case of a meeting called under SOs 4.4.2, 4.4.3 and 4.5.1 failure to serve such a notice on more than three (3) Governors will invalidate the meeting.

4.6 Setting the Agenda

4.6.1 The Council may determine that certain matters shall appear on every agenda for an ordinary meeting and shall be addressed prior to any other business being conducted.

4.6.2 A Governor desiring a matter to be included on an agenda shall make his request in writing to the Chair at least seven (7) working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 (ten) working days before a meeting may be included on the agenda at the discretion of the Chair.

4.7 Motions

4.7.1 **Notices of motion:** A Governor desiring to move or amend a motion shall send a written notice thereof at least seven (7) working days before the meeting to the Chair who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This SO shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

4.7.2 **Withdrawal of motion or amendment:** A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.7.3 **Motion to Rescind a Resolution:** Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governor who gives it and also the signature of four other Governors. Such notice shall be sent to the Chair at least 10 (ten) working days before the meeting, who shall insert it in the agenda for the meeting. When any such motion has been disposed of by the Council, no Governor may propose a motion to the same effect within six months. However, the Chair may do so if they consider it appropriate.

4.7.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.7.5 When a motion is under discussion or immediately prior to discussion, it shall be open to a Governor to move one of the following motions:

(a) an amendment to the motion
(b) the adjournment of the discussion or the meeting
(c) that the meeting proceed to the next business*
(d) the appointment of an ad hoc committee to deal with a specific item of business; or
(e) that the motion be now put*

provided that in the case of sub-paragraphs denoted by * above and to ensure objectivity, motions may only be put by a Governor who has not previously taken part in the debate.

4.7.6 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

4.8 Petitions

Where a petition has been received by the Trust not less than 10 (ten) working days before a meeting of the Council, the Chair of the Council shall include the petition as an item for the agenda of the next meeting of the Council.

4.9 Chair of Meeting

4.9.1 At any meeting of the Council the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair or another Non-Executive Director, if there is one present, shall preside.

4.9.2 If the Chair, Vice-Chair and all Non-Executive Directors are absent, the Lead Governor, if present, shall preside. If the Lead Governor is not present, such Governor to be appointed from amongst the Council present shall preside.

4.10 Chair's Ruling

Statements of Governors made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

4.11 Record of Attendance

4.11.1 The names of the Chair and Governors present at a meeting shall be recorded in the minutes. Board Directors who attend a meeting will be recorded in the minutes as 'in attendance'.

4.11.2 Governors who are unable to attend a Council meeting should advise the Trust Secretary in advance of the meeting so that their apologies may be submitted.

4.11.3 A meeting of the Council refers to officers being physically present or officers being present via the use of technology, as defined in SO 4.12.6.

4.12 Quorum

4.12.1 The quorum for every meeting of the Council shall be one-third of the total number of Governors in office on the date of the meeting, a majority of whom must be Public Governors.

4.12.2 If at the time of the meeting no quorum is present:

(a) The Chair shall announce a 30 minute delay
(b) If after the delay a quorum is present, the meeting shall proceed
(c) If a quorum is not present after the delay, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such a time and place as the Chair shall determine and a notice of the adjourned meeting shall be circulated to Council members. When the meeting reconvenes, if a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Governors present during the meeting is to be a quorum

4.12.3 Where during a meeting of Council a quorum is no longer present:

(a) The Chair shall announce a five (5) minute delay
(b) If after the delay there remains no quorum, the Council meeting shall be adjourned

4.12.4 Where the Council is adjourned under SO 4.12.3(b), the Trust Secretary shall list the uncompleted business from the meeting as the first items for consideration at the next following meeting of Council.

4.12.5 If a Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration

of a conflict of interest, they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.12.6 Governors may participate (and vote) in its meetings by telephone, teleconference, video or computer link in accordance with SO 4.19 below. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

4.13 Voting and Decisions

4.13.1 At the end of a discussion on business not subject to a decision, the Chair may summarise the view of the Council for recording in the minutes.

4.13.2 On any matter requiring a decision, Council shall determine its position by voting.

4.13.3 Subject to statutory or constitutional requirements, a decision of the Council is reached by a majority of Governors present and voting. Votes in abstention shall not be counted in determining a majority. In the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote. No resolution can be passed if it is opposed by all of the Public Governors present and voting.

4.13.4 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

4.13.5 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands.

4.13.6 On the request of the one-third of the Governors present, a recorded vote shall be taken:

(a) The Trust Secretary will call the names of all Governors
(b) Each Governor shall declare their vote as 'In Favour', 'Against' or 'Abstain'
(c) The vote of each Governor shall be recorded in the minutes accordingly

4.13.7 On the request of the majority of Governors present at the meeting, a vote may be taken by secret ballot:

(a) Each Governor shall be issued with a ballot paper allowing a vote of 'In Favour', 'Against' or 'Abstain'
(b) Each Governor shall have the opportunity to vote in secret
(c) The Trust Secretary shall count the ballots, and record the number of votes cast for each option on the minutes
(d) Governors may not record their vote in the minutes if a secret ballot is taken.

4.14 Voting by Paper Ballot

4.14.1 If the Chair of the Trust calls an extraordinary meeting of the Council under SOs 4.4.2, 4.4.3 and 4.5.1 they may, subject to SO 4.16.2 below, determine that any Governor may cast their vote on the matter(s) to be dealt with at the

meeting by paper ballot in accordance with the process set out at SOs 4.16.3 - 4.16.5 (inclusive) below.

4.14.2 The Chair may only determine that Governors may cast their vote by paper ballot on any matter where this is compatible with the 2006 Act.

4.14.3 Where the Chair makes a determination pursuant to SO 4.14.1 in respect of any extraordinary meeting of the Council, the Trust Secretary shall circulate a ballot paper to all of the Governors together with the papers for the meeting.

4.14.4 Any Governor may cast their vote at the meeting or by:

(a) marking the ballot paper, in accordance with the instructions on the ballot paper, to show how he wishes to vote
(b) subject to SO 4.14.6, signing the ballot paper
(c) returning the ballot paper to the Trust Secretary so that it arrives before the date and time stipulated on the ballot paper.

4.14.5 Governors must return the ballot paper by hand, by email or by post. Any ballot paper received on or after the date and time stipulated shall be rejected.

4.14.6 If a Governor returns a ballot paper to the Trust Secretary by email, the ballot paper does not have to be signed by the relevant Governor provided that it is returned from an email address that the Governor has previously notified to the Trust Secretary.

4.14.7 Any votes duly cast by paper ballot shall be added to the votes cast by Governors voting in person at the meeting. Unless otherwise provided by the Trust's constitution or by law, every matter shall be determined by a majority of votes cast and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote. No resolution can be passed if it is opposed by all of the Public Governors voting, whether at the meeting or by paper ballot.

4.14.8 The Trust Secretary shall ensure that the Trust keeps a record, in writing, of all ballot papers for at least twelve (12) months from the date of the meeting in respect of which the votes were cast. The votes (whether in person or by ballot) shall recorded in the minutes in accordance with SO 4.13.

4.15 Prevention of Disorder at a Meeting

If there is disorder in the public gallery (including members of the public attending in a virtual capacity) at a meeting of the Council:

4.15.1 The Chair may direct those causing the disorder to leave the meeting, and they shall thereupon leave and not return to the meeting.

4.15.2 The Chair may suspend the meeting to a stated time (not longer than 30 minutes from the time of the suspension) to allow order to be restored

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4.15.3 If those causing disorder refuse to comply with the Chair's direction, the Chair may move *that the public gallery be cleared to allow the Council to proceed in proper order.*

4.15.4 A motion under SO 4.15.3 shall be voted on immediately and without debate.

4.15.5 If Council agrees to a motion under SO 4.15.3, the Chair shall suspend proceedings until the public gallery is cleared; the gallery shall remain cleared for the remainder of the meeting, unless the Council shall otherwise decide.

4.16 Written Resolution Process

4.16.1 Subject to SO 4.16.2, the Council may use the process for adopting a written resolution set out in this SO 4.16 to enable it to transact business between meetings of the Council. The process for adopting a written resolution shall not be used to replace meetings of the Council.

4.16.2 The Council may only use a written resolution for transacting business where this is compatible with the 2006 Act.

Proposing written resolutions

4.16.3 At the Chair's request, the Trust Secretary shall propose a written resolution to the Governors**.**

4.16.4 A written resolution is proposed by giving notice of the proposed resolution to the Governors. Such notice shall stipulate:

(a) the proposed resolution; and
(b) the long-stop date by which the written resolution is to be adopted, which shall be not less than ten (10) days from the date the written resolution is dispatched by the Trust Secretary
(c) Notice of a proposed written resolution must be given in writing to each Governor. Notice by email or post is permitted.

Adopting written resolutions

4.16.5 Unless otherwise provided by the Trust's constitution or by law and subject to SO 4.16.7 below, a proposed written resolution shall be adopted when it has been signed and returned to the Trust Secretary by hand, by email or by post by a majority of the Governors.

4.16.6 If a Governor returns a written resolution to the Trust Secretary by email, the written resolution does not have to be signed by the relevant Governor provided that it is returned from an email address that the Governor has previously notified to the Trust Secretary.

4.16.7 For the avoidance of doubt, the proposed written resolution shall lapse if it has not been returned by the requisite number of Governors pursuant to SO 4.16.6 above, by the longstop date.

4.16.8 Once a written resolution has been adopted, it shall be treated as if it had been a decision taken at a Council of Governors' meeting in accordance with these SOs.

4.16.9 The Trust Secretary shall ensure that the Trust keeps a record, in writing, of all written resolutions for at least six (6) years from the date of their adoption.

4.17 Meetings: Electronic Communication

4.17.1 In this SO, 'communication' and 'electronic communication' shall have the meanings as set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

4.17.2 A Governor in electronic communication with the Chair and all other parties to a meeting of the Council or of a committee of the Council shall be regarded for all purposes as being present and personally attending such a meeting provided that, and only for so long as, at such a meeting they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

4.17.3 A meeting at which one or more of the Governors attends by way of electronic communication shall be deemed to be held at such place at which the Chair is physically present. If the meeting takes places by way of electronic communication entirely, the meeting shall deemed to have been held via the electronic communication platform and will be recorded in the minutes as such.

4.17.4 Meetings held in accordance with this SO are subject to SO 4.12. For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

4.17.5 The minutes of a meeting held in this way must state that it was held (whether wholly or partly) by electronic communication and that the Governors were all able to hear each other and were present throughout the meeting.

4.18 Minutes

4.18.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting where they will be signed by the person presiding at it, including electronically.

4.18.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.18.3 Minutes shall be retained in the Trust Secretary's office.

4.18.4 Minutes shall be circulated in accordance with Governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

4.19 Additional Powers

4.19.1 The Council may require one or more of the Directors to attend a Council meeting to obtain information about the Trust's performance of its functions or the directors' performance of their duties, and to help the Council to decide whether to propose a vote on the Trust's or Directors' performance.

4.19.2 The Trust may choose to involve Governors in hospital/service visits or volunteering. However, Governors acknowledge that they do not have a right to inspect Trust property or services and they are not under a duty to meet patients and conduct quality reviews.

4.19.3 Governors may refer a question concerning whether the Trust has failed, or is failing, to act in accordance with its constitution, or Chapter 5 of the 2006 Act to the Panel for Advising Governors appointed by NHS England under the 2006 Act.

4.20 Variation and Amendment of Standing Orders

4.20.1 Any variation of these SOs shall not constitute a variation of the constitution. These SOs shall be amended only if:

(a) unless proposed by the Chair, a notice of motion under SO 4.7 has been given; and
(b) not fewer than half of the Trust's Governors vote in favour of amendment; and
(c) at least half of the Governors are present at the meeting at which the amendment is considered; and
(d) the variation proposed does not contravene a statutory provision or requirement, condition or notice issued by NHS England; and
(e) the amendment is approved by the Council.

5. ARRANGEMENTS FOR THE EXERCISE OF COUNCIL FUNCTIONS

5.1 The Council may not delegate its functions to any committee of the Council. Subject to the constitution and any requirements of NHS England, the Council may appoint committees to assist the Council in the proper performance of its functions under the constitution and the regulatory framework, consisting wholly of the Chair and members of the Council.

5.2 A committee appointed under this SO 5 may, subject to such requirements, conditions or notices as may be given by NHS England or such directions as may be issued by the Council, appoint sub-committees consisting wholly of members of the committee.

5.3 The SOs of the Council, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council. In which case the term "Chair" is to be read as a reference to the chair of the committee as the context permits, and the terms "member of the Council" or "Governor" is to be read as a reference to a member of the committee also as the context permits.

5.4 There is no requirement to hold meetings of committees established by the Council in public.

5.5 Each such committee shall have such terms of reference and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the regulatory framework and any requirement, condition, notice or guidance issued by NHS England. Such terms of reference shall have effect as if incorporated into the SOs.

5.6 The Council shall approve the terms of reference and appointments to each of the committees which it has formally constituted.

5.7 The committees established by the Council shall be such committees as are required to assist the Council in discharging its responsibilities.

5.8 A Governor and/or a member of a committee of the Council and/ or any non-Governor shall not disclose a matter dealt with by, or brought before, the Council or a committee of the Council without the permission of the Council or such committee (as applicable) until such matter shall have been concluded or in the case of such committee, until the committee shall have reported to the Council.

5.9 A Governor or a non-Governor in attendance at a committee or of a meeting of the Council shall not disclose any matter dealt with by the committee or the Council, notwithstanding that the matter has been reported or concluded, if the Council or committee resolves that it is confidential.

5.10 The Trust Secretary or his deputy or assistant will attend all meetings of the committees in support of them.

5.11 Notwithstanding anything in these SOs, the Chair and Governors may meet informally or as a committee of the Council at any time and from time to time, and shall not be required to admit any member of the public or any representative of the media to any such meeting or to send a copy of the agenda for that meeting or any draft minutes of that meeting to any other person or organisation. For the avoidance of doubt, no business shall be conducted at such meetings.

6. PREVENTION OF CONFLICTS OF INTEREST

6.1 Declaration of Interests

6.1.1 The Trust recognises that, as volunteers, Governors may have private interests that could conflict with those of the Trust. It is the responsibility of Governors to ensure that any potential conflicts of interest are registered and declared at meetings in accordance with this SO and paragraph 22 of the constitution.

6.1.2 The Trust policy for Conflicts of Interest, Gifts and Hospitality (CP80) defines a conflict of interest as "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold".

6.1.3 A conflict of interest may be

- **Actual:** There is a material conflict between one or more interests.
- **Potential:** There is the possibility of a material conflict between one or more interests in the future.

6.1.4 Governors may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see if different and perceived conflicts of interests can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

6.1.5. Interests fall into the following categories:

(a) Financial interests: Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.

(b) Non-financial professional interests: Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

(c) Non-financial personal interests: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

(d) Indirect interests: Where an individual has a close association[2] with another individual who has a financial interest, a non-financial

[1] This may be a financial gain, or avoidance of a loss.

[2] A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

6.1.6 Governors must declare interests which are relevant and material to the Council. All existing Governors should declare such interests. Any Governors appointed subsequently should do so on appointment

6.1.7 At the time Governor's interests are declared they should be recorded in the Council register of interests and in the minutes of the relevant meeting at which the declaration is made. Any changes in interests should be declared at the next meeting following the change occurring.

6.1.8 Governors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the annual report. The information should be kept up to date for inclusion in succeeding annual reports.

6.1.9 During the course of a meeting of the Council, if a conflict of interest is established, the Governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.1.10 There are a number of common situations which can give rise to risk of conflicts of interest, as follows:

- Gifts
- Hospitality
- Outside employment
- Shareholdings and other ownership issues
- Patents
- Loyalty interests
- Donations
- Sponsored events
- Sponsored research
- Sponsored posts
- Clinical private practice

6.1.11 The interests of Governors' spouses or partners if living together, in contracts are to be declared. If Governors have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.2 Register of Interests

6.2.1 The Trust Secretary will ensure that a register of interests is established to record formally declarations of interests of Governors. In particular the register will include details of all directorships and other actual and potential interests which have been declared by Governors, as defined in paragraphs 22 of the constitution and SO 6.1.3.

6.2.2 The Trust Secretary shall keep these details up to date by means of an annual review of the register, for which Governors will be required to complete a further declaration via an Annual Declaration of Interest Form. It

is the responsibility of each Governor to provide an update to the Trust Secretary of their register entry if their interests change. The form will also require Governors to provide consent to process and publish this information as per GDPR or equivalent requirements.

6.2.3 The register will be available to the public and the Trust Secretary will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

6.2.4 In establishing, maintaining, updating and publicising the register, the Trust shall comply with all guidance issued from time to time by the NHSE/I.

6.3 Interests of Relatives, Spouses and Partners

6.3.1 A Governor is required to declare, as if it was their own interest, interests owned or otherwise held by:

6.3.1.1 Their spouse or civil partner
6.3.1.2 Any person with whom they have a long-term relationship as a couple on a domestic basis
6.3.1.3 Their children, step-children or other minors living in the same household as them
6.3.1.4 Any parent, grandparent, uncle or aunt living in the same household as them

6.3.2 Where a declaration is made under SO 6.3, the Governor shall declare and the Trust Secretary shall note on the Register:

6.3.2.1 The name of the individual having the interest
6.3.2.2 Their relationship to the Governor making the declaration.

6.4 Interest of Governors in Contracts

6.4.1 If it comes to the knowledge of a Governor that a contract in which they have any pecuniary interest not being a contract to which they are themselves a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Trust Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

6.4.2 A Governor should also declare to the Trust Secretary any other employment or business or other relationship of theirs, or of a cohabiting spouse, civil partner or person living together with them as partner, that conflicts or might reasonably be predicted could conflict with the interests of the Trust. Interests, employment or relationships declared, are to be entered in a register of Governor's interests.

6.4.3 Further details are included in the Conflict of Interest, Gifts and Hospitality policy & procedure.

7. STANDARDS OF BUSINESS CONDUCT

7.1 Standards of Conduct

7.1.1 The Council shall agree, from time to time, codes of conduct for the proper execution of the office of Governor.

7.1.2 Governors must comply with the Council's *Code of Conduct,* the requirements of the regulatory framework, the constitution and any guidance, requirement condition or notice issued by NHS England.

7.2 Canvassing of, and Recommendations by, Members of the Council of Governors in Relation to Appointments

7.2.1 Except in relation to the appointment of a person as a member of the Trust, a Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this SO shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.2.2 This SO does not prevent a Governor from contributing to the appointment of a Non-Executive Director to the Trust or the Chief Executive in accordance with the statutory requirements.

7.2.3 Informal discussions outside appointment panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8. MISCELLANEOUS

8.1 Standing Orders to be given to all Governors

It is the duty of the Trust Secretary to ensure that existing Governors and all new appointees are notified of and understand their responsibilities within these SOs.

8.2 Review of Standing Orders

The SOs shall be reviewed annually by the Council. The requirement for review extends to all documents having the effect as if incorporated in the SO.

8.3 Potential Inconsistency

In the event of any conflict or inconsistency between these SOs and any of the legislation and guidance listed in these SOs, the legislation shall prevail. In the event of any conflict or inconsistency between these SOs and the licence and/or the constitution, the licence and/or the constitution shall prevail.

9. DISPUTE RESOLUTION

9.1 Where there is a dispute between the Council of Governors and the Board of Directors, Governors shall follow the procedure set out in the current *Council of Governors Policy for Engagement with the Board of Directors where there is disagreement and/or concerns regarding performance.*

9.2 Where a dispute arises out of or in connection with the constitution, including the interpretation of these SOs and the procedure to be followed at meetings of the Board, the Trust and the parties to that dispute shall use all reasonable endeavours to resolve the dispute as quickly as possible.

9.3 Where a dispute arises that involves the Chair, the dispute shall be referred to the Senior Independent Director who will use all reasonable efforts to mediate a settlement to the dispute.

9.4 For the avoidance of doubt, the Trust Secretary shall deal with any membership queries and other similar questions in the first place including any voting or legislation issues and shall otherwise follow a process for resolving such matters in accordance with any procedures agreed by the Board.

10. RELATIONSHIP BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

10.1 Governors should discuss and agree with the Board how they will undertake their statutory roles and responsibilities, and any other additional roles, giving due consideration to the circumstances of the Trust and the needs of the local community and emerging good practice.

10.2 Governors should work closely with the Board and must be presented with, for consideration, the annual report and accounts (including any report of the auditor on them) and the annual plan at a general meeting. The Governors must be consulted on the development of forward plans for the Trust and any significant changes to the delivery of the Trust's business plan.

10.3 The annual report should state how performance evaluation of the Board, its committees, and its Directors, including the Chairman is conducted and the reason why the Trust adopted a particular method of performance evaluation.

10.4 The annual report should identify the members of the Council, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the appointed Lead Governor. A record should be kept of the number of meetings of the Council and the attendance of individual Governors and Directors and it should be made available to members on request.

10.5 The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. The Council will need to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the Trust's Audit Committee, which provides information to the Governors on the external auditor's performance as well as overseeing the Trust's internal financial reporting and internal auditing.

10.6 If the Council does not accept the Audit Committee's recommendations, the Board should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council has taken a different position.

10.7 The annual report should describe the process followed by the Council in relation to appointments of the Chair and Non-Executive Directors.

END

		Agenda Item No: 10d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

Report Title:	Emergency Preparedness, Resilience and Response (EPRR) National Core Standards Return 2022					
Executive/Non-Executive Lead:	Nigel Leonard Executive Director of Major Projects & Programmes / EPRR Accountable Emergency Officer					
Report Author(s):	Amanda Webb, Senior Emergency Planning and Compliance Officer					
Report discussed previously at:	Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

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

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

Purpose of the Report		
This report presents the Emergency Preparedness, Resilience and Response (EPRR) national core standards self-assessment 2022-23 completion of which is a requirement for all NHS organisations.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required
The Trust Board of Directors are asked to: • Note the final Emergency Preparedness, Resilience and Response national core standards 2022-23 compliance level for EPUT

Summary of Key Issues

The NHSE/I Emergency Preparedness, Resilience and Response (EPRR) Framework 2022 places a responsibility on the Trust to have effective emergency preparedness, resilience and response arrangements in place to ensure that it can respond so far as is reasonably practicable, in the event of an emergency.

All NHS organisations are required to complete an annual self-assessment which is submitted to NHSEI. Following submission a core standards peer review confirm and challenge meeting is held, at which there is an opportunity to revise submission.

On 1st August 2022, the Trust received communication from the regional EPRR team at NHSE/I (East) informing the Trust of the newly published national EPRR core standards and the process for the national annual assurance process for 2022.

The Standards are split into two sections, the main EPRR Core Standards and a Deep Dive which changes each year. For 2022 the deep dive is in relation to 'Shelter & Evacuation'. It should be noted that there are an additional 20 standards within the Core Standards compared to 2021.

The following process was used in the Trust for completing the Core Standards self-assessment:

1. Review of all standards by EPRR Team to complete initial self-assessment identifying how the Trust meets the standards, any gaps and actions required
2. Review of initial self-assessment by the Associate Director of Risk and Compliance
3. Review and challenge of self-assessment by extraordinary Health Safety and Security Committee (HSSC)
4. Review of Self Assessment by Executive Operational Team
5. Self-Assessment submitted for sign off to Quality Committee and Trust Board of Directors

As part of the national process, the next step following submission of the Core Standards was for the Trust to attend a "confirm and challenge" meeting with the Regional EPRR team. This took place on 10th October 2022.

Following the "self- assessment" and "confirm and challenge" process; the position being reported by the LHRP is that EPUT are **substantially compliant** (90%). 50 out of the 55 EPRR Core Standards have been assessed as compliant, with 5 having been assessed as partially compliant (meaning the Trust aims to achieve compliance within 12 months) and the deep dive has been assessed as partially compliant. The following standards were assessed as partially met:

Ref.	Domain	Action to be taken
6	Governance - Continuous Improvement	Policy Statement required within the EPRR Policy summarising the Trusts process' for continual learning
16	Duty to maintain plans - Evacuation and Shelter	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy.
24	Training and exercising - Responder Training	It was agreed by HSSC that this cannot be assessed as compliant due to the current lack of available training from Region. The EPRR Team envisage that once Region identify what training is available, this will be undertaken as a priority.
39	Co-operation - Mutual Aid Arrangements	Military Aid to Civil Authorities (MACA) to be included within the Mutual Aid section of the Major Incident Policy.

50	Business Continuity - BCMS monitoring and evaluation	Trust to review and report on BCMS KPI's

The NHS England Core Standards inform the Trusts annual EPRR work Programme which is overseen by the Health Safety and Security Committee. (Appendix 1)

Acronyms/Terms Used in the Report			
EPRR	Emergency Preparedness Resilience and Response	BCP	Business Continuity Plans
BCMS	Business Continuity Management System		

Supporting Reports /Appendices or further Reading

Appendix 1 EPRR Workplan

Lead

Nigel Leonard,
Executive Director of Major Projects & Programmes (EPRR Accountable Emergency Officer)

Appendix 1

EPRR Work plan 2022/2023 (last updated at 2nd November 2022)								
Lead Title	**Initials**	**Name**	**Lead Title**	**Initials**	**Name**	**Status**		
AEO	NL	Nigel Leonard				High		Outstanding Action
EPRR Lead	AW	Amanda Webb				Medium		Ongoing Action
Head of EPRR	JC	Jane Cheeseman				Low		Closed Action
VAPR Manager	SP	Sarah Pemberton				Future		Future Action

NHSERef	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
Part 1 – Actions to fully achieve Core Standards						
6	Governance	**Continuous Improvement** The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Policy Statement required within the EPRR Policy summarising the Trusts process' for continual learning	AW Jan 2023	Added to policy, currently under consultation with aim to take to HSSC in Nov 2022 for approval	
16	Duty to maintain plans	**Evacuation and Shelter** In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy.	AW Jan 2023	Added as appendix, currently under consultation with aim to take to HSSC in Nov 2022 for approval	
24	Training and exercising	**Responder Training** The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance	Work with region to identify appropriate training	AW / JC Jan 2023	It was agreed by HSSC that this cannot be assessed as compliant due to the current lack of available training. The EPRR Team envisage that once Region identify what training is available, this will	

NHSERef	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
		with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role			be undertaken as a priority.	
39	Co-operation	**Mutual Aid Arrangements** The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Military Aid to Civil Authorities (MACA) to be included within the Mutual Aid section of the Major Incident Policy.	AW Jan 2023	Added, currently under consultation with aim to take to HSSC in Nov 2022 for approval	
50	Business Continuity	**BCMS monitoring and evaluation** The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status	Trust to review and report on BCMS KPI's			

NHSERef	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
		of any corrective action are annually reported to the board.				
D1 – D13	Evacuation and Shelter	Activation Incremental Planning Evacuation patient triage Patient movement Patient transportation Patient dispersal and tracking Patient receiving Community Evacuation Partnership Working Communications – Warning and Informing Equalities and Health inequalities Exercising	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy.	AW Jan 2023	Added as appendix, currently under consultation with aim to take to HSSC in Nov 2022 for approval	
Part 2 – Actions increase robustness of EPRR processes						
2	Governance	**EPRR Policy Statement** The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Routine review of EPRR policy	AW Jan 2023	Reviewed and currently under consultation	
3	Governance	**EPRR board reports** The Chief Executive Officer ensures	Development of annual report for 2022/23	AW July 2023		

NHSERef	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
		that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually.				
15	Duty to maintain plans	**Mass Casualty** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Update EPRR and Major Incident Policy to strengthened detail relating to the Core Standard		Updated EPRR and Major Incident Policy currently under consultation with aim to take to HSSC in November 2022 for approval	
17	Duty to Maintain Plans	**Lockdown** In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Develop and implement lockdown testing plan	AW / SP March 2023		
21	Command and Control	**Trained On-Call Staff** Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Develop information pack for Directors on Call	AW March 2023		
23	Training and Exercising	**EPRR Exercising and testing programme** In accordance with the minimum requirements, in line with current guidance, the organisation has an	Develop and implement proposal for table top EPRR exercise plan 2023	JC / AW Jan 2023		

NHSERef	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
		exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)				
26	Response	**Incident Co-Ordination Centre (ICC)** The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance.	Development of ICC SOP	AW Jan 2023	Currently out for consultation	
26	Response	**Incident Co-Ordination Centre (ICC)** The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance.	Quarterly check of ICC physical components including site, memory stick, major incident box etc	AW Jan 2023		
28	Response	**BCPs** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident	Take forward actions required following IA outcome	TBC	Actions to be added to workplan once final report received	
29	Response	**Decision Logging** To ensure decisions are recorded during business continuity, critical and major incidents	Pull together all C19 logs and email log to show decision making through Covid 19	AW March 2023	Part of Inquiry preparation	
29	Response	**Decision Logging** To ensure decisions are recorded during business continuity, critical and major incidents	Pull together Covid 19 recovery plans and outcomes	AW March 2023	Part of inquiry preparation	

NHSERef	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
51	Business continuity	**BC audit** The organisation has a process for internal audit, and outcomes are included in the report to the board.	Commission and undertaken internal audit for BCPs	AW June 2023		

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 11a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**30 November 2022**

Report Title:	**Use of Corporate Seal**					
Executive/ Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Horley, PA to Chair, Chief Executive Officer and Non-Executive Directors					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

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

Project reports only:	
If this report is project related please state whether this has been approved through the Transformation Steering Group	Not applicable

Purpose of the Report		
This report provides the Board of Directors with information of when the Trust 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 Issues

The EPUT Corporate Seal has been used on the following occasions since the last Board of Directors meeting:

- 24 October – Deed of Release of Covenants relating to land at Runwell Hospital (signed by Nigel Leonard, Executive Director of Major Projects & Programmes and Alex Green, Executive Chief Operating 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			

Supporting Reports/ Appendices /or further reading
None

Lead

Paul Scott
Chief Executive Officer

Board of Directors 30 November 2022